



KENTUCKY

Cabinet for Health and Family Services

**DEPARTMENT FOR MEDICAID SERVICES
(DMS)**

HOME AND COMMUNITY BASED SERVICES (HCBS)

FEDERAL FINAL RULES

ADVISORY COUNCIL FOR MEDICAL ASSISTANCE (MAC)

MARCH 26, 2015

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HCBS Federal Final Rules Overview

The Centers for Medicare & Medicaid Services (CMS) implemented new regulations for Medicaid's 1915(c) Home and Community-Based Services (HCBS) waivers on March 17, 2014. Key elements of the rule include:



PERSON-CENTERED SERVICE PLAN

Reflect the needs identified through an assessment, as well as the individual's strengths, preferences, identified goals, and desired outcomes

CONFLICT-FREE CASE MANAGEMENT



Providers of HCBS for the individual must not provide case management or develop the person-centered service plan, unless the provider is the only willing and qualified provider in the geographic area (30 miles).



PERSON-CENTERED PLANNING

Individual leads the process to the maximum extent possible and is provided information and support to make informed choices regarding his/her services, as well as providers

PROVIDER SETTINGS



The setting is integrated in and supports full access of individuals receiving HCBS to the greater community, giving the individual initiative and independence in making life choices

Intent of HCBS Federal Final Rules

The HCBS federal final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for HCBS. The intent of the rules are:

Outcome-Centered

“The rule creates a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting’s location, geography, or physical characteristics”

Quality

“To enhance the quality of HCBS and provide protections to participants”

Access

“To ensure that individuals receiving long-term services and supports through HCBS programs...have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate”

HCBS Federal Final Rules State Response

While some parts of the rule require immediate implementation, CMS allows states to implement the setting requirements over five years. Specific requirements around this transition include:

State Transition Requirements		
<ul style="list-style-type: none"> • Submit a waiver-specific transition plan at the time of the first waiver renewal or amendment to CMS 	<ul style="list-style-type: none"> • Submit a statewide transition plan for all waivers to CMS within 120 days of submitting the first waiver renewal or amendment 	<ul style="list-style-type: none"> • Be in full compliance with the HCBS final rules by the timeframe approved in the transition plan, and no later than Mar. 17, 2019

Kentucky Timeline

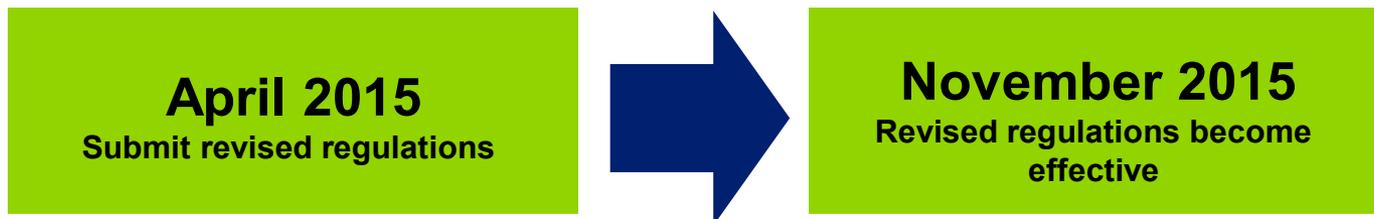


HCBS Federal Final Rules Summary

The non-setting requirements of the person-centered planning process are outlined below and focus on the individual leading and/or participating to the maximum extent as possible.

Summary of Person-Centered Planning Process Requirements¹:

- Individual leads the process
- Individual is provided necessary information to make informed choices about his/her services
- Is timely and convenient for the individual
- Reflects cultural considerations of the individual
- Includes a method for the individual to request updates to the plan as needed
- Records the alternative settings that were considered by the individual
- Includes strategies for solving conflict or disagreement within the process
- Providers of HCBS for the individual must not provide case management or develop the person-centered service plan (geographic exception allowed)



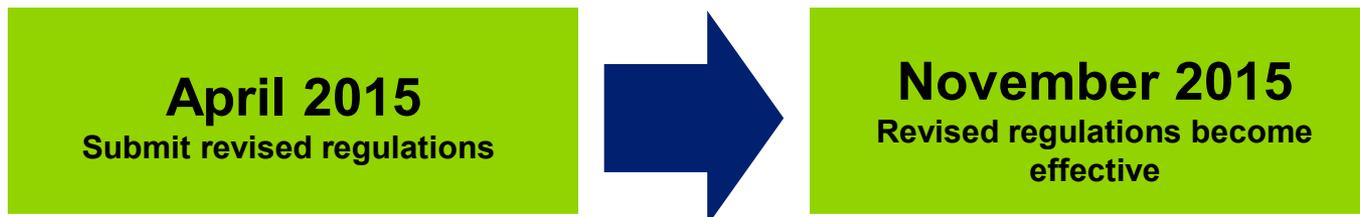
1. The complete HCBS federal final rule language is located in the appendix

HCBS Federal Final Rules Summary *(continued)*

The non-setting requirements of the person-centered service plan rules are outlined below and focus on individualized goals and needs.

Summary of Person-Centered Service Plan Requirements¹:

- Reflect the needs identified through a functional assessment
- Reflect the individual's strengths, preferences, identified goals, and desired outcomes
- Reflect the services and supports (paid and unpaid) that will meet the individual's needs
- Reflect that the residential setting is chosen by the individual
- Prevent the provision of unnecessary or inappropriate services and supports
- Reflect risk factors and measures to minimize them
- Identify the individual responsible for monitoring the plan
- Be understandable and distributed to the individual, and all people involved in the plan
- Be finalized, agreed to, and signed by all individuals and providers responsible for implementation



1. The complete HCBS federal final rule language is located in the appendix

HCBS Federal Final Rules Summary *(continued)*



The HCBS Federal Final Rules define settings that cannot be HCB and settings that are presumed not to be HCB. **This rule will be part of the second round changes, with an effective date of 2019 in Kentucky Regulations.**

Home and community-based settings do not include:

- A nursing facility
- An institution for mental diseases
- An intermediate care facility for individuals with intellectual disabilities

Settings presumed not to be HCB include:

- Any other locations that have qualities of an institutional setting
- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment
- Any setting in a building on the grounds of, or immediately adjacent to, a public institution
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS

If a setting is presumed not to be HCB, the State may present evidence that the setting does not have the qualities of an institution, and that the setting does have the qualities of HCB to CMS. The Secretary of Federal HHS may determine through heightened scrutiny that the setting does or does not have the qualities of an HCB setting.

HCBS Federal Final Rules Summary *(continued)*



The HCB setting requirements are outlined below and include rules for all waiver HCB settings and residential specific settings. Setting rules that will be implemented in the second round of changes are denoted below.

Summary of All Settings Requirements¹:

- Individual is integrated in and has full access to the greater community **(second round)**
- Individual selects both the setting (location) and provider
- Individual has rights of privacy, dignity and respect, and freedom from coercion and restraint
- Individual has autonomy, and independence in making life choices, where possible
- Individual is provided choice regarding services and supports, and who provides them

Summary of Provider-Owned Residential Setting Requirements¹:

- Individual has a legally enforceable agreement documenting the eviction and appeals process **(second round)**
- Individual has privacy in their living unit, including doors lockable by the individual, choice of roommates/housemates, and the freedom to furnish/decorate living unit
- Individual has freedom to control his/her own schedule and activities, including access to food **(second round)**
- Individual is able to have visitors of their choosing at any time
- The setting is physically accessible to the individual
- Any modification of the above rules, except physical accessibility, must be supported by a specific assessed need and justified in the POC plan

1. The complete HCBS federal final rule language is located in the appendix

Statewide Transition Plan

The statewide transition plan outlines how DMS will transition its policies, waiver applications, processes, and providers to compliance with the HCBS final rules.

Statewide transition plan components:

- **Assessment Process:** Describes how the workgroup evaluated state policies, procedures, and waiver applications against the HCBS final rules, including the current monitoring process
- **Provider Assessment:** Summarizes the provider surveys, outlines plans for ongoing assessments, and categorizes all providers by level of compliance
- **Remedial Strategies:** Includes the state-level remedial actions required for compliance and sample remedial actions providers may complete
- **Public Comment Process:** Explains how the public can provide input on the transition plan and the deadline to submit comments

DMS is waiting on approval from CMS for the submitted transition plan.

Assessments

The assessment process in the statewide transition plan explains DMS' methodology to assess state policies, processes, and providers.

1

Regulations, Waiver Applications, Manuals Incorporated by Reference

- Analyzed language related to HCBS final rules in state policies
- Determined level of compliance for each waiver

2

Monitoring Process

- Outlined current procedures for monitoring providers
- Identified areas of monitoring that will need to be updated to comply with HCBS final rules

3

Provider Assessment

- Created residential and non-residential surveys for provider self-assessment to obtain initial estimates of compliance
- Validated provider responses and categorized providers into four levels of compliance

Provider assessments related to HCBS final rules will continue as part of routine monitoring reviews conducted by state staff.

Provider Assessment Results

After DMS conducted surveys and quality assurance (QA) staff reviewed provider responses, DMS determined providers' level of compliance and categorized them into one of four categories, defined by CMS. Estimating the providers that fall into one of the four categories is a Federal requirement for the transition plan.

Federal Compliance Categories	Residential Total ¹	Non-Residential Total ¹
Category 1: Fully align with the federal requirements	1%	0%
Category 2: Do not comply with the federal requirements and will require modifications	40%	62%
Category 3: Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals	0%	0%
Category 4: Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)	Not Isolating:	
	31%	5%
	Potentially Isolating:	
	17%	18%
	Isolating:	
	11%	15%

1. These counts are initial estimates and subject to change after further assessments are completed.

Remedial Strategies

The state-level remedial strategies are actions DMS is planning to implement across all waivers to achieve compliance with the HCBS final rules. The provider-level remedial strategies are sample actions for providers to implement before the HCBS final rules become effective.

State-level Remedial Strategies

Policies	Operations	Participants	Technology
<ul style="list-style-type: none"> Add/revise regulation and waiver application language to comply with all HCBS final setting rules 	<ul style="list-style-type: none"> Conduct staff training Update internal processes Conduct stakeholder webinars 	<ul style="list-style-type: none"> Distribute HCBS final rule information to participants 	<ul style="list-style-type: none"> Modify forms and screens in the Medicaid Waiver Management Application

Implementation Dates

April 2015 – January 2019	January 2015 – January 2019	January – May 2015	January – December 2015
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Provider-level Remedial Strategies

Short-term	Long-term
<ul style="list-style-type: none"> Develop plan to bring settings into compliance with HCBS final rules Coordinate timelines of implementation with state policies 	<ul style="list-style-type: none"> Adjust settings and practices as needed to comply Implement processes to ensure that the participants are integrated into the community

Waiver staff representing various departments across the Cabinet for Health and Family Services (CHFS) comprise the HCBS rules workgroup that will be implementing the key activities outlined in the transition plan.

Key Workgroup Activities¹

Completed	Upcoming ²
<ul style="list-style-type: none">• Submitted statewide transition plan to CMS• Drafted HCBS rules language changes to include in revised regulations• Developed stakeholder engagement strategy to seek input from participants and providers• Confirmed presentation dates/times for participant and provider meetings• Attended various participant and provider meetings to provide an overview of the HCBS rules• Created compliance plan template for providers to complete	<ul style="list-style-type: none">• Continue to attend participant and provider meetings• Update monitoring tools for provider reviews that comply with HCBS final rules• Host informational webinars for providers and instruct how to complete the compliance plan• Submit waiver renewals to CMS• File amended regulations for each waiver• Review/follow up with providers on compliance plan templates

1. Not an exhaustive list of all activities

2. Upcoming activities in the next 3 months

Activities Timeline

This timeline provides an overview of key activities that will be completed as KY implements the HCBS federal final rules.

2015		
Provider Compliance	1/1/15	Ongoing
First Round Changes¹		
Develop HCBS evaluation tool (monitoring tool for determining compliance)	1/1/15	3/31/15
Develop compliance plan template for providers to complete and notify providers of initial compliance level	1/1/15	3/31/15
Host public forums for providers and participants (families, advocates, etc.)	1/1/15	3/31/15
Conduct routine evaluations and on-site assessments with the updated HCBS evaluation tool to validate each provider's compliance plan and level of compliance	3/1/15	10/31/15
Host webinars for providers and distribute compliance plan template	4/1/15	4/30/15
Review and approve/deny providers' plans	5/1/15	10/1/15
Deadline for providers to submit compliance plans for first round changes	9/15/15	9/15/15
Incorporate first round HCBS final rules in all ongoing reviews	11/1/15	Ongoing
Regulations & Waiver Amendments		
	1/1/15	1/1/19
Determine regulation language with workgroup for first round of changes	1/1/15	2/28/15
Draft revised regulations	3/1/15	4/1/15
Review regulations by department/leadership	4/1/15	4/14/15
Submit revised regulations	4/15/15	4/15/15
Regulation public comment period	4/15/15	6/1/15
Draft revised waiver amendments	1/1/15	2/15/15
Review waiver amendments by department/leadership	2/15/15	2/28/15
Waiver amendment public comment period	3/1/15	3/31/15
Submit HCB waiver amendments to CMS	4/1/15	4/1/15
Submit SCL waiver amendment to CMS	6/1/15	6/1/15
Submit MIIW waiver renewal to CMS	7/1/15	7/1/15
Submit MPW, ABI, ABI-LTC waiver amendments to CMS	8/1/15	8/1/15
Regulations become effective	11/1/15	11/1/15
Begin operational changes	1/1/15	Ongoing

HCBS Federal Final Rule Resources:

- **Federal Final Rules**

http://www.ecfr.gov/cgi-bin/text-idx?SID=016b7fc85a6068e0abc1c346bad17ebd&node=se42.4.441_1725&rgn=div8

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

DMS Resources:

- **Kentucky Statewide Transition Plan**

<http://chfs.ky.gov/nr/ronlyres/bbddaa60-d27c-46dd-b0c9-b4e882bb512d/0/kystatewidetransitionplan.pdf>

For questions or comments:

Email: CMSFinalHCBRule@ky.gov
Lynne.Flynn@ky.gov

You may also directly contact CHFS Waiver Staff.

Appendix: HCBS Federal Final Rules

<h2>HCBS Final Rule – Federal Language</h2>
<p>Person-Centered Planning Process Rules</p>
<p>The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative.</p>
<p>Includes people chosen by the individual.</p>
<p>Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.</p>
<p>Is timely and occurs at times and locations of convenience to the individual.</p>
<p>Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.</p>
<p>Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.</p>
<p>Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.</p>
<p>Offers informed choices to the individual regarding the services and supports they receive and from whom.</p>
<p>Includes a method for the individual to request updates to the plan as needed.</p>
<p>Records the alternative home and community-based settings that were considered by the individual</p>

Appendix: HCBS Federal Final Rules

HCBS Final Rule – Federal Language

Person-Centered Service Plan Rules

<p>The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports</p>
<p>Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.</p>
<p>Reflect the individual's strengths and preferences.</p>
<p>Reflect clinical and support needs as identified through an assessment of functional need.</p>
<p>Include individually identified goals and desired outcomes.</p>
<p>Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.</p>
<p>Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.</p>
<p>Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.</p>
<p>Identify the individual and/or entity responsible for monitoring the plan.</p>

Appendix: HCBS Federal Final Rules

HCBS Final Rule – Federal Language
Person-Centered Service Plan Rules (Continued)
Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
Be distributed to the individual and other people involved in the plan.
Include those services, the purpose or control of which the individual elects to self-direct.
Prevent the provision of unnecessary or inappropriate services and supports.
Home and Community Based Settings Rules
Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan
The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
Facilitates individual choice regarding services and supports, and who provides them.

Appendix: HCBS Federal Final Rules

HCBS Final Rule – Federal Language

Home and Community Based Settings Rules (Continued)

Home and community-based settings do not include the following:

- (i) A nursing facility;
- (ii) An institution for mental diseases;
- (iii) An intermediate care facility for individuals with intellectual disabilities;
- (iv) A hospital; or
- (v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

Provider-Owned or Controlled Residential Settings Rules

The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Each individual has privacy in their sleeping or living unit:

- Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
- Individuals sharing units have a choice of roommates in that setting.
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Appendix: HCBS Federal Final Rules

HCBS Final Rule – Federal Language

Provider-Owned or Controlled Residential Settings Rules (Continued)

Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

Individuals are able to have visitors of their choosing at any time.

The setting is physically accessible to the individual.

Any modification of the additional conditions, except the physically accessible rule must be supported by a specific assessed need and justified in the person-centered service plan.
 The following requirements must be documented in the person-centered service plan: identify a specific and individualized assessed need, document the positive interventions and supports used prior to any modifications to the person-centered service plan, document less intrusive methods of meeting the need that have been tried but did not work, include a clear description of the condition that is directly proportionate to the specific assessed need, include regular collection and review of data to measure the ongoing effectiveness of the modification, include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated, include the informed consent of the individual, include an assurance that interventions and supports will cause no harm to the individual.

