

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

IN RE: CHILDREN'S HEALTH TECHNICAL ADVISORY COMMITTEE

March 13, 2019
2:00 P.M.
Health Services Building
Conference Room C
275 East Main Street
Frankfort, Kentucky 40601

APPEARANCES

Julia Richerson
CHAIR

Mahak Kalra
Randall Elliott
Beth Savchick
Pat Glass
Lisa Powell
TAC MEMBERS PRESENT

Sharley Hughes
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APPEARANCES
(Continued)

LeAnn Magre
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Felicia Wheeler
Cathy Stephens
Martha Campbell
HUMANA-CARESOURCE

Mendy Pridemore
AETNA BETTER HEALTH

Rae Bennett
ANTHEM

Cheri Schanie
Jessica Beal
PASSPORT

David Lohr
Chief Medical Officer
DEPARTMENT FOR
COMMUNITY-BASED SERVICES

Appearing Telephonically:

Eva Stone
JEFFERSON COUNTY PUBLIC
SCHOOLS

AGENDA

- * Welcome and Introductions
- * Establish Quorum
- * Approval of January Minutes
- * Updates from the MAC meeting - Mahak Kalra
- * NEW BUSINESS
 - 1. Discussion topics:
Psychopharmacologic prescribing for
KY children, David Lohr, M.D.
- OLD BUSINESS:
 - 1. HPV vaccines - next steps to monitor
and improve rates
 - a. HEDIS data UTD report - available
3/20/19 for 2018
 - b. Update re collaborative from DMS
 - 2. Obesity
 - a. Other next steps suggested: CHOPT for
Medicaid, Lisa Powell RE: H/B codes
payment, regional meetings, dieticians
as provider type to MAC, ideas from DMS
about further actions we can take to
address pediatric obesity treatment
 - 3. School-based services and Free-Care Rule
and Collaborative - Eva Stone
 - 4. Increasing well adolescent visits
- DMS Updates and Reports
 - 1. 1115 Waiver updates and impact on
families
 - 2. Integrated Care for Kids (InCK) update
 - 3. Other topics
- * MCO Updates/Questions or Data Request
Reporting - none
- * General Governance Issues
 - 1. Changes to TAC processes from DMS
 - 2. Incoming Chair decision
 - 3. Video conferencing options - need a hot
spot, can we use other phone-based apps?
- * Other Business
- * Action Items

1 DR. RICHERSON: We will call
2 the meeting to order. Thanks, everyone, for coming
3 to our meeting.

4 So, we will go ahead and do
5 introductions around the table.

6 (INTRODUCTIONS)

7 DR. RICHERSON: So, we have
8 five people. So, we have a quorum.

9 MS. HUGHES: And you
10 technically don't have a quorum.

11 DR. RICHERSON: It's supposed
12 to be five plus one?

13 MS. HUGHES: Yes. You have to
14 have a majority.

15 DR. RICHERSON: So, the minutes
16 were distributed, I believe. Everyone got them back
17 about a month ago, so, we'll just hold approval of
18 those but we could bring up any discussion if people
19 had comments or anything and we'll vote on those next
20 time.

21 So, I had just a few comments
22 for the Commissioner but I'll go ahead. Shall I wait
23 for Stephanie?

24 MS. HUGHES: You can go ahead.

25 DR. RICHERSON: I'll hold. I

1 can plug it back in.

2 So, Mahak, updates from the
3 MAC.

4 MS. KALRA: So, the MAC met a
5 couple of months ago. A lot of the discussion was
6 around guidance for TACs. With that being said, the
7 Commissioner sent out a letter early January to all
8 TAC Chairs going ahead and changing what--thank you.
9 This would be helpful.

10 DR. RICHERSON: I had it also
11 later on the agenda but we can do it now.

12 MS. KALRA: So, it was a
13 discussion among all TACs. So, I think we need to go
14 ahead and bring it up when we discuss the MAC.

15 As you can see, some of the
16 changes are about agenda, quorum, scheduling
17 meetings, as well as TAC recommendations and, then,
18 recommendations to the MAC.

19 So, a couple of key things that
20 we need to highlight and this is just for the group
21 in general. Agendas brought two weeks prior to
22 Sharley. She will be our DMS liaison. Will you be
23 sending the emails out with the agenda?

24 MS. HUGHES: I will try to get
25 the emails out. I cannot guarantee that I will be

1 able to get them out. It depends on how busy my
2 schedule gets because I understand I think this is
3 your last meeting. So, whoever the Chair is next can
4 send them to me and I will put them in this format.
5 I'll try my best to get it back out.

6 I think I sent the agenda. Did
7 I send the agenda back out? I can't remember.

8 DR. RICHERSON: Yes. You did
9 last week.

10 MS. HUGHES: Okay.

11 MS. KALRA: Obviously nothing
12 has changed with open meetings. This meeting is for
13 anyone that wants to come. So, feel free to join us.

14 And, then, quorum, obviously
15 for us, it's five members plus one. Hopefully we
16 have a quorum soon.

17 There is one thing that I do
18 want to mention is the alternatives aren't a part of
19 the quorum. I think prior to that, we were kind of
20 confused on how that really works. So, now we have
21 straight language telling us who can count for a
22 quorum.

23 I don't know if there's
24 anything else, Sharley, you wanted to say.

25 DR. RICHERSON: Well, actually,

1 there's no alternates anymore at all.

2 MS. KALRA: Okay. Yes.

3 DR. RICHERSON: Anybody can
4 come because it's an open meeting.

5 MS. HUGHES: Anybody can come.
6 It's just that they don't count towards your quorum
7 because I understand. If you're on the TAC and
8 especially for the association, that designated
9 person may not be able to come. So, the association
10 may want to still send someone but they just don't
11 get paid mileage and they don't get to count towards
12 the quorum and so forth. So, that's the only thing.

13 MS. KALRA: That makes sense.
14 Scheduling of meetings, we're usually ahead of the
15 curve and go ahead and schedule for the whole year.
16 So, that's set already.

17 TAC recommendations - this is
18 just for the MAC liaison and just making sure that we
19 send MAC recommendations that Monday before the MAC
20 meeting. So, that's just a note for me personally,
21 but anybody else that is going to represent us at the
22 MAC, this is just key information to know.

23 And that's pretty much it. I
24 don't think there's anything else that needs to be
25 discussed. I don't know if TAC members have any

1 questions.

2 DR. RICHERSON: I think the
3 only thing to add, Sharley, when we were first formed
4 back twelve years ago, a set of bylaws were
5 established and that's what we were functioning
6 under.

7 And, so, if you all remember
8 the bylaws, they no longer exist basically because
9 they're not allowed.

10 MS. HUGHES: The TACs all roll
11 up under the MAC who has created bylaws. And within
12 those bylaws, there are some bylaws for the TAC as
13 well.

14 MS. KALRA: So, there's an
15 upcoming MAC meeting later this month that I will be
16 attending. So, if there's anything that comes out of
17 this and we do have a quorum, I will go ahead and
18 present those, but other than that, there's really
19 not much of an update.

20 DR. RICHERSON: Thank you. So,
21 we can jump straight into New Business then. And if
22 you remember and for Sharley, what we have been doing
23 is about every two meetings, we have identified an
24 issue and invite a speaker in to help stimulate
25 discussion, think about opportunities to advise

1 Medicaid as a TAC in our advisory role.

2 And, so, we have asked Dr. Lohr
3 to come in to talk about psychopharmacology. So,
4 that's sort of the purpose of having speakers to
5 stimulate discussion, bring up issues to help us in
6 our advisement around Medicaid issues. So, thank you
7 so much.

8 MS. HUGHES: And I think most
9 people have picked up a copy of his presentation so
10 you can follow along.

11 DR. LOHR: Sure, and I'll
12 project here. I can certainly send out electronic
13 copies of it, too. So, Sharley, I can send that to
14 you if there's anybody left.

15 Let me introduce myself. So, I
16 am the Medical Director of DCBS. I have been in this
17 position since January, 2018. I'm here three days a
18 week. The other two days a week I'm still on the
19 faculty at the University of Louisville, Department
20 of Pediatrics and Child Psychiatry.

21 And, so, some of my interest in
22 this topic takes place from the years that I was
23 working with the University of Louisville Pediatric
24 CAHRDS team on a state contract in which we were
25 taking Medicaid data to identify and analyze

1 psychotropic medication rates in children on Medicaid
2 and on foster care.

3 So, the grant started in 2014,
4 and this part of the grant ended in June of 2018.
5 So, you may have heard of this project beforehand,
6 and, so, that's the connection, and we'll talk a
7 little bit more about over time where the different
8 threads have led.

9 But the goal here is to give
10 some basic background on the problem. It's difficult
11 when you are developing a talk for an audience and
12 you really don't know what their level of background
13 is on this.

14 So, forgive me if there is any
15 information that is obvious to you, but the focus on
16 our efforts include education, psychotropic
17 medication oversight and then a discussion on next
18 steps with psychotropic medications.

19 So, to start with, what is a
20 psychotropic medication? A psychotropic medication
21 is any medication that is targeted to act on the
22 brain. So, that's the central nervous system and you
23 treat mental, emotional or behavioral conditions.
24 And in general, you're talking about maybe we like to
25 class them into categories which makes it easier to

1 understand.

2 You have medications that are
3 categorized in treating anxiety, those that are
4 classified as antipsychotic medications, medications
5 that treat depression, a whole category of
6 medications known as mood stabilizers which include
7 Lithium for bipolar disorder but, then, all those
8 anticonvulsants of seizure medications that also have
9 an effect on mood.

10 You have psycho-stimulants that
11 are typically for ADHD or Attention Deficit Disorder
12 and, then, you have medications that are classified
13 as sleep medications.

14 So, most epidemiological
15 studies will classify categories when they look at
16 national rates or state rates into six or seven
17 categories.

18 Kentucky historically, we are
19 in the region of the country that has very high rates
20 of psychotropic medications. And on average, the
21 national average is about 7% of all children on
22 Medicaid are treated with a psychotropic medication.
23 In Kentucky, that's doubled to about 14%.

24 And, then, nationally, children
25 in foster care always have about two to three times

1 the rate of those normal children in Medicaid. So,
2 the national average for foster children is about
3 26%, and in Kentucky, the state average of children
4 in foster care, about 40% of those, 42% are on a
5 psychotropic medication.

6 And that has held steady over
7 the last four to five years. It's right around 40%.
8 So, four out of every ten kids, children in foster
9 care are on a psychotropic medication and that's one
10 concern.

11 The other concern is that
12 nationally the rates of psychotropic medications are
13 not really increasing. They're kind of holding
14 steady. And, in fact, as you look at the rates of
15 antipsychotic medications, the rates are coming down
16 a little bit; but what we're seeing is that you're
17 seeing more polypharmacy.

