

COMMONWEALTH OF KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES

**IN RE: CHILDREN'S HEALTH TECHNICAL ADVISORY COMMITTEE**

---

March 12, 2014  
2:00 P.M.  
Community Action Kentucky  
101 Burch Court  
Frankfort, Kentucky 40601

---

APPEARANCES

Mary Burch  
CHAIR

Tara Grieshop-Goodwin  
Charlotte Haney, DMD  
Michael Flynn  
TAC MEMBERS

Lucy Senters  
Wayne Dominick  
Cindy Arflack  
MEDICAID SERVICES

---

**CAPITAL CITY COURT REPORTING**

TERRI H. PELOSI, COURT REPORTER  
900 CHESTNUT DRIVE  
FRANKFORT, KENTUCKY 40601  
**(502) 223-1118**

---

APPEARANCES  
(Continued)

---

Dr. Julia Richerson  
AAP-KY/FHC

Ms. Katie Carter  
KENTUCKY YOUTH ADVOCATES

Ms. Regan Hunt  
KENTUCKY VOICES FOR HEALTH

Ms. Marcelline Coots  
PASSPORT HEALTH PLAN

Ms. Lee Ann Magre  
Mr. Alan Daniels  
WELLCARE

Mr. Matt Fitzner  
Ms. Carrie Hardie  
Ms. Peg Patton  
Mr. Jeff Sutherland  
ANTHEM BLUE CROSS-BLUE SHIELD

AGENDA

Welcome and Introductions .....	4
Approval of Minutes from December 11, 2013.....	4
Cabinet Updates on Medicaid & KCHIP.....	4 - 40
General Discussion .....	40 - 43
Provider Issues .....	43 - 64
Other Business .....	64 - 87
* Future Agenda Items	
Next Meeting Date - June 11, 2014 .....	84

1 MS. BURCH: Welcome, everybody.  
2 My name is Mary Burch. I'm a school nurse and health  
3 coordinator with Erlanger-Elsmere Schools and Chair of  
4 this committee.

5 (INTRODUCTIONS)

6 MS. BURCH: Thank you. Has  
7 everybody had time to review the minutes from the  
8 December 11th meeting? Are there any changes,  
9 modifications? So, could I get a motion to approve?

10 MS. GRIESHOP-GOODWIN: So moved.

11 DR. HANEY: I can second.

12 MS. BURCH: All in favor.

13 Opposed. Minutes are approved.

14 The Cabinet updates on Medicaid  
15 and KCHIP.

16 MS. SENTERS: I'll start. As far  
17 as Medicaid, they are currently extremely busy and  
18 reviewing public comments for regulations that have been  
19 changed due to the Affordable Care Act. So, they are  
20 currently reviewing those.

21 KCHIP is actively involved in  
22 outreach again. Last year, we focused on dental health.  
23 We plan to do the same thing this year using our give-  
24 aways, our dental accessories - toothpaste, toothbrushes  
25 and so on. And, so, we are still focusing on dental

1 health. Back-to-school events are starting to crop up.  
2 So, we will remain actively involved with that.

3 We have several SPA's which are  
4 State Plan Amendments which all have to be changed due  
5 to the Affordable Care Act. I believe about 95% of  
6 those have been approved. There are still a few that  
7 need to be approved but they are all looking good. The  
8 SPA's and the regs may be reviewed online if anyone  
9 would like to review those.

10 MS. BURCH: Lucy, do you mind if I  
11 interrupt?

12 MS. SENTERS: Sure.

13 MS. BURCH: I don't know what that  
14 is, the SPA.

15 MS. SENTERS: The State Plan  
16 Amendment which that's our guidebook. We can't operate  
17 without those and each program has one. KCHIP has one.  
18 Medicaid eligibility, the benefits plan. Everything has  
19 a State Plan to go by.

20 The KCHIP Annual Report is  
21 completed and is available online if you would like to  
22 look at that. There's lots of good information in there  
23 about how we're doing with the program. There's one in  
24 there for Medicaid as well.

25 And I think that's about all I

1 have. Anything you want to add, Cindy?

2 MS. ARFLACK: I think Lucy  
3 included the enrollment numbers. They've gone up  
4 drastically since Kynect has been in existence. We knew  
5 there would be about 300,000 people eligible, uninsured  
6 folks. We thought by June of 2014, we would enroll at  
7 least 150, 180,000, and we've already surpassed that.  
8 So, the enrollment is going very well. Lucy has been  
9 over at Kynect and they have a big backlog of  
10 enrollment.

11 That doesn't have anything to do  
12 with the children; but if you get the parents, then, if  
13 there are any uninsured children, you hope that those  
14 will come next as well but they have grown drastically.

15 Open enrollment for the MCO's is  
16 May 5th through June 18th, and that includes everything  
17 except Region 3. So, just to keep you aware, that's the  
18 time when everybody can change to a different MCO.

19 Everybody will be a player.  
20 Anthem will at that time be receiving children. Up to  
21 this point, Anthem has not had children, but they will  
22 be a player and able to enroll children at that time.

23 So, May 5th through June 18th, and  
24 then the effective date will be July 1.

25 MS. BURCH: Cindy, when a parent

1 goes on Kynect, how are the children identified then?

2 MS. ARFLACK: Well, they do a  
3 household assessment at that time. And Lucy could  
4 probably speak to that better than me, but they do a  
5 household determination. When you go in there and go on  
6 Kynect, it asks you about how your household is set up,  
7 the members of the household. And they go by household  
8 income is how it's determined.

9 Now, from what I'm told is if you  
10 have like a 21-, 22-year-old young adult who is living  
11 with you and then filing taxes separately, then, they  
12 don't have to count Mom and Dad's income.

13 So, the household is considered in  
14 the whole application, but they may pull the son out and  
15 put a different case. It's about how they file their  
16 taxes. It's very complicated; but just to give you an  
17 idea, there's a lot of young adults who are signing up  
18 in large numbers.

19 MS. BURCH: And at that point,  
20 then, it should identify the kids?

21 MS. ARFLACK: It should identify  
22 the kids. At that time, it would ask when you go to the  
23 application, when you're on Kynect, it asks who is in  
24 your household. So, if there's children and it asks if  
25 they've got insurance. What we're finding is that most

1 of the time, it's Mom and Dad who don't have insurance.  
2 The children have already got insurance through KCHIP or  
3 Medicaid. They just weren't eligible.

4 MS. BURCH: And if they don't,  
5 that will flag them so that they could be covered also?

6 MS. ARFLACK: Right. They would  
7 be covered, yes.

8 MS. BURCH: This is really a silly  
9 logistical question, but is the parent then notified or  
10 do they have to do something more?

11 MS. SENTERS: That would be  
12 notified, I'm sure.

13 MS. ARFLACK: When you finish the  
14 application, it tells you at that time whether you're  
15 approved or not.

16 MS. BURCH: And it would tell them  
17 if their child is also approved?

18 MS. ARFLACK: Correct.

19 MR. DOMINICK: The way it works,  
20 it checks with your tax returns; and if you have filed  
21 dependents on your tax returns, it will ask you about  
22 why aren't you putting any dependents on the Kynect.  
23 Theoretically that's the way it works.

24 MS. ARFLACK: It goes out and  
25 checks the federal hub and it hits the taxes, it hits

1 Social Security. It checks all those things. So, it  
2 hits a lot of different things and checks them. That's  
3 been the problem with Kentucky's is the federal hub  
4 wasn't working correctly. So, when it went out there,  
5 it couldn't hit anything. So, that was some of our  
6 problem with our side. We were working fine but the  
7 federal hub wasn't working accurately. But like Wayne  
8 says, it bumps up against the tax.

9 Now, there are some instances  
10 where they would require additional information, so,  
11 they wouldn't determine eligibility, like they would  
12 need some kind of verification. If more verification is  
13 needed, then, it would pin the application and send it  
14 on and then you would have to send that information in.

15 MS. HUNT: Sort of like Social  
16 Security award letters, things like that. They would  
17 need proof of income for it.

18 MS. ARFLACK: But if everything is  
19 there and it hits the hub and gets your taxes and it  
20 comes back and says, okay, you're all eligible, then, it  
21 would say you're approved and good. Then, the MCO that  
22 they selected would then contact them and give them a  
23 welcome packet and they would proceed.

24 MS. HUNT: I'm trying to pull up  
25 enrollment from Kynect and the folks that are eighteen

1 and under who have gotten coverage over the last little  
2 while. So, give me just a second and I will tell you  
3 what the number is because they do a really good job.  
4 Every time that new data is uploaded, it goes to the  
5 Governor's Healthier Kentucky site.

6 So, if you type in Healthier  
7 Kentucky into Google, that's the first thing that pops  
8 up. And every other week, they produce statistics by  
9 county level, by age group, and by the plan that folks  
10 have selected, so, whether it's private coverage with a  
11 subsidy, without a subsidy and Medicaid coverage.

12 DR. HANEY: Let me ask a question.  
13 I know you all have focused on dentistry. How do you  
14 feel like that has worked so far?

15 MS. SENTERS: It's gone real well.

16 DR. HANEY: Do you know if they're  
17 actually not only signing up but utilizing it? Is there  
18 any way we can get any----

19 MS. SENTERS: Utilizing their  
20 dental?

21 DR. HANEY: Yes, their benefits  
22 because in the past, we would many times find families  
23 where the children had dental benefits through Medicaid  
24 or KCHIP but they weren't utilizing it except for  
25 episodic issues.

1 MS. SENTER: The only way I think  
2 that we can actually determine that is through the 416  
3 Report which comes out in April or May.

4 DR. HANEY: So, when we have our  
5 next meeting----

6 MS. SENTER: It should be  
7 available by then, yes.

8 MS. HUNT: The last numbers which  
9 came out two weeks ago, so, right at the end of  
10 February, over 37,000 folks who had enrolled through  
11 Kynect were kids under the age of eighteen out of  
12 269,000. So, a little less than 10%.

13 DR. HANEY: We don't know whether  
14 those are new enrollees that were not covered at all----

15 MS. HUNT: And that's also  
16 including Medicaid and private insurance plans. So,  
17 that's all of them.

18 DR. RICHERSON: What's the open  
19 enrollment for Region 3?

20 MS. ARFLACK: I'm not sure they've  
21 determined that yet. We take one enrollment at a time.  
22 This one is going to be really big, a lot of movement we  
23 think because they have a lot more to choose from  
24 because Passport and Humana have now made it into those  
25 markets. So, this is going to be a really big

1 enrollment change, we think.

2 MS. BURCH: Any other questions or  
3 comments?

4 DR. RICHERSON: With the SPA's, I  
5 know that there's opportunity with ACA to have asthma  
6 educators as reimbursable providers, but it's my  
7 understanding there has to be a SPA to do that. Do you  
8 know if that's in any of the current SPA's?

9 MS. ARFLACK: That's not one of  
10 our new provider types. Most of the new provider types  
11 have all been mental health.

12 DR. RICHERSON: CMS has approved  
13 asthma educators as a reimbursable provider, but it's my  
14 understanding that you do have to do a SPA.