CoventryCares of Kentucky

Presentation to the Advisory Council for
Medical Assistance (MAC)

March 26, 2015



History of CoventryCares of Kentucky

November 2011

Doors open for business

May 2013

Coventry purchased by Aetna

January 2014

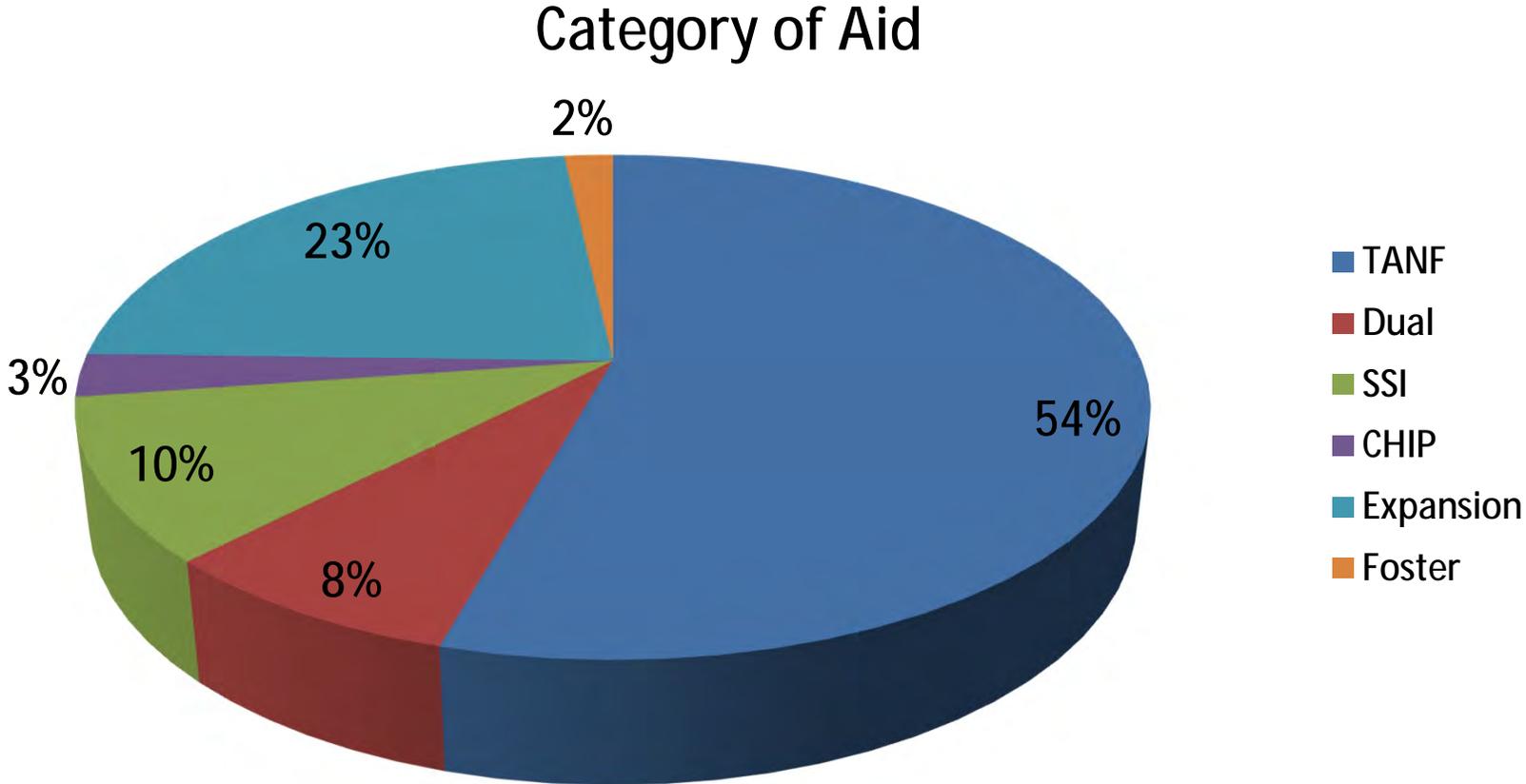
Participated in Medicaid Expansion

February 2015

Added Prior Authorization to Louisville office

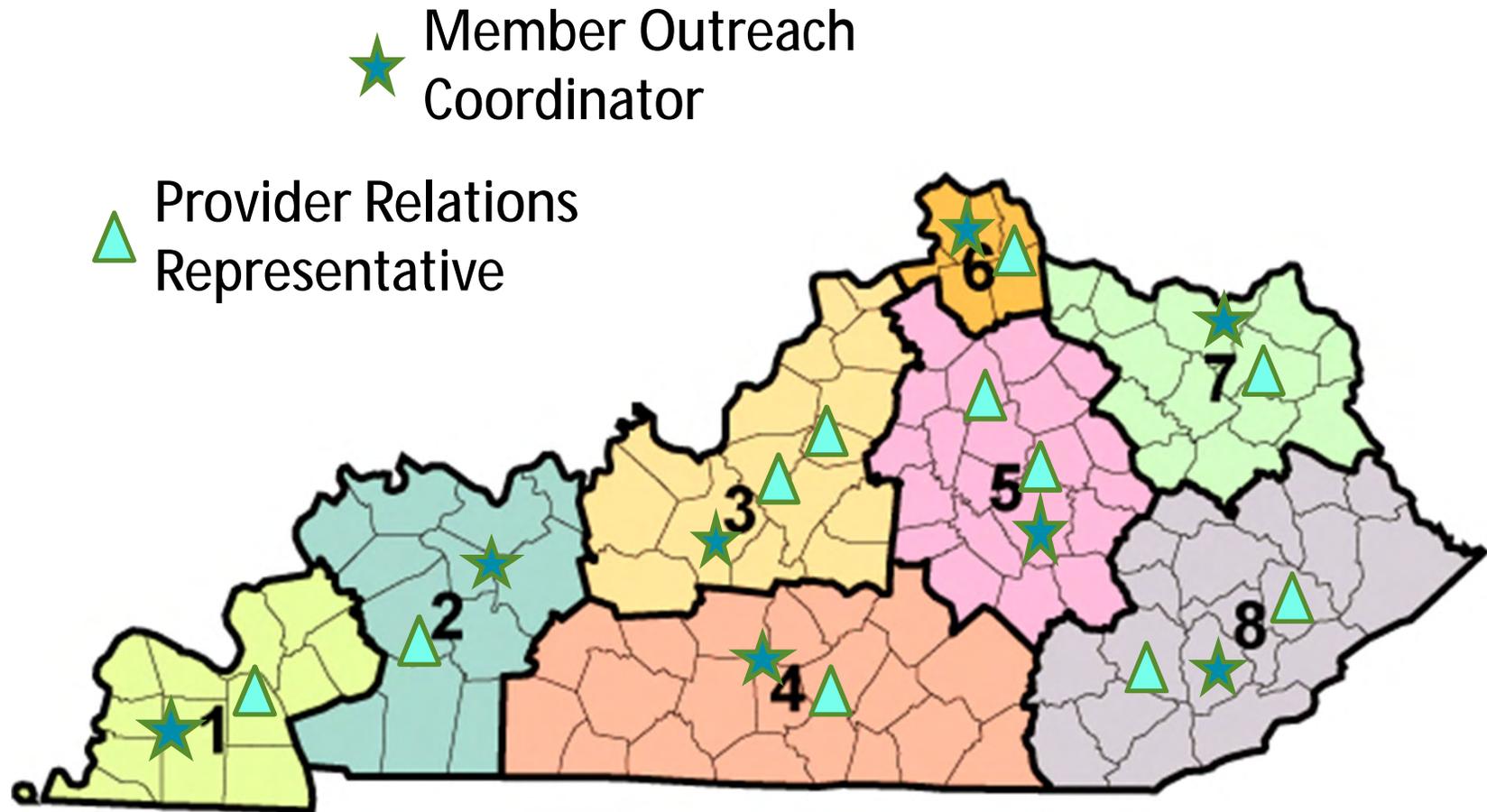
281 employees in Kentucky

Over 300,000 members



*306,085 members as of February 2015. Membership varies monthly.

Provider Relations and Member Outreach



Community Outreach

Diabetes Nutrition Classes

Chronic Disease Self-Management Program

Homeless Population Outreach

Education and support for Pregnant Women, New Moms and their children

Anti-Bullying curriculum

Involvement with Medicaid members, providers and advocates in all 120 counties

Provider Relations

Initiates credentialing of new providers

Schedules orientation for staff or practices new to
CoventryCares

Coordinates and facilitates education to providers

Assists providers with updates to their practice information

Quality

National Committee for Quality Assurance (NCQA)

Accreditation achieved August 2014

Score 49.6 out of 50

Value Based Purchasing

Implemented standards and incentives for large provider groups

Address key HEDIS® rates and Healthy Kentuckian measures



Quality Initiatives

Performance Improvement Projects

Antipsychotic Medication Utilization in Children

Attention Deficit Hyperactivity Disorder

Comprehensive Diabetes Care

Decreasing Readmission Rates

Emergency Department

Major Depression

Focus Study Activities

Dental Initiative

Case Management

Focus on many different needs within our membership with tailored programs

- Co-Morbid Condition Management

- Enhanced Case Management

- Emergency Room Utilization

- Foster Care and Guardianship

Case Management



Programs for specific diagnoses and at risk groups

Hepatitis C

Neonatal Abstinence Syndrome (NAS)

Neonatal Intensive Care (NICU)

High Risk Obstetrics (HROB)

Disease Management

Specialized programs designed to help our members manage their chronic conditions

Asthma

Chronic Kidney Disease (CKD)

Chronic Obstructive Pulmonary Disease (COPD)

Coronary Artery Disease (CAD)

Diabetes

Heart Failure

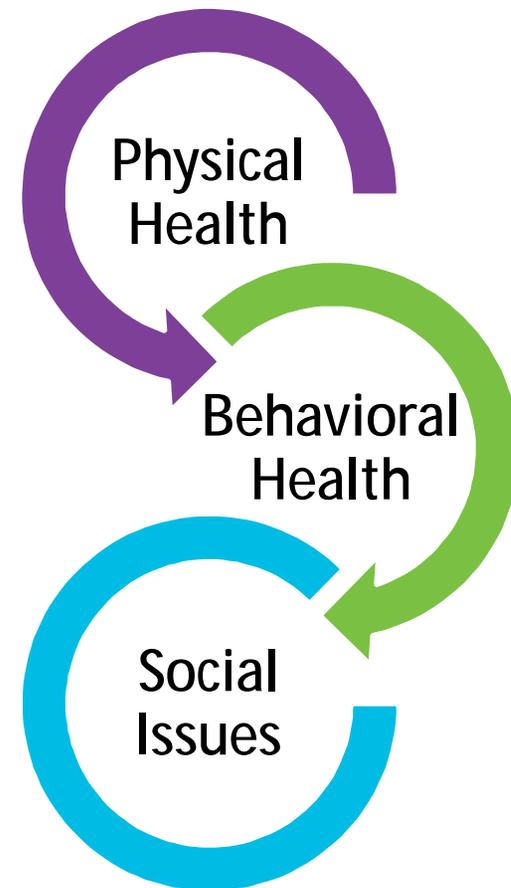
Physical, Behavioral and Social Integration

Fully integrated care encompassing physical health, behavioral health and social economic status of members

Strong provider partnerships and alliances with community based organizations

Interdisciplinary care teams that include the member and family

Leveraging technology to ensure care team has a view of the whole person



Improving the Health of Kentuckians

HEDIS Measures

Increased well child visits from 55.8% to 62.7%

Adolescent immunization rates raised from 78.7% to 86.1%

Hemoglobin A1c testing in diabetics up to 83.1%



CoventryCares

Improving the Health of Kentuckians

Reducing unplanned 30 day hospital readmissions

Program focused on the members with chronic illnesses at risk for readmission

Rate reduced from 11.0% to 4.9%

Enhancing follow-up after hospitalization

After inpatient admissions at a behavioral health facility

“Day of Discharge” planning encounter

75% of members keep an appointment within 30 days

The future for CoventryCares of Kentucky

2015

Expanding Louisville Office

Member Services and Member Outreach

Adding 40 new employees

Adding Face-to-Face Case

Management

Rebranding as Aetna Better Health of Kentucky





CoventryCares

MCO Facility Admissions and Denials - Jan-Nov 2014

	Anthem	Coventry	Humana	Passport	WellCare	TOTAL	
MCO MEMBERSHIP	Adults(Average)	34,961	144,508	53,008	107,175	204,191	543,842
	Children(Average)	4,558	163,674	16,046	100,451	187,593	470,364
	Total(Average)	39,519	308,182	69,054	207,626	391,785	1,014,206
Report 103-Facilities Report							
ADULTS							
Acute Psychiatric Adults	In-State Client Count	321	2,270	265	1,174	1,923	5,953
	Out-of-State Client Count	1	13	7	6	52	79
	Number of Admissions	356	2,418	79	512	806	4,171
	Average Length of Stay(days)					1	
	Readmissions	188	1,126	25	162	642	2,143
	Denials	35	161	26	348	23	593
PRTF Level I	In-State Client Count	-	-	1	20	-	21
	Out-of-State Client Count	-	-	-	2	-	2
	Number of Admissions	-	-	-	14	-	14
	Average Length of Stay(days)	-	-	-	78	-	
	Readmissions	-	-	-	1	-	1
	Denials	-	-	-	-	4	4
PRTF Level II	In-State Client Count	-	-	-	-	-	-
	Out-of-State Client Count	-	-	-	-	-	-
	Number of Admissions	-	-	-	-	-	-
	Average Length of Stay(days)	-	-	-	-	-	-
	Readmissions	-	-	-	-	-	-
	Denials	-	-	-	-	-	-
State Psychiatric Hospital	In-State Client Count	-	33	-	-	124	157
	Number of Admissions	-	34	-	-	60	94
	Average Length of Stay(days)	-		-	-	1	
	Readmissions	-	4	-	-	43	
	Denials	-	6	-	15	4	25
SA Residential	In-State Client Count	4	62	75	199	3	343
	Out-of-State Client Count	-	-	1	6	-	7
	Number of Admissions	4	187	8	56	3	258
	Average Length of Stay(days)	-				1	
	Readmissions	-	48	1	13	2	64
	Denials	7	31	1	206	16	261
CHILDREN/YOUTH							
Acute Psychiatric Children	In-State Client Count	3	1,476	44	734	454	2,711
	Out-of-State Client Count	-	4	-	6	13	23
	Number of Admissions	3	1,599	20	257	151	2,030
	Average Length of Stay(days)	-				1	
	Readmissions	1	822	4	42	79	948
	Denials	6	176	13	468	27	690
PRTF Level I	In-State Client Count	-	122	4	302	42	470
	Out-of-State Client Count	-	-	1	3	-	4
	Number of Admissions	-	244	3	254	2	503
	Average Length of Stay(days)	-				42	
	Readmissions	-	29	1	88	3	121
	Denials	1	33	1	24	9	68
PRTF Level II	In-State Client Count	-	-	-	-	-	-
	Out-of-State Client Count	-	-	-	-	-	-
	Number of Admissions	-	-	-	-	-	-
	Average Length of Stay(days)	-	-	-	-	-	-
	Readmissions	-	-	-	-	-	-
	Denials	-	-	-	-	-	-
SA Residential	In-State Client Count	2	229	14	327	4	576
	Out-of-State Client Count	-	-	2	16	3	21
	Number of Admissions	2	657	6	171	33	869
	Average Length of Stay(days)	-				4	
	Readmissions	-	206	2	57	2	267
	Denials	-					

Data is from processed claims and not actual census

MCO Facility Admissions and Denials - January 2014

		Anthem	Coventry	Humana	Passport	WellCare	TOTAL
MCO MEMBERSHIP	Adults	17,752	116,465	24,636	61,195	149,724	369,772
	Children		163,273	11,260	89,442	184,367	448,342
	Total	17,752	279,738	35,896	150,637	334,091	818,114
Report 103-Facilities Report							
ADULTS							
Acute Psychiatric Adults	In-State Client Count	3	138	4	31	1923	2099
	Out-of-State Client Count	0	1	0	0	52	53
	Number of Admissions	3	146	3	11	806	969
	Average Length of Stay(days)	2.33	29.36	5	4	1.21	
	Readmissions	0	48	3	0	642	693
	Denials	3	10	3	14	2	32
PRTF Level I	In-State Client Count	0	0	0	10	0	10
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	8	0	8
	Average Length of Stay	0	0	0	27	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay	0	0	0	0	0	0
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
State Psychiatric Hospital	In-State Client Count	0	6	0	0	124	130
	Number of Admissions	0	6	0	0	60	66
	Average Length of Stay	0	13.17	0	0	1.25	
	Readmissions	0	0	0	0	43	43
	Denials	0	0	0	0	0	0
SA Residential	In-State Client Count	0	0	0	1	3	4
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	3	3
	Average Length of Stay	0	0	0	0	1	1
	Readmissions	0	0	0	0	2	2
	Denials	0	1	0	0	0	1
CHILDREN/YOUTH							
Acute Psychiatric Children	In-State Client Count		109	8	28	454	599
	Out-of-State Client Count		0	0	2	13	15
	Number of Admissions		146	1	11	151	309
	Average Length of Stay		29.36	18	5	1.28	
	Readmissions		101	1	2	79	183
	Denials		17	3	25	1	46
PRTF Level I	In-State Client Count		5	0	4	42	51
	Out-of-State Client Count		0	0	0	0	0
	Number of Admissions		11	0	3	2	16
	Average Length of Stay		14.09	0	15	41.5	
	Readmissions		0	0	0	3	3
	Denials		2	0	1	0	3
PRTF Level II	In-State Client Count		0	0	0	0	0
	Out-of-State Client Count		0	0	0	0	0
	Number of Admissions		0	0	0	0	0
	Average Length of Stay		0	0	0	0	0
	Readmissions		0	0	0	0	0
	Denials		0	0	0	0	0
SA Residential	In-State Client Count		13	0	14	4	31
	Out-of-State Client Count		0	1	2	3	6
	Number of Admissions		23	0	12	1	36
	Average Length of Stay		6.74	0	22	4	
	Readmissions		7	0	5	2	14
	Denials		10	0	0	3	13

MCO Facility Admissions and Denials - February 2014

		Anthem	Coventry	Humana	Passport	WellCare	TOTAL
MCO MEMBERSHIP	Adults	21,976	119,659	32,486	73,798	174,855	422,774
	Children		172,881	12,112	93,309	191,562	469,864
	Total	21,976	292,540	44,598	167,107	366,417	892,638
Report 103-Facilities Report							
ADULTS							
Acute Psychiatric Adults	In-State Client Count	7	191	0	44	1540	1782
	Out-of-State Client Count	0	0	0	0	43	43
	Number of Admissions	7	201	1	39	0	248
	Average Length of Stay(days)	3	27.39	8	5	0	
	Readmissions	0	79	0	4	0	83
	Denials	5	13	0	22	0	40
PRTF Level I	In-State Client Count	0	0	1	2	0	3
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	2	0	2
	Average Length of Stay(days)	0	0	0	14	0	
	Readmissions	0	0	0	1	0	1
	Denials	0	0	0	0	0	0
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay(days)	0	0	0	0	0	0
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
State Psychiatric Hospital	In-State Client Count	0	3	0	0	108	111
	Number of Admissions	0	3	0	0	0	3
	Average Length of Stay(days)	0	21.33	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
SA Residential	In-State Client Count	0	2	0	1	1	4
	Out-of-State Client Count	0	0	0	2	0	2
	Number of Admissions	0	3	0	1	0	4
	Average Length of Stay(days)	0	5.67	0	14	0	
	Readmissions	0	3	0	0	0	3
	Denials	0	1	0	3	0	4
CHILDREN/YOUTH							
Acute Psychiatric Children	In-State Client Count		128	1	44	454	627
	Out-of-State Client Count		0	0	0	13	13
	Number of Admissions		146	2	12	151	311
	Average Length of Stay(days)		6.13	4	5	1.28	
	Readmissions		54	2	1	79	136
	Denials		10	1	27	0	38
PRTF Level I	In-State Client Count		0	0	12	42	54
	Out-of-State Client Count		0	0	0	0	0
	Number of Admissions		0	0	15	2	17
	Average Length of Stay(days)		0	0	22	41.5	
	Readmissions		0	0	4	3	7
	Denials		2	0	0	0	2
PRTF Level II	In-State Client Count		0	0	0	0	0
	Out-of-State Client Count		0	0	0	0	0
	Number of Admissions		0	0	0	0	0
	Average Length of Stay(days)		0	0	0	0	0
	Readmissions		0	0	0	0	0
	Denials		0	0	0	0	0
SA Residential	In-State Client Count		19	0	16	4	39
	Out-of-State Client Count		0	0	2	3	5
	Number of Admissions		61	0	10	0	71
	Average Length of Stay(days)		5.59	0	20	4	
	Readmissions		32	0	2	2	36
	Denials		11	0	0	2	13