18 And, so, what do you mean by
19 polypharmacy? What is the definition? And that
20 depends on your source. It can be very broad or very
21 narrow; but in general, we defined polypharmacy as
22 having one or more classes of medications for at
23 least fifteen days. That's one definition.

24 We've also looked at ninety
25 days in our studies to be a little bit more

1 conservative. And depending on the source, every
2 article is slightly different, so, you have to
3 extrapolate between the different articles.

4 But what you're seeing is that
5 the rates of polypharmacy are increasing. More
6 visits involving multi-class medications occurred
7 between 1996 and 2007, and that's twelve years ago
8 now. Twenty percent of all office visits involving
9 children involved two or more medications.

10 And where I think you're really
11 seeing the growth is in conditions like Attention
12 Deficit Disorder with disruptive behavior. You're
13 seeing that a large number of these children are on
14 three or more classes of medications.

15 So, you're seeing certain
16 conditions, typically disruptive behavior, emotional
17 behaviors where you're seeing--it's kind of like a
18 salad where you get a little bit of this and a little
19 of that and you're layering on different medications
20 to try to address these things.

21 We looked at this a little bit
22 closer to home. So, we looked at Kentucky trends
23 in pediatric psychotropic polypharmacy and we used a
24 very conservative definition, not that that matters,
25 but we looked at ninety days of two or more classes

1 of medications.

2 And all kids in Medicaid, about
3 12%, so, one out of eight children enrolled in
4 Medicaid received interclass polypharmacy between
5 2012 and 2015, and we found that certain things were
6 predictive.

7 Interesting enough, the age
8 range of six to eleven predicted more than teenagers.
9 You would think that teenagers closer to adults would
10 always be more. We didn't see that, but we did see
11 that foster care had an odds ratio of about 1.7, so,
12 1.7 times more likely to have this, a diagnosis of
13 bipolar disorder and, then, the total number of
14 psychiatric diagnoses listed.

15 So, this is all Medicaid claims
16 data. So, the data is only as good as the value of
17 the claims in terms of the diagnoses, but we feel
18 pretty comfortable about how much medications they're
19 getting.

20 And we did see that children in
21 foster care received more alpha-agonists which are a
22 type of medications that are often used to treat ADHD
23 in conjunction with stimulants.

24 The reason that antipsychotic
25 medications are very important to consider when

1 you're talking about the polypharmacy, they're often
2 an additional agent in polypharmacy. So, they're one
3 of the medications that are used when you have a
4 number of medications.

5 They present a great deal of
6 cost. And, so, when you look at the cost data for
7 children in foster care, a big portion of that is
8 related to how much medication that they're on. And,
9 so, antipsychotic medications have typically been the
10 most expensive.

11 For example, Abilify is a
12 fairly common antipsychotic medication. A month's
13 worth of Abilify retails for about \$1,000 a month
14 and, so, that presents a lot of cost.

15 And, then, these medications
16 have tremendous side effects. When they were first
17 introduced, they were hailed as free of side effects
18 in many ways. They did have less immediate side
19 effects such as movement abnormalities such as
20 tardive dyskinesia or extrapyramidal side effects
21 and they had some mood components.

22 So, they were adopted in wide
23 scale; and only after about ten years of use, we
24 began to notice that these medications presented with
25 weight gain, a higher risk of diabetes, lipid

1 abnormalities.

2 So, about ten to fifteen years
3 ago, the American Diabetes Association along with the
4 American Psychiatric Association recommended that you
5 start to have baseline lipid testing, cholesterol
6 checking and testing for diabetes when you use these
7 medications, and these medications can promote
8 tremendous weight gain.

9 And, so, what you have is a
10 population of children who are on these medications
11 that they're being exposed to longer-term side
12 effects that may take years to develop and they may
13 be on these medications for a long period of time.

14 What we're seeing in foster
15 care, as I told you, about 40% of all children in
16 foster care are on a medication. And if you just
17 look at antipsychotic medications, about 20% or one
18 in five children in foster care are receiving an
19 antipsychotic medication and about 15% are on
20 polypharmacy.

21 I was interested in looking at
22 a cohort of these kids, what I call the highest-risk
23 kids and this is what I called high-level
24 polypharmacy.

25 And we decided to look at a

1 group of kids in 2012 that had these medications.
2 And what I mean by high-level polypharmacy, four or
3 more classes of medications. So, you could actually
4 have more medications but at least four or more
5 classes.

6 And starting in 2012, there
7 were 403 children in foster care that had received at
8 least ninety days of four or more classes of
9 medications. And we followed them over the next five
10 years and we saw that of that 400, that after five
11 years, about 300, 273 to be exact were still on four
12 or more classes of medications at least for ninety
13 days during a calendar year.

14 So, they stay on these
15 medications, and I think that that is what you see in
16 practice, too, is once you see a child on these
17 medications, it's very difficult. You're swimming
18 upstream to try to get these children off medications
19 because they're complicated. They have a lot of
20 needs. They're disrupting placements. They're going
21 into hospitals.

22 So, it's a challenge and I
23 think it takes a philosophical mind change to get to
24 this point.

25 When you look at the

1 medications that are a part of this, this group, this
2 highest risk group, antipsychotics were the biggest
3 medication than medications for mood anti-
4 depressants, stimulants and alpha-agonists.

5 So, sometimes you will see a
6 cocktail of these four medications where you have a
7 child with trauma, emotional problems, ADHD,
8 disruptive behavior. They're on a stimulant, alpha-
9 agonist. They're on a medication for mood, a
10 medication for anger and so on.

11 DR. RICHERSON: Just real
12 quick, Sharley. I think there are people on the
13 phone. Somebody sent me a text. Is the phone on?

14 MS. HUGHES: I'll do that.
15 Sorry.

16 DR. RICHERSON: I didn't want
17 them to miss your information. So, go ahead.

18 DR. LOHR: Thank you. And, so,
19 that is what has been driving this.

20 And, so, in my role as Medical
21 Director, we have been attacking this in several
22 ways. But the question that I want you to consider
23 is do the benefits of psychotropic medications
24 outweigh the risks? And that's a hard question to
25 answer and these are children who have a lot of

1 trauma. They have a lot of difficulty with
2 behaviors, emotions. In some cases, these
3 medications may make it possible for them to live in
4 a lower level of care, to receive community benefits,
5 but I think we want to make sure that these children
6 are receiving trauma-focused therapy and that the
7 psychotropic medication side effects are being
8 monitored.

9 The sad truth is there is not a
10 lot of evidence, little or no evidence for what we're
11 doing in polypharmacy. When a medication is
12 introduced on the market, it's typically tested solo
13 against placebo in a child or youth.

14 In many cases, you don't even
15 have evidence in children or adolescents. It's adult
16 data and, then, it's extrapolated down. So, you get
17 placebo versus active agent data. You don't really
18 get much data that really helps you understand the
19 risk. There are certain risks involved.

20 When we started the CAHRDS
21 project, basically we were looking at three different
22 prongs. One was additional secondary peer review.
23 One was a psychotropic consultation line with child
24 and adolescent psychiatrists and primary care
25 providers, and one was a consultation line to DCBS

1 workers.

2 Since I'm now in this position,
3 I am trying to take those components and implement
4 them internally as much as possible.

5 So, in terms of the educational
6 part, we have been working to develop the Clinical
7 Branch. You'll hear that there is a new
8 organizational name for the Clinical Branch, Clinical
9 Division which involves hiring more people at DCBS,
10 more clinical nurses.

11 And also we've been reaching
12 out lately with the regional clinical associates.
13 The goal is to educate them on psychotropic
14 medications to help them filter down in every region
15 awareness concerning medication practices and to
16 begin a discussion on what I consider to be effective
17 informed consent.

18 Education is taking place with
19 some of the providers, in facilities as well and
20 working with MCOs on an ongoing basis to help
21 identify these concerns and help move them along,
22 too, as they play a part in prior authorization and
23 monitoring of these medications.

24 There's a couple of screens in
25 here from the Florida Best Practices Guidelines. And

1 you may not be able to read this but this is
2 available online but it's a document that Florida
3 Medicaid produced along with community partners on
4 best practices guidelines for a lot of different
5 conditions.

6 And what they promote is common
7 sense in many ways. You start with effective
8 evaluations and diagnostic information, taking a good
9 history. We assume that this is always taking place
10 in our children but it's not always. And, so, in
11 some cases, you do want to evaluate whether they've
12 had a careful trauma and developmentally important
13 evaluation.

14 Then, mental health conditions,
15 once they are diagnosed, typically you want them to
16 be treated with psychosocial therapy first, a trauma-
17 informed, developmentally-based psychosocial therapy
18 before you move on to medications but then
19 medications.

20 There are certain guidelines
21 that I think you would want to advocate for. You
22 start with one medication, maximize the dose, be very
23 rational.

24 DR. RICHERSON: Could you talk
25 a little bit about the trauma, non-CBT therapies like

1 the eye movement therapies, things like that that are
2 more trauma specific and if people are doing that in
3 the younger ones? Is that growing?

4 DR. LOHR: I think that the
5 best evidence would need to start with trauma-focused
6 CBT. That has the most evidence, but you'll see
7 people using eye movement therapies for these
8 children.

9 And when I look at the
10 evidence, I mean, it seems to be there's some
11 evidence that's there but not--it's not university-
12 accepted as best practices; but I think that in some
13 cases, it makes sense to use it and supplement with
14 those therapies.

15 I think when you start with a
16 formulation with these children, I'm involved with
17 polypharmacy calls now and conference calls; but
18 going back to the beginning with the basic birth
19 history, the family history of the mother, the in
20 utero exposure, all the ACES, the adverse child
21 events that these children are exposed to, you start
22 to develop more of a trauma-informed
23 neurodevelopmental formulation that leads to things
24 like behavioral therapy or speech therapy with these
25 young children.

1 I can look around the table at
2 the different MCO reps and we've already been on
3 several calls where in each case for many of these
4 things, we may not necessarily be stopping
5 medications yet but I feel like we're building a
6 groundwork for that or at least building a framework
7 which perhaps down the road, medications may be
8 decreased.

9 I think when you look at
10 concerning medication practices, this is where I
11 think it gets to the heart of what I see as a
12 mission. It's how do you get the evidence out there,
13 the education out there that certain medication
14 practices raise concerns.

15 And if you look at these, and
16 you can start with some of the easiest ones, if you
17 look at the very young children, children under the
18 age of six, in vary rare cases should they be treated
19 with psychotropic medication.

20 There's FDA indications for
21 autism and irritability in this group. There's FDA
22 indications for ADHD down to age three. So, there's
23 guidelines there; but if you start seeing a six-year
24 old child on four or more classes of medications,
25 that raises a lot of red flags to me.