15 MS. ARFLACK: It would have to be  
16 a SPA change. You're correct.

17 DR. RICHERSON: So, I didn't know  
18 if that was in the works anywhere.

19 MS. ARFLACK: Right now the  
20 behavioral health are the only provider types we've  
21 added. Some of the physical therapists were just for  
22 cross-over, QMB for the Medicare population. So, those  
23 have now been accepted for all the population. So,  
24 those are the only provider types we've added.

25 DR. RICHERSON: And would this be

1 where we would advocate to have that change made?

2 MS. ARFLACK: That would probably  
3 be a recommendation you would want to make up to the  
4 MAC.

5 MS. BURCH: I'm assuming, then, as  
6 far as school nurses not employed by Boards of Health,  
7 that's the same way, that they're not a recognized  
8 provider unless it's through the school system.

9 MS. ARFLACK: Or the health  
10 department.

11 MS. GRIESHOP-GOODWIN: Regarding  
12 the regulation discussion, early last year I know it was  
13 recommended that Kentucky do a six-month waiting period  
14 when kids went from private insurance to Medicaid. Was  
15 that ever passed?

16 MS. SENTERS: Yes. That went into  
17 effect January 1 of this year.

18 MS. BURCH: Julia, when you  
19 brought up the asthma educators, what are your thoughts  
20 with that?

21 DR. RICHERSON: There is a  
22 certification process to become a certified asthma  
23 educator. I just know on some of the national asthma  
24 calls that I'm on, that that's a big question of many  
25 states because asthma is such a high-burden disease in

1 Kentucky as it is in many states and especially in  
2 children as well as adults, and the outcomes with more  
3 intensive case management and education are much better.  
4 And, so, if we had an opportunity to have more resources  
5 for our kids with asthma with something like an asthma  
6 educator who is trained with evidence-based  
7 interventions, I really think it's an opportunity to hit  
8 on asthma since it's such a high-burden disease.

9 MS. ARFLACK: Do you know what the  
10 MCO's are doing currently with asthma?

11 DR. RICHERSON: Asthma educators  
12 are not paid for by the MCO's. I believe that Anthem  
13 has a special program to do some higher reimbursement  
14 around asthma, but it's not through the asthma educator  
15 process.

16 MS. ARFLACK: I was just wondering  
17 if you could train a case manager.

18 DR. RICHERSON: It's a more  
19 intensive training process, but, yes, they could be----

20 MS. ARFLACK: You could take a  
21 case manager and train them and certify them.

22 DR. RICHERSON: Does not have to  
23 be in----

24 MS. ARFLACK: Passport doesn't  
25 have one? I know you all are big into asthma.

1 MS. COOTS: We actually have one  
2 on staff.

3 DR. RICHERSON: But it would be  
4 more office-based to have somebody in the office.

5 MS. ARFLACK: To come into your  
6 office when you had patients.

7 DR. RICHERSON: Just to have them  
8 on staff.

9 MS. ARFLACK: Oh, you would have  
10 one on staff.

11 DR. RICHERSON: Yes. So, we would  
12 train one of our nurses, for example, who could do it  
13 part of the day when asthma patients were there.

14 MS. ARFLACK: So they could bill.  
15 So, you would train your nurse. Okay. I'm sorry. I  
16 wasn't following this very well.

17 DR. RICHERSON: It would just be a  
18 new provider type.

19 MS. BURCH: And to piggyback on  
20 that, I know with the health departments in the state,  
21 the majority of them are pulling out of school nursing  
22 and that left the Boards of Education to fund the school  
23 nurses, and most of the services that they generate to  
24 the regular population, or all of the services that they  
25 generate to the regular population are not reimbursable.

1 And asthma education could be a big thing because some  
2 of the nurses are already certified in that.

3 And I know we've talked about this  
4 a couple of meetings ago, and I think, Cindy, you were  
5 going to do maybe an update but I think we missed that  
6 meeting. We had talked about the changes in the schools  
7 were the school nurses were not employed by health  
8 departments any longer. So, that left a great void in  
9 the care of the children.

10 And, so, unless a child has an  
11 IEP, an Individual Education Plan, through special  
12 education in schools, the services that are generated  
13 through the school nurse, they're not able to be  
14 reimbursed at all.

15 MS. ARFLACK: It's just through  
16 the clinics.

17 MS. BURCH: That's not true.  
18 Through school nursing itself. For instance, if----

19 MS. ARFLACK: But, I mean, it's  
20 separate than the clinics. There's clinics that are in  
21 some of the schools.

22 MS. BURCH: That's true. That's  
23 separate.

24 MS. ARFLACK: That's a separate  
25 entity than the school nurse.

1 MS. BURCH: For instance, if you  
2 have a student who is a diabetic and they need an  
3 insulin injection and the student is not able to do it  
4 themselves, with the new law that was changed, it's  
5 possible that it could be delegated to somebody else;  
6 but for the actual instruction of it, it makes sense to  
7 have a nurse do that. For students who are on  
8 medication that need to be given that don't have IEP's,  
9 a nurse either has to give that or train somebody to do  
10 that. None of that is reimbursable currently.

11 MS. ARFLACK: Can you tell me how  
12 they decide what schools get school nurses? I thought  
13 it was based on the Board of Education in that area.  
14 How is that done?

15 MS. BURCH: It depends on the  
16 school district. For instance, you may have one nurse  
17 going around to eight or ten buildings.

18 MS. ARFLACK: That's the way it is  
19 here in Frankfort in my child's school.

20 MS. BURCH: They just drive around  
21 a lot.

22 MS. ARFLACK: Because currently  
23 don't the funds come from Education? They pay for that  
24 nurse?

25 MS. BURCH: Right now in the

1 state, the majority of that is true. There is some  
2 blending across the state where it's maybe Public Health  
3 money and the local School Board money.

4 And I believe at one time, and  
5 correct me if I'm wrong with this, but at one time, it  
6 was recognized under Family Resource Youth Service  
7 Centers. Nurses were recognized under that, I guess is  
8 what I'm trying to say, I think.

9 MR. FLYNN: At one time, we  
10 partnered with our local health departments to provide  
11 school nurses in our schools.

12 MS. ARFLACK: That's what I was  
13 thinking is in areas that they do have them, then, they  
14 kind of partnered and the health department kind of  
15 picked up that piece of it. That's what I thought at  
16 one time.

17 MR. FLYNN: We haven't done that  
18 in ten years.

19 MS. ARFLACK: In Frankfort, I'm  
20 just speaking from my experience in Frankfort, that in  
21 the county schools, we have one that transfers around,  
22 but the city school had one out of the health  
23 department. So, that's different pots of money, I  
24 guess.

25 MR. FLYNN: Most of the health

1 departments pulled out of the schools when they couldn't  
2 bill for all the students that they were having to see.  
3 If a kid had some kind of insurance, then, they would  
4 bill for it. If a kid didn't have it, they couldn't, or  
5 not all services they were providing were billable  
6 services.

7 MS. ARFLACK: No private insurance  
8 will pay for a school nurse. So, you could only bill  
9 for Medicaid was the only choice.

10 MS. BURCH: But I believe once  
11 managed care came in, that changed the way that Public  
12 Health had nurses in schools. So, that pulled them out  
13 and it left a void for the school districts to pick up  
14 the cost of that. Obviously, the children still needed  
15 the healthcare services so they could attend school.

16 MS. ARFLACK: The MCO's are still  
17 paying the same services that we have to cover, but I  
18 guess they didn't pay the same rate or something maybe.

19 MS. BURCH: I don't know what it  
20 was but I noticed that there was a huge void or there is  
21 a huge void and it's putting a stress on the local  
22 school districts to fund it and some of the services are  
23 left not being delivered.

24 Do we need to have more discussion  
25 about either of those two issues?

1 DR. RICHERSON: I don't know  
2 around asthma educators whether you would be comfortable  
3 proposing this recommendation to the MAC or not or if  
4 you need more information or what the next steps might  
5 be. And certainly the school nurse issue is huge.  
6 Counties have just cut them out completely. Jefferson  
7 County never had many to start with, but I know Madison  
8 County, it's a huge impact for access to school nurses.

9 I guess the term is that they  
10 become billable providers or what's the term that they  
11 get a MAID number?

12 MS. ARFLACK: They would have to  
13 be a provider type and that's where we would have to  
14 change the State Plan Amendment. And right now we have  
15 lots and lots of enrollment that we're trying to do for  
16 behavioral health to get all of those folks in.

17 All of the MCO's are building a  
18 network because this all became effective January 1st,  
19 and we didn't give them a lot of details. We just said  
20 go out there and find you some people. So, it's kind of  
21 been hard on the MCO's to build a network when they  
22 didn't have rates, they didn't have anything.

23 So, they're kind of like behind  
24 the curve on that. So, the network is just now getting  
25 kind of built up for the MCO's.

1 I guess I'm trying to figure out  
2 this school nurse thing because the MCO's were supposed  
3 to cover the same services. So, I'm not sure that's a  
4 new provider type. I think we're different here.

5 Probably what we might want to do  
6 is this one needs to have a different look at. It needs  
7 to be addressed at a different level like why they've  
8 pulled out. Like maybe we should talk to the MCO's, and  
9 if they say, well, WellCare is the one or Passport, what  
10 the issue is, which it leads me to believe Passport and  
11 Humana and Anthem are now statewide. So, they pulled  
12 out before those three even came about.

13 So, it had to be something with  
14 WellCare and Coventry, I assume, or something happened  
15 and they didn't get paid - I don't know - but that's a  
16 different issue than this. To me, that would be a  
17 recommendation you would make up to the MAC that you  
18 would like to see this looked at to add as a provider  
19 type.

20 MS. BURCH: Cindy, it kind of is  
21 the difference but it's really not because even when the  
22 health department nurses were in the schools, the  
23 registered nurses employed by Boards of Education still  
24 could not do any billing; for instance, if you could  
25 have a contract with your local health department to

1           somehow make that work.

2                           MS. ARFLACK:  They all have  
3           contracts with the local health departments, all the  
4           MCO's do.

5                           MS. BURCH:  But they're not  
6           employed by Boards of Education I guess is what I'm  
7           trying to say.

8                           MS. ARFLACK:  Let's think this  
9           through.  So, you're a nurse and you go and you're  
10          working for the Board of Education and it's not working  
11          and it's not going to work.  So, could they not go to  
12          Public Health and Public Health say, okay, we're going  
13          to put you in the school and we're going to bill for it?

14                          MS. BURCH:  But Public Health has  
15          pulled out of the nursing for school nursing.  So,  
16          that's what the issue is.  And I can say in Northern  
17          Kentucky, they weren't into it heavily anyway with their  
18          health departments.

19                          MS. ARFLACK:  Maybe it wasn't  
20          feasible with what they were getting.

21                          MS. BURCH:  Could be.

22                          MS. ARFLACK:  Well, I think that's  
23          what we need to figure out is what the issue was.  The  
24          health departments are the only ones that can answer  
25          that question why they pulled out and don't want to

1 provide the services. What I would do is that somebody  
2 needs to contact the health departments and ask them why  
3 did you do this and they could either say it was a  
4 financial investment that we couldn't make anymore. It  
5 wasn't feasible. So, then you've got an answer. But  
6 until we know what for sure was the answer, I don't know  
7 what we could do.