MCO Facility Admissions and Denials - March 2014

		Anthem	Coventry	Humana	Passport	WellCare	TOTAL
MCO MEMBERSHIP	Adults	28,201	130,093	38,799	83,143	190,526	470,762
	Children		176,793	12,626	94,414	194,833	478,666
	Total	28,201	306,886	51,425	177,557	385,359	949,428
Report 103-Facilities Report							
ADULTS							
Acute Psychiatric Adults	In-State Client Count	28	248	33	27	1651	1987
	Out-of-State Client Count	0	1	0	3	50	54
	Number of Admissions	28	263	2	8	1098	1399
	Average Length of Stay(days)	3.46	27.79	4	3	1.14	
	Readmissions	0	113	0	0	769	882
	Denials	3	13	0	22	2	40
PRTF Level I	In-State Client Count	0	0	0	1	0	1
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	1	0	1
	Average Length of Stay(days)	0	0	0	21	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay(days)	0	0	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
State Psychiatric Hospital	In-State Client Count	0	3	0	0	100	103
	Number of Admissions	0	3	0	0	63	66
	Average Length of Stay(days)	0	18	0	0	1.14	
	Readmissions	0	4	0	0	42	46
	Denials	0	0	0	0	0	0
SA Residential	In-State Client Count	0	8	0	7	2	17
	Out-of-State Client Count	0	0	0	1	0	1
	Number of Admissions	0	42	0	2	1	45
	Average Length of Stay(days)	0	13.14	0	18	1	
	Readmissions	0	0	0	1	1	2
	Denials	0	0	0	10	0	10
CHILDREN/YOUTH							
Acute Psychiatric Children	In-State Client Count		151	8	26	304	489
	Out-of-State Client Count		1	0	0	13	14
	Number of Admissions		230	2	18	206	456
	Average Length of Stay(days)		5.8	6	6	1.25	
	Readmissions		64	0	2	102	168
	Denials		18	0	40	1	59
PRTF Level I	In-State Client Count		6	3	16	1	26
	Out-of-State Client Count		0	0	0	0	0
	Number of Admissions		13	2	12	1	28
	Average Length of Stay(days)		9.08	14	20	1	
	Readmissions		0	0	1	0	1
	Denials		3	1	1	3	8
PRTF Level II	In-State Client Count		0	0	0	0	0
	Out-of-State Client Count		0	0	0	0	0
	Number of Admissions		0	0	0	0	0
	Average Length of Stay(days)		0	0	0	0	
	Readmissions		0	0	0	0	0
	Denials		0	0	0	0	0
SA Residential	In-State Client Count		22	4	21	2	49
	Out-of-State Client Count		0	0	3	2	5
	Number of Admissions		140	1	9	2	152
	Average Length of Stay(days)		3.44	26	22	1.5	
	Readmissions		19	1	7	2	29
	Denials		10	0	0	2	12

MCO Facility Admissions and Denials - April 2014

		Anthem	Coventry	Humana	Passport	WellCare	TOTAL
MCO MEMBERSHIP	Adults	31,506	146,974	46,584	95,134	196,492	516,690
	Children		173,621	13,136	95,629	195,247	477,633
	Total	31,506	320,595	59,720	190,763	391,739	994,323
Report 103-Facilities Report							
ADULTS							
Acute Psychiatric Adults	In-State Client Count	9	245	34	56	2019	2363
	Out-of-State Client Count	0	1	0	0	67	68
	Number of Admissions	9	266	11	22	1236	1544
	Average Length of Stay(days)	4.44	4.32	4	4	1.17	
	Readmissions	0	156	1	11	840	1008
	Denials	1	13		31	2	47
PRTF Level I	In-State Client Count	0	0	0	2	0	2
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay	0	0	0	0	0	0
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay	0	0	0	0	0	0
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
State Psychiatric Hospital	In-State Client Count	0	0	0	0	129	129
	Number of Admissions	0	0	0	0	74	74
	Average Length of Stay	0	0	0	0	1.22	
	Readmissions	0	0	0	0	53	53
	Denials	0	0	0	0	0	0
SA Residential	In-State Client Count	0	6	0	6	1	13
	Out-of-State Client Count	0	0	0	1	0	1
	Number of Admissions	0	6	0	5	1	12
	Average Length of Stay(days)	0	31	0	19	1	
	Readmissions	0	0	0	0	1	1
	Denials	0	0	0	13	0	13
CHILDREN/YOUTH							
Acute Psychiatric Children	In-State Client Count		186	7	29	404	626
	Out-of-State Client Count		1	0	1	25	27
	Number of Admissions			3	15	258	276
	Average Length of Stay(days)		4.45	12	4	1.26	
	Readmissions		65	0	0	132	197
	Denials		20	2	47	2	71
PRTF Level I	In-State Client Count		10	0	12	1	23
	Out-of-State Client Count		0	0	0	0	0
	Number of Admissions		20	0	10	1	31
	Average Length of Stay(days)		11.45	0	15	1	
	Readmissions		3	0	2	1	6
	Denials		4	0	2	2	8
PRTF Level II	In-State Client Count		0	0	0	0	0
	Out-of-State Client Count		0	0	0	0	0
	Number of Admissions		0	0	0	0	0
	Average Length of Stay(days)		0	0	0	0	0
	Readmissions		0	0	0	0	0
	Denials		0	0	0	0	0
SA Residential	In-State Client Count		20	1	17	5	43
	Out-of-State Client Count		0	0	3	1	4
	Number of Admissions		47	1	11	5	64
	Average Length of Stay(days)		8.09	14	13	1	
	Readmissions		19	1	1	1	22
	Denials		3	0	0	3	6

MCO Facility Admissions and Denials - May 2014

		Anthem	Coventry	Humana	Passport	WellCare	TOTAL
MCO MEMBERSHIP	Adults	34,605	150,054	51,223	101,885	204,484	542,251
	Children	1,244	166,343	13,502	92,288	189,317	462,694
	Total	35,849	316,397	64,725	194,173	393,801	1,004,945
Report 103-Facilities Report							
ADULTS							
Acute Psychiatric Adults	In-State Client Count	9	203	38	25	2570	2845
	Out-of-State Client Count	0	0	0	0	80	80
	Number of Admissions	9	213	1	10	1535	1768
	Average Length of Stay(days)	6.22	4.55	7	6	1.17	
	Readmissions	0	105	0	1	975	1081
	Denials	1	16	1	31	0	49
PRTF Level I	In-State Client Count	0	0	0	2	0	2
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay(days)	0	0	0	0	0	0
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay(days)	0	0	0	0	0	0
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
State Psychiatric Hospital	In-State Client Count	0	2	0	0	183	185
	Number of Admissions	0	2	0	0	108	110
	Average Length of Stay(days)	0	14	0	0	1.18	
	Readmissions	0	0	0	0	74	74
	Denials	0	0	0	1	1	2
SA Residential	In-State Client Count	0	3	0	7	2	12
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	3	0	1	1	5
	Average Length of Stay(days)	0	8.33	0	2	3	
	Readmissions	0	3	0	0	1	4
	Denials	0	0	0	7	1	8
CHILDREN/YOUTH							
Acute Psychiatric Children	In-State Client Count		152	2	34	466	654
	Out-of-State Client Count		0	0	0	26	26
	Number of Admissions		182	0	15	268	465
	Average Length of Stay(days)		5.37	0	5	1.32	
	Readmissions		111	0	1	151	263
	Denials		22	0	55	0	77
PRTF Level I	In-State Client Count		21	1	11	0	33
	Out-of-State Client Count		0	0	0	0	0
	Number of Admissions		38	0	8	0	46
	Average Length of Stay(days)		13.24	0	22	0	
	Readmissions		3	0	2	0	5
	Denials		3	0	6	1	10
PRTF Level II	In-State Client Count		0	0	0	0	0
	Out-of-State Client Count		0	0	0	0	0
	Number of Admissions		0	0	0	0	0
	Average Length of Stay(days)		0	0	0	0	0
	Readmissions		0	0	0	0	0
	Denials		0	0	0	0	0
SA Residential	In-State Client Count		23	3	16	3	45
	Out-of-State Client Count		0	1	0	1	2
	Number of Admissions		94	2	10	0	106
	Average Length of Stay(days)		5.01	21	15	0	
	Readmissions		20	0	2	0	22
	Denials		6	0	1	4	11

MCO Facility Admissions and Denials - June 2014

		Anthem	Coventry	Humana	Passport	WellCare	TOTAL
MCO MEMBERSHIP	Adults	35,821	146,848	55,032	106,352	209,112	553,165
	Children	1,065	169,339	15,192	90,656	184,417	460,669
	Total	36,886	316,187	70,224	197,008	393,529	1,013,834
Report 103-Facilities Report							
ADULTS							
Acute Psychiatric Adults	In-State Client Count	31	232	42	74	1919	2298
	Out-of-State Client Count	0	0	0	0	65	65
	Number of Admissions	31	248	12	57	1645	1993
	Average Length of Stay(days)	5	4.5	4	4	1.1	
	Readmissions	19	126	2	11	1010	1168
	Denials	2	11	7	30	0	50
PRTF Level I	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	1	0	1
	Average Length of Stay	0	0	0	9	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	3	3
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay	0	0	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
State Psychiatric Hospital	In-State Client Count	0	3	0	0	119	122
	Number of Admissions	0	3	0	0	96	99
	Average Length of Stay	0	8.67	0	0	1.14	
	Readmissions	0	0	0	0	62	62
	Denials	0	1	0	2	1	4
SA Residential	In-State Client Count	1	9	2	10	1	23
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	1	20	2	7	0	30
	Average Length of Stay	0	6.7	9	7	0	
	Readmissions	0	8	0	0	0	8
	Denials	0	2	1	26	3	32
CHILDREN/YOUTH							
Acute Psychiatric Children	In-State Client Count	0	123	5	102	284	514
	Out-of-State Client Count	0	0	0	0	15	15
	Number of Admissions	0	141	1	8	224	374
	Average Length of Stay(days)	0	5.15	11	5	1.19	
	Readmissions	0	107	0	1	123	231
	Denials	0	17	1	41	0	59
PRTF Level I	In-State Client Count	0	12	0	6	1	19
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	23	0	7	1	31
	Average Length of Stay(days)	0	11.91	0	21	1	
	Readmissions	0	0	0	5	0	5
	Denials	0	5	0	2	0	7
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay(days)	0	0	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
SA Residential	In-State Client Count	0	23	2	9	7	41
	Out-of-State Client Count	0	0	0	2	0	2
	Number of Admissions	0	60	1	11	5	77
	Average Length of Stay(days)	0	5.87	5	13	2	
	Readmissions	0	19	0	4	3	26
	Denials	0	3	0	1	2	6

MCO Facility Admissions and Denials - July 2014

		Anthem	Coventry	Humana	Passport	WellCare	TOTAL
MCO MEMBERSHIP	Adults	38,078	152,383	60,567	113,720	216,270	581,018
	Children	2,084	155,394	15,998	91,790	183,376	448,642
	Total	40,162	307,777	76,565	205,510	399,646	1,029,660
Report 103-Facilities Report							
ADULTS							
Acute Psychiatric Adults	In-State Client Count	20	226	10	253	1632	2141
	Out-of-State Client Count	0	3	0	0	53	56
	Number of Admissions	20	240	9	50	1681	2000
	Average Length of Stay(days)	3	4.84	6	4	1.06	
	Readmissions	6	118	6	10	1043	1183
	Denials	5	29	2	39	3	78
PRTF Level I	In-State Client Count	0	0	0	1	0	1
	Out-of-State Client Count	0	0	0	1	0	1
	Number of Admissions	0	0	0	2	0	2
	Average Length of Stay(days)	0	0	0	7	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay(days)	0	0	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
State Psychiatric Hospital	In-State Client Count	0	2	0	0	96	98
	Number of Admissions	0	2	0	0	92	94
	Average Length of Stay(days)	0	10.5	0	0	1.12	
	Readmissions	0	0	0	0	56	56
	Denials	0	2	0	7	1	10
SA Residential	In-State Client Count	0	3	0	6	1	10
	Out-of-State Client Count	0	0	1	0	0	1
	Number of Admissions	0	3	0	7	1	11
	Average Length of Stay(days)	0	8.67	0	12	1	
	Readmissions	0	0	0	2	0	2
	Denials	0	3	0	53	3	59
CHILDREN/YOUTH							
Acute Psychiatric Children	In-State Client Count	0	80	1	93	186	360
	Out-of-State Client Count	0	0	0	0	13	13
	Number of Admissions	0	99	2	7	199	307
	Average Length of Stay(days)	0	5.69	8	6	1.15	
	Readmissions	0	56	1	0	85	142
	Denials	0	12	1	28	3	44
PRTF Level I	In-State Client Count	0	9	0	10	1	20
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	15	0	12	1	28
	Average Length of Stay(days)	0	13	0	17	3	
	Readmissions	0	2	0	1	0	3
	Denials	0	2	0	1	1	4
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay(days)	0	0	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
SA Residential	In-State Client Count	0	21	0	17	8	46
	Out-of-State Client Count	0	0	0	2	0	2
	Number of Admissions	0	55	0	7	8	70
	Average Length of Stay	0	7.4	0	19	1.13	
	Readmissions	0	19	0	0	3	22
	Denials	0	2	0	1	0	3

MCO Facility Admissions and Denials - August 2014

		Anthem	Coventry	Humana	Passport	WellCare	TOTAL
MCO MEMBERSHIP	Adults	41,068	154,291	62,688	116,298	220,119	594,464
	Children	4,183	156,733	16,735	92,863	183,690	454,204
	Total	45,251	311,024	79,423	209,161	403,809	1,048,668
Report 103-Facilities Report							
ADULTS							
Acute Psychiatric Adults	In-State Client Count	28	203	0	137	5081	5449
	Out-of-State Client Count	0	2	0	0	174	176
	Number of Admissions	62	218	9	52	1553	1894
	Average Length of Stay(days)	4	4.86	3	4	7.52	
	Readmissions	47	110	5	10	1235	1407
	Denials	7	11	3	44	0	65
PRTF Level I	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay(days)	0	0	0	0	0	0
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	1	1
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay(days)	0	0	0	0	0	0
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
State Psychiatric Hospital	In-State Client Count	0	5	0	0	0	5
	Number of Admissions	0	5	0	0	0	5
	Average Length of Stay(days)	0	21	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	1	0	0	1	2
SA Residential	In-State Client Count	1	9	0	9	2	21
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	1	39	1	9	1	51
	Average Length of Stay(days)	0	2.1	9	12	11	
	Readmissions	0	12	0	2	0	14
	Denials	2	8	0	15	0	25
CHILDREN/YOUTH							
Acute Psychiatric Children	In-State Client Count	0	111	0	26	579	716
	Out-of-State Client Count	0	0	0	0	36	36
	Number of Admissions	0	134	0	9	143	286
	Average Length of Stay(days)	0	4.99	0	8	10	
	Readmissions	0	37	0	1	91	129
	Denials	0	11	0	25	0	36
PRTF Level I	In-State Client Count	0	13	0	14	1	28
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	25	0	11	0	36
	Average Length of Stay(days)	0	17.68	0	13	0	
	Readmissions	0	8	0	2	0	10
	Denials	0	2	0	4	2	8
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay(days)	0	0	0	0	0	0
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
SA Residential	In-State Client Count	0	41	0	14	13	68
	Out-of-State Client Count	0	0	0	1	0	1
	Number of Admissions	0	65	0	7	0	72
	Average Length of Stay(days)	0	9.58	0	15	0	
	Readmissions	0	21	0	0	0	21
	Denials	0	6	0	0	2	8

MCO Facility Admissions and Denials - September 2014

		Anthem	Coventry	Humana	Passport	WellCare	TOTAL
MCO MEMBERSHIP	Adults	43,695	155,844	67,872	136,022	225,453	628,886
	Children	5,826	156,473	20,375	114,127	185,574	482,375
	Total	49,521	312,317	88,247	250,149	411,027	1,111,261
Report 103-Facilities Report							
ADULTS							
Acute Psychiatric Adults	In-State Client Count	62	216	30	77	2,933	3318
	Out-of-State Client Count	0	2	3	1	124	130
	Number of Admissions	62	227	12	52	1,750	2103
	Average Length of Stay(days)	4	4.66	4	4	6.57	
	Readmissions	47	94	2	17	1,523	1683
	Denials	3	12	1	39	-	55
PRTF Level I	In-State Client Count	0	0	0	0	-	0
	Out-of-State Client Count	0	0	0	0	-	0
	Number of Admissions	0	0	0	0	-	0
	Average Length of Stay(days)	0	0	0	0	-	
	Readmissions	0	0	0	0	-	0
	Denials	0	0	0	0	-	0
PRTF Level II	In-State Client Count	0	0	0	0	-	0
	Out-of-State Client Count	0	0	0	0	-	0
	Number of Admissions	0	0	0	0	-	0
	Average Length of Stay(days)	0	0	0	0	-	
	Readmissions	0	0	0	0	-	0
	Denials	0	0	0	0	-	0
State Psychiatric Hospital	In-State Client Count	0	1	0	0	-	1
	Number of Admissions	0	2	0	0	-	2
	Average Length of Stay(days)	0	19	0	0	-	
	Readmissions	0	0	0	0	-	0
	Denials	0	0	0	0	-	0
SA Residential	In-State Client Count	1	8	34	5	2	50
	Out-of-State Client Count	0	0	0	0	-	0
	Number of Admissions	1	33	2	4	1	41
	Average Length of Stay(days)	0	1.88	2	16	29	
	Readmissions	0	12	1	3	-	16
	Denials	1	6	0	25	5	37
CHILDREN/YOUTH							
Acute Psychiatric Children	In-State Client Count	0	144	2	31	289	466
	Out-of-State Client Count	0	1	0	0	11	12
	Number of Admissions	0	173	5	15	171	364
	Average Length of Stay(days)	0	5.27	5	6	8.4	
	Readmissions	0	52	0	1	75	128
	Denials	1	11	2	53	6	73
PRTF Level I	In-State Client Count	0	16	0	16	0	32
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	38	0	15	0	53
	Average Length of Stay(days)	0	12.03	0	12	0	
	Readmissions	0	3	0	8	0	11
	Denials	1	5	0	1	0	7
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay(days)	0	0	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
SA Residential	In-State Client Count	0	15	0	14	9	38
	Out-of-State Client Count	0	0	0	0	1	1
	Number of Admissions	0	30	1	6	8	45
	Average Length of Stay(days)	0	9.37	2	22	10.75	
	Readmissions	0	21	0	2	5	28
	Denials	0	3	0	0	1	4

MCO Facility Admissions and Denials - October 2014

		Anthem	Coventry	Humana	Passport	WellCare	TOTAL
MCO MEMBERSHIP	Adults	44,990	157,726	69,195	142,274	228,829	643,014
	Children	6,741	155,468	21,547	123,511	184,653	491,920
	Total	51,731	313,194	90,742	265,785	413,482	1,134,934
Report 103-Facilities Report							
ADULTS							
Acute Psychiatric Adults	In-State Client Count	64	183	45	213	2567	3072
	Out-of-State Client Count	0	2	2	0	92	96
	Number of Admissions	64	194	19	134	1800	2211
	Average Length of Stay(days)	4	4.24	5	5	6.54	
	Readmissions	37	73	6	71	1276	1463
	Denials	3	21	9	28	8	69
PRTF Level I	In-State Client Count	0	0	0	1	0	1
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay	0	0	0	0	0	0
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay	0	0	0	0	0	0
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
State Psychiatric Hospital	In-State Client Count	0	3	0	0	0	3
	Number of Admissions	0	3	0	0	0	3
	Average Length of Stay	0	9	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	1	0	2	0	3
SA Residential	In-State Client Count	1	5	14	16	1	37
	Out-of-State Client Count	0	0	0	1	0	1
	Number of Admissions	1	22	1	6	1	31
	Average Length of Stay	0	2.05	11	10	31	
	Readmissions	0	10	0	2	0	12
	Denials	2	7	0	23	4	36
CHILDREN/YOUTH							
Acute Psychiatric Children	In-State Client Count	1	176	4	140	316	637
	Out-of-State Client Count	0	1	0	2	15	18
	Number of Admissions	1	217	2	96	236	552
	Average Length of Stay(days)	2	5.04	6	7	7.79	
	Readmissions	0	100	0	25	104	229
	Denials	5	21	2	57	11	96
PRTF Level I	In-State Client Count	0	16	0	96	0	112
	Out-of-State Client Count	0	0	0	2	0	2
	Number of Admissions	0	31	0	94	0	125
	Average Length of Stay	0	13.39	0	21	0	
	Readmissions	0	3	0	58	0	61
	Denials	0	2	0	2	0	4
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay	0	0	0	0	0	0
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
SA Residential	In-State Client Count	2	16	2	88	9	117
	Out-of-State Client Count	0	0	0	1	1	2
	Number of Admissions	2	38	0	49	4	93
	Average Length of Stay	0	6.89	0	18	27	
	Readmissions	0	14	0	25	4	43
	Denials	0	6	0	0	2	8