1 So, I have been sending this
2 message to the DCBS folks, to the MCOs to let's help
3 identify and focus on these kids, to the young kids
4 first to make some effort.

5 If you see a child without an
6 evaluation, that's a concern. At any age, I think if
7 you see a child on four or more classes of
8 medications, you probably can question about what are
9 we trying to do. In some cases, it may be indicated.

10 Then you have medications from
11 the same class, high dosage or use of antipsychotic
12 medications without checking labs. Those are some of
13 the leading concerning practices.

14 What I have been trying to do
15 is to work with the MCOs on this. We have a new
16 Pharmacy Director. I don't know if you've had a
17 chance to meet with Jessin Joseph or Doug Oiler but
18 they have an interest in looking at antipsychotic
19 medications.

20 And, so, I'm hoping that
21 perhaps we can build some momentum and start to
22 perhaps in a fee-for-service model of Medicaid start
23 to look at some different flags for prior
24 authorization or review.

25 If you look at antipsychotic

1 medications, I think you want to be checking lipid
2 panels and glucose on a regular basis; medications
3 under the age of six, in very rare cases and, then,
4 if we're looking at ages, the whole polypharmacy.

5 I think it's individual and
6 there's not a lot of evidence here, but I'm looking
7 to say the age of eight to ten, if you start to see
8 certain polypharmacy combinations in a child that's
9 eight to ten years of age, that raises some concern.

10 Like an antipsychotic and an
11 antidepressant and a stimulant, Lithium, a mood
12 stabilizer and an antipsychotic just raises
13 questions. And I think that would make sense to
14 start looking at that because I think what you're
15 really getting at is that that combination of ADHD,
16 disruptive behavior, compulsive behavior, mood that
17 leads to these medications. And in many cases, you
18 want to be sure that you're getting appropriate
19 therapy in places.

20 One other thing is informed
21 consent. I haven't made a lot of progress in this
22 area yet with DCBS but it's on my list of things to
23 do involving more effective informed consent because
24 that is a stop right there.

25 Typically, that could be an

1 area that we make a great deal of progress and other
2 states have implemented in some cases Draconian
3 systems to monitor this.

4 In Illinois, to get a consent
5 for a psychotropic medication, you have to call a 1-
6 800 line and every medication is reviewed. In
7 California, it involves a judicial order.

8 I don't know that we want to
9 see that here. I mean, you would hope that you could
10 make progress in this without going to that extent.

11 In order to get those types of
12 services, I think you're going to need revenue and
13 it's going to take legislative action for that to
14 happen. So, we have not had that yet.

15 In many cases, in California,
16 in Illinois, I think it all comes from class action
17 lawsuits perhaps that has driven this. Nobody has
18 the money it seems in the country until they're
19 forced to do it.

20 MS. SAVCHICK: What type of
21 consent did you say?

22 DR. LOHR: Informed consent.
23 So, informed consent, basic background.

24 So, if I am seeing your child,
25 before I can, as a doctor, prescribe medication, I

1 need to sit down with you, talk about the condition.
2 What is it that we're treating? What are the options
3 for treatment? What are the pros and cons of treating
4 versus not treatment? If I do treat with a
5 medication, what are the side effects? What happens
6 if you stop the medication? What happens if you had
7 an emergency with it?

8 Just as best as possible, you
9 give the parent as much information as possible to
10 make the decision, do I feel comfortable having my
11 child on this medication?

12 And children in foster care,
13 DCBS is the parent surrogate for this, so, they are
14 charged with making that decision.

15 I think what happens is that
16 foster parents may be able to give consent and, then,
17 get DCBS approval within twenty-four hours. On
18 certain hospital units, they call the DCBS worker
19 before they make a medication initiation or stop.

20 MS. SAVCHICK: So, a doctor
21 says a child needs it and, then, the parent has to
22 make a separate appointment to talk with someone else
23 about the information and then goes back to the
24 doctor to get the medications?

25 DR. LOHR: In a foster care

1 setting or in a normal setting?

2 MS. SAVCHICK: Foster care.

3 DR. LOHR: So, in a foster care
4 setting, if I'm seeing a complication, technically,
5 the DCBS worker is not in the room. I'm with the
6 foster parent.

7 And, so, I would most likely
8 have that discussion and informed consent with the
9 foster parent and they, then, are charged with
10 contacting a DCBS worker who gives approval and they
11 would go ahead and start the medication, but they
12 would leave the office most likely with a
13 prescription in their hand but they have a way to do
14 that.

15 Now, in the hospital setting, I
16 think sometimes what happens is that the DCBS workers
17 give blanket consent to a child entering a hospital
18 and the doctor makes medication decisions and, then,
19 they leave. They're informed of what's going on but
20 they may not always be contacted before.

21 Most DCBS workers and foster
22 parents don't feel comfortable contradicting the
23 advice of a doctor. I think the DCBS workers
24 probably feel in some cases less capable than the
25 foster parents. Sometimes foster parents will say,

1 no, I don't understand. You need to tell me. It
2 depends on how much of a role they take in the care.

3 So, I think informed consent,
4 effective informed consent is really a strong point.
5 And I'm hoping that in my role as DCBS Medical
6 Director that we have a chain at the command from the
7 worker out in the field, the supervisor up to the
8 SRCA where they could send up information if they had
9 questions or concerns about the medications.

10 And if they knew the concerning
11 practices, we can start to catch and have a
12 discussion. The medication may be needed. I mean,
13 there's a practice and medication out there that
14 takes place well outside of FDA guidelines and that's
15 standard of care; but in some cases, I think that we
16 can catch some.

17 If we can catch 5 to 10% of the
18 most worrisome cases, I think that we will make a lot
19 of headway because I think that there's--most studies
20 have said that if you can--in Florida, they looked at
21 improving that 5 to 10% of practices, that 5 to 10%
22 of providers that you can reach and maybe improve
23 practices.

24 Part of my goal is developing
25 lectures on de-prescribing. I don't know if you've

1 heard that talk yet. You probably have because of
2 geriatrics. It's been well-described for many years.
3 There's a lot of literature in geriatrics on the role
4 of de-prescribing which is really rational use of
5 medication.

6 In older adults in nursing
7 homes, if they are on certain medications like
8 antihistamines or anxiolytics, they have a lot of
9 sedation. They can get dizzy, they fall, they break
10 hips and they have poor outcomes. So, there's a big
11 improvement there.

12 You haven't seen as much in
13 literature on this in children but it's growing.
14 It's a type of practice that I think can be proposed
15 and educated to have every provider become more aware
16 of the relative value and limitations of a medication
17 so that they know if I'm using an antipsychotic,
18 okay, I'm going to use it for six months and I'm
19 going to look to stop it because I'm really not
20 treating an indication of schizophrenia or bipolar.
21 What I'm treating is aggression or disruptive
22 behavior.

23 MS. SAVCHICK: Okay. So, I'm
24 just wanting to clarify----

25 DR. LOHR: Yes. This helps.

1 MS. SAVCHICK: ----and educate
2 me where I'm wrong. It is my understanding that
3 ADHD, when it is truly diagnosed correctly, it is a
4 chemical imbalance in the child's body.

5 DR. LOHR: Yes.

6 MS. SAVCHICK: So, a medication
7 to give them for that illness would be equally as
8 valuable as insulin is to a diabetic.

9 DR. LOHR: Exactly.

10 MS. SAVCHICK: So, there's
11 really no way to get rid of the expense when you
12 compare it to insulin.

13 Now, I am very intelligent to
14 know that there's an over-diagnosis of ADHD and that
15 the symptoms are very much cloudy when it comes to
16 the high ACES of trauma experiences because the
17 behaviors that you see are very similar between
18 someone who has a lot of trauma and someone who has
19 ADHD.

20 So, I'm hesitant to put out a
21 lot of education about de-prescribing or trying to
22 temporarily put a child, like, it's an
23 antidepressant. I'm all pro about I'm going on an
24 antidepressant for a year but I'm also going to go to
25 counseling because my intention is to be off of it.

1 But if I truly have ADHD, I can't just be off my
2 medicine over the summer and drive my family crazy
3 and wait until August to go back on it. That's an
4 old eighties' belief that you could be on it during
5 the school year and off in the summer.

6 So, if you really need that
7 medicine, you really need it, but I don't think
8 there's enough education out there helping teachers
9 and parents figure out what is trauma.

10 DR. LOHR: And I appreciate the
11 input on the message because, to me, I agree with you
12 totally. I would never question the use of psycho-
13 stimulants or alpha-agonists to treat ADHD.

14 MS. SAVCHICK: It's amazing how
15 it helps.

16 DR. LOHR: To me and to a child
17 psychiatrist, it's a given that these medications
18 have indications. They treat very well, stimulants.

19 Where I think that I'm getting
20 to is you have a child with ADHD who is on a
21 stimulant, an alpha-agonist, an antipsychotic and a
22 mood stabilizer.

23 And de-prescribing to me means,
24 okay, let's get them back to the stimulant and an
25 alpha-agonist perhaps. Be careful on the

1 antipsychotic because what really are you treating?
2 You're adding an antipsychotic to these two
3 medications to treat disruptive behavior, aggression
4 and irritability.

5 And in some cases, you can work
6 with that population and have appropriate therapy and
7 supports. You may not need the antipsychotic
8 medication.

9 So, when I think about de-
10 prescribing, I'm not really going to the conclusion
11 of getting children off all medications. That would
12 be a very difficult message to put out there and I
13 don't think that would be well-received.

14 But getting children on the
15 right medications, the right dose, the right amount
16 of time, for the right diagnosis, that's really what
17 I mean by de-prescribing.

18 When you present this
19 nationally, you get the same discussion, and it's
20 almost like we need to change--the term de-
21 prescribing needs to be changed to rational
22 prescribing because we do understand there's a role
23 in medications.

24 MS. SAVCHICK: Intentional.

25 DR. LOHR: Yes, but really

1 de-prescribing is, again, the right medication for
2 the right diagnosis, the right dose, the right amount
3 of time and it's shepherding the evidence.

4 When you think about de-
5 prescribing, there are certain medications that have
6 much higher risk than others. Antipsychotics are
7 always at the top of the list because the risk of
8 diabetes in a child exposed to an antipsychotic is
9 two to three times than a child that wouldn't be.

10 There's risk of sudden death
11 that's being proposed. There's lifelong lipid
12 changes, cardiovascular changes that can be
13 associated with these medications.

14 And if you go to - I'm not
15 going to pick on any one facility - but if you go to
16 Home of the Innocents or Maryhurst and you look at
17 the teenager female population, by and large, you're
18 going to see a body mass index of thirty to thirty-
19 five - a lot of obesity, low exercise. And, so,
20 medications are contributing to a higher risk.