8 DR. RICHERSON: And certainly does  
9 Eva Stone come to these meetings regularly because she's  
10 certainly articulate on the challenges that school  
11 nurses are facing?

12 MS. HUNT: Kentucky Nurses for  
13 Health has a Children's Health Task Force and this has  
14 been something that we have been discussing for almost a  
15 year now is the situation of each school system, each  
16 county does it differently and the payment is different.  
17 Some of it is housed in the Department of Education.  
18 Some of it is housed in the Department of Public Health,  
19 and we have spent almost a year trying to figure some of  
20 this.

21 We've made baby steps just to get  
22 to that point and getting the right people around the  
23 table, and that's where we're at right now is starting  
24 to get the folks from the Department of Education and  
25 the folks from physical activity, folks from school

1 nursing, all of it together, but we still don't have an  
2 answer.

3 And I think it's just all working  
4 together so that we have good questions to ask, but I  
5 don't know what to tell you other than it's going to be  
6 a big heavy job.

7 MS. ARFLACK: Because everybody  
8 does it differently. You have some health departments  
9 that provide nurses and then some are hired through the  
10 Board of Education.

11 MR. DOMINICK: Some districts  
12 contract with the health department.

13 MS. BURCH: Some districts do, but  
14 some health departments won't allow that to happen.

15 MS. ARFLACK: And that's the  
16 problem we have, and I'm sure you've run into this  
17 dilemma, if the local health department doesn't want to  
18 play, we can't force them to do something.

19 MS. HUNT: And the State Health  
20 Department Association won't come out with what should  
21 be the rules for all of the local health departments to  
22 trickle down.

23 MS. ARFLACK: They allow them to  
24 operate separately and independently, but the  
25 frustration is the children are the ones who are getting

1 the short end of it.

2 MR. DOMINICK: As far as this  
3 committee is concerned, it seems like the concern is  
4 what would the MCO's pay for. No matter who the nurse  
5 is getting paid for, will the MCO pay for the service?  
6 You've got two separate issues here. Who is going to  
7 pay for the nurse; and if you are able to hire a nurse,  
8 will the MCO's reimburse the nurse?

9 MS. BURCH: Yes, and that's where  
10 I see this group being helpful with that.

11 MS. ARFLACK: We'll have to tread  
12 very lightly with the health department. That's the  
13 other problem with this wheel. I guess that's the  
14 difference with the asthma is you've already got a  
15 provider type which is the health department that can  
16 bill. So, you want to be independent nurses billing.

17 MS. BURCH: That's kind of what we  
18 were just talking about with the physical therapists,  
19 speech and language therapists, OT. To me, it seems  
20 like the same issue, not different, but I understand  
21 what you're saying.

22 MS. ARFLACK: You could make a  
23 recommendation to the MAC that you think that the issue  
24 needs to be brought to the attention of Public Health.  
25 Public Health is a sister agency of Medicaid and we're

1 all trying to work together. Have you all met with  
2 Public Health at all? Have you brought them to the  
3 table?

4 MS. HUNT: We have had some  
5 discussions, but not like Executive Director level,  
6 Executive Director level. I don't think we've had those  
7 discussions yet, but I'll bring them into the loop.

8 MS. ARFLACK: Dr. Connie White is  
9 Deputy Commissioner. She would be a good person to  
10 start the discussion with. Maybe that would be a good  
11 discussion. Do you mind letting us know if there's any  
12 report on any of that?

13 MS. HUNT: Absolutely.

14 MS. BURCH: So, at this time, you  
15 don't think there's a recommendation that needs to be  
16 made, that we have a recommendation to the MAC that  
17 school nurses will become independent providers.

18 MS. ARFLACK: You could make that  
19 recommendation. That's a bigger ask than the asthma.  
20 It's a lot more----

21 MS. BURCH: A lot more what?

22 MS. ARFLACK: Well, I just think  
23 that----

24 MS. BURCH: They could be the  
25 asthma person.

1 MS. ARFLACK: If you just say  
2 school nurses, they're going to say can all nurses? You  
3 have to have a reg. There's going to be a regulation to  
4 be changed. The regulations would have to be changed.  
5 It's actually going to be some major changes to the  
6 current.

7 MS. BURCH: And if we add asthma  
8 educators, there aren't?

9 MS. ARFLACK: But it's not going  
10 to make Public Health mad. Public Health has already  
11 got nurses and you're treading on their territory, so to  
12 speak. You can do anything you want. I'm just  
13 advising.

14 MS. BURCH: Public Health also has  
15 asthma educators.

16 MS. ARFLACK: But they're billing  
17 under their umbrella. They may say they don't want it.  
18 You're right. They may say they don't want it.

19 MR. FLYNN: They're pulling out of  
20 schools. So, they're saying they don't want their  
21 nurses in our schools. So, at that point, we're being  
22 forced to hire other nurses but having no way of billing  
23 for those services; whereas, before, when they were with  
24 us, we were contracting with the health departments to  
25 help pay for the nurses to offset anything that wasn't

1 billable. But, then, when they decided that  
2 wasn't economically viable enough for them, they pulled  
3 out and they've left us with the option of hiring our  
4 own nurses with no billing options. So, I have to agree  
5 with Mary. I think that it's something that should be  
6 looked at.

7 MS. GRIESHOP-GOODWIN: Do you  
8 think we should take the next couple of months to try  
9 and have some conversations and come up with more of a  
10 proposal?

11 MS. BURCH: I do. I think that  
12 might be a good idea. I just don't want it to be  
13 forgotten because I feel like we were forgotten three or  
14 four months ago when we were talking about it and the  
15 need is still there and it's greater than it ever was.

16 DR. HANEY: If they could become  
17 independent providers, then, they're responsible for  
18 doing all billing and everything themselves or the  
19 entity that they work under would still do that billing  
20 for them?

21 MS. BURCH: That would be part of  
22 the discussion, Charlotte, similar to OT, PT, speech  
23 language.

24 DR. HANEY: Because I could see  
25 where some people, if they had to do all of that billing

1 and stuff themselves, they would say, I don't want that.  
2 I would rather it be done for whatever school system or  
3 whoever I work under.

4 MR. DOMINICK: And the schools  
5 would balk at having to do that, too. It would be a  
6 burden on the school secretary or whoever.

7 MS. BURCH: The majority of the  
8 schools are already billing for services through IEP's.

9 DR. HANEY: So, the setup is  
10 there.

11 MS. BURCH: The setup is there.

12 MS. ARFLACK: This comes from a  
13 different pot of money. It's totally different.

14 MS. BURCH: But it's a Medicaid  
15 number, I guess.

16 MS. SENTERS: The school-based  
17 program.

18 MS. ARFLACK: Yes, it comes from  
19 them, whereas, you go to the MCO's for those services.  
20 So, it's a little bit different.

21 DR. HANEY: So, it doesn't come  
22 from the MCO's, then?

23 MS. ARFLACK: Not the IEP.  
24 Anything on the IEP, school-based services, that's  
25 exempt from the MCO world. So, they do come out of two

1 different buckets of money. They have to cover the same  
2 services we cover, but I think what the school nurses  
3 probably had problems with is the rate of reimbursement,  
4 I assume, for the health departments maybe. It wasn't  
5 feasible to send a nurse out to that location.

6 DR. HANEY: Because you have the  
7 liability and the transportation and a whole lot of  
8 things that go into that.

9 MS. GRIESHOP-GOODWIN: So, it  
10 seems like there are more questions and it may be good  
11 to go ahead and put it on the agenda for next time and  
12 have some more discussion and try to come up with some  
13 more concrete ideas on recommendations.

14 MS. BURCH: I'll be glad to  
15 contact some of the health departments and ask them what  
16 the issues were, why they pulled out.

17 MS. ARFLACK: I think that will  
18 give you some information that would help you go  
19 forward.

20 MS. HUNT: This is the main topic  
21 of the next Children's Health Task Force meeting  
22 actually which is in April, if you would be willing to  
23 attend that meeting. It would be great to have your  
24 perspectives.

25 MS. BURCH: When is that?

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

MS. HUNT: April 9th, 2:00.

MS. BURCH: I'll be out of the country.

DR. HANEY: And just on some dental issues, it has been real interesting to me how the different health departments function so different, and even within the same region.

MS. ARFLACK: Can you imagine what the MCO's thought when they came to town.

MS. GRIESHOP-GOODWIN: On the other question, though, of the asthma educators, is that something that this group would feel comfortable recommending now or is it something we would want more information on before recommending?

DR. RICHERSON: We could recommend it, and then I'm sure they're going to ask for additional information. So, I don't know. Would it be better to go ahead? And I can prepare some content as well to get it out there. Just to go ahead and get it out there and see what the response is so then it speeds things up. I'm just not sure what you want to do with that.

DR. HANEY: So, what is your goal? What are you hoping for?

DR. RICHERSON: So, the goal would

1 be across the state, that there would be trained asthma  
2 educators in medical offices, whether it's a hospital or  
3 an outpatient office, that has a Medicaid number and can  
4 bill for their asthma education and intervention.

5 DR. HANEY: And this would be for  
6 adults or children?

7 DR. RICHERSON: Adults or  
8 children.

9 DR. HANEY: I can certainly see  
10 where that would be useful.

11 DR. RICHERSON: And it's a new  
12 opportunity because CMS I believe just sort of gave the  
13 blessing that they can be, from my understanding----

14 MS. ARFLACK: A billable service?

15 DR. RICHERSON: That it is an  
16 acceptable new provider type but it requires a SPA is  
17 what I was told.

18 MS. ARFLACK: So, if there was an  
19 asthma educator, they're in a primary care facility,  
20 they couldn't bill because there's no----

21 DR. RICHERSON: And they don't  
22 have a Medicaid number.

23 MR. FLYNN: I don't have a problem  
24 making that recommendation.

25 MS. GRIESHOP-GOODWIN: I think

1 knowing what we know about asthma costs when you get to  
2 the hospitalization point, it would make a lot of sense  
3 to support that effort to educate and keep the disease  
4 under control.

5 And I was just looking. Our next  
6 meeting date is not until June and I don't know if the  
7 timing--I think maybe making the recommendation now  
8 would make more sense.

9 MS. ARFLACK: Right. I don't  
10 think they're going to say, no, we're just too busy,  
11 we're not going to do it. CMS is still approving  
12 things, so, we hate to give them another one, but----

13 DR. RICHERSON: Just get it in  
14 line.

15 MS. ARFLACK: If you get the  
16 blessing, then, yeah, by all means you would want to go  
17 forward.

18 MR. DOMINICK: That could help you  
19 with the school nursing thing, too. If school nurses  
20 became asthma educators, that would give them another  
21 chance to bill more.

22 MS. BURCH: From what Julia said,  
23 only if they're employed by a medical office.

24 DR. RICHERSON: No. That I'm not  
25 sure. I don't know in detail how independent, if they

1 could be like a PT, OT, SOP is now or if it has to be  
2 within a medical office; but typically it is in the  
3 context of a medical situation, but it doesn't mean that  
4 they--I just don't know the answer to that.