MCO Facility Admissions and Denials - November 2014

		Anthem	Coventry	Humana	Passport	WellCare	TOTAL
MCO MEMBERSHIP	Adults	46,874	159,246	74,007	149,100	230,239	659,466
	Children	7,450	154,101	24,019	126,936	186,491	498,997
	Total	54,324	313,347	98,026	276,036	416,730	1,158,463
Report 103-Facilities Report							
ADULTS							
Acute Psychiatric Adults	In-State Client Count	60	185	29	237	3375	3886
	Out-of-State Client Count	1	1	2	2	127	133
	Number of Admissions	61	202	0	77	1659	1999
	Average Length of Stay(days)	3	4.92	0	5	6.52	
	Readmissions	32	104	0	27	1216	1379
	Denials	2	12	0	48	6	68
PRTF Level I	In-State Client Count	0	0	0	1	0	1
	Out-of-State Client Count	0	0	0	1	0	1
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay	0	0	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay	0	0	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
State Psychiatric Hospital	In-State Client Count	0	5	0	0	0	5
	Number of Admissions	0	5	0	0	0	5
	Average Length of Stay	0	21.6	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	1	0	3	0	4
SA Residential	In-State Client Count	0	9	25	131	1	166
	Out-of-State Client Count	0	0	0	1	0	1
	Number of Admissions	0	16	2	14	0	32
	Average Length of Stay	0	0.88	6	5	0	
	Readmissions	0	0	0	3	0	3
	Denials	2	3	0	31	0	36
CHILDREN/YOUTH							
Acute Psychiatric Children	In-State Client Count	2	116	6	181	442	747
	Out-of-State Client Count	0	0	0	1	24	25
	Number of Admissions	2	131	2	51	210	396
	Average Length of Stay(days)	3	4.84	6	3	10.11	
	Readmissions	1	75	0	8	110	194
	Denials	0	17	1	70	3	91
PRTF Level I	In-State Client Count	0	14	0	105	0	119
	Out-of-State Client Count	0	0	1	1	0	2
	Number of Admissions	0	30	1	67	0	98
	Average Length of Stay	0	9.03	19	16	0	
	Readmissions	0	7	1	5	0	13
	Denials	0	3	0	4	0	7
PRTF Level II	In-State Client Count	0	0	0	0	0	0
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	0	0	0	0	0
	Average Length of Stay	0	0	0	0	0	
	Readmissions	0	0	0	0	0	0
	Denials	0	0	0	0	0	0
SA Residential	In-State Client Count	0	16	2	101	1	120
	Out-of-State Client Count	0	0	0	0	0	0
	Number of Admissions	0	44	0	39	0	83
	Average Length of Stay	0	6.75	0	10	0	
	Readmissions	0	15	0	9	0	24
	Denials	0	5	0	0	3	8



February 18, 2015

VIA CERTIFIED MAIL

Lisa Lee, Commissioner
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

RE: Submission of Encounter Data

Dear Commissioner Lee:

As you are aware, Kentucky Spirit Health Plan, Inc.'s ("Kentucky Spirit") MCO contract to provide services in the Commonwealth has terminated. Since the termination, Kentucky Spirit has diligently paid any outstanding claims and timely submitted encounter data. Kentucky Spirit believes it has met the encounter criteria and requirements of the now terminated MCO Contract.

Consequently, this letter provides courtesy notice that, because all known claims have been processed and encounters submitted to the Department of Medicaid Services, Kentucky Spirit will not be submitting any more encounter reports to the Department of Medicaid Services.

If you have any questions about this letter, please do not hesitate to contact me.

Sincerely,

Mark Sanders, President
Kentucky Spirit Health Plan, Inc.

cc Finance and Administration Cabinet
Office of Procurement Services
Attn: Executive Director
Room 96 Capitol Annex
Frankfort, Kentucky 40601



John Hickenlooper
Governor of Colorado
Chair

Greg Hildner
Governor of Utah
Vice Chair

Dan Clippen
Executive Director

February 18, 2015

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
Washington, DC 20510

The Honorable Fred Upton
Chairman
House Committee on Energy and Commerce
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member
House Committee on Energy and Commerce
Washington, DC 20515

Dear Chairman Hatch, Senator Wyden, Chairman Upton and Representative Pallone:

On behalf of the nation's governors, we urge you to act quickly to continue federal support and provide stability for the Children's Health Insurance Program (CHIP) until children and pregnant women covered by the program have access to affordable alternative coverage options.

CHIP is widely supported by governors, who recognize that access to health insurance is critical to ensuring a healthy start for our nation's children. According to an analysis from the Kaiser Family Foundation, the program has contributed to a 50 percent decline in the uninsured rate for children—from 14 percent in 1997 to 7 percent in 2012. Governors have consistently voiced their support for CHIP through the National Governors Association and, more recently, in nearly 40 responses to your committees' request for input on the future of the program.

Without congressional action, federal support for CHIP will expire September 31, 2015, creating uncertainty for states and millions of working families. More than two million children could lose access to the services they need to thrive and lead healthy, productive lives. Although governors have offered a range of perspectives on long-term funding for CHIP, certainty of funding in the near-term is needed so that states may appropriately budget and plan for their upcoming fiscal years.

The future of CHIP is a critical issue—one that should be addressed early in the 114th Congress. Governors urge you to protect children's coverage and give states certainty by moving quickly to maintain support for this important program.

Sincerely,

Governor Steve Beshear
Chair
Health and Human Services Committee

Governor Bill Haslam
Vice Chair
Health and Human Services Committee



QUARTERLY TREND ADVISORY

February 2015
Volume 2, Issue 1

Why are Some Generic Drugs Skyrocketing in Price?

This was the title of a November 2014 Senate subcommittee hearing where pharmacists and physicians testified about the impact of soaring generic drug prices. On the whole, generic drugs save the U.S. health system a tremendous amount of money. Generics account for more than 85 percent of all the prescriptions filled in the U.S. and have saved the health care system \$1.5 trillion in the past decade. Recently, however, there has been a trend in escalating prices for generic medications. From July 2013 to July 2014, approximately half of all generic drugs decreased in cost (median decline -6.8 percent) while the other half of all generic drugs increased in cost (median increase of +11.8 percent). While the overall median increase was much higher than the overall median decrease, the real concern is a small percentage of generic drugs that have seen recent massive price increases of 100 percent to over 1,000 percent. The Senate subcommittee hearing focused on ten drugs in particular that have seen these “mega price increases.” The poster child for this phenomenon of skyrocketing generic drugs seems to be digoxin, a drug used for decades to treat patients with heart failure. According to pharmacist testimony at the Senate subcommittee hearing, the price of digoxin has risen from \$15 to \$120 for a 90-day supply—more than an 800 percent price increase. Other generic drugs seeing massive price inflations include albuterol tablets, levothyroxine, captopril, doxycycline, and amitriptyline—all drugs that have been on the market for at least 30 years. What is behind this dramatic increase in the price of certain generic drugs? The answer seems to be decreased market competition.

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Historically, most prescription medications have experienced a two-part life cycle. The first cycle occurs after the drug wins FDA approval and is on the market under patent protection. The second cycle occurs after the patent(s) expires when several generic manufacturers enter the market and, over time, competition drives the price of the medication downward. It now appears, however, that there may be a third part of a drug life cycle. This third part occurs if several generic drug manufacturers cease production due to declining profitability. According to Dr. Aaron Kesselheim, a professor of health economics at the Harvard School of Public Health, “Studies show it is not until you have four or five generics in the market that the prices really start to go down.” In the case of digoxin, there are currently only two to three generic manufacturers who are supplying the drug to patients in the U.S. Multiple factors have contributed to the decline in the number of generic manufacturers producing certain generic medications. These reasons include shortage of raw materials, price increases in the supply chain, and increased FDA oversight associated with manufacturing processes. All of these conditions make manufacturing these products less

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profitable. Other factors include mergers of manufacturing companies and the current backlog of FDA applications for generic approvals.

Left with few competitors in the marketplace, some generic manufacturers are taking advantage of the conditions to maximize their profits. With these fragile supply chains supported by only one or two manufacturers, any disruption in manufacturing can result in drug shortages, as well as increased pricing. Sudden price increases are a concern for pharmacies, physicians, consumers, and health plans. In response to the recent dramatic price increases, Senator Barry Sanders of Vermont has introduced a bill entitled the “Medicaid Generic Drug Price Fairness Act.” Manufacturers who increase brand name drug prices faster than inflation are already required to pay an additional rebate to state Medicaid programs. This bill would extend the requirement to include generic drugs. Other suggestions for dealing with rising generic drug prices have included the FDA offering expedited reviews and waiving generic-drug user fees to manufacturers seeking approvals for generics with substantial price increases. Critics suggest the proposed act or other interventions may have negative downstream consequences associated with legislated price regulation. Pharmacy benefit managers may be able to assist their clients in dealing with price increases by focusing on utilization. In areas where other therapeutic alternatives exist, proper management may be able to direct patients to equivalent products with more favorable pricing. In situations where there are generic drugs with significant price increases, the impact can be minimized by carefully shifting utilization patterns to minimize impact and disruption.

Did You Know?

There are now more than 100 medications on the market containing “personalized medicine” information in their labeling. Some of these are older medications, such as codeine. Individual genetic characteristics can now identify groups of patients who are more likely to experience toxicity (or reduced efficacy) with codeine. Many newer drugs also leverage personalized medicine technology, especially in the treatment of cancer. With a deeper

understanding of the underlying mechanisms causing cancer, drugs are being developed that target a particular mutation in the cancer cell. This mutation may only be found in small subsets of patients with a particular type of cancer. In the rapidly developing field of personalized medicine, the role of companion diagnostic tests, which identify an individual’s genetic characteristics, are becoming crucially important. Companion diagnostic tests define the subset of patients who are most likely to benefit from a therapy or who should not receive the therapy because of ineffectiveness or predicted adverse effects. It is necessary for both clinicians and those involved with health care benefits administration to understand the importance of companion diagnostic tests. These new technologies are making it increasingly possible to individualize medical treatment to ensure the most optimal patient outcomes and avoid unnecessary expenditures.

Keep on Your Radar: Community Management of Opioid Overdose

The crisis of abuse and addiction to opioid analgesics has emerged in the past decades and has worsened over the last few years. Visits to emergency rooms related to opioid abuse increased 117% between 1994 and 2001. Opioids were involved in 60% of drug overdose deaths in 2010, compared to approximately 30% in 1999. More startling, deaths related to prescription opioid analgesic overdose now surpass the combined overdose deaths involving all illicit drugs such as cocaine and heroin. The World Health Organization (WHO), in November 2014, launched guidelines on the community management of opioid overdose. Historically, naloxone has been used only in hospitals and by ambulance workers to reverse the effects of an opioid overdose; however, in April 2014, the FDA approved a naloxone auto-injector for the emergency treatment of known or suspected overdose, as manifested by respiratory and/or central nervous system depression. The WHO strongly recommends people likely to witness an opioid overdose should have access to naloxone and be instructed on how to use it for the emergency management of suspected opioid overdose. The WHO guidelines focused not only on life-saving measures performed by healthcare professionals, but also

emergency administration of naloxone by people who are not medically trained. They recognize there are two main groups that are likely to witness an overdose 1) people at risk of an opioid overdose, their friends and families and 2) people whose work brings them into contact with people who overdose (e.g., health care professionals or first responders). To date, 25 states have enacted laws allowing the prescribing and dispensing of naloxone for use by “Good Samaritans.” This brings up an important issue for benefit plans. Insurers may be supplying naloxone to a plan member, knowing the intended recipient of the medication is not covered by the plan. This is a first for benefit plans. If this medication is added to a payer’s formulary, careful consideration is needed in regards to: drug utilization review, clinical criteria, and medication counseling. Nonetheless, while there are still uncertainties about the magnitude of the benefit from a wider availability and lay use of naloxone, the life-saving nature of the intervention should not go unnoticed.

“Right-to-Try” Laws

Right-to-Try laws are intended to provide terminally ill patients access to investigational drugs and circumvent the established FDA expanded access or “compassionate use” pathways. Five states have already passed these laws and similar legislation is being considered in additional states. Much of the publicity and public support for “right-to-try” legislation has come as a result of social media campaigns. Terminally ill patients and their families, desperate for access to therapies showing promise in early Phase I clinical trials, have launched social media campaigns such as the #SaveJosh campaign to garner support. Although the laws are well-intended, critics say these laws may actually provide false hope. The laws provide no mandate for drug companies to provide the drugs and no funding source to cover any of the costs. Drug companies may be hesitant to provide drugs outside of FDA oversight and may even lack the means to produce enough supply for all patients who desire access to the drug. These laws may also reduce enrollment in clinical trials, which are required to win drug approval. Payers may be pressured to provide coverage for these drugs and the medical services related to their use despite no

mandate to do so in these newly enacted laws. While other states are expected to pass similar “right-to-try” laws, skeptics doubt these laws will provide any meaningful benefit to terminally ill patients and may pose problems for both drug companies and insurance providers.

The Changing Landscape of Newly Approved FDA Drugs

A near record number of new drugs, a total of 41, were approved by the FDA in 2014. Additionally, several characteristics about the 2014 FDA approvals are noteworthy and likely indicate a trend to watch in coming years. Approximately 40 percent of the approved drugs in 2014 were designed to treat rare or “orphan” diseases, defined as a disease affecting 200,000 or fewer Americans. This finding reflects the pharmaceutical industry’s shifting focus to orphan drugs for rare diseases. There are usually lower costs associated with performing smaller clinical trials in these patient populations and there are government incentives for the development of drugs to treat rare diseases. These factors combine to lead to a corresponding larger return on investment for the developer of orphan drugs. Another trend was that 66 percent of the 2014 FDA approvals underwent an expedited review process. One type of expedited pathway is the “breakthrough therapy” designation. This designation was created in 2012 and is intended for drugs that may demonstrate substantial improvement over existing therapies. The FDA’s accelerated approval program often allows for earlier approval of drugs based on surrogate endpoints such as lab tests or radiologic studies. The use of a surrogate endpoint can considerably shorten the time required to receive FDA approval. The approved drugs in 2014 point toward a shift in the types of drugs pharmaceutical companies are pursuing. This shift seems to be moving away from the “me-too” era, when every pharmaceutical company developed its own version in a popular drug class, such as beta blockers or NSAIDs. Instead, the landscape today appears to focus on developing niche drugs that are less costly to bring to market and capitalize on FDA incentive programs that result in faster approval.

Pipeline Report: 2nd and 3rd Quarter, 2014

Drug/Manufacturer	Clinical Use	Anticipated Date	Projected Market Impact
Select Branded Pipeline Agents: Potential New Emerging Expenses for Health Plans			
ivabradine Amgen, Servier	Oral – treatment of chronic heart disease	02/27/2015	Large market with unmet needs; ivabradine has a novel mechanism of action (I _f channel inhibitor acting on sinoatrial node of the heart) reducing heart rate without lowering blood pressure; although fast-tracked by the FDA, conflicting clinical trial results regarding endpoint of cardiovascular death have led to uncertainties.
isavuconazole Astellas, Basilea	Oral and IV – broad spectrum antifungal agent	4Q14/1Q15	Market competitors include Vfend®, Noxafil®; will predominantly be used to treat fungal infections occurring in immunosuppressed patients; may have less pronounced drug interactions than competitors; IV formulation may be less toxic than competitors due to lack of need for certain inert ingredients.
brexpiprazole Otsuka, Lundbeck	Oral – schizophrenia, add-on for depression	2Q15	Otsuka's successor to aripiprazole (Abilify®) expected to go generic in 2Q15—see below; will compete with other generics including olanzapine, quetiapine as well as several branded products; also being studied in PTSD and behavioral symptoms of Alzheimer's disease.
New Generics / Patent Expirations			
colesevelam-generic for Daiichi's Welchol®	Hypercholesterolemia, improvement of glycemic control in type 2 diabetes	3/2015	Welchol is available as both an oral powder for suspension and an oral tablet; there appears to be no 180-day exclusivity rights and at least two generic competitors are expected to launch.
aripiprazole-generic for Otsuka's Abilify®	Schizophrenia, bipolar, depression, autism, Tourette's	4/2015	Abilify accounted for worldwide sales of \$5.5 billion in 2013 making it one of the top drugs in terms of pharmaceutical sales; multiple competitors are expected at time of generic launch.
aprepitant-generic for Merck's Emend®	Post-operative nausea and vomiting; prevention of chemotherapy induced nausea/vomiting	4/2015	Although only one generic manufacturer is expected initially; it is unclear if that manufacturer has 180-day exclusivity rights. The FDA has asked Merck to conduct pediatric studies and it is possible Emend may be granted an additional 6 months patent extension related to pediatric exclusivity which would delay generic launch until 4Q15.
linezolid-generic for Pfizer's Zyvox®	Gram – positive infections including methicillin resistant staph aureus (MRSA)	2Q15	Teva Pharmaceuticals have 180-day exclusivity rights to Zyvox tablets; other generic manufacturers are expected to enter the market in 4Q15 after the 180-day exclusivity expires. It is unclear if Roxane has 180-day exclusivity rights for Zyvox oral suspension but is also expected to launch in 2Q15.

Introduction to Kentucky's Health Data Trust (KyHDT)



Linda Green
Amy Lischko

Today's Agenda



20 min.	Welcome and Opening Remarks <ul style="list-style-type: none">• John Langefeld, Chief Medical Officer, Department of Medical Services• Carrie Banahan, Executive Director, Ky. Health Benefits Exchange• The Role of the University of Kentucky: Vince Kellen, Senior Vice Provost & CIO, University of Kentucky• Freedman HealthCare's Role: Linda Green and Amy Lischko
5 min.	Agenda Overview: Linda Green
60 min.	Overview of Multi-Payer Databases ("Data Trusts") Amy Lischko
15 min	Break
45 min.	Framing the Project (Small Group Discussion)
30min	Small Groups Report Out – Linda and Amy
20min.	Project Overview -- Linda
10 min.	Next Steps and Adjourn Linda and Amy

Background: Components of this Assessment



- ▶ Learn about current data collection efforts and where gaps exist
- ▶ Hear from stakeholders
- ▶ Assess options for IT infrastructure, data collection and analysis
- ▶ Propose options for managing and sustaining a "Health Data Trust"

Background: Kentucky's Health Care Goals



- ▶ Reduce Kentucky's rate of uninsured individuals to less than 5%.
- ▶ Reduce Kentucky's smoking rate by 10%.
- ▶ Reduce the rate of obesity among Kentuckians by 10%.
- ▶ Reduce Kentucky cancer deaths by 10%.
- ▶ Reduce cardiovascular deaths by 10%.
- ▶ Reduce the percentage of children with untreated dental decay by 25% and increase adult dental visits by 10%.
- ▶ Reduce deaths from drug overdose by 25% and reduce by 25% the average number of poor mental health days of Kentuckians.