21 So, I appreciate your concerns
22 because it's very helpful for me to hear. If this
23 message causes people to think that we don't want
24 people on medications, then, it's not going to be an
25 effective message. So, thank you for clarifying. I

1 don't feel that way professionally. I feel like
2 medications have a role on the therapy. A
3 combination of therapy and medications usually give
4 you best practices.

5 One of the things that we
6 developed at DCBS is it's a Tableau dashboard and it
7 allows me to look at claims data over the last
8 fifteen months, and I can also focus on the last
9 three months.

10 So, I can look at trends of
11 children and also case management, but I can identify
12 children on different levels of polypharmacy.

13 So, I can use that dashboard to
14 help the clinical associates and Clinical Division to
15 identify a child who is, say, six or eight years of
16 age who is on, say, six medications, and I have been
17 able to reach out to the clinical associates, the
18 guardian and initiate a phone call and say what's
19 going on here. Let's talk about what's happening.

20 These calls may take an hour or
21 so but we go through a full history and we end up
22 generating a lot of recommendations that have really
23 nothing to do with medications.

24 I don't find myself telling
25 providers to stop medications so much as I'm telling

1 them, okay, let's put this service in place, let's
2 get testing, let's get ABA, let's get OT because in
3 many cases what you're seeing are children who have
4 intellectual disabilities or a diagnosis of autism.
5 They may have had a trauma. They may need a lot of
6 services in place that they may not be getting.

7 These children on these
8 medications are the most impaired and they need a lot
9 of services.

10 So, on a case-by-case basis,
11 I'm hoping that we're providing better care for these
12 individuals and I'm hoping that the message resonates
13 throughout the system so that when I'm not around,
14 they can catch this themselves and say, hey, this is
15 what we need to do.

16 We're working with MCOs to help
17 in this regard. They've been helpful with this
18 education and training. The Children's Review
19 Program is also helping look at lists of children on
20 polypharmacy and medications.

21 We have placement support calls
22 where we look at children who are decertified. It's
23 not surprising, but in many cases, these are the same
24 kids, the ones that are on a lot of medications and
25 the ones that have trouble with placement, too.

1 So, I've been at this for about
2 a year and moving forward. I think this year, I'll
3 be outreaching a little bit more with providers and
4 facilities, hospitals to take this message on the
5 road.

6 I'm working with foster care
7 parents to help educate them and ask them to be
8 mindful and be watchful.

9 So, I appreciate concerns and
10 questions and any thoughts. I'm always aware of
11 possible unintended consequences that we need to be
12 thinking about.

13 I'm open for questions and
14 discussion.

15 DR. RICHERSON: Questions?

16 MS. SAVCHICK: A person who is
17 on a controlled substance in the State of Kentucky, I
18 have no idea if it's like the rest of the country,
19 but if you're on a controlled substance, then, every
20 three months, you have to see your doctor before you
21 can continue to be on it because they're highly
22 regulating the medication.

23 Is it also a policy to say if
24 it's a minor that is taking a controlled substance
25 for ADHD, that they would have to see a counselor, to

1 be going to therapy before they could continue?

2 If you have to go see your
3 doctor for blood work or whatnot, they're looking for
4 abuse is what they're doing, so, making sure you're
5 actually taking the meds and not selling them, so,
6 they check your blood work, but if that visit could
7 be combined with counseling just to show that they're
8 going to counseling so they can continue to be on the
9 medication because that's what we're promoting is
10 that it's just not meds. It's meds plus therapy.

11 DR. LOHR: When you think about
12 that, you think about--you know, if you look at all
13 children in Medicaid, there's probably a number of
14 children who receive one medication for ADHD
15 prescribed by their family practice physician or
16 primary care physician, they do great and they may
17 not need medication and that's standard of care.

18 DR. RICHERSON: Or need
19 therapy. They may not need therapy.

20 DR. LOHR: They may not need
21 therapy. I'm sorry. So, the medications may control
22 their symptoms and they're good.

23 So, I think when you think
24 about recommendations, it's helpful for me to be
25 mindful of the broad range of conditions.

1 that's a MAC recommendation or some other avenue.

2 DR. LOHR: I would agree. That
3 probably would be well-received to improve the
4 relative function of informed consent.

5 MS. KALRA: That's good to
6 know.

7 MS. POWELL: Just as a followup
8 to that, I wonder if it would also be useful to have
9 something else similar for the alternative
10 recommendations because, to me, the de-prescribing
11 piece, the important piece to me that people I would
12 think want to hear is that, okay, well, then, what
13 else instead?

14 I am always as a provider
15 trying to offer recommendations about other options,
16 other things that we can do to help support the
17 child. And to me, that's the most important thing
18 that foster parents, schools, teachers, anybody
19 involved with the child wants to know what else can
20 we do, if not this, then, what.

21 So, one of the frustrations, I
22 think, as a provider, it's hard to get some of those
23 other things approved. And, so, maybe if we had
24 something that was best practice to say here's the
25 education on what we're trying to do in terms of de-

1 prescribing, but these are also evidence-based
2 interventions that we recommend as first-line
3 interventions before we get here because psych
4 testing we're still struggling mightily to get
5 approved for kids that we know need it.

6 We know that based on clinical
7 observation, this child is probably developmentally
8 delayed, cognitively delayed, all of these things
9 undiagnosed and we're going down this road instead of
10 other things that we could do.

11 Occupational therapy we know
12 there's good evidence for but we have a really hard
13 time getting that approved.

14 DR. RICHERSON: And access.

15 MS. POWELL: Yes, access,
16 absolutely.

17 So, I was just kind of
18 thinking, to me, that's the most important piece.
19 What are the other options that we have besides
20 prescribing because I think that's what people get
21 to. That's the only thing they know to do, but if we
22 had other options for them that we provide that are
23 effective, I think we will have more luck in getting
24 people on board.

25 DR. LOHR: I think so. I think

1 that's probably one of the biggest reasons that
2 people will use antipsychotic medications or
3 polypharmacy is they don't have other resources.

4 I'm wondering if this best-
5 practice guidelines out of Florida, if I could share
6 it with the group and have you guys look at it and
7 give me your thoughts about that and see if that's a
8 document that you would want to help propagate and
9 send out widespread. Who should I send that to?

10 MS. HUGHES: You can send it to
11 me and I will send it out to the TAC.

12 DR. LOHR: Okay, but it
13 includes guidelines on approaching medications, the
14 evaluation and there's sections for different
15 conditions including aggression, disruptive behavior.
16 There's a short section on de-prescribing which puts
17 it, I think, in relative terms and helps explain its
18 role in the overall use of medications and I find it
19 very helpful.

20 I think Florida Medicaid has
21 had several editions of this but I will send this to
22 you guys. I've sent it out to the SRCA's and I'll be
23 sharing it with the foster care people that I'll be
24 training. So, it's free domains and available for
25 distribution. They just ask that if you include the

1 title with the author's information on it.

2 MS. HUGHES: Lisa, just out of
3 curiosity, you said you had such a hard time getting
4 other options approved. We're speaking of children.
5 So, with EPSDT, is it more that you just don't have
6 the providers in your area?

7 MS. POWELL: Sometimes it's an
8 access problem. Like, for instance, if we know the
9 recommendation is ABA which has good evidence behind
10 it but we have a very hard time finding an ABA
11 provider. So, sometimes it's access.

12 So, for instance, occupational
13 therapy, I often want that for especially kids in
14 care we know to help regulate them, but without a
15 diagnosis that is appropriate in terms of getting a
16 PA, we can't get that service.

17 So, those are the things that I
18 feel like if we had some recommendation, if we could
19 say these are the things that are clinically
20 indicated and best practice for a child with this
21 condition, it would give us a replacement to
22 medication.

23 In my mind, one of the biggest
24 pieces is what are the other things that we can do
25 and make sure that your child has access to those

1 things.

2 MS. HUGHES: Then, I would
3 encourage you as a TAC because, I mean, that's the
4 type of recommendation that the Commissioner is
5 looking for is how we can better serve our members,
6 our beneficiaries.

7 So, if you all are having
8 difficulty in getting these services for children
9 approved, then, certainly make a recommendation and
10 we can possibly look at that and see how we can, you
11 know, because it's going to save us money and
12 certainly if it's going to save a child from being on
13 antipsychotic medications for the rest of his or her
14 life.

15 DR. RICHERSON: And we have
16 certainly brought up this issue time and time again
17 in this TAC and we've never brought it up in the
18 context of avoiding psycho polypharmacy, though.

19 The ABA issue is that many ABA
20 providers won't take Medicaid. They'll take Michele
21 P but they won't take Medicaid because of the
22 payment. When I've met with therapists, they say we
23 wish we could take more Medicaid kids. We just don't
24 get paid enough and we've talked about this in here
25 over and over and over again but never in the context

1 of trying to avoid medication.

2 MS. HUGHES: We certainly don't
3 want to put up barriers. I don't think the
4 Commissioner - and this is just me speaking - I don't
5 think the Commissioner would want us to put barriers
6 up for them receiving something else if it would keep
7 them off of certain medications.

8 So, I would certainly encourage
9 you as a TAC to make a recommendation along those
10 lines so we can look at it to see if we can do
11 something to improve that.

12 DR. RICHERSON: As the
13 psychologist, would you like to craft that since we
14 can't take a vote today but----

15 MS. HUGHES: You can. You've
16 had another member join you.

17 DR. RICHERSON: Oh, okay.

18 MS. KALRA: I think that would
19 be helpful if you could draft something. I think
20 that makes sense.

21 MS. SAVCHICK: I think that
22 would be really exciting to parents, too, because a
23 lot of parents who get referred that's a screening
24 stage, they get all stressed out. I'm not putting
25 much out on medications, you know, to know that

1 there's support in other areas and that they're
2 valued in the medical field.

3 MS. HUGHES: And, again, I
4 can't guarantee you anything but I'm thinking of
5 myself. I don't even have children, but I'm thinking
6 of my little great nieces that are coming up and if
7 they had the option of taking antipsychotic drugs or
8 doing some kind of treatment, that would certainly be
9 best.

10 MS. CAMPBELL: Dr. Lohr, in
11 your work since you've mentioned quite a few times
12 working with providers, and, of course, the EPSDT
13 Medicaid benefit when used appropriately is really
14 comprehensive, preventive and further diagnosis
15 testing, even if it's not on the Medicaid fee
16 schedule but is medically necessary.

17 And certainly with
18 psychotropics or other medications you've talked
19 about today, integrated care is essential and is
20 difficult even when a child is in a stable home with
21 birth parents sometimes to get the communication of
22 what meds are being prescribed by behavioral health,
23 what meds are being prescribed by the primary care
24 physician. There's sometimes a lack of
25 communication.

1 It's doubly-well, it's much
2 more difficult when a child is in the foster care
3 system; and when they are placed, they have a period
4 of forty-eight hours in which that new foster care
5 parent is supposed to get that child in for an EPSDT
6 visit but they may have a number of primary care
7 physicians.