5 MS. BURCH: Because I would hate  
6 for that to go through with the understanding that they  
7 could go into schools and then can't because of the--  
8 they would go in and not be reimbursable I guess is what  
9 I'm trying to say.

10 DR. RICHERSON: And while we're on  
11 provider types, and with all the new SPA's, are  
12 nutritionists now independent? Can they get a Medicaid  
13 number and bill independently?

14 MS. ARFLACK: I haven't seen  
15 that. Like I said, the only ones that I have been aware  
16 of were all behavioral health provider types.

17 DR. RICHERSON: Because I know  
18 that's another thing I know that's been on the table for  
19 a long time because of the whole pediatric obesity  
20 issue. Not having access to nutrition services is a  
21 huge deal, and I believe that right now they have to be  
22 hospital-based to be able to bill.

23 MS. ARFLACK: In a certain  
24 setting.

25 MS. BURCH: So, do we have a

1 recommendation to the MAC?

2 DR. HANEY: I think the sooner we  
3 do, it will get things moving. I don't think I'm the  
4 person to make the--I can't give you the wording for it.  
5 Do you know how you would like the recommendation  
6 stated?

7 DR. RICHERSON: I don't know what  
8 typically the lingo is when you ask for a new provider  
9 type. Ask that certified asthma educators be a provider  
10 type. What does that get us?

11 MS. ARFLACK: They can enroll.  
12 That's what you want. You want them to be able to  
13 enroll with Medicaid.

14 DR. RICHERSON: And the codes,  
15 then, reimbursed? Do I need to get like the specific  
16 codes?

17 MS. ARFLACK: I'd say there are  
18 codes already out there.

19 DR. RICHERSON: Does that need to  
20 be in the recommendation?

21 MS. ARFLACK: I would recommend.  
22 It would be easier. I mean, I'm sure there's only a  
23 couple of codes.

24 MS. BURCH: And when you say  
25 trained, it's a national recognized training.

1 DR. RICHERSON: It's a  
2 certification.

3 DR. HANEY: And who provides that  
4 training?

5 DR. RICHERSON: In the State of  
6 Kentucky, it's coordinated by the American Lung  
7 Association. They coordinate and hold the training  
8 across the state.

9 DR. HANEY: We had one come to our  
10 residents and speak to them, and most of them are asthma  
11 patients themselves, and they were like amazed at what  
12 they learned.

13 MS. GRIESHOP-GOODWIN: Are you  
14 working on language?

15 MS. BURCH: I am but I'm trying to  
16 be careful. I would love for them to recognize those  
17 folks because that's access to the kids, but we also  
18 want to be careful that it's not going to be expected to  
19 happen in schools without some reimbursement for it to  
20 happen if it can happen through other avenues.

21 MS. GRIESHOP-GOODWIN: So, what  
22 language do you have, Mary?

23 MS. BURCH: I just have recommend  
24 to the MAC that certified asthma educators - and, Terri,  
25 we're just talking words for a second - become

1 independent providers.

2 MS. GRIESHOP-GOODWIN: Does that  
3 capture everything?

4 DR. RICHERSON: Unless we want to  
5 mention and be reimbursed. I don't know how you word  
6 language around reimbursement rates. Is there a typical  
7 reimbursement rate so that it's not assigning a \$2  
8 reimbursement rate to the CPT codes or something. I  
9 don't know how reimbursement rates are assigned to CPT  
10 codes. So, I don't know if that's part of this  
11 discussion as well.

12 When the PT's, OT's, when that  
13 went through, was language around----

14 MS. ARFLACK: They had a  
15 reimbursement rate for them.

16 DR. RICHERSON: Could you just say  
17 national standard reimbursement rate.

18 MS. ARFLACK: For Medicare.

19 DR. HANEY: Would it be Medicare  
20 if it was for children, though?

21 MS. ARFLACK: That's the standard  
22 language - no less than what Medicare pays.

23 DR. HANEY: So, we're going to  
24 have a recommendation. Does that have to be approved  
25 and seconded?

1 MS. BURCH: Yes. So, Julia, when  
2 you were talking about this initially, you said that  
3 they would work in a medical office that already had a  
4 Medicaid number. So, when you say that, it almost looks  
5 like it's a tag-on.

6 I'm just looking back. If speech  
7 language, OT, PT, they will become independent  
8 providers, and then the licensed psychologists, licensed  
9 clinical social workers, licensed marriage and family  
10 therapists and licensed professional clinical counselors  
11 will become independent providers.

12 So, to me, that means they don't  
13 have to work in another office that already has a  
14 license.

15 DR. RICHERSON: Ideally, they  
16 would be independent licensed Medicaid providers. So,  
17 they're a Medicaid provider just like the new rules  
18 around therapists. I think typically they're going to  
19 be in a medical setting, but they should be able to bill  
20 independent medical office visits.

21 MS. ARFLACK: If you're a licensed  
22 provider with Medicaid, you could go anywhere. The  
23 setting, it's called place of service. So, you could go  
24 in to the schools and provide services.

25 DR. HANEY: That would only be

1 limited if you had worked under a board and the board  
2 limited where you did those services because that  
3 happens sometimes.

4 MS. ARFLACK: I know with some of  
5 the new people that we've added like with peer support,  
6 they can't go out independently but they're not enrolled  
7 independently. That's the key. Right now, they are not  
8 allowed to enroll with us separately in Medicaid. But  
9 if you're an enrolled Medicaid provider, you could go in  
10 to the schools and provide services. If Dr. Haney was a  
11 Medicaid provider, she could go to the schools and  
12 provide services if she wanted.

13 DR. RICHERSON: Independent, not  
14 location.

15 MS. ARFLACK: Of location, yes.

16 MS. BURCH: So, with the asthma  
17 educators.

18 DR. RICHERSON: So, I would think  
19 we would ask for the independent.

20 MS. ARFLACK: That would go with  
21 what you wanted to do with the schools. If they cannot  
22 be a Medicaid enrolled provider type and you just made  
23 them a provider, being able to bill, they would have to  
24 bill under the facility and they wouldn't be able to go  
25 to the schools in that entity unless you had a provider-

1 -I mean, you as a provider took them with you and then  
2 you could bill their services.

3 DR. HANEY: So, that's what I  
4 think you would ask for is the independent.

5 MS. BURCH: Independent provider,  
6 and it still comes back to the reimbursement.

7 MS. GRIESHOP-GOODWIN: So, I have  
8 recommend certified asthma educators be added as  
9 independent licensed Medicaid providers and be  
10 reimbursed at no less than the standard Medicare rate.

11 MS. BURCH: There's a motion.

12 MS. GRIESHOP-GOODWIN: So, I move  
13 that we recommend this to the MAC.

14 MR. FLYNN: I second.

15 MS. BURCH: All in favor.  
16 Opposed. Motion carries. So, will you write that up?

17 MS. GRIESHOP-GOODWIN: Sure.

18 DR. RICHERSON: And I'll get you  
19 some background information for the MAC.

20 MS. BURCH: General Discussion or  
21 have we had enough? Thank you. That was hard work.

22 DR. RICHERSON: Since we're  
23 talking about provider types and we mentioned nutrition,  
24 so, what would it take to have certified diabetes  
25 educators and medical nutrition therapy? And I'm just

1 asking just from a logistical perspective.

2 In Louisville, you would think we  
3 would have tons of nutritionists but there are very,  
4 very few because they have to be--like there's one at  
5 Baptist East and there's one at--there's like three that  
6 basically we can refer to and we don't have them in our  
7 offices because of not being able to receive payment for  
8 their services.

9 DR. HANEY: Most people that I  
10 know that are clinical nutritionists aren't working as  
11 clinical nutritionists because there's only so many  
12 places that they can work and those places usually have  
13 one, maybe two persons.

14 DR. RICHERSON: I just didn't  
15 know, not that we have to sort it all out today but what  
16 would be the information we would need to make a  
17 proposal around trying to get those services.

18 MS. ARFLACK: If they want to be  
19 an independent provider, they would have to go through  
20 the same----

21 DR. RICHERSON: So, would it be a  
22 SPA or could that be an administrative decision, do you  
23 think?

24 MS. ARFLACK: To be honest with  
25 you, I'm not--I know that the SPA had to be changed to

1 add provider types. So, I would assume anytime we add a  
2 provider type, it would be a SPA change because that's  
3 kind of our guidelines from CMS to say, yes, you can do  
4 this. CMS may say no.

5 DR. RICHERSON: But typically if  
6 other states are doing it, then, probably CMS would say  
7 yes or you can't even go by that?

8 MS. ARFLACK: Well, you could but  
9 it's how you present how we're going to do the program  
10 and they may say no and then they may suggest other  
11 ways.

12 I know I've probably said this  
13 before. What you may want to do is talk to an MCO. If  
14 you have an MCO that you bill on a regular basis, then,  
15 you may want to talk to them and say have you ever  
16 thought about doing a pilot proposal, just take a group  
17 of kids. They're always looking for pilots. That would  
18 boost and say look what it did and the MCO's would have  
19 that data documented for you.

20 DR. HANEY: That's a good  
21 suggestion.

22 MS. ARFLACK: Anytime you have an  
23 idea like that, I would recommend and then you could  
24 come back to all of them and say would you be  
25 interested, I've got this idea, because one of the MCO's

1 called me the other day about wanting to do something  
2 with obesity. They're always looking for ideas.  
3 They're bouncing things off. They have to do two PIPS,  
4 a Performance Enhanced Projects a year. A lot of them  
5 have been around combining the behavioral health with  
6 the primary care, integrated care, but they're always  
7 looking at stuff. The asthma, somebody did one on  
8 asthma.

9 MR. DANIELS: We have an asthma  
10 project.

11 MS. MAGRE: And we have an obesity  
12 one, too.

13 MS. ARFLACK: Coordinate with them  
14 and then they've got the data that can show that it's  
15 useful and would be a good tool. That would boost your  
16 argument a little bit. And then if they've been  
17 successful and it helps them reduce costs, they're going  
18 to be all for it. They're going to help you fight that  
19 battle.

20 MS. BURCH: Anything further on  
21 that?

22 The next item is Provider Issues,  
23 and we had Mark Deis' email.

24 MS. ARFLACK: I've got it. His  
25 issue was about the co-payment. Children are not

1 supposed to be charged a co-payment unless they're KCHIP  
2 children.

3 DR. RICHERSON: This is for office  
4 visits or for medication?

5 MS. ARFLACK: Office visits, KCHIP  
6 children can be charged but not for preventative, no  
7 preventative services at all. That would affect dental  
8 as well. Anything preventative should not have a co-pay.

9 Now, WellCare is here and they  
10 were saying that they have had some people say that--we  
11 found out I think it was yesterday that we, the State,  
12 may be sending the wrong indicator to the MCO's. So,  
13 that may be part of the problem. So, that's being  
14 investigated on our end.

15 But Mark is saying that there were  
16 some foster kids which Lee Ann, that's her specialty,  
17 and she said that foster children should never, ever,  
18 ever be charged a co-payment. If you look on file and it  
19 says a child, unless it says that it's a KCHIP child,  
20 but a foster child should never be a KCHIP child.

21 MS. BURCH: So, as far as his  
22 question, if they're on SSI, that should not be  
23 happening.

24 MS. ARFLACK: No.

25 MS. BURCH: So, we can tell him

1 the State is looking into it.