What is a Health Data Trust?

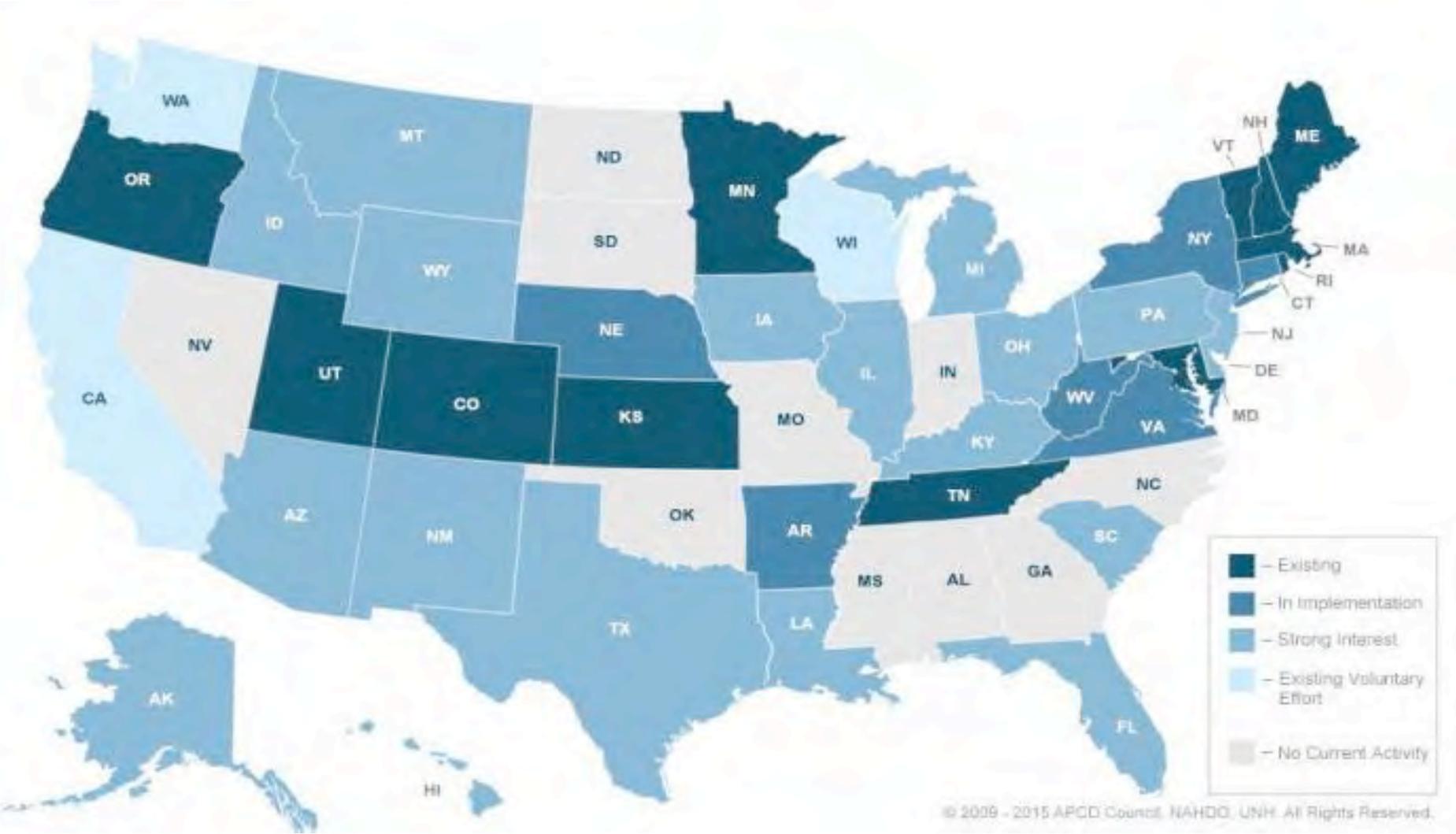
- ▶ “We cannot manage what we cannot measure”
- ▶ Designed to address need for comprehensive information across health care and other settings
- ▶ Aggregation of data from multiple sources
- ▶ Various governing structures across states depending on needs, environment, resources
- ▶ Can include: disease registry, public health program data, vital statistics, lab, emr, multi-payer claims data

What does a multi-payer claims data set include?



- Encrypted social security
- Patient demographics (date of birth, gender, residence, relationship to subscriber)
- Type of product (HMO, POS, Indemnity, etc.)
- Type of contract (single person, family, etc.)
- Diagnosis codes (including E-codes)
- Procedure codes (ICD, CPT, HCPC, CDT)
- NDC code / generic indicator / other Rx
- Revenue codes
- Service dates
- Service provider (name, taxid, payer id, specialty code, city, state, zip code)
- Prescribing physician
- Plan charges & payments
- Member liabilities (co-pay, coinsurance, deductible)
- Date paid
- Type of bill
- Facility type
- Other 835/837 fields

Multi-payer Claims Data Development



Broader Vision for Kentucky: Data Streams for Health Data Trust

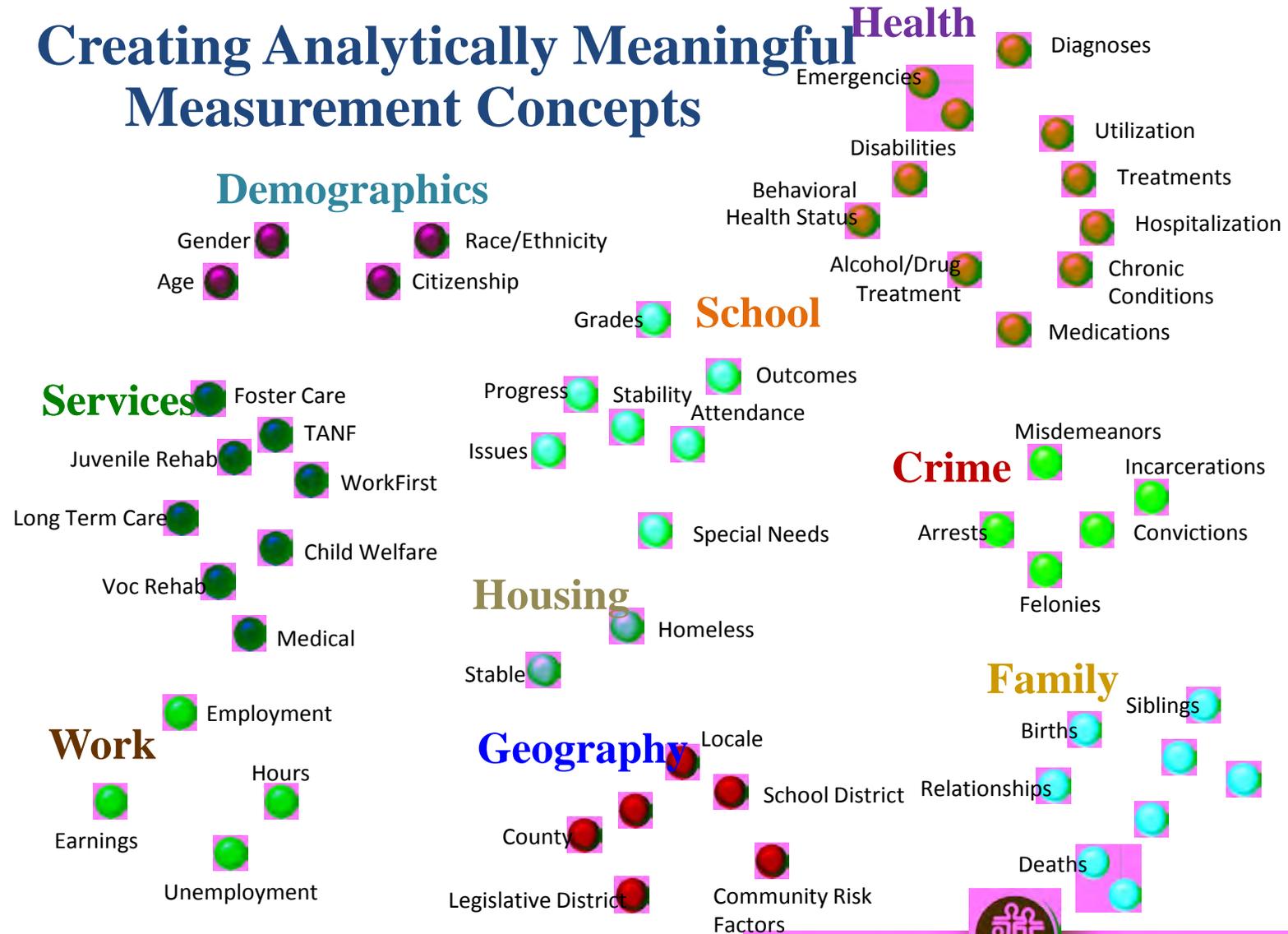


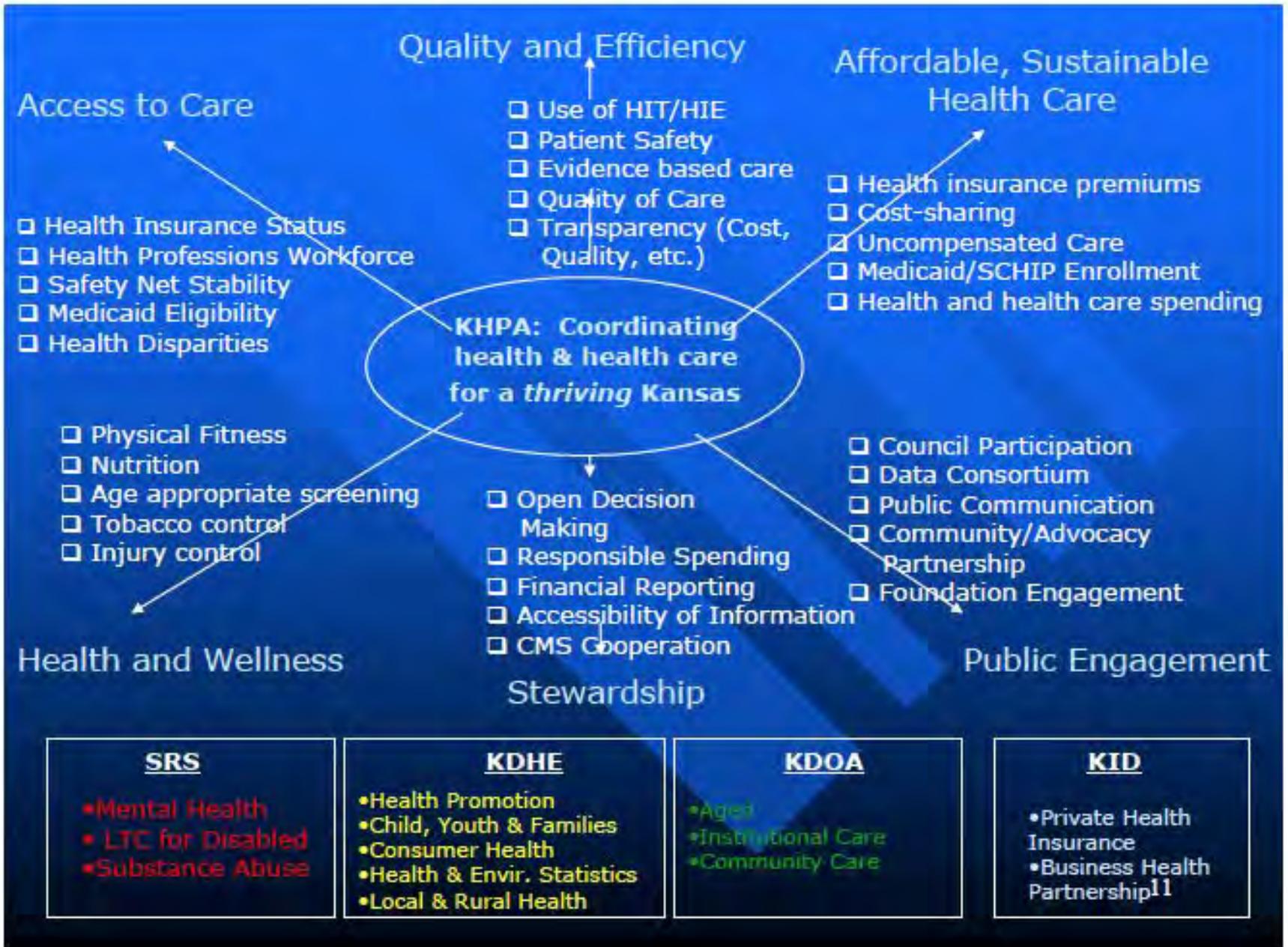
CHFS "Internal" Data Sources	"External" Data Sources	"Other" Data Sources
Medicaid DSS (Includes Medical, Rx, all MCO)	KEHP (State Employees)	Corrections
Medicare (Dual-eligible: Part A,B,D)	KY Commercial MCO: HEDIS	Revenue
DBHDID	Medicare (KY Non-Dual: Part A,B,D)	Housing
KASPER	Medicare (Dual-eligible: Part A,B,D)	Transportation
TWIST	Ky Other Public Institutions: Universities	
DPH: Vital Records	Commercial Carriers (Self-funded)	
DPH: Immunization Registry	Commercial Carriers (Fully-insured)	
OHP: KHA Data	BPHC: UDS	
DPH: BRFS	Hospital Billing Data	
Medicaid MCO: HEDIS	Independent Laboratory	
KHIE (Clinical ADT, CCD, EMR, ETC.)	Software Systems (Case Mgmt. notes, etc.)	
KHBE/HIX		
TANF		
SNAP		
Medicaid: Provider Integrity		
DPH: Cancer Registry		
DPH: State Laboratory		
DAIL		

State Efforts that Go Beyond APCD

- ▶ Washington State: Integrated Client database includes over 10 years worth of data across social service spectrum
- ▶ Kansas: Data Consortium: Health Indicator Dashboard
- ▶ Vermont: Merges data from various sources for reporting including APCD, ACO payment and reporting, EMR, and BRFSS
- ▶ Colorado: Interest in merging APCD with clinical, patient experience, and SES

Creating Analytically Meaningful Measurement Concepts





How can a “Health Data Trust” be useful?

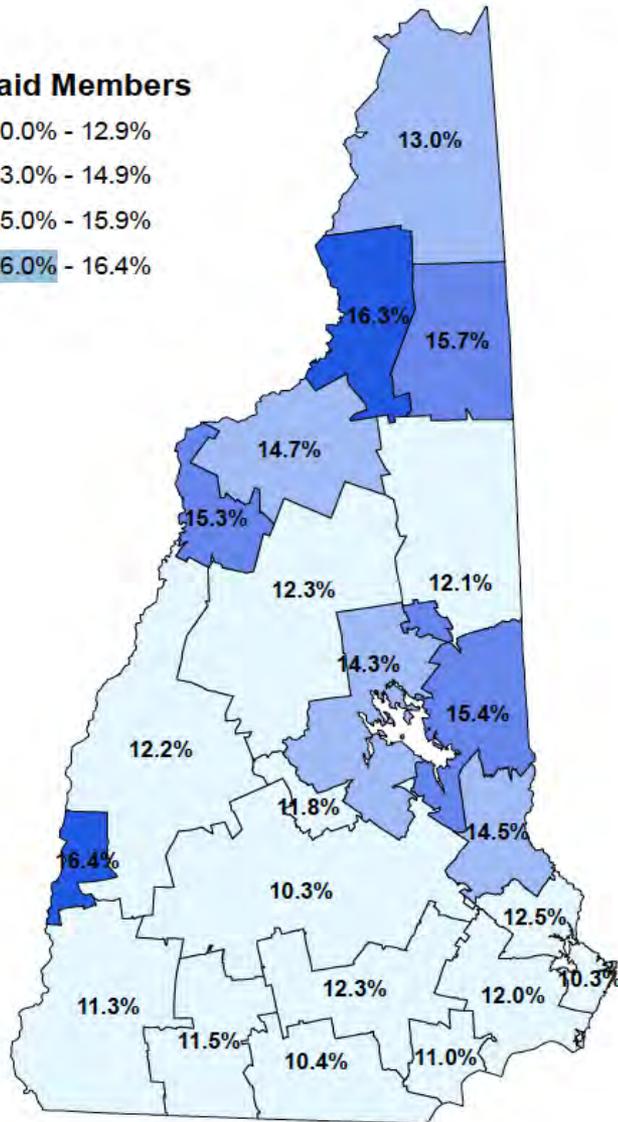
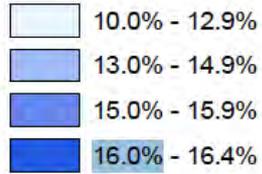
- ▶ Population Health Analysis
 - ▶ Clinical Performance Improvement
 - ▶ Information for decision makers
 - ▶ Studying geographic variation
 - ▶ Public reporting on price and quality