8 What do you find in your work
9 about that communication from the medical side to the
10 behavioral health side?

11 DR. LOHR: I think that
12 integrated care is very important. Two, when you
13 think about improving the health of these children,
14 I'm drawn to some data out of the state of
15 Washington.

16 They have had a peer review
17 consultation program that has been implemented over
18 time for all children on Medicaid and they have
19 gradually become more involved with antipsychotic
20 medications, dosing and things, stimulants.

21 But what they've always done
22 from the beginning is, in addition to having a system
23 where prior authorization was shot in to a child
24 psychiatrist for approval or not, they also had a
25 system by which they had an elective consultation

1 with primary care providers and other providers and
2 they have always proposed that having that elective
3 consultation makes the whole system work because then
4 it's not just saying no but it's saying yes but let's
5 do this. Let's get connected to the services that
6 Lisa is talking about.

7 Massachusetts has had a
8 consultation line for years and it's regionally
9 distributed with all pediatricians involved in this.

10 There's a couple of grants that
11 I'm hearing about that people are interested in
12 putting together that would, in a small case, would
13 allow for integrated care consultation. So, you hope
14 that those get approved. Those are federal.

15 But I think at a certain level,
16 states like Washington and Massachusetts at some
17 point have committed funds to make these consultation
18 lines active and they seem to have made a difference
19 in terms of their utilization. They seem to have
20 acceptability from the providers who find it helpful.

21 Passport has been trying to get
22 a system like this running for a long time and it
23 just kind of found that it's being used.

24 So, certain states have figured
25 out a way to pay the providers to use the system,

1 primary care providers to compensate for their time
2 or other things to make it work, but I think that
3 that's an extremely important point when you start
4 thinking about overall monitoring of health of these
5 children in foster care and children in Medicaid is
6 having a system where you have integrated care.

7 MS. KALRA: And to piggyback
8 off of that, I was wondering how does the Family
9 First Act play into all of this? Is there a way that
10 kids play into all of this?

11 DR. LOHR: I think it should.
12 What I understand about Family First is it's going to
13 be taking money that's being spent in certain areas
14 such as, for example, residential facilities and
15 allowing for more funds to be placed in preventative
16 efforts.

17 So, you're going to be
18 identifying children who are at risk for removal,
19 families that are missed for disruption. So, if you
20 think about that population, a lot of it is going to
21 be involved with the opioid epidemic, the crisis of
22 that and figuring out ways to implement services with
23 more parental support. So, their pilot is Head
24 Start, K STEP that come to mind.

25 That's an entirely different

1 question than psychotropic medication oversight
2 because you're really getting at secondary prevention
3 of disruption and family support which very much a
4 long-term goal is to keep children from coming into
5 care in the first place and maintaining their
6 families.

7 DR. RICHERSON: Any other
8 questions?

9 MS. KALRA: I just have one
10 last one. This is more for the MCOs and they
11 probably don't have the answer right on top of their
12 head. So, this could be probably a discussion for
13 next time, but what are you all doing in regards to
14 combating or for the prior authorization or what
15 examples are you doing to kind of tackle this issue,
16 per se? And, again, you probably don't know right
17 off the top of your head. So, I don't expect an
18 answer right now.

19 MS. MAGRE: I can tell you
20 exactly what WellCare is doing because I started it.

21 We have a pool of our kids on
22 psychotropic meds on a monthly basis and I have a
23 care manager who is assigned to look at all of the
24 kids that are in care starting with our youngest and
25 she works her way up the list and she touches as many

1 of them as she can possibly touch.

2 And our Pharmacy Director, she
3 will flag which one of those kids are not just on
4 antipsychotics but also on polypharmacy.

5 So, we are trying to touch all
6 of those kids that way on a monthly basis.
7 Surprisingly enough, the majority of those kids we
8 already knew about and already had them engaged in
9 some way, shape or form in case management as it was.

10 But one of the biggest barriers
11 - and this is where Dr. Lohr is working so hard on -
12 is the ability to connect and collaborate with the
13 State partner and the State guardian around what
14 really needs to happen.

15 And, then, with the bundled
16 society that we're in right now, getting access to
17 those other services and feeling comfortable enough
18 to get those added into what's already going on is
19 really difficult to do.

20 So, we're trying to do that.
21 We've participated in a lot of the phone calls with
22 Dr. Lohr already on some of those more complex cases.
23 And our Medical Director for Behavioral Health, Dr.
24 Houchin, also collaborates with Dr. Lohr a lot on
25 some high-issue cases that he eyeballs within our

1 shop.

2 The other piece that we are
3 working on, there is an enterprise-wide process in
4 place where our Pharmacy Department is looking at
5 polypharmacy utilization across all markets that we
6 have, and there is some work that's being done in
7 that and I am trying to get with that group to
8 establish what can you do precisely with this
9 specific population as you review those medications.

10 MS. CAMPBELL: I can't speak to
11 a lot of specifics but we absolutely--of course, we
12 have a flag for any child that's in foster care and
13 they immediately get a case manager, but there is a
14 lot of work with behavioral health, with our Medical
15 Director, with our Pharmacy Director going on with
16 tracking the medications.

17 MS. STEPHENS: Yes. We do
18 track and trend the polypharmacy already and try to
19 report on that on a regular basis, so, a very similar
20 fashion to what you were discussing.

21 MS. CAMPBELL: We could
22 certainly get a lot more detail for you but----

23 MS. STEPHENS: And I think
24 we've provided that to DCBS in our meetings, our
25 regular meetings.

1 MS. KALRA: That would be
2 really helpful for members to hear just as a followup
3 conversation to what we just heard.

4 DR. RICHERSON: So, in the
5 past, we've had to submit that as an official request
6 through DMS to ask the MCOs, and if you wanted to
7 word that for Sharley, and, then, that way, the MCOs
8 are responding to DMS, not directly to the TAC.
9 That's what they've asked for in the past.

10 MS. KALRA: So, process fine?

11 MS. HUGHES: Yes.

12 DR. RICHERSON: I had a couple
13 of questions. One is a couple of things have been
14 going on simultaneously, well, many things, but two
15 things that just quickly came to mind at the same
16 time we're seeing high polypharmacy.

17 One is the frequency of autism,
18 so, the increasing incidence of autism. Are you
19 seeing that that is playing a role in especially
20 children with autism with behavioral issues? Do you
21 think that that's adding to the need for
22 polypharmacy?

23 DR. LOHR: I think that they're
24 certainly a high-risk group because they can have
25 difficult behaviors and resources to treat them are

1 limited. So, that's a setup for polypharmacy.

2 And I think that when you look
3 at the children that are decertified, those with
4 autism, intellectual disability, sexual behaviors or
5 other forms of aggression, I think they're the most
6 difficult to treat, and I think we've already talked
7 about just there's problems with immediate access to
8 ABA's throughout the state.

9 Each of the MCOs have given me
10 a list of ABA providers and neuropsychologists on
11 their formulary that can see children; but even if
12 those that are available, rates have to be part of
13 the discussion, too, and they have to be feasible in
14 order for the providers to work with those kids.

15 DR. RICHERSON: The other thing
16 that we talked about over the years here is the
17 shorter, allowable stay inpatient and how we feel
18 like sometimes that pushes increased meds to
19 stabilize to discharge and, then, as a primary care
20 provider in a rural community where I would be
21 discharged a child and I would have to manage because
22 it could be months before they could see an
23 outpatient psychiatrist.

24 So, I think there are probably
25 many situations where PCP's, especially child PCP's

1 are the prescriber but never the initiator. And, so,
2 I think that could add to longer time periods with
3 higher polypharmacy because I'm much less likely to
4 stop something that a psychiatrist is and, then,
5 having them come out on more meds maybe than
6 necessary because you only have however many days to
7 get somebody stabilized so that they can go back into
8 the community.

9 DR. LOHR: So, I think in
10 addition to looking at the question of rates at some
11 point, the Health Information Exchange, hopefully
12 that will reappear at some point in an effective form
13 but that allows for effective information of flow
14 from provider to provider following a child so that
15 you may have a history of previous medications or
16 previous trials, but I think that in some cases, not
17 having information can lead to either erroneous or
18 extra medication trials.

19 And I think the inpatient stay,
20 that's an important question. I've always argued
21 that children who are in foster care with all the
22 evidence, the trauma, the ACES, things, it's
23 difficult to hold them to the same criteria as a
24 child without those. They're just not going to
25 respond as quickly and they're going to have more

1 relapses.

2 It's openly discussed that
3 starting in 2020, there will be a single MCO for
4 children in foster care, and perhaps that will be a
5 time where you will have certain cases where children
6 with certain risk factors, they might be able to stay
7 in the hospital longer.

8 I think there are a lot of
9 things that are working to address that with MCOs and
10 payment continuing. So, it's a complicated answer to
11 think about what to do about shortening patient stays
12 but I think it's recognized by other people.

13 MS. POWELL: Can I ask one more
14 question? I'm just wondering if there's been any
15 discussion on different areas around the issue of
16 kids who are in care in private placements because
17 often the foster parents are saying, well, that's why
18 we're looking to medication. The child isn't getting
19 enough therapy. It's always a hard position because
20 you can't provide something else. They're already
21 being paid for to have therapy, but if the agency is
22 not increasing the level of care in response to the
23 child where they are, their presentation, it's really
24 difficult because we can't provide anything
25 additional.

1 DR. LOHR: So, will decoupling
2 help that or hurt that?

3 MS. POWELL: Hopefully help.

4 DR. LOHR: We hope, yes.

5 DR. RICHERSON: Any other
6 questions or comments? Great discussion. So, I
7 think we have one question to DMS about the MCOs,
8 what they're doing, what techniques or strategies
9 they have to look at, evaluate and respond to the
10 patients that they have that have lots of medications
11 prescribed, the children specifically.

12 And, then, you're going to do a
13 MAC recommendation. Do you want to hit on some high
14 points and we can approve it and then you can sort of
15 do the wording?

16 MS. POWELL: So, should I send
17 that to--who do I send that to?

18 MS. KALRA: You can send it to
19 me.

20 DR. RICHERSON: Do you want to
21 like right now just tell us the high points so we can
22 vote?

23 MS. POWELL: Sure. I haven't
24 formulated that all in my brain yet but basically I
25 think we would want to recommend some guidelines and

1 best practice that if we have a child with a
2 presentation who has maybe multiple diagnoses who is
3 potentially going to be prescribed medication and
4 maybe more than one medication, that these are first
5 line sort of interventions. So, of course, ABA,
6 occupational and speech therapy, that we would
7 consider the appropriateness of psychological testing
8 if that is clinically indicated and recommended by a
9 practitioner, following evidence-based interventions,
10 of course, for those. Did I miss anything?