2 MS. ARFLACK: Yes. I'll be glad  
3 to email him if you want me to.

4 MS. BURCH: Would you?

5 MS. ARFLACK: Yes. I'll be glad  
6 to email him and tell him that.

7 DR. HANEY: I think they ran into  
8 some issues with some of that in the last few months  
9 with dentistry as well. I don't know if it was a  
10 miscommunication or what.

11 MS. ARFLACK: We had a discussion  
12 with Avesis because they were kind of confused. They  
13 were getting stuff from Coventry and WellCare and  
14 Passport because they do the majority of the dental, and  
15 we had to kind of help them through. So, it was new for  
16 everybody. It changed in January.

17 The children issue is a problem  
18 because when we changed the SPA, it didn't exclude the  
19 KCHIP children. So, it's allowed the MCO's to charge  
20 that.

21 MS. SENTERS: And I think that the  
22 provider letter that was sent out really wasn't clear on  
23 the issue either. It did not even mention KCHIP.

24 MS. ARFLACK: The MCO's were  
25 struggling with it and I think now we have a system

1 problem. So, yes, this is a big mess.

2 MR. DOMINICK: That's the  
3 technical term.

4 MS. ARFLACK: I was in a meeting  
5 yesterday and they discussed that our Cabinet statement  
6 is that no one should turn away a member - and I know no  
7 one in here would - due to their inability to pay a  
8 co-pay.

9 DR. HANEY: And that's been the  
10 accepted rule, if you will, but I don't think that's  
11 always been the case unfortunately.

12 MS. ARFLACK: We had co-payments,  
13 Medicaid did, but we didn't deduct it. And, so, the  
14 providers got used to, well, I just won't charge, but  
15 now the MCO's are deducting that from their payment.  
16 So, you've got to be aware and look it up.

17 DR. HANEY: And that's a different  
18 thing altogether.

19 MS. ARFLACK: It is. That's  
20 totally different. It's different. So, that's the  
21 difference that this has made, but I will address Mark.  
22 Probably what he needs to do is just send us the members  
23 he's had an issue with.

24 MS. BURCH: That's for the first  
25 issue, and then the second issue is about the foster

1 child needing a checkup which required forty-eight hours  
2 of placement.

3 MS. ARFLACK: That would shouldn't  
4 be charged.

5 MS. MAGRE: There's an issue with  
6 that and we have been trying to address it within  
7 WellCare. The issue is that when a child is placed in a  
8 new placement, placement is required to have in-hand a  
9 paper copy of their physical within so many hours. If a  
10 child has already had their well child billed for the  
11 year, we can't bill for it again. They just can't be  
12 done.

13 But the provider doesn't know that  
14 and has already set aside their appointment time and all  
15 of that. They're kind of stuck. They can go for  
16 another code but that is not always the same rate. They  
17 can call us. We'll tell them if it's been billed. We  
18 will help that whole process, but sometimes it doesn't  
19 happen until after the fact. So, it's not that we won't  
20 pay, but we can't pay for a well child more than one  
21 time a year. And, unfortunately, some kids are getting  
22 those three and four times a year because they get moved  
23 and they don't have the actual paper physical to go with  
24 them; but if they call us, we will help with that  
25 process as much as possible.

1 MS. BURCH: What do you mean when  
2 you say you'll help with that?

3 MS. MAGRE: We can get a hold of  
4 the medical record ourselves and send that to the  
5 provider.

6 DR. RICHERSON: It looks like you  
7 need a new code that is foster care intake because we're  
8 doing a full well child and they're at higher risk than  
9 any other well child we're doing.

10 MS. MAGRE: I agree, absolutely,  
11 and we're talking internally about what needs are there  
12 because their needs are so much greater, what that needs  
13 to look at, and I've kind of floated some ideas that  
14 everyone is kind of yelling at me about but I'm going to  
15 keep doing it anyway because that's a big issue. That's  
16 the issue that we have.

17 But if the providers want to call  
18 us, we can walk them through all of the claims that we  
19 have on our system to let them know what has been done  
20 and we can also get a hold of the medical records from  
21 other places.

22 I'm working on a kid we just got  
23 who has had extensive medical issues in New York and I'm  
24 trying to track down medical records for that person  
25 right now because we need them. We've got to have them.

1 So, that's the main issue that we've run into.

2 MS. BURCH: So, one of the  
3 problems I see in hearing this is that you as a provider  
4 won't know. So, you won't know to call.

5 MS. MAGRE: What I would do is if  
6 you know you have a foster kid and you know they have  
7 WellCare, call us, period, because then we can walk you  
8 through.

9 MS. BURCH: So, I'll communicate  
10 that to Mark.

11 MS. ARFLACK: What's the number  
12 you want them to call?

13 MS. MAGRE: 502/253-5107.

14 MS. ARFLACK: So, you're not  
15 calling the 800 number. Did you notice that? That's  
16 her staff number. Don't call the Customer Service. And  
17 you can always call Lee Ann anytime you have a foster  
18 care problem whatsoever.

19 MS. BURCH: I have a question. I  
20 don't know this. Do you all work with all foster  
21 children or do the other MCO's also deal with that and  
22 do they all have a special person?

23 MS. ARFLACK: They all should have  
24 a special person.

25 MS. COOTS: We do.

1 MS. ARFLACK: They all have a  
2 special person that does deal with this because this is  
3 a very specialized population and has a lot of  
4 healthcare needs.

5 DR. RICHERSON: But the providers  
6 don't know about the special people.

7 MS. BURCH: So, do we have the  
8 names and numbers of the other special people?

9 MS. ARFLACK: Do you want to give  
10 Passport's special person?

11 MS. COOTS: I do not have her  
12 number but I do have her name, and her name is Susan  
13 Heibert.

14 MS. BURCH: Is there a way we  
15 could get her number so we can pass it to the providers?

16 MS. COOTS: Sure. I can take care  
17 of it right now.

18 MS. ARFLACK: I'm not sure Anthem  
19 has a person in place because they don't have children  
20 until July but they will give that information as soon  
21 as that person is hired. So, we need Humana's and  
22 Coventry's.

23 MS. HUNT: And that needs to go on  
24 a sticker so that everybody has all five MCO's and their  
25 contact for foster care and the phone number of all.

1 MS. ARFLACK: Maybe we ought to  
2 send it down to DCBS and let them send it out to their  
3 case people.

4 MS. MAGRE: I don't know about  
5 everybody else, but we meet with all the liaisons on a  
6 monthly basis, and I've been trying to educate everyone  
7 that as soon as you have any child come into care, the  
8 first question out of your mouth is who is the MCO and  
9 how do I get in touch with them. That needs to be the  
10 first thing that happens, and it's starting. We'll get  
11 there.

12 MR. SUTHERLAND: And also we meet  
13 with Children's Alliance and say the same thing to the  
14 PPC's that are in that, meeting with them to give out  
15 all of those contacts as well.

16 MS. BURCH: Mark's other issue is,  
17 is the rule to pay for only two 99214 or 99215's per  
18 year per patient or per provider per patient.

19 MS. ARFLACK: The 99214, that's an  
20 office visit, isn't it?

21 DR. RICHERSON: It's an office  
22 visit code.

23 MS. ARFLACK: To be honest, I  
24 don't know.

25 DR. RICHERSON: Do the MCO's know?

1 Do you all restrict the number of 99214's or 99215's per  
2 patient? That's not unheard of in the commercial world  
3 to have a restriction on the number of upper level  
4 codes. So, he must have gotten a rejection from  
5 somebody.

6 MS. BURCH: He gets the questions  
7 from across the state from other pediatricians.

8 MS. ARFLACK: I just thought those  
9 were office visits. I guess I'm lost on why.

10 DR. RICHERSON: Some commercial  
11 payors will only allow a certain number of 99214's or  
12 99215's per patient per year.

13 MS. ARFLACK: You're supposed to  
14 code them down?

15 DR. RICHERSON: Well, they will  
16 only pay for two.

17 MS. ARFLACK: And then you code  
18 them to 99213's?

19 DR. RICHERSON: That would depend  
20 on how you choose to play the system.

21 MS. ARFLACK: Oh, I'm not playing  
22 the system. I don't play.

23 DR. RICHERSON: Well, you only  
24 code them if you do. So, if you did more, then, they  
25 would just be unpaid potentially; but if people know

1 they only get two, then, they probably would down code  
2 them.

3 MS. BURCH: His question was per  
4 year per patient or per provider per patient, two of  
5 them per year per patient or two of them per provider  
6 per patient.

7 MS. ARFLACK: They don't have a  
8 limit on primary care--is it the primary care doesn't  
9 have a limit?

10 MR. DANIELS: I'm sure the system  
11 doesn't look at the provider. It just looks at the  
12 code; and if the code hits twice served, if there's a  
13 limit to it, then, it's going to. It has nothing to do  
14 with the number of providers that they go to.

15 MS. SENTERS: We can check on this  
16 for you. There just wasn't enough time by the time I  
17 got the email.

18 DR. RICHERSON: And that would be  
19 Medicaid level, not MCO level?

20 MS. SENTERS: Right.

21 MS. BURCH: And will you either  
22 email all of us or let us know at the next meeting,  
23 whichever?

24 MS. SENTERS: Certainly.

25 MS. COOTS: And I do have a

1 telephone number for Susan Heibert is Area Code  
2 502/585-7337.

3 MS. BURCH: Thank you. Any other  
4 provider issues?

5 DR. HANEY: When we met the last  
6 time, I asked if there was any data available on  
7 operating room utilization for dental problems and Ms.  
8 Epperson stated that this would have to be discussed  
9 internally to see what can be made available to the TAC  
10 and would report back at this meeting. I don't think  
11 we've received anything.

12 MS. SENTERS: You haven't received  
13 it but we are working on one. It's really difficult to  
14 do concerning operating room codes and dental codes.  
15 We're still trying to validate numbers. It may be more  
16 hopeful if the MCO's could furnish you what information  
17 that you need.

18 DR. HANEY: I'm just getting  
19 complaints from various people across the state that  
20 they were denied being able to take a child to the  
21 operating room because they didn't meet all of the  
22 criteria and yet the provider felt like the need was  
23 genuine, and they wanted to know is that something  
24 that's isolated to them or is it happening across the  
25 state. Are children being denied care? Since there are

1 more children enrolled, has OR utilization gone up,  
2 especially since you're having less and less parents who  
3 won't allow their child to be restrained.

4 I've had comments from dentists  
5 that I know when I was practicing until July when I  
6 retired where they would encourage us to do sedations  
7 and sometimes the child would not meet the criteria for  
8 sedation for a lot of reasons, or even if they did, we  
9 would try and it would not be successful.

10 And, so, I want to know is there  
11 really an issue out there, or are these just isolated  
12 incidents or is there in general, are we running into a  
13 problem? We have this huge need to take children to the  
14 operating room for dental care but we can't do it, or we  
15 have this huge need and it's being provided.