COPD Prevalence

Rates Standardized for Age

Medicaid Members



CHIS Commercial

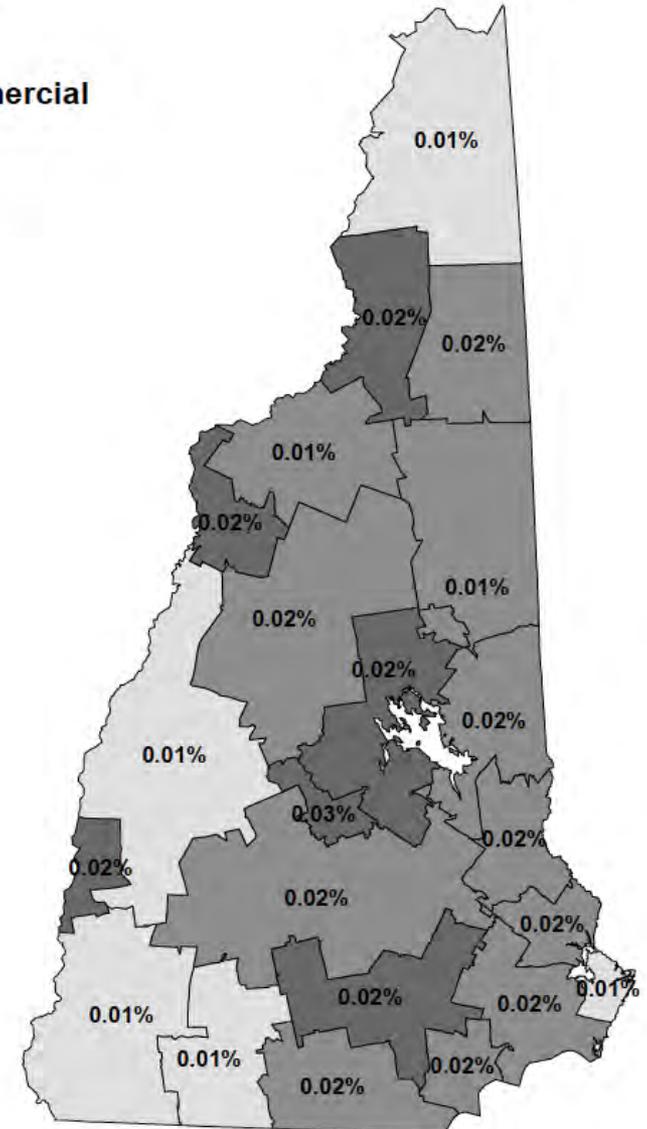
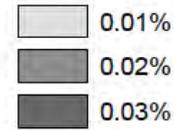
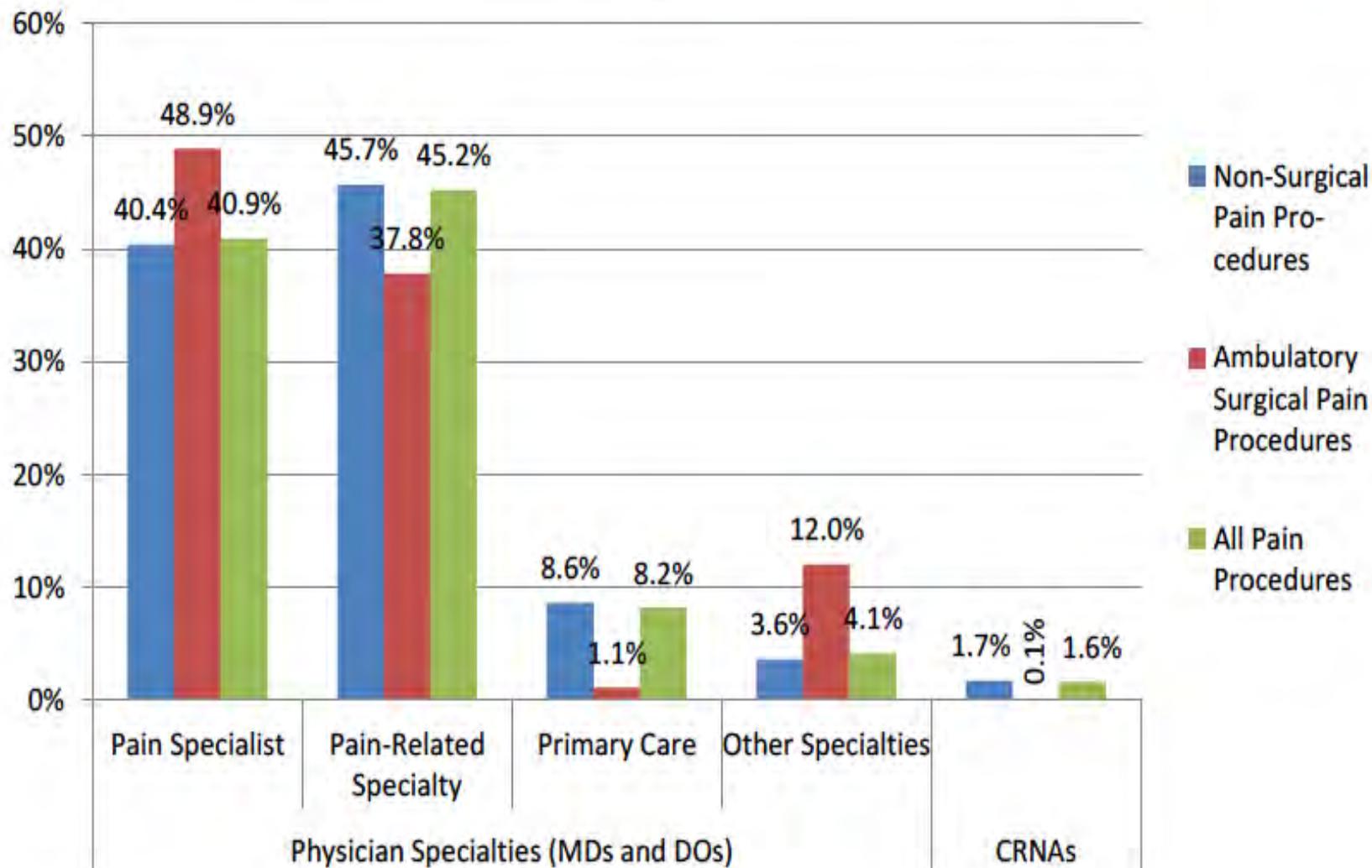


Figure 5: Distribution of Pain Management Services Delivered in Minnesota, by Provider Type (2010 to 2012)



How can a “Health Data Trust” be useful?

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- ▶ Clinical Performance Improvement
- ▶ Information for decision makers
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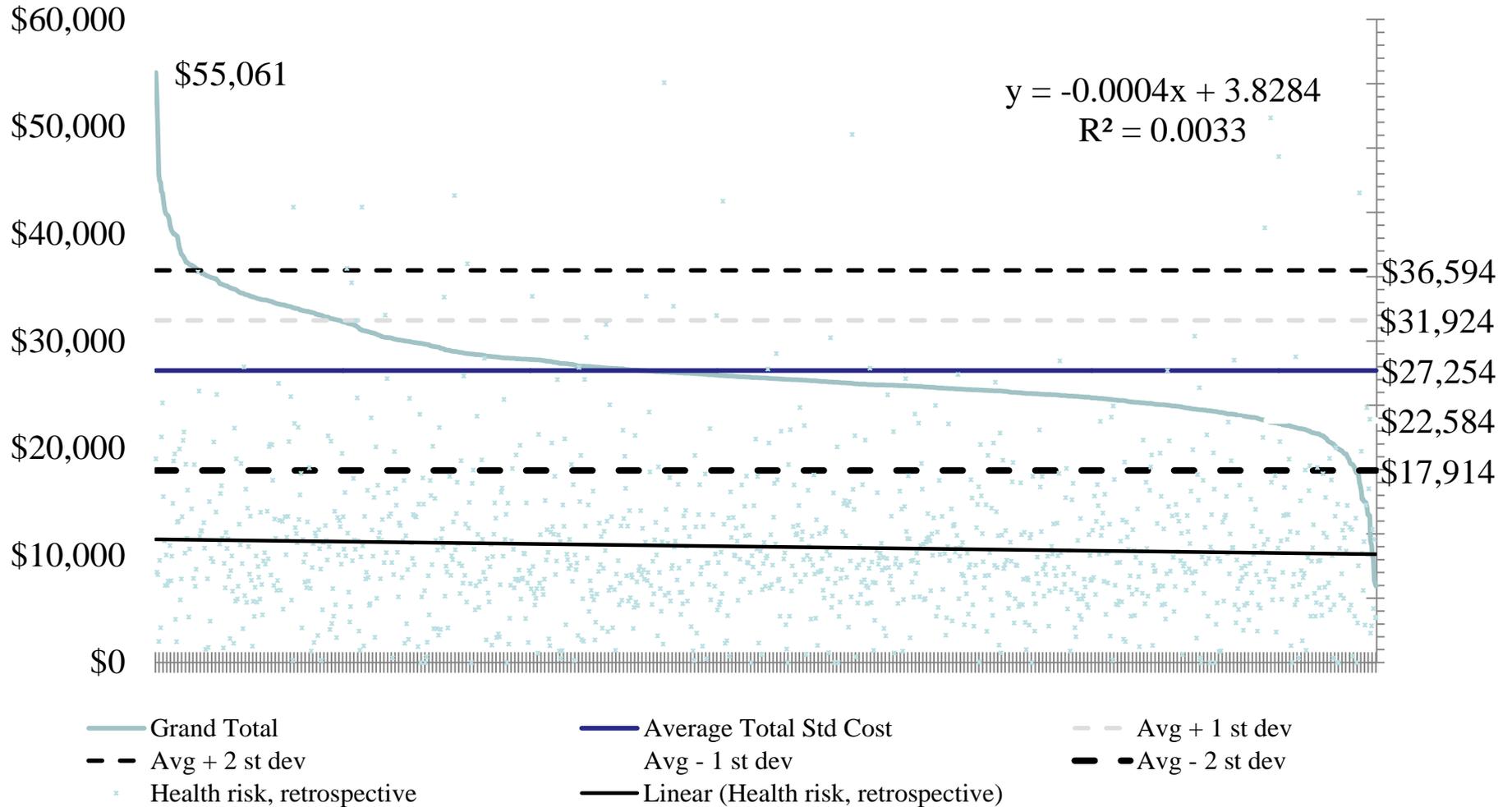


CPT 27447/ETG ID 676

KNEE REPLACEMENT EPISODES

SINGLE KNEE, SINGLE ADMISSION, SEVERITY 1

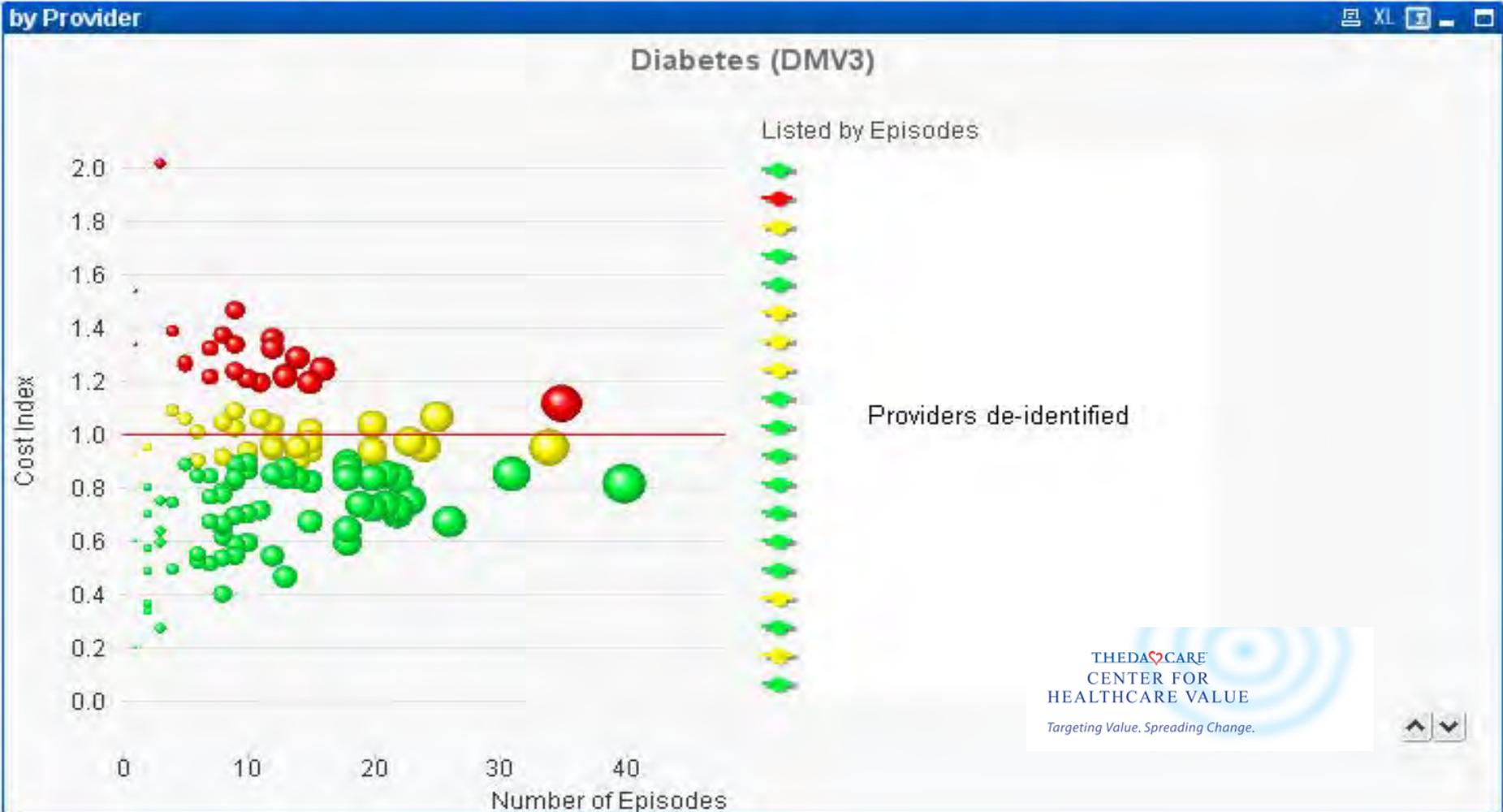
WHIO DMV4 *Analysis by WMS*



ETG by Provider – Diabetes Severity 1 Cost

Severity Level

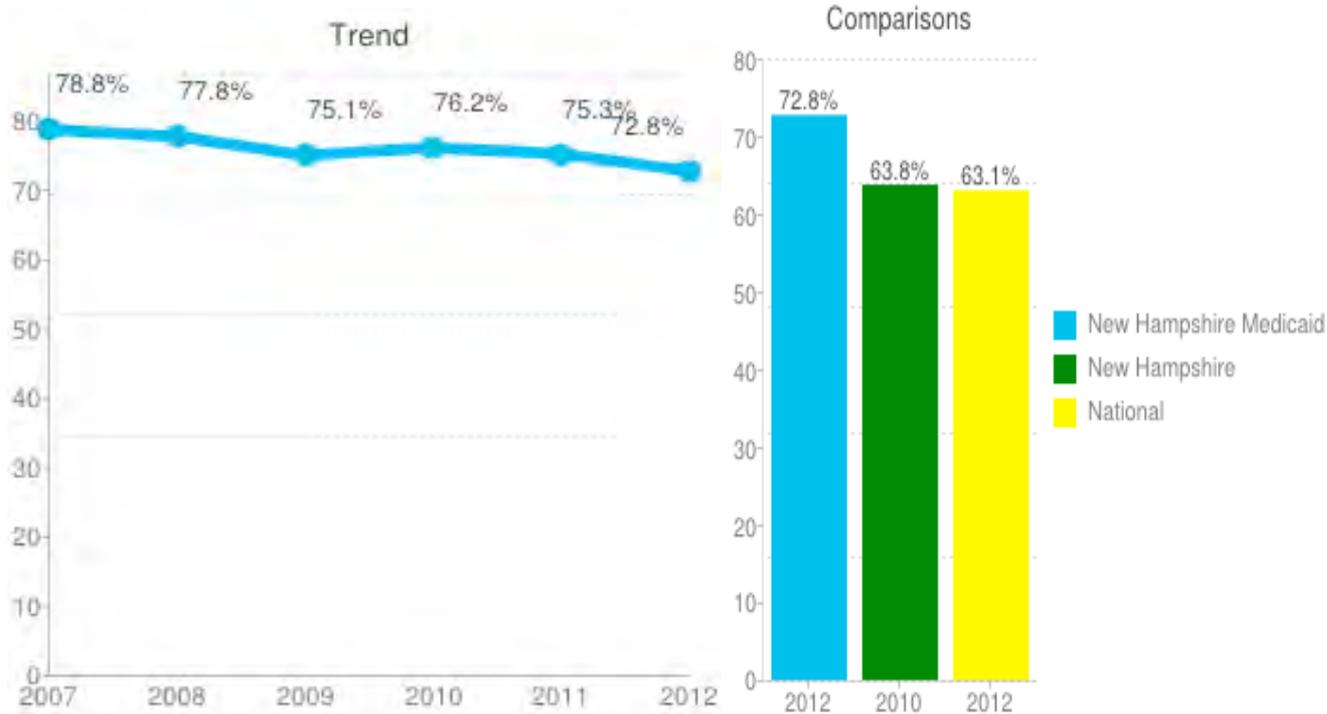
Severity 1	Severity 2	Severity 3	Severity 4
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How can an “Health Data Trust” be useful?

- ▶ Population Health Analysis
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New Hampshire: Percent of Discharges for Hospitalization for Mental Health Disorder Treatment - Beneficiary Follow-up within 30 Days

