CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

275 East Main Street, 6W-A
Frankfort, KY 40621
P: 502-564-4321
F: 502-564-0509
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

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Mr. Ron Poole, RPh
102 W. Broad Street
Central City, KY 42330

Dear Ron:

Thank you for your submitted recommendations from the Advisory Council for Medical Assistance (MAC). We have reviewed each recommendation and made comments on each recommendation listed below.

It is my understanding that most of the revised recommendations were addressed in a letter dated June 7, 2012 to you and that all MAC members received a copy of that letter. However, I would like to restate our responses and provide responses to any new recommendations you provided at the last meeting.

Recommendations from the Medicaid Advisory Council to be acted on by the Cabinet for Health and Family Services:

1. The Medicaid Advisory Council asks the Cabinet for Health and Family Services to evaluate how the Managed Care Organizations (MCO's) are working with our Home Health Agency and Hospice Providers. If Medicaid deems the behavior of the MCO's to be substandard when working with Home Health and Hospice Agencies, then Medicaid needs to take appropriate action to get the MCO's abiding by their contracts and to send out a timeline for these improvements to all contracted Home Health Agency and Hospice Providers.

   a. Suggestions for evaluation:
      i. The authorization process for services and supplies
      ii. The low reimbursement rates for these services and supplies
      iii. The amount of time it takes for reimbursement
      iv. The response time in dealing with the MCO's on any of these issues

   Response: CHFS/DMS continually monitors each MCO for contract compliance and when non-compliant issues are identified the appropriate notification for corrective action is submitted to the MCO with timelines for resolution. It should also be noted that State Medicaid agencies are required under federal law 42 CFR 438 to contract with an independent External Quality

Review Organization (EQRO) for the purpose of performing an annual External Quality Review (EQR) for each contracting MCO. DMS has contracted with Island Peer Review effective September 1, 2012 with the goals and objectives the following:

- Ensure the Quality of data collection from MCO's
- Achieve measurable improvements in the health status of Medicaid and CHIP MCO enrollees
- Ensure that Medicaid MCO enrollees have access to and availability of an adequate provider network
- Reduce the gap between evidence-based recommendations/standards of care and actual practice
- Facilitate collaboration among and between MCO's and their common provider networks on shared focused quality improvement goals
- Promote the delivery if primary and preventive care and contain costs over the long term, at a level which can be supported by the Commonwealth.

2. The Medicaid Advisory Council asks the Cabinet for Health and Family Services to persuade Kentucky Spirit to credential Psychiatric Nurse Practitioners as agreed upon last fall. Nurse Practitioners were assured by all the MCOs in meetings last fall that Psych Nurse Practitioners would be credentialed and recognized. Kentucky Spirit uses Cenpatico, which is their behavioral health subsidiary, to credential psych providers. While Kentucky Spirit says that they recognize Psych Nurse Practitioners as mental health care providers, Cenpatico refuses to credential them. This makes it impossible for Psych Nurse Practitioners to provide care for patients who have coverage under Kentucky Spirit.

   Response: Although CHFS/DMS cannot dictate provider network contracting for the MCO's, we agree that the MCO's should demonstrate the efforts to assure that Psychiatric Nurse Practitioners are credentialed and recognized psychiatric providers. We will continue to work with Kentucky Spirit to ensure that Cenpatico does demonstrate an effort to credential Psychiatric Nurse Practitioners.

3. The Medicaid Advisory Council asks the Cabinet for Health and Family Services to persuade Coventry to not implement the pharmacy lock-in program which again is another mechanism for barriers to care. Takes away patient choice and the[y] could prevent patient from getting medicine filled on Sundays.

   Response – Each MCO is required to follow KY Statutes and Administrative Regulations. 907 KAR 1:677 outlines the Lock-In program. Each MCO may "lock-in" a Medicaid recipient to:

   - One (1) primary care provider;
   - One (1) controlled substance prescriber who shall serve as the sole prescriber and manager of controlled substances for the lock-in recipient;
   - One (1) pharmacy; and
   - If the recipient meets the criteria established in Section 4(2)(b) of this administrative regulation, one (1) hospital.