16 MS. SENTERS: Is this an issue the  
17 MCO's could help her out with?

18 MS. ARFLACK: Because it's not  
19 emergency services. It's just for sedation, just for  
20 sedation.

21 DR. HANEY: It's usually for  
22 behavior issues and the child may or may not be mentally  
23 or physically compromised in any other way other than  
24 their poor oral condition. It is a rare parent nowadays  
25 who will allow us to restrain the child, even to do a

1 toothbrush prophylaxis or an exam. It's just bizarre  
2 compared to where it was when I was trained. It's a  
3 different world. So, the perceived need for sedation  
4 in the OR is out there.

5 MS. ARFLACK: I think the criteria  
6 for the MCO's is different than what Medicaid utilized.

7 DR. HANEY: It's different than  
8 what it was before.

9 MS. ARFLACK: Medicaid's criteria  
10 was not as stringent as the MCO's. I would say that  
11 that's correct.

12 DR. HANEY: I would say that that  
13 is definitely correct, although when I was the Program  
14 Director, if I had a child who didn't meet the magic  
15 number of twenty or whatever it was, twenty or twenty-  
16 three or whatever it was, I could write a note at the  
17 bottom and sign it and I was never turned down. It  
18 could have been because of the position that I was in as  
19 a Program Director at the University. I don't know.

20 So, I encouraged my colleagues to  
21 do the same thing, but they would say, well, they didn't  
22 pay any attention to that. I don't know that they  
23 really wrote or asked for an extenuating thing or not,  
24 but they're saying that they're getting turned down if  
25 they have a child that, granted, they only have four or

1 five things but they are major things. Some of them are  
2 obese children. You don't want to sedate those kids in  
3 your office. They're a high risk for sedation, and they  
4 won't even fit into the chairs, some of them, and you're  
5 talking about two- and three-year-olds that are obese.  
6 They're the size weight-wise of eight-year-olds.

7 MS. ARFLACK: I guess my question  
8 is because if you ask the MCO's, okay, can you give us  
9 how many sedations were denied, well, that tells you  
10 they were denied. Maybe they weren't supposed to be.

11 DR. HANEY: It doesn't tell you  
12 why.

13 MS. ARFLACK: Maybe they should  
14 have been denied. I mean, I guess that's my question.

15 DR. HANEY: And maybe the people  
16 who ask for these procedures don't necessarily need to  
17 be 100% approved just because they asked for it, but I  
18 don't know. Is this a real issue or is it not but I  
19 still hear complaints all the time. Do something about  
20 that. Just because I sit on this committee, I could do  
21 something about it.

22 MS. BURCH: So, if the operating  
23 room utilization for dental problems, if they're denied,  
24 we still won't know why they were denied.

25 MS. ARFLACK: I'd say that

1 sedation would be a PA, a prior authorization. So, we  
2 have a report now that tells us how many denials for  
3 dental but that could be anything but it's denials for  
4 prior authorizations. So, we'd have to take that and  
5 break it down for each MCO and let them report to us how  
6 many are denied, but just because you know they've been  
7 denied, you don't know that the provider didn't provide  
8 the right information----

9 DR. HANEY: Could the MCO's tell  
10 me who is it that looks at these requests?

11 DR. RICHERSON: That's what I was  
12 going to suggest. Are the standards clinically  
13 acceptable, the standards to get somebody into the OR?

14 MR. DANIELS: What you're asking  
15 is for somebody to review the criteria under which they  
16 are reviewed.

17 MS. ARFLACK: WellCare, Coventry  
18 and Passport all have Avesis, and DentaQuest is going to  
19 be Anthem's dental provider.

20 DR. RICHERSON: So, we wouldn't  
21 have to look at three different places.

22 MS. ARFLACK: Avesis should be  
23 able to get us a good sample. Of course, they don't  
24 have any children yet. So, the only other one would be  
25 Humana and I'm not sure who they have.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

MS. COOTS: I think they have MCNA.

MS. SENTER: But, again, we can look at the encounter data which we're doing, but it's not going to tell us----

MS. ARFLACK: I think you're going to have to look at the prior authorization process.

DR. HANEY: Something that I think you should be able to tell is have the number of OR cases for dental treatment gone up, down, stayed the same.

MS. ARFLACK: I can tell you right off they've gone down.

DR. HANEY: That's what I'm hearing.

MS. ARFLACK: But is that a problem? I think that's what you're trying to get at. I think you're trying to say is that a problem? Maybe they should have gone down.

DR. HANEY: That's exactly. Just because they've gone down, to me, when they tell me that, I'll say, so.

MS. ARFLACK: Lucy and I were talking about that. Utilization for dentists, if it's gone down, that's a problem. That to me is a problem.

1 Why? I want that looked into. But because the sedation  
2 has gone down, I'm not sure that's a red flag yet.  
3 There's got to be more looked at. Do you see?

4 DR. HANEY: Here's what I'm  
5 concerned about especially. I'll ask the provider, I'll  
6 say, okay, so, you got turned down. How did you do that  
7 child's treatment? We didn't. We haven't seen him.  
8 Nothing gets done until the child ends up in the ER.

9 MS. ARFLACK: But I think you have  
10 to look at if the dentist has to do this because the  
11 child has bad behavior, it's not a medical necessity, so  
12 to speak.

13 DR. HANEY: What the child needs  
14 to have done may be a medical necessity. Not the  
15 behavior is not a medical necessity, but the fact that  
16 the child has disease in the mouth may be a medical  
17 necessity. Ongoing, rampant caries, you wouldn't  
18 tolerate infection in every single one of your----

19 DR. RICHERSON: I was going to  
20 say, we sedate all the time for MRSA because they're  
21 uncooperative because they can't lay there and let  
22 somebody cut into them.

23 MS. ARFLACK: But I think we need  
24 to look at what is being denied. The sedation is being  
25 asked for to fill a cavity.

1 DR. HANEY: Which is infection,  
2 and if that is not filled, what's it going to be next  
3 and then what's it going to be after that? So, you  
4 can't look at, oh, it's just a cavity as not a medical  
5 necessity because that cavity would not be tolerated  
6 anywhere else from here to here other than on a tooth.  
7 That hole, that infection would not be tolerated  
8 anywhere else.

9 DR. RICHERSON: Could we look at  
10 the new standards, the Avesis standards?

11 MS. ARFLACK: I think we need to  
12 look at their criteria, what their criteria is.

13 DR. HANEY: The criteria are not  
14 really all that bad when you look at them. They will  
15 say, okay, the child has one to five caries and that  
16 gets a number one. Five to seven or five to eight gets  
17 a number of five or something, and you total up all of  
18 these things. You've attempted to do sedation and you  
19 failed, you get ten points or six points or whatever.  
20 And then they have to total up to a magic number. And  
21 if it doesn't total up, they toss it out.

22 I had some that only had one tooth  
23 infected but it was so severe that I was afraid to allow  
24 that child to go on for fear because of the proximity to  
25 the sinuses, to the brain, etcetera that the child's

1 health could really be at risk. We had to get something  
2 done, and I would write a note and they would approve  
3 it.

4 MS. ARFLACK: Here's another  
5 thing. If you get denied, you have a process. You have  
6 an appeal process for that PA.

7 DR. HANEY: So, what I would like  
8 to know, something is denied and they appeal, what  
9 happens to those? There's no place that I can find this  
10 out other than to talk to each individual dentist. So,  
11 what happened to that? Well, we appealed and it was  
12 approved, so, we finally did it. Well, it was appealed,  
13 it wasn't approved, or we just said the heck with it, we  
14 don't have the time to appeal it.

15 MS. BURCH: So, it sounds like  
16 you're looking for the denials. Then out of those  
17 denials, how many were appealed and what happened with  
18 those appeals.

19 MS. ARFLACK: But you want the  
20 PA's. You don't want the claims. Lucy is working in  
21 the claims and that's not what you need.

22 DR. HANEY: You gave me the  
23 information. The number of OR cases for dental has gone  
24 down. Okay. So, why? Why did they go down?

25 MS. SENTERS: I have no way of

1 knowing that.

2 DR. HANEY: When I first started  
3 seven years ago, there were not that many dentists who  
4 were doing dental cases in the OR. I can guarantee you  
5 I trained a bunch who are out there doing it right now  
6 because they were well-trained and they felt  
7 comfortable. They were able to get the OR's to set it  
8 up for them. So, it should be going up, not going down  
9 because there's a lot more providers out there going to  
10 the OR than there ever was seven years ago.

11 MS. SENTERS: I guess that's where  
12 we need a report, then, from the managed cares  
13 themselves.

14 DR. RICHERSON: Would that be from  
15 Avesis, though, or from the MCO's?

16 MS. ARFLACK: They have a contract  
17 with Avesis. So, it's their provider. But I think you  
18 need more of the PA process because they're not being  
19 approved for the sedation.

20 DR. HANEY: Why not and what is  
21 happening.

22 DR. RICHERSON: So, the number of  
23 denials, number of appeals, results of the appeals.

24 DR. HANEY: Because I'm assuming  
25 that that's the reason why the numbers have gone down,

1 not because there's not providers out there with OR time  
2 to do it.

3 DR. RICHERSON: And not because  
4 there are no more cavities.

5 MS. BURCH: So, we think that's  
6 doable from the MCO's, to get that information - the  
7 number of denials and the number of appeals----

8 DR. HANEY: And even if they could  
9 just give us a narrative as to what the general reason  
10 is.

11 MS. ARFLACK: How about the top  
12 five reasons?

13 DR. HANEY: Because then I can go  
14 back and maybe do some type of education to the  
15 providers, depending on what the reasons are.

16 MS. BURCH: So, could we ask that  
17 of the MCO's?

18 MS. ARFLACK: Sure.

19 DR. HANEY: I don't have anything  
20 else on my list.

21 MS. GRIESHOP-GOODWIN: If we're  
22 moving on to the Other Business, I did want to see if  
23 there was an update on the other pieces discussed at the  
24 last meeting. I think at the last meeting, it sounded  
25 like you all were working on getting separate status

1 codes to help track foster children.

2 MS. ARFLACK: The former foster?

3 MS. GRIESHOP-GOODWIN: Yes.

4 MS. ARFLACK: The foster care is a  
5 problem.

6 MS. SENTERS: But they do have  
7 codes already. The problem is that we won't be able to  
8 get any reports actually from the Exchange until June,  
9 but there are codes.

10 MS. ARFLACK: Yes, we are coding  
11 them. They are coded differently. It's X through XA,  
12 XA through XB, F or something, XA through XB, F, not B.  
13 Sorry, Terri.

14 MS. GRIESHOP-GOODWIN: The  
15 children who were formerly in foster care is one of  
16 those, or there are different types of kids who----

17 MS. SENTERS: It's one of those.

18 MS. ARFLACK: The children of  
19 foster care don't automatically--they have to apply.  
20 So, if they age out, they'll have to apply.

21 MR. SUTHERLAND: And, Cindy, they  
22 self-identify on the Kynect site, so, you guys aren't  
23 cross-checking names in any way.

24 MS. SENTERS: If they deny, then,  
25 the system is supposed to look at it again as part of

1 the 19- through 64-year age. So, if one says they're a  
2 foster child and is denied, the system is supposed to  
3 automatically look at this in another category to  
4 approve them.

5 MS. GRIESHOP-GOODWIN: So, by the  
6 June meeting or would it be the following meeting that  
7 you all would have data?