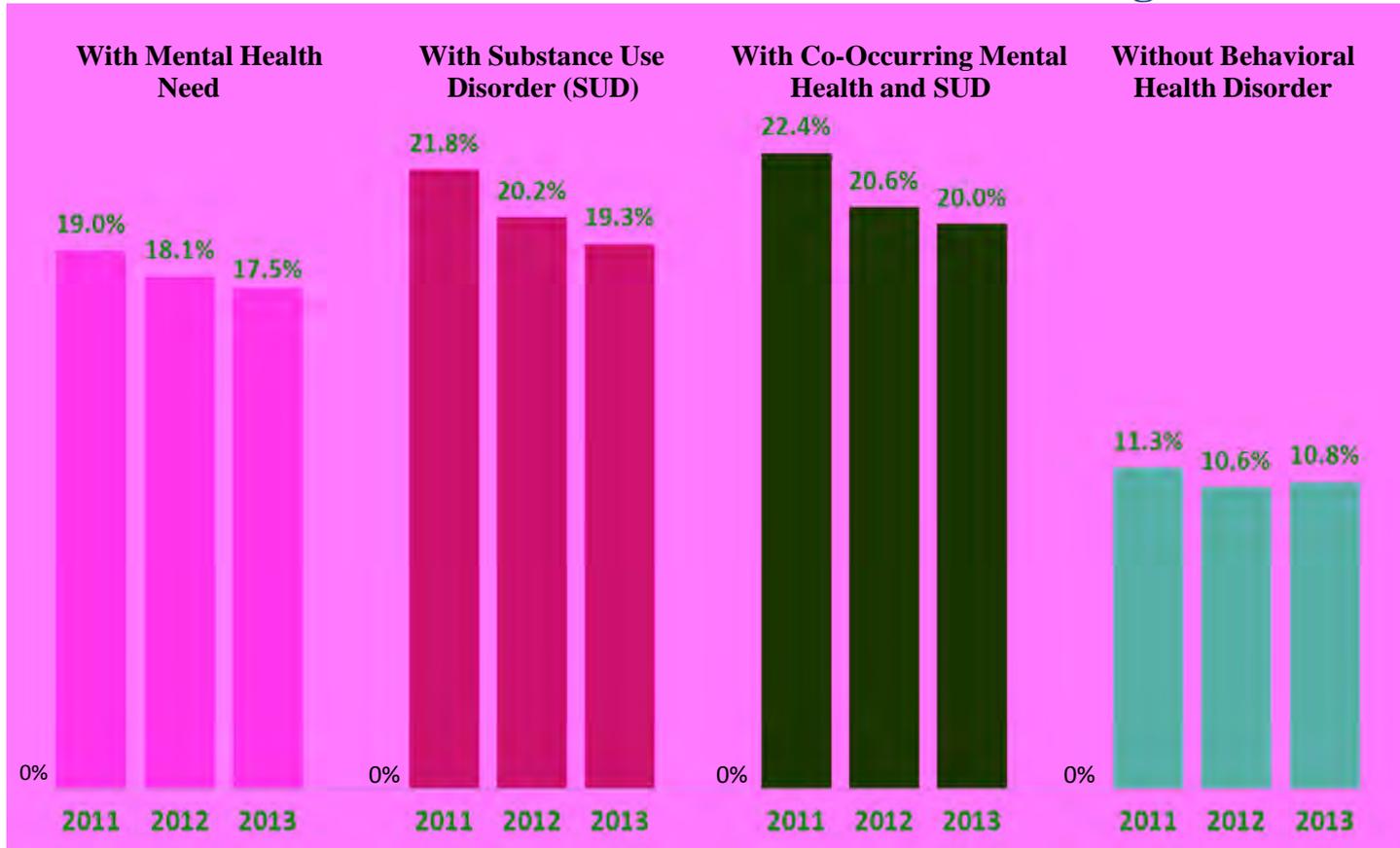


NH Quality Indicators, Last updated: 04/09/2014

All-Cause 30-day Hospital Readmission Rate

DISABLED MEDICAID ADULTS AGES 18-64 (EXCLUDES DUALS) HEDIS-PCR

Individuals with behavioral health conditions have higher rates of readmission



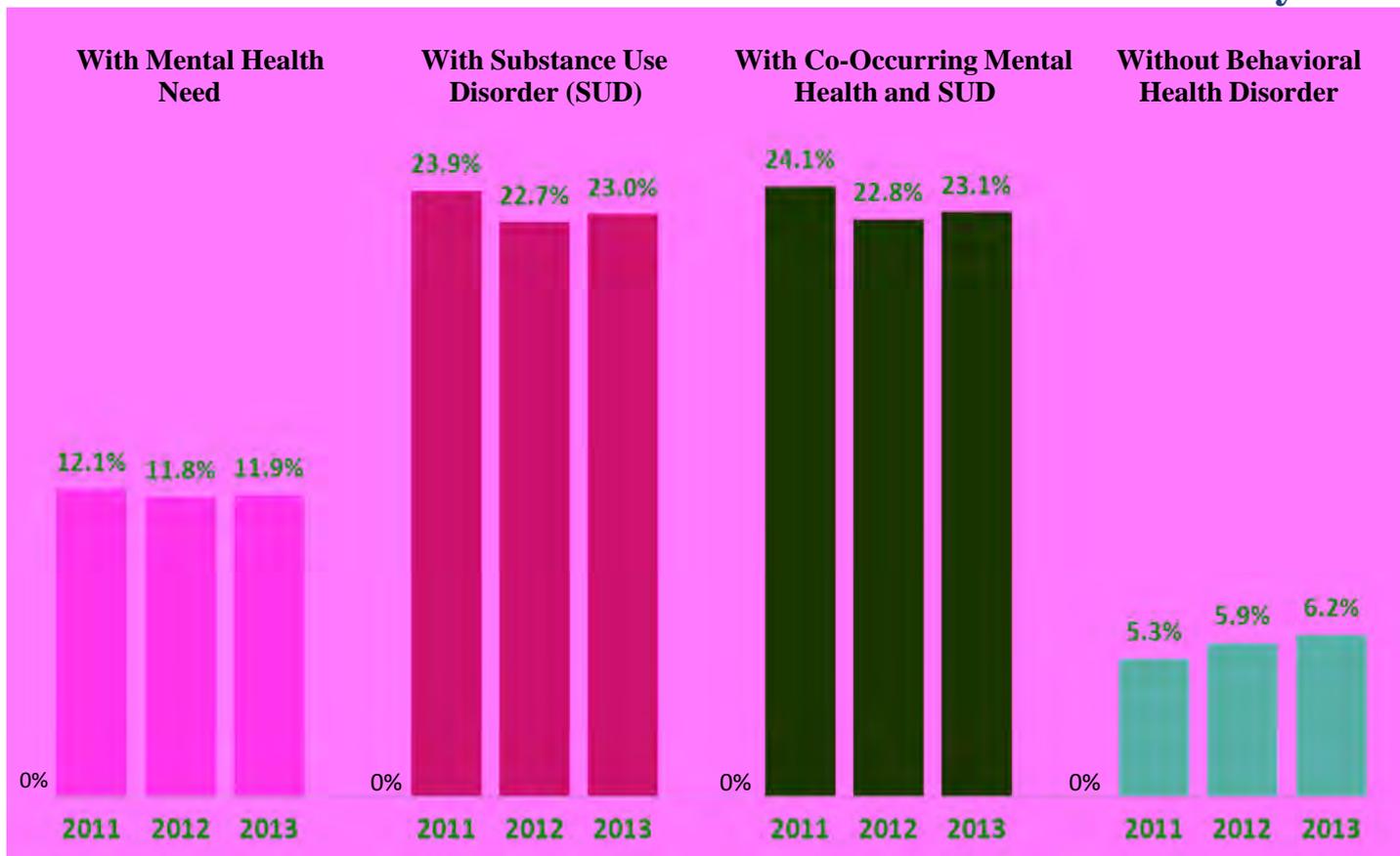
SOURCE: DSHS Research and Data Analysis Division, *Managed Medical Care for persons with Disabilities and Behavioral Health Needs: Preliminary Findings from Washington State*, paper in progress.



Percent with Arrests

DISABLED MEDICAID ADULTS AGES 18-64 (EXCLUDES DUALS)

Individuals with substance abuse issues are much more likely to be arrested



SOURCE: DSHS Research and Data Analysis Division, *Managed Medical Care for persons with Disabilities and Behavioral Health Needs: Preliminary Findings from Washington State*, paper in progress.



Imaging Services: Range of Average Imaging Payments to Facilities - 2011

Notes

Dollar amounts reflect health plan payments made to facilities for imaging services and does not include patient payments (co-pays, deductibles, etc.) or professional charges. The statewide average reflects payments made across all facilities represented in the APCD as of July 2012. Range from high to low is calculated based on the 20 largest imaging facilities by volume of procedures. Total imaging reflects all categories of imaging services. High cost imaging reflects computerized tomography (CT) scans and magnetic resonance imaging (MRI).

Source

Colorado All Payer Claims Database
www.cohealthdata.org

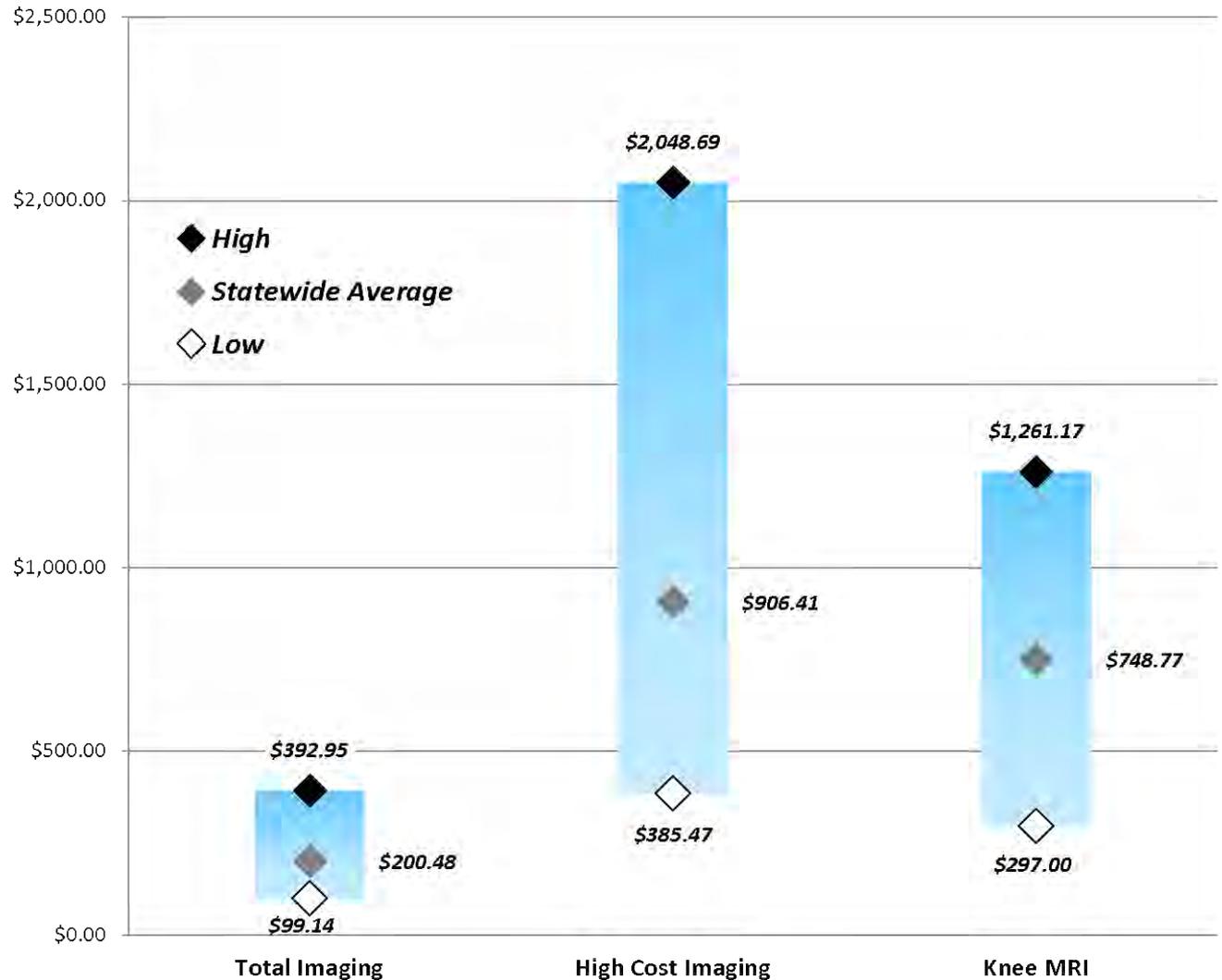
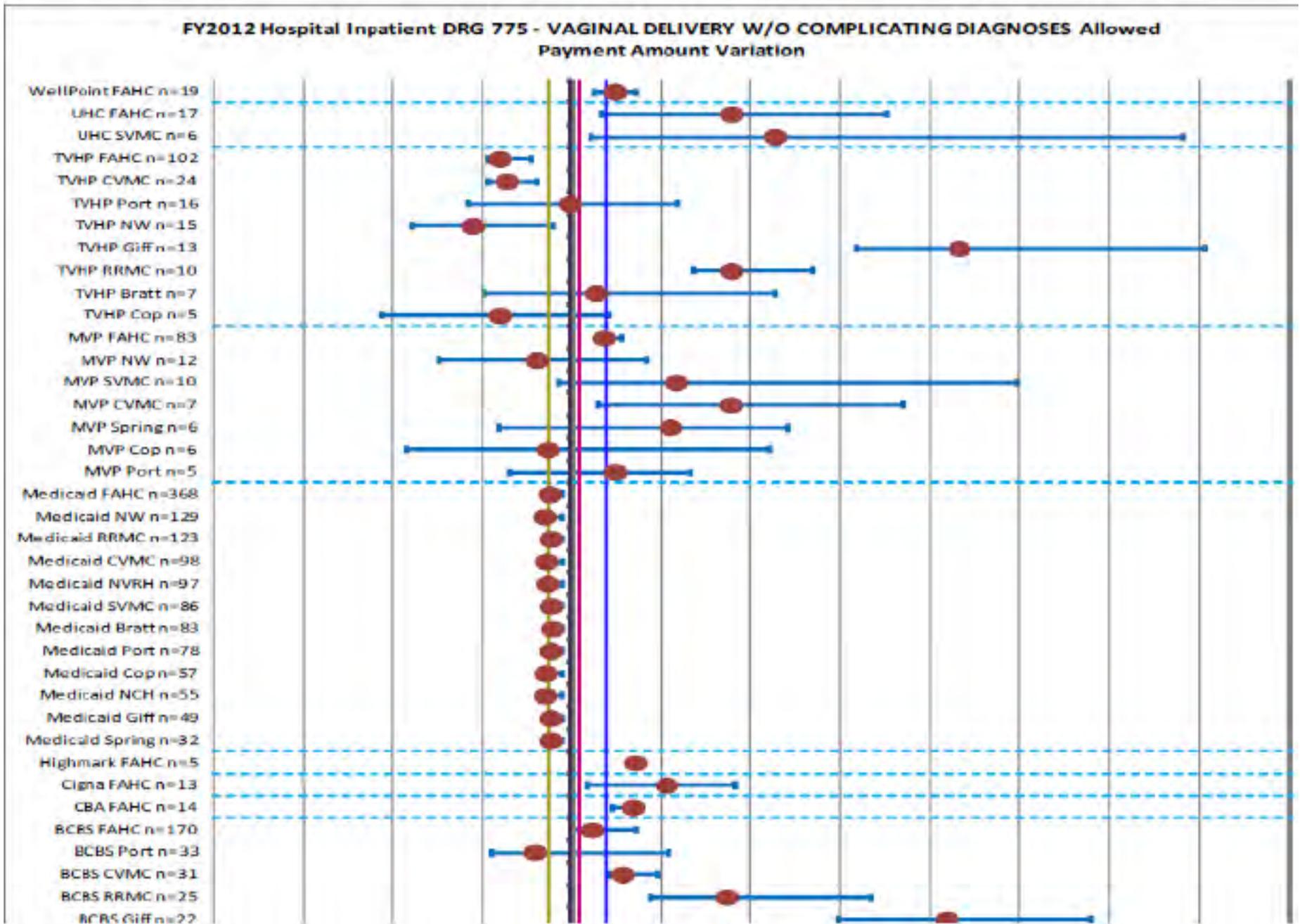


Figure 4.8 Inpatient Payment Variation by Payer, by Hospital, by DRG 775 – Vaginal Delivery



Map 3. Average Cost Per Emergency Department Visit, All Current Payers, Ages 0-64, 2011

- Less than 85% of the state average
- 85% - 115% of the state average
- Greater than 115% of the state average

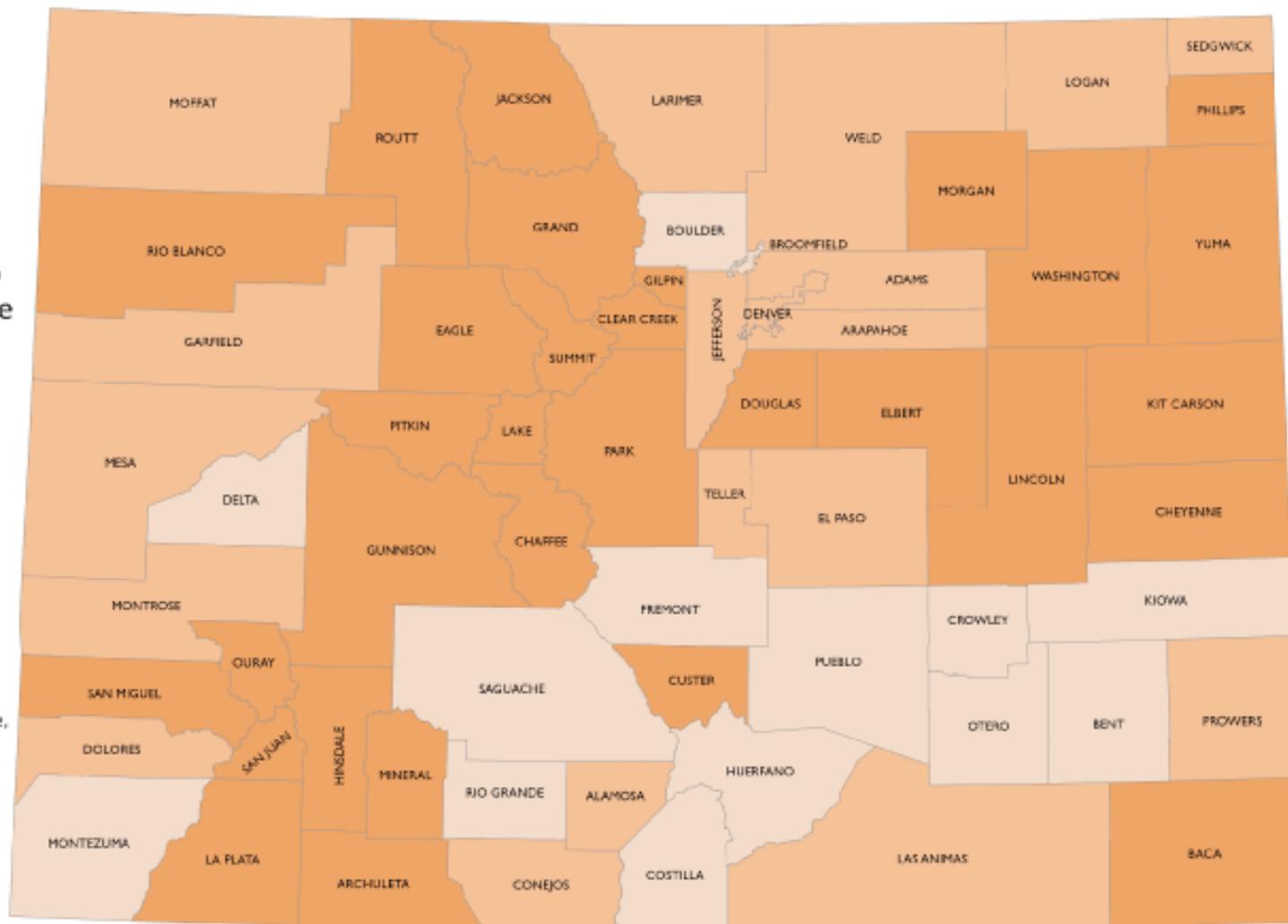
State Average: \$359

Notes

Data based on residence of 2.0 million individuals insured by Medicaid and commercial payers. Only reflects facility costs. Includes patient cost sharing. Data not adjusted for case mix.

Source

Colorado All Payer Claims Database, Center for Improving Value in Health Care, October 2012
www.cohealthdata.org



CIVHC
 CENTER FOR IMPROVING
 VALUE IN HEALTH CARE



Map created by the Colorado Health Institute



How can an “Health Data Trust” be useful?

- ▶ Population Health Analysis
- ▶ Clinical Performance Improvement
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CO: Chronic Conditions, All Current Payers 2012

	Adams		Alamosa		Arapahoe		State
Completeness Score	C3		C2		C3		C2
Illness Burden Score	1.02		1.20		1.00		1.00
	Value	Index	Value	Index	Value	Index	Value
Total Cost of Care: Diabetes	\$14,867	1.12	\$12,297	0.92	\$12,905	0.97	\$13,316
Total Cost of Care: Population	\$2,631	0.99	\$3,011	1.14	\$2,863	1.08	\$2,647
Disease Prevalence	2.35%	1.17	2.70%	1.35	2.14%	1.07	2.01%
Chronic Dollar Distribution							
Inpatient Facility Cost	28%	1.13	13%	0.54	24%	0.94	25%
Outpatient Facility Cost	23%	1.13	22%	1.06	18%	0.86	21%
ER Facility Cost (subset of Outpatient Cost)	5%	1.30	3%	0.74	5%	1.28	4%
Professional Cost	16%	0.84	28%	1.47	21%	1.14	19%
Ancillary Cost	3%	0.85	4%	1.25	4%	1.09	4%
Rx Cost	29%	0.92	33%	1.02	33%	1.04	32%

How can an “Health Data Trust” be useful?