   There was an issue with the Lock-In program that Coventry implemented. The Administrative Regulation lays out a list of "conditions" for which a member may be put in the Lock-In program.

This list of conditions are all "and" statements. However, Coventry misunderstood them as "or" statements.

- Medicaid recipients may be put in the Lock-In program if in two (2) consecutive 180 calendar day periods, the recipient:
  - Received services from at least five (5) different providers;
  - Received at least ten (10) different prescription drugs; **AND**
  - Received prescriptions from at least three (3) or more different pharmacies; **OR**
  - Had at least four (4) hospital emergency department visits for a condition that was not an emergency medical condition; **OR**
  - Received services from at least three (3) different hospital emergency departments for a condition that was not an emergency medical condition.

CoventryCares has corrected their logic in their system and corrected letters have been sent and members that received the original lock-in letter have been notified if they received it in error.

4. The Medicaid Advisory Council asks the Cabinet for Health and Family Services to persuade Kentucky Spirit to eliminate its 4 prescription limit per 30 days. Every prescription thereafter requires prior-authorization. It's true that Medicaid had this limit before the MCO implementation; however, there was a Drug Class Exclusion list that allowed for more prescriptions per month based off of these chronic medical condition exclusions. This process delays Medicaid recipients' access to care.

   Response: As mentioned in this recommendation, this policy has been in existence with Medicaid prior to implementation of Managed Care. 907 KAR 1:019 states: the department shall cover no more than a total of four (4) prescriptions, of which no more than three (3) shall be brand name prescriptions per recipient per month.

   - The four (4) prescription limit shall not apply if the recipient:
     - Is under nineteen (19) years of age;
     - Uses insulin for the management of diabetes; or
     - Is a nursing facility resident who does not have Medicare Part D drug coverage.
   - 907 KAR 1:019 also outlines a listing of chronic conditions/diseases for which prescriptions to treat those conditions are excluded from the 4 Rx per month limit. Kentucky Spirit also considers chronic disease states and currently exempts drugs directly related to that disease.
   - The four drug limit only affects drugs not considered chronic drug maintenance, i.e., non-emergent drugs.
   - Kentucky Spirit continually monitors its drug benefit and makes adjustments when in the best interest of the patient based of medical necessity.

5. The Medicaid Advisory Council asks the Cabient for Health and Family Services to convince the MCO's to allow drug therapy management for behavioral health patients to be wholly determined by the prescribers and pharmacists working together to obtain the best health outcomes. Behavioral Health medications will be exempt from prior-authorization processes. A request and/or justification inquisition may be made by the MCO's to verify the validity of the drug therapy, but the request cannot interrupt drug therapy management in any manner.
   Mental Health Issues that need to be addressed with the MCO's:
   a. Lack of coverage with local private hospitals with psychiatric wards
   b. Arbitrary shortening of hospital stays.

- It can take as long as two weeks for meds to reach therapeutic level in bloodstream. Short-term sedation does not always mean symptoms such as hallucinations are alleviated.

c. Medications
- With psychiatric medications, generics don't always work.
- First generation antipsychotics can have horrible side-effects and can leave persons so heavily sedated, they can actually mask symptoms.
- Because of this, many people refuse to take meds at all and are likely to end up in jail.
- Many others will be homeless (evection often follows arrest)
- Others will end up in personal care homes ($1200.00 mo)

d. Proposed titration out of day programs or TRPs
- For many, these programs are the only socialization they have
- TRPs often keep people out of the hospital, or jail

e. Refusal to pay for Crisis Stabilization Unit Services

Response: The MCOs have been contracted to provide management for Medicaid patients. Only allowing pharmacists and providers to determine drug therapy does not allow MCOs to provide a service they are being paid to provide. Patients stabilized on behavioral health medications should be maintained on current drug therapy to ensure that they are not a danger to themselves or others. This can be accomplished by submitting a prior authorization request with past drug history. Behavioral health drugs are available on each MCO's preferred drug list and others may be made available by prior authorization.

6. The Medicaid Advisory Council asks the Cabinet for Health and Family Services to examine why the states of Connecticut and Oklahoma ceased to allow their Medicaid programs to be operated by contracted Managed Care Organizations.