8 MS. SENTERS: Hopefully we'll have  
9 some numbers from the Exchange by then.

10 MS. ARFLACK: I think one of the  
11 MCO's said that their biggest population they would get  
12 is people over forty right now is what we're seeing and  
13 what they're seeing also.

14 MS. GRIESHOP-GOODWIN: Also on  
15 data at the last meeting, we had talked about a list of  
16 data items that we were interested in and we had sorted  
17 through whether all of those items needed to be seen  
18 regularly or if there were some that weren't needed on a  
19 regular basis.

20 And, so, Katie had looked at that  
21 list and shared it with the members of the TAC and had  
22 gotten some feedback. And, so, we have that list  
23 prepared. I think Katie could share quickly what is on  
24 there that's helpful or we could just share the list and  
25 see what the process would be and who we would need to

1 talk with to see about getting those.

2 So, we tried to break them up into  
3 things that we thought would be helpful to see quarterly  
4 and things that we didn't think were needed on a regular  
5 basis but maybe having one report on it just to see what  
6 the numbers say and if there's any interest in digging  
7 any deeper would be helpful.

8 MS. CARTER: Here's a copy of the  
9 list. I think we shared this with everyone. It's just  
10 organized in a different way from when we talked about  
11 this back in December.

12 So, at the top of the list is data  
13 that you all provided to us in December, and that is  
14 broken out by what we might like to see quarterly versus  
15 annually. And this may require a little bit more  
16 discussion, too, by TAC members.

17 And, then, there was data that we  
18 would still like to see. I know that Charlotte's data  
19 that you had talked about is on this list, too.

20 This list came out of some  
21 conversations we had with TAC members last fall and it's  
22 come out of conversations we've had with members of the  
23 Children's Health Task Force and the Kentucky Voices for  
24 Health and also the Pediatric Behavioral and Mental  
25 Health Alliance in Louisville, too.

1                   This is data we would love to see  
2 just so that we can have a better understanding of how  
3 kids are faring under managed care.

4                   I'm not sure based on the previous  
5 discussion of the operating room utilization, I'm not  
6 sure that this data will come from the Cabinet or if it  
7 will come specifically from the managed care companies.

8                   DR. HANEY: It sounds like  
9 probably a little bit of both. And by regularly, you  
10 mean?

11                   MS. CARTER: At every TAC meeting.  
12 And, again, I'm not sure about the feasibility of how  
13 often we can get some of this or if some of this is even  
14 available.

15                   DR. HANEY: And some of them, we  
16 weren't certain whether the age groups would apply to  
17 each individual MCO.

18                   MS. CARTER: I think I have  
19 changed that based on advice from Lucy back last fall.  
20 And I see some of this is in this month's report, too,  
21 actually.

22                   Neither Tara nor I or anyone else  
23 from Kentucky Youth Advocates was at the last MAC  
24 meeting. Was there a decision made about how data  
25 requests are made? Do our requests have to first go to

1 the MAC before we can get data or do we go directly to  
2 you all?

3 MS. ARFLACK: I don't think they  
4 talked about that.

5 MR. DOMINICK: Some of this is  
6 already on reports that the MCO's give us. In fact, the  
7 report you are looking at now, it's a compilation of all  
8 the behavioral health group reports. That's something  
9 new that the Commissioner thought of.

10 MS. CARTER: And this addresses  
11 some of the things on the list. So, what would be best?  
12 Would it be good for us to have a conversation, then,  
13 between maybe now and the June meeting and figure out  
14 what is feasible for us to get from this list?

15 MS. BURCH: And, then, Katie, if  
16 that happens, then, could you put whatever is on here on  
17 here?

18 MS. CARTER: Yes.

19 MS. ARFLACK: I don't see anything  
20 that would be----

21 MR. SUTHERLAND: Cindy, the only  
22 one I saw was that I don't know that on some of the  
23 HEDIS things if it's broken out by adult and child.

24 MS. SENTERS: The only HEDIS  
25 measures that I would have are the children at this

1 point, I think.

2 MS. ARFLACK: The other issue is  
3 and their outcome. Number of non-formulary medication  
4 requests and their outcome. What do you mean by  
5 outcome?

6 MR. DANIELS: Initially being  
7 denied, suggestion for a preferred product changed to a  
8 different product in the same therapeutic class,  
9 therefore, the outcome was good, they got the medication  
10 as opposed to just a flat-out denial. Denial is a very  
11 nebulous word when it comes to especially in the  
12 pharmacy world because there's a lot of things.

13 If you look at the number of  
14 claims that are denied at point-of-sale from pharmacies,  
15 it's almost 40% and it's all over the board. It's not  
16 because of preferred or non-preferred. It's because the  
17 pharmacy put in the wrong NPI or the pharmacy put in the  
18 wrong information on the patient. There's just a  
19 thousand reasons, but the outcomes is an issue.

20 They also need to define  
21 psychotropic drugs. We went around and around with the  
22 State for months on a list of psychotropic drugs and I  
23 don't know that the list we're using is all that. It  
24 has not been updated for over two years, but what you  
25 consider a psychotropic, I might not.

1 MS. SENTERS: What would be the  
2 purpose for this? What are you going to do with this  
3 information?

4 MS. CARTER: I think it's just to  
5 know what is happening. I know we've heard a lot of  
6 issues from child psychiatrists of the availability or  
7 the reimbursement rates of certain medications  
8 prescribed and they just want to know more just to have  
9 the data to back up what we're hearing or to not back up  
10 what we're hearing. And I can go back to some of the  
11 folks that have brought these issues up to me and get  
12 some clarification on those definitions.

13 MR. DANIELS: I would assume most  
14 of the MCO's have some pretty serious edits on age  
15 limits for anti-psychotics and for ADHD drugs, and I've  
16 taken a lot of heat about that and I don't think we're  
17 wrong. When we get PA requests for Risperidone for a  
18 three-year-old child, I'm sorry, I need more  
19 information. I need to know why. It sounds to me like  
20 chemical restraint. It doesn't really sound like  
21 therapy, and I know that BH/DID is really trying to  
22 decrease the number of atypicals and stuff that are  
23 being used in children.

24 MS. BURCH: So, at that point,  
25 then, you would get back with the provider who ordered

1 it and ask for more information on that?

2 MR. DANIELS: Well, through the  
3 appeal process.

4 DR. HANEY: I think some of this  
5 conversation started with some children - and it wasn't  
6 just isolated incidents - is with children that they  
7 really struggled getting them on therapy meds that  
8 worked for that particular child and they finally get  
9 them on something and it's working really well, and then  
10 all of a sudden it's time to renew the prescription and  
11 it's denied. Yeah, they can get the meds but not what  
12 they had them on. So, I think that's what started a lot  
13 of this.

14 MR. DANIELS: I can see that being  
15 an issue with somebody switching from MCO to MCO because  
16 PA's don't follow. It's not like money following the  
17 child. PA's don't follow the child. So, that is an  
18 issue definitely, especially right after open enrollment  
19 periods and most of us have some type of transition  
20 policy that allows a fill for the first month or two  
21 before it's denied.

22 And they get it the first or  
23 second time, sure, the member gets a letter, but it kind  
24 of gets lost and then they don't understand why they  
25 can't get it the third time.

1 DR. HANEY: I think some of it was  
2 these were children that were in a program. They were  
3 maybe housed someplace and they were ready to be  
4 released. Their therapy had gone well. They finally  
5 got them to where they were doing well on their meds and  
6 they're ready to be released; but when they go out,  
7 then, they can't get the meds.

8 MR. DANIELS: Being proactive and  
9 getting those requested prior to dismissal is a huge  
10 thing, not wait until they go to the pharmacy and it's  
11 denied and they have one day of medication left.

12 MS. MAGRE: Hospitals need to  
13 provide us a prior authorization for why those drugs are  
14 being prescribed so when a foster parent or someone goes  
15 to the pharmacy, that PA is not on file. So, it will  
16 automatically get denied as a result.

17 So, we are diligently trying to  
18 work with facilities to educate them on that need. And  
19 if we get phone calls for some of those kiddos, we'll  
20 try to head that off as much as possible, but that's  
21 usually the issue.

22 DR. HANEY: So, that will go in  
23 the minutes so Mark will be able to be aware of that?

24 MR. DANIELS: The quality of the  
25 data we get also. I mean, a lot of times, I see these

1 PA forms and it's got the patient name, number, an ICD-9  
2 code and the name of the drug. Why? It's not a  
3 preferred product. Why? If they say patient was  
4 stabilized in the hospital, been on it for six months,  
5 blah, blah, blah, chances are it's going to fly through.

6 MS. BURCH: So, do we need to  
7 define some of this stuff a little bit more?

8 MS. CARTER: Can we get back to  
9 you before the June meeting?

10 MR. DOMINICK: Some of these  
11 reports we already do but we don't do them in the form  
12 that you necessarily want. We're switching everything  
13 over to line up with the State fiscal year. MCO's  
14 started in November for some reason. The State's fiscal  
15 year is July to June. So, I had these reports and they  
16 didn't line up with the fiscal year, so, we're lining  
17 everything up with the fiscal year. So, when we give  
18 you a yearly report, it will be July to June.

19 I don't have any problem with  
20 getting them together but they might not be in the exact  
21 time frame. Like the benefits by region one that you  
22 have on there, I do that quarterly and I don't do a  
23 yearly one. So, I'll just give you two quarters.

24 A lot of these I have, a lot of  
25 these I don't, but whatever I have I'll be able to put

1 together and it should be no problem.

2 MS. BURCH: And the ones you  
3 don't, is there something that we need to ask  
4 differently?

5 MS. GRIESHOP-GOODWIN: You could  
6 start with what you've got because if it covers a lot,  
7 we could see where it leaves us.

8 MR. DOMINICK: I'd be glad to do  
9 the work. I just want to make sure that it's okay with  
10 my boss.

11 MS. SENTER: I think the  
12 encounter data that you have on page one, I think that  
13 probably will be huge. So, I'm not quite sure about  
14 that one because that's a lot of information right  
15 there.

16 MR. FLYNN: Sometime between now  
17 and the June meeting, can someone just let us know what  
18 reports are already readily available out of this list?

19 MS. SENTER: Sure.

20 MR. FLYNN: Because, like she  
21 said, if the majority of it is already available, then,  
22 maybe we could start looking at that without having to  
23 request more reports and seeing if we do actually need  
24 the other reports.

25 MS. BURCH: And, Katie, I would

1 ask if you wouldn't mind is if it's in this, can you put  
2 it in ours?

3 MS. CARTER: Yes, and I will email  
4 it to you all of you and then make sure Lucy gets it,  
5 too.

6 MR. DOMINICK: Well, five through  
7 eleven are available.

8 MS. CARTER: On the front page?

9 MR. DOMINICK: Yes.

10 MS. CARTER: That first part, we  
11 got a lot of those the last time, too. And I want to  
12 talk to the TAC members again just to make sure that  
13 what's regularly and what's annually is what we want to  
14 see. I can email you all the updated list.