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- ▶ Clinical Performance Improvement
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- ▶ Public reporting on price and quality



Detailed estimates for Arthroscopic Knee Surgery (outpatient)

Procedure: [Arthroscopic Knee Surgery \(outpatient\)](#)

Insurance Plan: Anthem - NH, Health Maintenance Organization (HMO)

Within: 20 miles of 03301

Deductible and Coinsurance Amount: \$200.00 / 10%

Lead Provider Name	Estimate of What you Will Pay	Estimate of What Insurance Will Pay	Estimate of Combined Payments
CONCORD AMBULATORY SURGERY CENTER	\$507	\$2769	\$3276
CAPITAL ORTHOPAEDIC SURGERY CENTER	\$553	\$3177	\$3730
DARTMOUTH HITCHCOCK SOUTH	\$601	\$3609	\$4210
LAKES REGION GENERAL HOSPITAL	\$664	\$4178	\$4842
SPEARE MEMORIAL HOSPITAL	\$673	\$4264	\$4937
FRANKLIN REGIONAL HOSPITAL	\$681	\$4334	\$5015
CATHOLIC MEDICAL CENTER	\$759	\$5036	\$5795



- For Patients & Families
- About The Ratings
- Frequently Asked Questions
- Resources & Tools
- About Us
- Feedback

Comparison of Providers

Start New Search

Return to Search Results

Bookmark

Choose a Topic

Patient Safety

- Patient Safety
- Serious Reportable Events
- Surgical Care

Patient Experience

- Patient Experience

Bone and Joint Care

- Back Procedure
- Hip Fracture
- Hip Replacement
- Knee Replacement

Cardiovascular Disease

- Angioplasty
- Bypass Surgery**
- Cardiac Screening Tests
- Heart Attack
- Heart Failure
- Heart Valve Surgery
- Stroke

Digestive System

- Gall Bladder
- Intestinal Surgery
- Weight-loss Surgery

Obstetrics

- Cesarean Section
- Normal Newborn

Cardiovascular Disease: Bypass Surgery

Bypass surgery involves transplanting a blood vessel from your leg or chest to the heart to get around (or "bypass") a blockage in the heart's blood supply. [\(more\)](#)

Diagnostic classification: Coronary Bypass with cardiac catheterization (APR-DRG 165); Coronary Bypass only (APR-DRG 166)

- Summarized Report**
- View Detailed Report
- View Statewide Procedure Costs

Quality of Care

[\(more\)](#)

	Boston Medical Center	Brigham & Women's Hospital	Massachusetts General Hospital
Quality Rating	★★★	★★★	★★★
Statistical Significance	Not different from State Average Quality	Not different from State Average Quality	Not different from State Average Quality

Cost of Care

[\(more\)](#)

	Boston Medical Center	Brigham & Women's Hospital	Massachusetts General Hospital
Cost Rating	\$	\$\$	\$\$\$
Statistical Significance	Below Median State Cost	Not Different from Median State Cost	Above Median State Cost

Boston Medical Center

[remove](#)

Brigham & Women's Hospital

[remove](#)

Massachusetts General Hospital

[remove](#)

Data Governance

- ▶ Data collection
- ▶ Data management
- ▶ Data release

Lessons Learned

- ▶ Consult with stakeholders
- ▶ Work closely with health plans
- ▶ Explain what will be reported – how and when
- ▶ Recognize privacy and security concerns
- ▶ Establish ground rules for access to data
- ▶ Be transparent
- ▶ Develop sustainability plan

Discussion

- ▶ What questions do you have about Kentucky's proposed "Health Data Trust?"
- ▶ What do you wish you could measure about health care in Kentucky?
- ▶ What are your concerns about this initiative?

QUESTIONS

▶ Questions

1. How fast? How do we prioritize? Start with APCD? How to integrate other things after we have started?
2. How do we get private payers in without a legislative mandate?
3. Timelines
4. Pay?
5. Work?
6. HBE has certain deliverables
7. How broad is governance?
8. Roles?
9. Monetize the data or sustain for charging data fees?

▶ Questions

1. What have other states done with policy changes?
2. How can KY best impact the state?
3. How does this interact with Medicaid waiver monitoring?
4. How much data can it hold?
5. Who would oppose?
6. Make it a Cabinet wide initiative as well as agencies outside the Cabinet

Questions/Concerns

1. Who will have access? How will that be determined?
 2. Data Quality – how to ensure? Minimize data corrections? More variance in the data types, the more corrections
 3. Analytic team: lots of individual knowledge; need for collective understanding
 4. Need for legislative mandate
1. How often data updated? How will systems talk to one another?
 2. How far will the data lag? Claims data.
 3. How will existing systems connect given other activity in the system?
 4. Costs?
 5. Levels of access to different data- some is already public, some not
 6. PHI protection
 7. At intake, would this system allow accessing info on the front end?

Concerns

1. Roll in more private sector ownership
2. Meeting HIPAA standards – limit access, data sharing strategies
3. Cabinet-wide policy for release
4. Data quality – do we start on a particular date or do we get historical data?

1. Data standards are different from one data set to another – matching up certain data may be difficult

What do we want to measure?

1. Are we improving anything? Is what we are doing working?
Use as an evaluation tool?
2. SA/Prescription drug abuse – look at population, co-morbidities, primary diag at first use, what kind of doctor prescribed

1. Population health – prevalence, longitudinal – nothing like PELL in MA
2. Need info on child maltreatment
3. Treatments/tests
4. Match across different data sources
5. Decision support – ROI for many of the programs – legislative
6. Geographic variation – social determinants
7. Public reporting to help the public make better choices e.g., C-section

What to measure

1. Specific outcomes
2. Evidence based
3. How Dollars are used
4. National quality metrics
5. Post-release from corrections/juvenile justice facilities – services while out, then in
6. Cost and quality – how services are delivered, over use
7. Shop for cost of services e.g., MRI
8. Geographic trends
9. Savings when out of an institution (Medicaid budget impact)

1. KY HealthNow – look at outcomes data
2. Consumer transparency and reporting
3. Use this to look at workforce and capacity issues across the state

What should we measure?

1. Impact and benefit of our programs
2. Housing, homelessness
3. Environmental health data – link to health outcomes on a patient specific basis

Next Steps

Task #1:
Stakeholder

Task #2:
Data Governance

Task #3:
System Feasibility

Task #4:
Critical Requirements

March

**Internal
Stakeholder**

**External
Stakeholder**

April



Recommendations

May



Recommendations



Recommendations

June



Final Report



KENTUCKY

“APCD”

Kentucky Health Data Trust

Challenges & Opportunities FOR



March 10, 2015

Our Governor's Narrative



"Poor Health
turns lives upside down"

"There is a direct line
from poor health to almost
every challenge Kentucky faces"

"For Kentucky to improve its
competitiveness and capacity, we
must address this weakness...
*AND incremental improvements
are not enough*"

*"BIG PROBLEMS Require BIG SOLUTIONS,
And that means.....BIG CHANGES!"*

Technology
is never a solution...

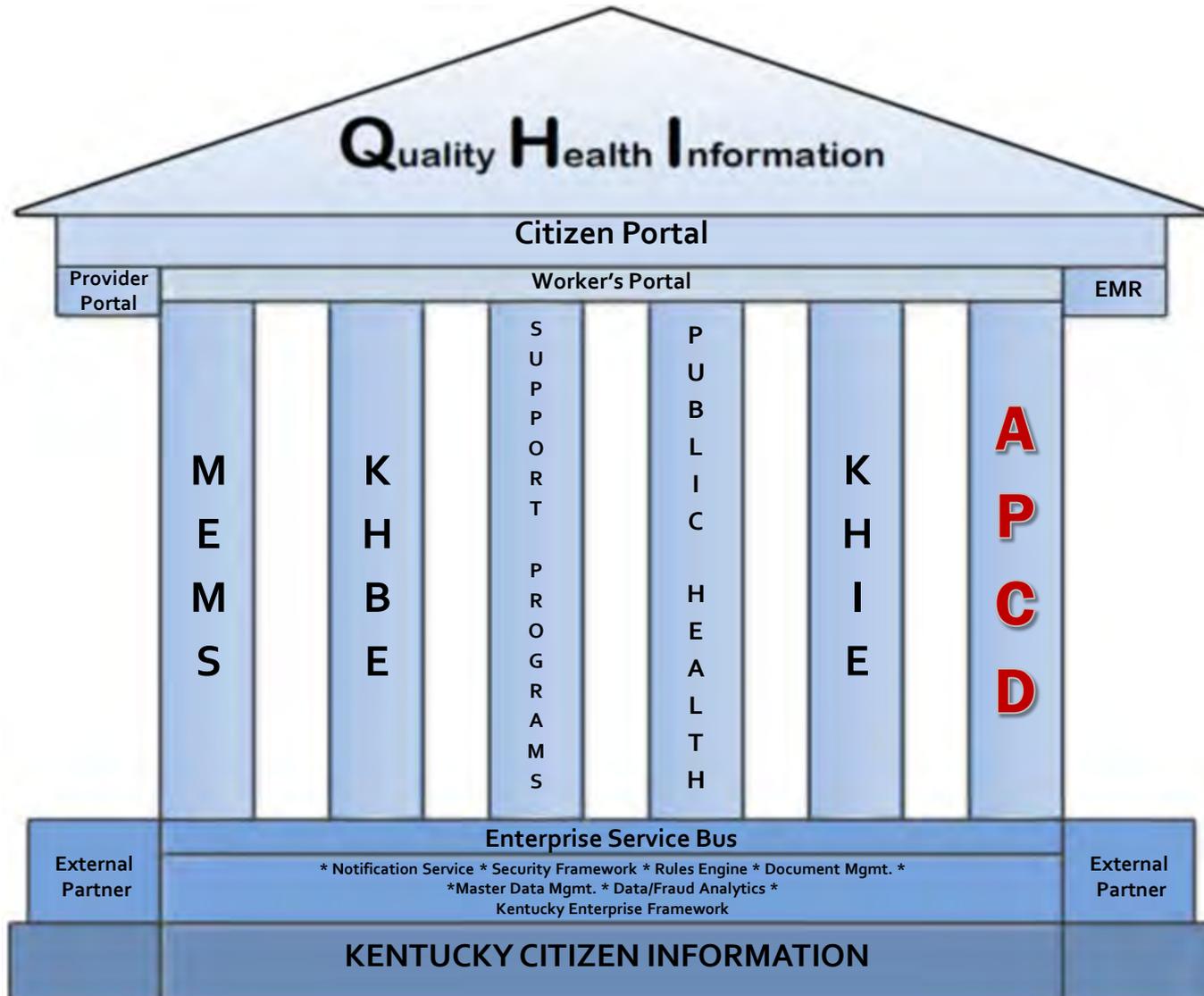
BUT

...without technology
there are few solutions

Rodney Murphy

Kentucky CHFS' Vision:

Be Data Driven AND Achieve Real Measurable Outcomes



February Meeting Notes

MCO Medical Director Meeting

Kentucky Medicaid Managed Care Plans

Monday, February 24, 2015

1:00 p.m. – 3:00 p.m.

Location

CoventryCares of Kentucky

9900 Corporate Campus

Suite 1000

Louisville, KY 40223

Attendees (MCO's): Dr. Vaughn Payne (Humana/CareSource), Dr. Steve Houghland (Passport), Dr. Fred Tolin (CoventryCares/Aetna), Dr. Jerry Caudill (Avesis), Dr. Peter Thurman (Anthem), Dr. Howard Shaps (WellCare), Dr. Rich (Dentaquest), Alan Daniels (WellCare-Pharmacy), Andrew Rudd (Anthem-Pharmacy), Owen Neff (Humana/CareSource-Pharmacy), Tom Kaye (CoventryCares-Pharmacy Director), Don Kupper (Passport)

Attendees (CHFS): Dr. John Langefeld (DMS), Dr. Allen Brenzel (DBHDID), Dr. Connie White (DPH), Samantha McKinley, PharmD (DMS), Andrea Adams (OHP), Patricia Biggs (DMS), Adi Mittrache (UKMC),

Attendees (Guests): Dr. Michael Smith (U of L Pediatrics), Dr. Michelle Stevenson (U of L Pediatrics), Dr. David Lohr (U of L Pediatrics)

Agenda Discussion Items

➤ **Update from past meetings**

• **Behavioral Health – Update**

▪ **Behavioral Health Project Plan Team/Workgroup**

The BH project team workgroup continues ongoing meetings. Next meeting is scheduled Monday January 26th. The current focus is on getting final clarification of codes and create conformance with NCCI. There is also a specific need to establish methodology for collecting SED/SMI designation in systems.

▪ **Naloxone Rescue**

An update was provided regarding the Naloxone rescue initiative. SATAC approved funding (~\$100,000) for use to purchase and distribute heroin overdose reversal kits for Kentucky hospitals with the highest rates of heroin overdose deaths – the University of Louisville Hospital, the University of Kentucky Hospital in Lexington, and the St. Elizabeth Hospital system in Northern Kentucky. This initiative was formally announced in a press conference with

Attorney General Jack Conway, Governor Beshear and the first lady. There was discussion the group regarding potential options available for a sustained initiative following this initial pilot. There was expressed interest and support from all MCO medical directors as well as pharmacy directors regarding creating a sustainable plan. We will plan to set up a specific call/meeting to pursue this discussion.

- **Dental Items - Dr. Caudill updated group:**

Dr. Caudill reported that they are still pursuing the identification and documentation of quality concerns with mobile dental providers.

- **Update Health Home**

Group was informed that the initial focus of our Health Home was to focus on Substance Use Disorder (specifically primary opioid), with secondary concern of development of blood-borne infectious disease such as Hepatitis C. Deloitte consulting has been engaged to facilitate pursuing SPA submission.

➤ **New Discussion Items**

- **Psychotropic Medication in Children Initiative: Update**

Dr. Smith (U of L Pediatrics) presented an update of this initiative. The group has narrowed the data set to focus initially on atypical antipsychotic utilization. They have developed and internally vetted a questionnaire that will be utilized for outreach and collection of information from the highest utilizers (top 80) identified in the initial data analysis.

This will be done via outreach phone calls. When completed, a summary will be presented to the group with an outline of recommendations for next operational steps and support of the MCO PIP's.

- **K AIR (Asthma): update**

Dr. White updated the group regarding current status of the K AIR proposal. She is waiting for her DPH team to give the MCO's a breakdown step-by-step of how this process would work. A deadline for this has been set for the end of March.

- **Orphan & Off-Label Drug Policy**

A current DMS policy statement was distributed to group for review and discussion.

Overview/Description

The drug label "**approved by the FDA**":

Is the official description of a drug product which includes indication (what the drug is used for); who should take it; adverse events (side effects); instructions

for uses in pregnancy, children, and other populations; and safety information for the patient. Labels are often found inside drug product packaging.

Off-label or “unlabeled” drug use is the use of a drug approved by the U.S. Food and Drug Administration (FDA) for other uses that are not included in approved product labeling. The FDA approves drugs for specific indications that are included in the drug’s labeling. When a drug is used for an indication other than those specifically included in the labeling, it is referred to as an off-label use. Many off-label uses are effective, well documented in the literature, and widely used.

An “**orphan drug**” is a product that treats a rare disease (e.g., affecting fewer than 200,000 people or for which there is no reasonable expectation of recovering the costs of development and marketing).

Expanded access refers to the use of an investigational new drug (IND) outside of a clinical trial by patients with serious or life-threatening conditions who do not meet the enrollment criteria for the clinical trial in progress. This type of access may be available, in accordance with FDA regulations, when it is clear that patients may benefit from the treatment, the therapy can be given safely outside the clinical trial setting, no other FDA approved alternative therapy is available, and the drug developer agrees to provide access to the drug. The FDA refers to such a program as an Expanded Access Program (EAP). The IND EAP allows physicians to request permission from the FDA to use an investigational drug in a patient with a severe or life threatening condition in which FDA approved drugs have failed. Safety data is collected at regular intervals on all patients receiving an investigational drug via an IND. EAPs can be used in a wide range of therapeutic areas including, HIV/AIDS and other infectious diseases, cancer, rare diseases, and cardiovascular diseases.

Summary of Clinical Indications & Coverage Guidelines

Medically Necessary:

Off-Label Drug Use

Off-label drug use is considered **medically necessary** when **all** of the following conditions are met:

1. The drug is approved by the U.S. Food and Drug Administration (FDA)

AND

2. The drug is being prescribed to treat a medical condition not listed in the product label and for which medical treatment is medically necessary.

AND

3. The prescribed drug use is supported in any **one** or more of the following:

- a. American Hospital Formulary Service Drug Information[®] (AHFS[®]); **or**
- b. Truven Health Analytics Inc., DrugPoints[®] meeting each of the following:
 - Strength of Recommendation Class I or IIa; **and**
 - Strength of Evidence Category A or B; **and**
 - Efficacy Class I or IIa; **or**
- c. National Comprehensive Cancer Network[®] (NCCN[®]) Drug & Biologics Compendium[®] Category of Evidence and Consensus 1 or 2A; **or**
- d. Sufficient evidence (minimum of two articles from major scientific or medical peer-reviewed journals; excluding case reports, letters, posters, and abstracts), or published studies having validated and uncontested data, which support the proposed use for the specific medical condition as safe and effective.
 - Examples of accepted journals include, but are not limited to, *Journal of American Medical Association*, *New England Journal of Medicine*, and *Lancet*.
 - Accepted study designs include, but are not limited to, randomized, double blind, and placebo controlled clinical trials.

If the off-label drug use is determined to be medically necessary, its use shall also be determined to be "non-investigational" for the purposes of benefit determination.

Orphan Drug Use

Use of an orphan drug is considered **medically necessary** when it receives FDA Orphan Drug designation and approval for marketing ("Designated/Approved").

A product may have an orphan drug designation but fail to meet the criteria to have FDA marketing approval. Use of a product with orphan drug designation alone without FDA marketing approval is considered **not medically necessary**.

Expanded Access (Compassionate Use) Drugs

Expanded Access (Compassionate Use) Drugs (e.g. when a single patient IND even if through a dedicated clinical setting such as a hospital group IND approval request is approved by the FDA on a compassionate use basis) are considered **experimental / investigational** but may be covered if Research Urgent or Off-Label Drug use requirements (I. A. 1.) are met.

A use is **not medically accepted** by a compendium if the indication is a Category 3 in NCCN, a Class IIb or III in DRUGDEX[®], or the narrative text in AHFS or Clinical Pharmacology is "not supportive".

➤ **Miscellaneous Items**

- **Buprenorphine PA update**

Dr. McKinley gave an update of status for prior authorization of Buprenorphine and related products. The final version is pending the just-released KBML regulations. Once incorporated the final DMS PA policy will be distributed.

- **LARC's**

The question of coverage of LARC's (long-acting & reversible contraceptives) and creating an option for coverage prior to hospital discharge was discussed with the group. There was unanimous support expressed from the MCO's and pharmacy directors. This will be presented to Commissioner Lee for submission of policy change.

- **LDCT**

DMS is currently in process of creating a rate and submitting a change order for coverage of LDCT screening for lung cancer. As required any ACA for all USPSTF category A or B recommended procedures (this is category B).

- **SIM Model Design**

The group was updated regarding the application for State Innovation Model Design. Kentucky has been awarded \$2 million to develop a state health innovation plan. We are currently assembling our team and getting organized, and anticipate reaching out to each of the MCO's as key stakeholders in the next few weeks.

- **APCD**

The group was also updated that tentative approval has been given for initial phase of planning and stakeholder engagement for the "All Payer Claims Database". The MCO's as also key stakeholder in this development process will be included in initial and ongoing discussions beginning in the coming weeks.

❖ **Next Meeting: The next meeting has been rescheduled for Wednesday April 29th (1-3pm) at Passport Health Plan location.**