Response: DMS will make contact with these two states to see if we can obtain additional information regarding this change from Managed Care Organizations. Oklahoma changed back in 2003 and Connecticut just changed as of January 1 2012. According to the Centers for Medicare and Medicaid Services, managed care organizations served more than 39 million Medicaid beneficiaries in 2010, or more than 70 percent of all enrollees. That's a sharp increase from fewer than 3 million beneficiaries enrolled in Medicaid managed care just a decade ago. Last year, California adopted a new managed care program for seniors and adults with disabilities, a move that affected more than 380,000 people. Florida's Republican Governor Rick Scott signed a law making managed care mandatory for a majority of Medicaid beneficiaries. And New York plans to move nearly all of its 4.7 million Medicaid recipients into managed care over the next three years. So, while only 2 states in the past 10 years have moved from Managed Care Organizations, more and more states are moving toward Manage Care.

7. Since KRS 205.550 states: Subjects on which council advises.
   (1) The council shall advise the Cabinet for Health and Family Services about health and medical care services.
   (2) The council shall have the opportunity for participation in policy development and program administration and shall advise the Cabinet for Health and Family Services on such matters.

(3) The council shall give advice regarding how to further the participation of recipient members in the policy development and program administration of the Medical Assistance Program.

a. The MAC would like clarification from the Governor's office and the Cabinet for Health and Family Services in defining the function and charge of the MAC.

Response: The MAC is an advisory committee compiled of representatives from the various provider and advocate organizations located throughout Kentucky. This committee meets and has the opportunity to make recommendations (such as those included in this letter) to the Department for Medicaid Services on how medical services are provided and what is provided. Because the MAC membership represents various regions of the state and various provider type and advocates, DMS looks to the MAC for information on what is happening out in the state and what specifically may be happening to determine if a pattern is developing what needs to be addressed. Because the MAC is an advisory committee, recommendations may or may not always be implemented. However, we do review all recommendations brought by the MAC for consideration and possible implementation.

b. Why was the Medicaid Managed Care Oversight Branch department within Medicaid formed? What purpose do they served that is different from ours? Are the members of the Medicaid Managed Care Oversight Branch paid positions?

Response: The Medicaid Managed Care Oversight Branch was created as a result of legislation passed in the 2011 General Assembly. However, with the implementation of statewide managed care, the DMS agreed with the Legislature that we indeed do need a Medicaid Managed Care Oversight Branch. This branch oversees the day-to-day activities of each of the four MCOs, provides contract monitoring, data research, audits of each MCO. The MAC is an advisory committee and not available for the day-to-day oversight provided by the Managed Care Oversight Branch. Yes, the employees of Branch are full-time employees of the Commonwealth of Kentucky and are paid positions. Each position was posted within the guidelines of the State Merit System with the exception of the two non-merit positions. However, those positions were posted on our website as well as in statewide newspapers (Courier Journal and Herald Leader).

c. When, if ever, will the actions and recommendations enacted by the MAC be given true consideration by the Cabinet for Health and Family Services to improve policies of Medicaid and to truly increase the quality of care provided to our Medicaid Recipients.

Response: As indicated above, DMS and the CHFS does take into consideration any actions and recommendations enacted by the MAC. However, these are recommendations and we may not be able to implement all recommendations. The DMS must operate within the confines of the laws and policies enacted by both the federal and state government. Otherwise we could be at risk to lose the Federal Medical Assistance Percentages (FMAP). Additionally, we have contracts that have been signed that prohibit us from making some changes at the time recommendations are made. Furthermore,

while we do consider the health and welfare of our recipients when making decisions, we must also make decisions based on the amount of money budgeted to Medicaid during each biennium. In previous years of good economy our decisions were much easier to make. However, in most recent years when the economy has negatively impacted our budget, we have seen little to no increase in our budget. However, we have seen cost increases in the cost of services and more so we have seen increases in enrollment in Medicaid with no increase in budget to help cover the cost of those additional enrollees.

Ron, I hope the above information has provided you and the other members of the MAC with sufficient information in response to each recommendation. If you desire additional information, please feel free to contact me at any time.

Sincerely,

Lawrence Kissner
Commissioner

cc: MAC Members