15 And as far as defining those  
16 pieces on the back, who should I direct that to?

17 MS. SENTERS: To me.

18 MS. ARFLACK: Like youth substance  
19 abuse treatment, we need a better definition.

20 MR. DANIELS: I think we need a  
21 better definition of exactly what they're looking for.

22 MS. ARFLACK: And youth, do you  
23 want like any child that's billed for a substance abuse  
24 treatment.

25 MR. DANIELS: I think the hospital

1 admissions is on that----

2 MS. ARFLACK: That one is, I  
3 think. Average length. We get a report that has the  
4 psychiatric hospitalizations. We even get a report of  
5 how many children are out of state.

6 MS. CARTER: Do we need to better  
7 define anything else?

8 MS. BURCH: What was that?

9 MS. ARFLACK: Out of state at a  
10 psychiatric facility, children that are out of state.

11 MS. BURCH: That have to go out of  
12 state for services because potentially there's no  
13 treatment here in Kentucky?

14 MS. ARFLACK: Correct. That was  
15 the best fit for them.

16 DR. HANEY: But it gets billed  
17 back to our state.

18 MS. ARFLACK: Yeah. The MCO pays  
19 for it. The MCO that has that member is responsible for  
20 their care. So, they find the best placement and  
21 sometimes it's out of state.

22 DR. RICHERSON: And I think that's  
23 one of the focuses of our Pediatric Behavioral Health  
24 Alliance is these kids should stay in state.

25 MS. ARFLACK: Well, they agree.

1 Everybody agrees. It's just getting a facility.  
2 They're working hard to keep them in state.

3 MS. MAGRE: I'm down to five.

4 MS. ARFLACK: We meet all the time  
5 and she's like celebrating when she can bring one home.

6 MS. MAGRE: I've got two coming  
7 home, one next week and another one almost this close.

8 MR. DOMINICK: I think a lot of  
9 the questions about behavioral health are answered in  
10 this stuff.

11 MS. CARTER: I will amend this  
12 based on what we've received today.

13 MS. ARFLACK: Their reports are  
14 really very fine-tuned.

15 MS. CARTER: Was there anything  
16 else I needed to better define before I send this back  
17 to you all?

18 MS. SENTERS: Not at this point  
19 for me. We'll have to let you know what we can or can't  
20 do.

21 MS. CARTER: Thank you.

22 MR. SUTHERLAND: Cindy, would it  
23 be useful to give this committee a peek at the DVH  
24 reports? If they had a peek at what's already being  
25 produced, they could select some of the items that they

1 would find useful.

2 MS. ARFLACK: This up here, number  
3 of appeals and their outcomes, is that appeals on prior  
4 authorization?

5 MS. CARTER: I think appeals of  
6 the denials.

7 MS. ARFLACK: Because down here  
8 you have number of fair hearings.

9 MS. CARTER: I can double check.

10 MS. ARFLACK: If they've had a  
11 state fair hearing, then, they've gone all through the  
12 MCO process.

13 MR. DANIELS: Are they wanting  
14 medication appeals also? I don't think you guys get  
15 that at all.

16 MS. ARFLACK: No, we don't. We  
17 don't have anything on the appeals for that.

18 MS. CARTER: On what, the  
19 medication?

20 MS. ARFLACK: Yes. We get a  
21 report on prior authorizations by provider type,  
22 category of service. We don't get a reason. Just  
23 partial denied, denied, but we don't----

24 MR. DOMINICK: And it's not by  
25 age.

1 MS. BURCH: Anything else on the  
2 data?

3 MR. DOMINICK: The other thing to  
4 keep in mind is that the contract calls for the MCO's to  
5 do a certain amount of reporting, and they're very good  
6 about when we ask for an occasional report that's  
7 outside of the scope of the contract; but if we start  
8 going with a lot of reports, there could be some  
9 backlash. So, we have to be careful about doing them on  
10 a regular basis.

11 MS. CARTER: Is there a list of  
12 what's included in the contract for reporting  
13 requirements that we could see?

14 MS. ARFLACK: It's an appendices.  
15 It's in the very back of the contract. They're out  
16 there on the web.

17 DR. RICHERSON: Are they the same  
18 for all of the MCO's or are they all different?

19 MR. DOMINICK: They're all the  
20 same.

21 MS. ARFLACK: There's about 118  
22 reports.

23 MR. DOMINICK: But they're not all  
24 broken down by age either.

25 MR. SUTHERLAND: Some of the

1 pharmacy data is.

2 MR. DOMINICK: Pharmacy and  
3 behavioral health is.

4 MS. CARTER: Is that what's in the  
5 contract is that it's not broken down by age?

6 MS. ARFLACK: The template that we  
7 have given them doesn't break it down, and that's what I  
8 said. We have a template in the back that shows how we  
9 want the reports. So, they're providing it in the  
10 format that we've requested.

11 MS. CARTER: Is that something  
12 that could be changed as the next round of contracts?

13 MS. ARFLACK: It could be at the  
14 next round, yes. In July, it could be changed.

15 DR. RICHERSON: Is that a  
16 recommendation that we should take to the MAC?

17 MR. DOMINICK: I would like to  
18 take a look at all 120 reports.

19 MS. ARFLACK: We want to open them  
20 up and really dive into them to see which ones we don't  
21 need and get rid of them.

22 MR. DOMINICK: Get rid of a lot  
23 that we don't need that duplicate what we're already  
24 getting and add ones or modify the ones that we're  
25 getting to make them more useful, but it's a long

1 process.

2 MR. FLYNN: I would imagine any  
3 report you get would have it broken out in sub  
4 populations.

5 MS. ARFLACK: If somebody is  
6 looking at it and using the data, that's our issue. If  
7 somebody is looking at the data and using it, not a  
8 problem. Some of these reports people aren't even  
9 looking at them.

10 So, yes, this is something that we  
11 would love to look at these reports and the MCO's are on  
12 board. Everybody is on board to look at the reports and  
13 make them better.

14 MS. SENTER: The enrollment  
15 reports are broken down in those age groups.

16 MS. BURCH: Anything else on data?  
17 I have one more thing before we adjourn. There are  
18 still some vacancies, I think. We are vacant for a  
19 parent of child enrolled in Medicaid or KCHIP, and that  
20 from my understanding has to be appointed by Head Start  
21 from what I remember. Then we have a vacancy from the  
22 Kentucky Psychological Association.

23 MS. HUNT: Sheila Schuster, who is  
24 the person that we asked to do this, she was coming back  
25 from D.C. yesterday, so, just timing wise, she couldn't

1 make it today. And I'm putting her in the loop of all  
2 the meetings that we have and hopefully she can attend  
3 or at least come up with an alternative if she can't.

4 MS. GRIESHOP-GOODWIN: So, it  
5 would be good to know if she's willing to be a member.

6 MS. HUNT: And I think she said  
7 yes.

8 DR. HANEY And the problem with a  
9 parent of a child that's in Head Start, that may change  
10 next year.

11 MS. ARFLACK: I think the  
12 recommendation just has to come from Head Start. I  
13 don't think they have to have a child in Head Start from  
14 what I remember.

15 MS. BURCH: Appointed by Head  
16 Start.

17 MS. ARFLACK: It has to be  
18 somebody appointed by Head Start. Mark had somebody.  
19 He went and contacted them and they didn't want to do  
20 that. That's what happened on that one, I remember.

21 MS. BURCH: So, does anybody have  
22 a link with the Kentucky Head Start Association?

23 MS. ARFLACK: I think I got the  
24 person's name and gave it to Mark and he contacted them.  
25 That's what you need to find out is if they even want to

1 participate. If they don't, then, maybe you need to  
2 change the statute.

3 DR. HANEY: It would be nice if it  
4 could be somebody local since our meetings are always  
5 here so they wouldn't have to travel a long distance.

6 MS. BURCH: And I believe Obea  
7 Patterson with the Kentucky Association for Early  
8 Childhood Education, her emails in the past have come  
9 back.

10 So, I think we had talked about  
11 removing that person and maybe trying to find a new one,  
12 and that's the Kentucky Association for Early Childhood  
13 Education. Any links? I will try to follow up with  
14 that.

15 DR. HANEY: So, we've got  
16 everybody else then?

17 MS. BURCH: Yes. If we could find  
18 a link with the Head Start Association, that would lead  
19 us to the parent of a child enrolled in Medicaid or  
20 KCHIP appointed by the Head Start Association.

21 The next meeting date is June  
22 11th.

23 MS. RICHERSON: I just had a  
24 future agenda item.

25 It's my understanding that about a

1 year and a half ago, that lab coverage shifted from the  
2 old Medicaid standard to Medicare standards as far as  
3 the lab billing. For example, in the past, if I had a  
4 child with Down Syndrome who needed their annual CBC and  
5 thyroid function test, it was covered and it is no  
6 longer covered. It's rejected. It's not covered by  
7 Medicaid anymore.

8 I'm assuming it's not just an  
9 individual MCO decision, that it came from Medicaid.  
10 So, that's wrecking havoc on preventive services  
11 because, as you know, Medicare doesn't cover a lot of  
12 preventive services. Medicaid is more traditionally a  
13 child, women's services, lots of prevention going on.  
14 So, preventive labs were covered.

15 MS. ARFLACK: I don't know what  
16 changed.

17 DR. RICHERSON: Some edit or  
18 something. It just shifted the coverage around labs.

19 MS. ARFLACK: Maybe it was a code  
20 change.

21 DR. RICHERSON: The lab codes did  
22 not change at all and the diagnoses codes didn't change.  
23 It's just what diagnoses codes cover the labs.

24 MS. ARFLACK: What's the rejection  
25 you get?

1 DR. RICHERSON: This diagnosis  
2 does not support this lab to be paid. Marcelline, do  
3 you know anything further about that?

4 MS. COOTS: No.

5 DR. RICHERSON: It is a huge deal  
6 as far as preventive services for children. I know  
7 there are lots of national standards that all the MCO's  
8 are held to. We should be following the AP guidelines  
9 for preventive services. Children need their  
10 cholesterols checked and all this stuff. We even had a  
11 hemoglobin rejected the other day on a two-year-old.

12 It was like a switch was flipped,  
13 and on one day everything was covered, and the next day  
14 everything was rejected. And, so, I don't know if we  
15 could do homework in the meantime. I don't know who  
16 that questions should go to.

17 MS. SENTERS: We'll take a look at  
18 it for you.

19 MS. BURCH: Anything else for  
20 future agenda items?

21 MS. GRIESHOP-GOODWIN: We should  
22 probably go ahead and put a Data Report of some sort on  
23 there.

24 DR. HANEY: If it's ready by then.  
25 A lot of these come out in June. By June 11th, would

1 they even be ready by then? So, maybe the September  
2 meeting, we could try to get all of the annuals or  
3 anything that's available.

4 MR. DOMINICK: The monthly reports  
5 and all that won't be a problem. I'll just give you all  
6 three months.

7 MS. CARTER: And did you have the  
8 school nurse discussion, too, on the agenda for next  
9 time?

10 MS. BURCH: Yes. That's all I  
11 have. Do we have a motion to adjourn?

12 MS. GRIESHOP-GOODWIN: So moved.

13 MR. FLYNN: Second.

14 MEETING ADJOURNED

15

16

17

18

19

20

21

22

23

24

25