11 MS. KALRA: I think that's it.

12 DR. RICHERSON: So, that's a
13 motion. Do I hear a second?

14 MS. KALRA: Second.

15 DR. RICHERSON: Any further
16 discussion on that MAC recommendation? Hearing none,
17 all those in favor, say aye. Any opposed?

18 And, then, I think one other
19 DMS question kind of bubbled up and is how can we
20 better understand as a TAC what role EPSDT plays in
21 access to treatments that are identified during the
22 EPSDT process?

23 So, for example, I identify a
24 child with autism. During the EPSDT process, they
25 are diagnosed and they need therapies that are not

1 accessible in the mainstream access to services
2 through Medicaid. So, I will word that for you.

3 We often talk about EPSDT
4 Special Services and alluding to the robustness of
5 that program but this will be a good example of how
6 do we sort of walk through that, and I will even
7 present a case because I have plenty to present.

8 The other thing with the MAC
9 recommendation, we have talked in the past
10 specifically with the Therapy TAC who are very
11 interested in this topic as well as the Behavioral
12 Health TAC. So, it might be strength in numbers for
13 discussions or get their perspective.

14 You are welcome to stay, Dr.
15 Lohr, for the rest of our conversation.

16 DR. LOHR: Thank you.

17 MS. STEPHENS: Will the
18 presentation be posted with the notes on the
19 Children's TAC website?

20 DR. LOHR: Yes. I will send
21 the presentation and the Florida best practice
22 guidelines to you, Sharley, to disseminate.

23 DR. RICHERSON: The next thing
24 we have under New Business is a potential new speaker
25 but it seems like we have enough discussion on this

1 to continue at the next meeting. So, unless people
2 want to go ahead and determine July's topic today, we
3 could or we could wait. What would you all like to
4 do?

5 MS. KALRA: Wait until May.

6 DR. RICHERSON: Is everybody
7 okay with that?

8 And, then, before we move on,
9 thank you so much, Dr. Lohr.

10 DR. LOHR: Thank you.

11 DR. RICHERSON: I think we had
12 some new people come in.

13 (INTRODUCTIONS)

14 So, let's go ahead and go into
15 Old Business. Sharley, are you the only DMS person
16 here?

17 MS. HUGHES: I am. I have sent
18 Stephanie an email like, where are you?

19 DR. RICHERSON: So, we are not
20 going to bombard you with stuff.

21 MS. HUGHES: If I know they're
22 not going to be here, I try to get updates on all the
23 topics and I did not on this. So, I apologize.
24 Stephanie has apparently had something else come up.

25 DR. RICHERSON: Okay. So,

1 these are some of our topics. So, in the past, like
2 Dr. Lohr came, we have a speaker on HVP, a speaker on
3 obesity. So, these are the way we follow up our
4 prior topics.

5 So, I guess there's nothing
6 really for this meeting, then, on HPV. We wanted
7 some updates from DMS on the immunization
8 collaborative. We were hoping to have the HEDIS
9 information available from 2018 around HPV. So, that
10 will just carry over for the next meeting. And even
11 if they can send it before the next meeting, that
12 would be great.

13 MS. KALRA: Before would be
14 great so we could discuss it.

15 MS. HUGHES: Okay.

16 DR. RICHERSON: And they could
17 even just do a paragraph on the immunization
18 collaborative as well, just kind of some bullet
19 points to update us before the next meeting.

20 Again, on obesity, there are a
21 lot of discussion topics that we have had looking at
22 this. CHOPT for Medicaid is something that has been
23 brought to us by DMS to continue discussing, so, we
24 can keep that on there.

25 Lisa had some concerns, well,

1 brought up that even though we can assess, we can't
2 treat using the health behavior codes, is that
3 correct, for obesity?

4 MS. POWELL: Right. The
5 intervention code is not loaded.

6 DR. RICHERSON: So, if we could
7 get feedback before the next meeting on that. What
8 is the intervention code?

9 MS. POWELL: 96152.

10 DR. RICHERSON: We had talked
11 about the RD/N. I presented just a little discussion
12 summary last time as a potential submission to the
13 MAC to request them as a provider type. I don't know
14 if people brought theirs from last time. I didn't
15 bring extra copies; but since DMS isn't here to get
16 feedback, maybe we'll hold that for next time.

17 I did bring another copy of the
18 obesity algorithm that I'll just pass around because
19 I think the same question comes up with obesity
20 around EPSDT coverage. So, we identify obesity all
21 day long during our EPSDT visits, and there are four
22 recommended steps.

23 The first two can be done in
24 the PCP office. Steps three and four cannot be done
25 in the PCP office. So, I will send that also to get

1 a response from DMS around the role of EPSDT and
2 treatment of things identified.

3 I don't know if any of the
4 EPSDT people in the room have any sort of facts on
5 your experience or working with other states around
6 EPSDT, if something is identified and we can't access
7 treatment for it, like, for obesity because we don't
8 have in the state Stage 3 and Stage 4 interventions.
9 Have you heard from any other states around, oh,
10 well, you're supposed to pay for it as EPSDT but
11 people aren't?

12 MS. CAMPBELL: There have been
13 instances where it's been pushed to find under
14 medical necessity something like the recommendation
15 as possible and, then, some really unique things have
16 happened where children have been - and the family -
17 not just the child - have been given scholarships
18 into TOPS or Weight Watchers and look for practices
19 that actually have a pilot within them which some
20 practices do if that's within the range of where that
21 particular child can get to.

22 I would be happy to look and
23 see if there are some other states within CareSource
24 that I work with on EPSDT if they've had success.

25 DR. RICHERSON: We certainly

1 know there are successful programs in different
2 states in the country in Stage 3 and Stage 4
3 interventions.

4 The University of Kentucky does
5 have, I think, Stage 3, Stage 4 limited, You know,
6 a very small number of children can access that.

7 MS. CAMPBELL: But the
8 multidisciplinary, I will tell you, that has been
9 paid under EPSDT medical necessity but you've got to
10 have that team around that family thing, you know,
11 getting the documentation for the prior authorization
12 and that needs to be walked through but that has
13 happened in Kentucky.

14 DR. RICHERSON: So, I will send
15 that as a question.

16 MS. HUGHES: Okay.

17 DR. RICHERSON: Does anybody
18 else want to say anything about the obesity topic for
19 right now?

20 Okay. The next thing on the
21 agenda, Eva, you're up. Can you hear us?

22 MS. STONE: Yes, I can hear
23 you.

24 DR. RICHERSON: Would you like
25 to give us an update on the Free Care Rule?

1 MS. STONE: Sure. And, then,
2 Mahak, if you're there, you chime in because you
3 probably know more than I do at this point.

4 The last I know is that things
5 were moving forward and I think the State, they're
6 working on the State Plan Amendment. It's not been
7 submitted yet because of the waiver and getting
8 things ready for that, but I think the intention was
9 for them to go ahead and move forward this coming
10 fall but using a Performance Improvement Project to
11 get things rolling out for the schools. Is that
12 right, Mahak? Am I telling that right?

13 MS. KALRA: So, DMS is making a
14 State Plan Amendment currently. That hasn't been
15 submitted yet.

16 And, then, right now, Deputy
17 Secretary Putnam and DMS is trying to figure out the
18 best avenue of how this rolls out through Medicaid.
19 They haven't identified whether it's a PIP or
20 whatever it might be. So, that's the last I have
21 heard and that was last week.

22 MS. STONE: So, I know with
23 Senate Bill 1 passing, the inclusion of mental health
24 providers in that, schools will definitely need
25 educated on qualifications for being able to bill

1 Medicaid and what kind of credentialing is required
2 through Medicaid, that not just everybody can bill
3 for services and those kinds of things, but I think
4 it's a great opportunity again for mental health
5 services and for school nursing services, but just to
6 make sure, too, I think it's important that we make
7 sure that things are tied back to a kid's medical
8 home so that there's a good coordination of care.

9 MS. KALRA: That's a great
10 point, Eva. I think also to tie back to Senate Bill
11 1, Senate Bill 1 does complement what the reversal of
12 the Free Care Rule would do and actually provide
13 sustainability for that mental health provider or a
14 school-based health professional I think the final
15 language was to be in the school setting.

16 So, I think overall, this
17 complements the legislation that was passed and
18 signed by the Governor last night. So, I think we're
19 moving on, moving forward and I think more kids are
20 going to have access to care because of this.

21 MS. POWELL: Can I ask a quick
22 question about that?

23 MS. KALRA: Yes.

24 MS. POWELL: Or maybe you don't
25 know yet but how will that work for kids who, say,

1 are getting school-based mental health services? Are
2 they also able to get other services outside or is it
3 an either/or?

4 MS. KALRA: No. That will
5 still be fine. I don't think it would really impact
6 that much or at all really.

7 MS. POWELL: If both providers,
8 though, are billing Medicaid?

9 MS. KALRA: So, I think the
10 goal would be--Eva, go ahead.

11 MS. STONE: I didn't mean to
12 cut you off. I was just going to say the school-
13 based Medicaid is a completely separate type of
14 Medicaid than through managed care.

15 And, so, that's one of the
16 things that I think there will have to be some
17 intentional discussions about because MCOs won't have
18 that claims data to know services that have been
19 provided in the school.

20 So, I think it's going to be
21 critical that we have conversations about how to do
22 this so that kids are truly getting wrap-around
23 services, but school-based Medicaid is completely
24 independent and, so, it should not interfere with
25 services kids are receiving.

1 be part of that plan.

2 So, typically, schools have
3 billed for occupational therapy, speech therapy,
4 physical therapy, those kind of services. Nursing
5 can be billed but it's typically just for that moment
6 in time.

7 So, if a student needed
8 catheterized or that sort of thing, that service
9 could be billed and then districts have been able to
10 bill some mileage for transportation on the days that
11 kids receive services but it's been limited to those
12 kids that had an IEP.

13 And in 2014, CMS decided that
14 they had misinterpreted that rule to limit the
15 billing to just those students with disabilities with
16 Individual Education Plans. So, they reversed the
17 Free Care Rule which is why it's called Free Care and
18 they have opened up that billing to any child with
19 Medicaid.

20 But in order for Kentucky to
21 participate, our State Plan has to be amended because
22 our State Plan limits the billing to those students
23 with IEP's, but it's an incredible opportunity for us
24 to be able to increase health services in schools -
25 school nursing, mental health services. Dental

1 services is another example of things we can do.
2 Some states have really coordinated their efforts and
3 it's a great opportunity for us to improve health of
4 children in Kentucky.

5 MS. SAVCHICK: I'm excited.
6 I'm very pro having services in the schools. My
7 concern is the communication.

8 So, it's nice to say that the
9 school-based Medicaid doesn't impact their regular
10 Medicaid services; but if they're getting services,
11 she just said dental at the end. If they're getting
12 services, we don't want to do double.

13 MS. KALRA: I think it's
14 identifying what's not being met.

15 MS. SAVCHICK: Okay. So, that's
16 where the communication comes in because we don't
17 want to double or we don't even worse yet have
18 someone give them opposite directions, like, this
19 doctor is saying go up and this one saying go down.
20 That would really be conflicting to the parent.

21 MS. KALRA: So, if you have a
22 school nurse that's doing an assessment or a
23 screening and sees that a child hasn't--like, there's
24 obviously a cavity or something that's blatant,
25 that's where they could go ahead and refer to someone

1 but an assessment would be needed or a screening
2 would be needed.

3 DR. ELLIOTT: And it is going
4 to get billed twice. It's going to get billed by the
5 school or whoever the provider is and it's going to
6 get billed by me. They can't do a cleaning without--
7 they can do it but it's only going to get billed
8 once. So, Medicaid is going to get charged for a
9 fluoride application, an exam and anything else out
10 of a cleaning.

11 So, you're going to get billed
12 twice if they do it in the school and then they get
13 referred to me. Well, I'm going to do another exam
14 to determine what needs to be done, take x-rays, all
15 those things. So, Medicaid is going to get billed
16 twice for two of those services.

17 So, the drawback to the school
18 system----

19 MS. STONE: Let me interject.
20 When I say dental, the dental would be for things for
21 screenings. Like, the state-required screening for
22 four- to five-year-olds, it's not going to be--when
23 providers come in and provide dental services in
24 schools that are clinicians, that's managed care.

25 What would be worked into the

1 State Plan would be things like dental screenings
2 that allow kids to be assessed and referred, not
3 provide the restorative care or even the cleanings or
4 that sort of thing. It's screenings that would be
5 included, not the screenings that include x-rays, not
6 the preventive exam. I'm talking about the four- to
7 five-year-old screening that RN's can do, that dental
8 hygienists can do, those kind of screenings.

9 MS. SAVCHICK: You wouldn't
10 want to do it with every single child because some of
11 those kids are already having regular visits at the
12 dentist, and, so, we don't want to waste money. So,
13 the children we know that their parents don't take
14 them, then, they can go ahead.

15 MS. KALRA: So, if a student
16 comes to a FRYSC, an example, and shares that they
17 don't have a toothbrush, that's a sign that this kid
18 probably--the student probably hasn't had a dental
19 exam or a screening or anything along those lines.

20 MS. SAVCHICK: Or he's my son
21 and he likes to embellish stories.

22 MS. STONE: For example, like,
23 in Jefferson County, in some of our elementary
24 schools, we've got less than 40% of students that
25 have had that five- to six-year-old required

1 screening. Those would be the kids that we would
2 target to make sure that somebody has looked at them
3 and referred if necessary because they're not getting
4 regular care. And if they've got a mouth full of
5 cavities, it's going to impact their learning
6 readiness.

7 DR. ELLIOTT: And who follows
8 up on the screenings, when they refer, that they
9 follow through with that referral?

10 MS. STONE: It's going to
11 depend on the school, but Family Resource Centers
12 have a health component. And, of course, if we have
13 nurses in the schools, that can be part of what they
14 are doing as well, but the State regulation for
15 school health requires followup for a referral.

16 DR. RICHERSON: Any other
17 questions on Free Care?

18 So, the same-day billing makes
19 no--it wouldn't apply at all? Let me rephrase that.
20 I know it wouldn't apply, but do you think that it
21 will get confusing once it hits the bank, so to
22 speak?

23 MS. KALRA: I think not
24 because, again, it's through different Medicaid
25 sources, the school-based Medicaid and---

1 DR. RICHERSON: But Medicaid,
2 it's all still going to one place.

3 DR. ELLIOTT: It's all coming
4 out of the same pot.

5 MS. STONE: The schools do
6 their own Medicaid billing. Most of them contract
7 with a third-party organization. School-based
8 billing for Medicaid is very different than what
9 happens on the health care side.

10 DR. RICHERSON: But I'm just
11 saying that it all still goes----

12 DR. ELLIOTT: The codes have to
13 be the same.

14 DR. RICHERSON: Are the codes
15 the same?

16 MS. STONE: There's ICD-10
17 codes but it's not the same at all, no. It's not
18 like there's a provider form filled out. The billing
19 goes through--Jefferson County uses a group called
20 Public Consulting Group. Most districts use the
21 Kentucky School Boards Association. They submit a
22 claim.

23 Some of the concern for the
24 school-based billing for the managed care
25 organizations is they don't see that claims data. If

1 a child, for example, had a preventive health exam at
2 school, they might not necessarily know that. So, it
3 impacts their quality indicators which that goes back
4 to my point of the fact that we need to be
5 coordinating these services, but it's not going to
6 impact providers--it's not the same type of billing.
7 It's not even through the same--it doesn't go through
8 managed care organizations.

9 DR. RICHERSON: But they are
10 CPT codes? Like, you will be billing 99211's,
11 99212's?

12 MS. STONE: I don't believe--
13 we've never billed in the school an office visit. We
14 just bill straight up for the services that were
15 provided which are primarily therapies.

16 MS. GLASS: Once this changes,
17 this is going to take a great deal of education on
18 everybody's part. And as Eva knows and I know,
19 school districts, that's going to be a major hurdle
20 but it will also be with people who are doing
21 services outside and with your MCOs as well because
22 this is going to be a huge change from what we've
23 done for years and years, as she can tell you.

24 So, it's going to take a huge
25 amount of education and a lot of information that's

1 going to have to be flowing out because there's
2 already--just in our group, you can see the questions
3 and the confusion that can go off with a lot of this.
4 I'm sorry, Eva. I didn't mean to interrupt.

5 MS. SAVCHICK: Just a quick
6 clarification. Did I hear this right? If the child
7 is at school and they get some services, the services
8 that they get will not be communicated to their I
9 guess family or regular doctor? There's a lot of
10 kids that jump from school to school to school.

11 So, if they go to a school in
12 one county and they get these services and, then,
13 they go to another school in another county in
14 Kentucky, are they going to get the same services?
15 Is there a place where their records are pulled
16 together?

17 MS. STONE: Kids that will get
18 services will have to have some sort of plan in place
19 to receive those services, so, those records would
20 transfer with the children. They're going to be tied
21 to a condition or a need or a screening and that type
22 of data is entered into the student data system which
23 is Infinite Campus.

24 DR. RICHERSON: And that's
25 statewide.

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MS. KALRA: Yes.

MS. GLASS: And it flows within school to school.

MS. STONE: Now, historically, one of the concerns has been, for example, a child could be referred for special education services for an evaluation for an orthopedic problem and be identified and placed into--get an IEP and be receiving therapy and a primary care provider never know.

I mean, that's been going on for a long time and this is the opportunity as the State Plan is being looked at to make sure that we're coordinating that care among providers. That was my point about making sure primary care providers are involved.

MS. SAVCHICK: And I bring it up because, as an adult, I had to get immunized as an adult because my immunizations were given randomly and not communicated. Anyway, long story, different state, but it would have been nice to have that record in there that I actually did get them.

MS. KALRA: Yes, but Eva and Pat were sharing that there is the Infinite Campus portal that every school has access to but there

1 isn't a Kentucky law that requires that medical
2 records transfers with every child wherever they go.
3 So, that's just a gap in general with our laws that
4 we have.

5 DR. RICHERSON: Great. Thank
6 you, Eva, for the update. Any other questions?

7 We still have increasing well
8 adolescent visits on our Old Business that came up
9 during our HPV discussion, I believe, when we were
10 looking at HEDIS data and less than 50% of teenagers
11 are meeting that HEDIS measure.

12 So, I will leave it on for now
13 just as a future topic unless somebody has any
14 insights today.

15 So, I think for the DMS
16 updates, if they could also just do a blurb to send
17 out between now and then unless you have some.

18 MS. HUGHES: I can give you
19 some updates on a couple of things. On the 1115
20 waiver, we're moving forward with the 4/1.

21 I believe based upon what I've
22 heard in other TACs, tomorrow oral arguments are
23 being heard and, then, we're after Arkansas in the
24 afternoon for Kentucky with the federal judge. So, a
25 ruling could come down at some point after that.

1 They should be getting their
2 Notices of Enrollment - I think that's what it is
3 called - sometime within the next week probably just
4 stating that they are in Kentucky HEALTH and that
5 they're going to have to pay a premium starting May
6 1.

7 I think that's about the only
8 thing that we've been telling in some of the other
9 TAC meetings. If you have questions about it, if I
10 know the answer, I will certainly try to tell you if
11 you have questions.

12 DR. RICHERSON: Questions on
13 the waiver?

14 MS. HUGHES: The Integrated
15 Care for Kids, I honestly didn't know what this was
16 when you set the agenda. So, I sent an email around
17 going anybody know what this is.

18 To make sure I've got the right
19 thing, it's a grant. We are pursuing the grant. So,
20 that's about all I can tell you on that. So, we are
21 pursuing it.

22 MS. KALRA: I think it would be
23 helpful to know what's the grant and knowing what
24 you're applying for. I think that would be helpful.

25 MS. HUGHES: I think they just

1 opened it up like a couple of weeks ago.

2 MS. KALRA: Yes. I think what
3 you guys are applying for, that would be helpful for
4 this group to know as we're the Children's Health TAC
5 and seeing if there's any way that we as TAC could do
6 or monitor or recommend or advise in whatever way.

7 MS. HUGHES: Okay. Well, let
8 me finish with this other. I don't know how much you
9 all are connected with the 1915(c) waivers at some
10 point in your lives.

11 Hopefully Friday, they're going
12 to start the public comment period again and they're
13 supposed to notify me if it does get out on Friday
14 and I'm going to send the notice out to all the TACs
15 just stating the 1915(c) waiver redesign's public
16 comment is back open and it will be open for an
17 additional thirty days.

18 Anybody that has made comments
19 from whenever it was first put out, I want to say
20 January 8th, something like that, if there's comments
21 that have been made, those comments are going to
22 still be good for this one. So, you don't
23 necessarily have to re-make your comment.

24 Anybody pretty much I think you
25 may get double or triple or any more notices on this

1 stuff because if you made a comment, they've set you
2 up in an email group but you're going to receive
3 notifications that the public comment is back out
4 again.

5 As they've gone out to these
6 stakeholder meetings and as they've gone out to any
7 kind of meetings with provider organizations, anybody
8 that has said I want to get on notifications, they
9 put them in the email list. So, you may get multiple
10 notifications but that's better than not getting any.

11 Other than that, I will say
12 that the Commissioner has spoken about and she has
13 let everybody know that as far as the TACs go, that
14 if we're going to be making changes that impact a
15 particular set of individuals or a particular
16 provider type, if it is something we can bring to
17 you, we're going to bring it to the TACs to get
18 advice on.

19 We do want to get more input
20 from you all. You all are the ones out there meeting
21 with the families and the kids, and for other TACs,
22 the adults. So, she has let us all know that she
23 expects us to start bringing more information to the
24 TACs.

25 Sometimes it's really nothing

1 we have control over even above the Commissioner's
2 head that we just have to implement it, but if it's
3 something that we want to do, we're going to bring it
4 to you all and say here's what we want to do. Is it
5 going to kill us or are you all going to kill us.
6 So, she has given that direction as the direction
7 that we want to go.

8 She has also mentioned in a TAC
9 meeting this morning because in a couple of other
10 TACs, we have heard that people in DMS are not being
11 responsive to emails being sent in. So, if that's
12 the case with you all, she said for you to let me
13 know. I will let her know and we will certainly
14 address that situation as well.

15 So, if you're having difficulty
16 with that----

17 DR. RICHERSON: I think the
18 biggest one is on the data requests. It's crickets
19 out there for data requests.

20 MS. KALRA: Yes. It's been a
21 while since we actually even sent one in because we
22 haven't even gotten a response from our first data
23 set and that was like a year ago.

24 MS. HUGHES: Okay. So, just
25 let me know. It would probably be easier if it's a

1 data request if you all just say, Sharley, this is
2 what we need. Put it in an email and say this is
3 what we want and, then, I can go from there rather
4 than me going back through trying to find the minutes
5 from last year and figure out what data you haven't
6 gotten. So, just let me know.

7 MS. KALRA: We'll be happy to
8 do that.

9 MS. HUGHES: And I know this is
10 Julia's last TAC meeting, and on behalf of the
11 Cabinet and the Department, we want to thank you for
12 being here and coming and participating and helping
13 and we look forward to working with your replacement.
14 You all have big shoes to fill.

15 And if there's anything we can
16 do even if you're not on the TAC, let us know and
17 we'll be more than happy to try to help you out on
18 something.

19 Other than that, if there is
20 anything in particular you have questions on, if I
21 don't have the answer, I will tell you and I will go
22 back and try to find it. So, any questions?

23 DR. RICHERSON: Any questions
24 for now?

25 MS. HUGHES: I meant to say

1 this to back up to what Eva said. I actually am the
2 person that does the State Plan Amendments otherwise
3 known as SPA and I tell people all the time, the boss
4 that hired me talked to me about doing SPAs and I was
5 like, hey, I can go to work and be in a spa. That
6 wasn't exactly what I had in mind, but we are working
7 on the SPA for the Free Care services.

8 DR. RICHERSON: And we love
9 having you here, but I think it's hard. We don't
10 want to dump on you. So, maybe they need a third
11 person on their bench so when Stephanie can't come,
12 somebody else can come.

13 MS. HUGHES: You can vent to me
14 all you want. I can take it. I don't mind that. I
15 often just take it back to the Commissioner and say
16 this is what they were upset over or this is what
17 they wanted.

18 And like I said, there's been a
19 couple that I knew I was going to be by myself and
20 I've gone around and said give me information to tell
21 them on this.

22 As close as 12:30, the
23 Commissioner said to me, Stephanie is going to be at
24 your meeting. So, I'm not real sure what transpired,
25 so, I do apologize, but you can still go ahead and I

1 can take it and I can take it back to them.

2 MS. POWELL: I just have a
3 quick question for you and probably for the MCOs.
4 So, the Kentucky Psych Association called to just
5 see. Can we get any clarification on where we all
6 are with the new CPT codes for psych testing?

7 There are lots of new codes
8 that went into effect January 1 and apparently people
9 across the state are getting lots of different
10 answers about are they on there, are the fee
11 schedules attached and loaded and are we ready to go.

12 So, I don't know if anybody
13 knows where we are with that. We were told January 1
14 but that then we should hold a little bit, that it
15 was taking the MCOs a bit to get ready. So, I don't
16 know if anybody has an update on where we are.

17 MS. HUGHES: I will send an
18 email right now, and maybe if they're at their desk,
19 they might must send me something back. So, these
20 are the new psych testing codes?

21 MS. POWELL: They're all new
22 codes that DMS published and January 1 they went into
23 effect but we're sort of holding waiting to hear.

24 DR. RICHERSON: Great. Any of
25 the MCOs know any word on that?

1 MS. STEPHENS: If you're
2 sending an email, we can respond. I don't know off
3 the top of my head.

4 MS. BEAL: We're waiting for
5 DMS approval.

6 DR. RICHERSON: Okay. So, we
7 will move just into general governance issues. So,
8 we already talked about the changes to the TAC
9 processes for DMS, that memo. Everyone got a copy.
10 Questions from TAC members on that?

11 Incoming Chair. I sent out
12 several times and gave everyone the opportunity to
13 volunteer to be Chair and I got nothing. So, does
14 anybody want to be a Chair?

15 MS. KALRA: I think we need to
16 say that first.

17 DR. RICHERSON: Lisa?

18 MS. POWELL: I'm sort of new
19 but tell me what is involved.

20 DR. RICHERSON: Just setting
21 the agenda and communicating with Sharley. So, just
22 what I've done.

23 MS. POWELL: I'm happy to do it
24 if you want me to. Do you stay where you are?

25 MS. KALRA: I'm happy to.

1 DR. RICHERSON: I coerced two
2 people into doing it. They both said but if somebody
3 else wants to do it, they're okay.

4 MS. POWELL: I like having a
5 counterpart, though.

6 MS. KALRA: I could be your
7 counterpart. I could still go to the MAC meetings
8 and present our recommendations.

9 MS. POWELL: That would be
10 great.

11 MS. KALRA: That is fine with
12 me. I just cannot commit to chairing.

13 DR. RICHERSON: I don't want to
14 make it a fight but anybody else want to be on the
15 ballot? So, Dr. Grigsby who is my replacement also
16 said she would do it but not right away. So, if you
17 want to do it for a while, then, she might do it when
18 you're ready to pass it on.

19 MS. POWELL: Is there a certain
20 period?

21 DR. RICHERSON: We used to go
22 by our bylaws which we had sort of internally decided
23 two years is a good time to put but there are no
24 rules. You can do it for a short time or a longer
25 time. Congratulations.

1 I think the video conferencing
2 options, the concept that you can't vote by phone but
3 you could by video, all the TACs are interested in
4 that and that conversation continues at the MAC. So,
5 we're waiting for a ruling from the Attorney
6 General's Office.

7 Any other business today?

8 Pending items just to run
9 through, and now that I'm leaving, you all can just
10 say, that was Julia's stuff. You can get rid of it.

11 There was a MAC recommendation
12 that we had made in the past. It was I think a time
13 period where there was not a quorum at the MAC and it
14 just kind of fell off.

15 MS. KALRA: We did refer this.
16 We did make this recommendation and they just said
17 no.

18 MS. HUGHES: What are those
19 codes?

20 MS. POWELL: Honestly, there's
21 like six of them and I haven't memorized all of the
22 new ones yet.

23 MS. CAMPBELL: 96152 was one.

24 MS. POWELL: No, no. That's a
25 health and behavior code. That's a different one.

1 MS. HUGHES: I'll have her just
2 send me an email on it. I was just trying to get an
3 answer while we were here at the meeting.

4 DR. RICHERSON: Is it in that
5 communication, Jessica? Are the codes listed in that
6 communication that you have?

7 MS. BEAL: Yes. Everything is
8 listed and the terms for them and that claims
9 submitted 1/1/19 using the old codes, please submit
10 corrected claims. If you submitted claims using the
11 new codes, they will be reprocessed.

12 MS. POWELL: Apparently, people
13 were calling KPA saying that they were trying to
14 submit codes. They were being bounced back and some
15 of the MCOs were saying they weren't ready yet.

16 MS. MAGRE: The fee schedule
17 came out not long ago and it's backdated to the first
18 of the year. So, we have to have a little time to
19 get the system readjusted to this and that may have
20 been exactly what was going on with that.

21 The other issue is it's an
22 event code, so, how prior authorizations are done,
23 you have to be careful how that's done.

24 MS. BEAL: Each MCO had to
25 determine how many hours they would---

1 MS. POWELL: Right, and it
2 sounds like that was part of the confusion for
3 people, too, is how to do a PA and that they were
4 trying to submit PA's and that they were getting
5 kicked back saying we don't have a process for the
6 new codes yet and for doing PA's.

7 MS. MAGRE: Well, WellCare
8 doesn't require a PA to----

9 MS. POWELL: But since these
10 are all different and there's add-on codes for all of
11 them and there are so many more codes versus just the
12 96101 that we only use one code. So, I think people
13 are just confused. How do we do it? When are the
14 MCOs ready? Can we start sending billing through
15 because I think people across the state have just
16 been holding their billing since January 1st.

17 So, now we're ready to send it
18 but also from now, what about the PA's and how do we
19 do that? So, maybe they can send something out to
20 providers to say----

21 MS. MAGRE: I will ask.

22 MS. HUGHES: He does think that
23 our fee schedule has been updated. Would you mind to
24 look and if it's not, let me know.

25 MS. POWELL: Sure.

1 MS. BEAL: It has and it was
2 published. There's a few discrepancies between the
3 physician and the behavior health side, so, they're
4 not related to these codes, and the MCOs were pretty
5 much notified of that in the last month. So, we
6 didn't have any dollars attached or anything that we
7 could go on to say what we were going to pay.

8 DR. RICHERSON: And, then, some
9 other CPT codes that have been--and in the past, DMS
10 said that these should not go to the MAC, that they
11 should go to--there's some place that you all
12 request--I can't remember where it was but to not go
13 to the MAC. So, maybe if you could find out where
14 the requests for inclusion of codes on the fee
15 schedule go.

16 MS. HUGHES: Usually Charles
17 Douglass is who does the codes. Does that sound
18 familiar?

19 DR. RICHERSON: That sounds
20 familiar. So, it's the Fragile X testing, the
21 newborn audio and, then, these other child audio
22 codes. We're still waiting for them to get on the
23 payment for audiologists, not for physicians.

24 So, Fragile X, it's just a lab
25 code and, then, the others would be on the audiology

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fee schedule.

MS. HUGHES: I'll check with them, but in case you need to email him at anytime, it's charles.douglass@ky.gov.

DR. RICHERSON: And he came to our meeting maybe six months ago.

MS. HUGHES: He said he tried to call in but he probably tried to call in before I did. So, he hung up.

DR. RICHERSON: So, that is all of our business and it is 3:59.

I prepared this for the Commissioner just to give her an idea about the TAC and what we've done in the past. So, I will just give everyone one of these.

Thank you, everyone, for attending.

MEETING ADJOURNED