

**CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE**

November 20, 2014
10:00 A.M.
Room 125 Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Donald Neel
Susie Riley
Susanne Watkins
Peggy Roark
Jonathan Van Lahr
Barry Whaley
COUNCIL MEMBERS PRESENT

CAPITAL CITY COURT REPORTING

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

AGENDA

1. Call to Order.....	4
2. Approval of Minutes	4
3. Old Business	
(a) Kentucky plans for continuation of payment supplements to primary care physicians	4 - 8
(b) DMS response to questions posed by MAC members at Sept. meeting	8 - 11
(1) That DMS respond in writing by the November meeting as to why Behavioral Health should not be carved out of managed care	
(2) That the MCO report admission rates to psych hospitals, average LOS and readmissions to psych hospitals. Also request that they report denials of inpatient care and denials of IOP care	
(3) That DMS respond to the request that it impose consistency across MCOs with regard to formularies, prior auths, etc.	
(4) There was a question about what indicators MCOs are providing to see that continuum of care is actually happening between medical side and behavioral health	
(5) Concern expressed about patients getting prescriptions beginning on Jan. 1 when there will be new patients in MCOs or patients will have changed their MCO. What has been done to assure that patients will be able to have their prescriptions filled and providers and pharmacists will know to which MCO the patient has been assigned	
(c) DMS working with MCOs to develop a common preauthorization form - update	11 - 12
(d) Suboxone Clinics - update on deeper look that DMS is giving these clinics	12 - 13
(e) Psych hospital and IOP denials, admission and readmission rates	13 - 17
(f) Any change in number of enrollees in each MCO	17 - 20

g) When enrolles renew medical card, they are being switched to different MCO. This is problem because enrollees are not aware they are being switched; the new MCO has a different formulary and medication that was previously covered is no longer covered; sometimes the current health care provider is not credentialed with MCO that the enrollee is switched to	20 - 21
4. Updates from Commissioner Kissner	21 - 23
5. Reports and Recommendations from TACs	
* Behavioral Health	23 - 24
* Children's Health	(No report)
* Consumer Rights & Client Needs.....	(No report)
* Dental	24 - 25
* Nursing Home Care	(No report)
* Home Health Care	(No report)
* Hospital Care	25 - 27
* Pharmacy & Therapeutics	(No report)
* Nursing Services	27 - 35
* Optometric Care	35
* Therapy Services	36 - 37
* Physician Services	37 - 38
* Podiatric Care	(No report)
* Primary Care	39 - 44
* Intellectual & Developmental Disabilities	(No report)
6. Approval of Recommendations from TACs and request for response from DMS	45
7. WellCare Presentation	45 - 73
8. Dates for 2015 Meetings	74 - 77
9. New Business	77 - 84
* DMS brochure and information sheet on MCOs	84 - 97
10. Other	97
9. Adjourn	97

1 CHAIR PARTIN: We will call the
2 meeting to order. Obviously we don't have a quorum
3 today but we will conduct business just the same.

4 The approval of the minutes will
5 have to wait until a subsequent meeting when we do have
6 a quorum.

7 Under Old Business, one of the
8 questions was from Old Business about Kentucky planning
9 to continue payment for supplements to primary care
10 physicians. We had discussed this at the last meeting
11 and had no feedback other than there was an article in
12 the American Medical News that Passport was going to
13 continue those payments for one year.

14 Is there any information from DMS
15 on this?

16 COMMISSIONER KISSNER: Yes. We
17 initially built into the budget a continuation of the
18 supplemental payments; and when the budget was cut, the
19 funding for the supplemental payments was also cut. So,
20 we at this point have no intention of continuing the
21 exact same program.

22 We are exploring on a fee-for-
23 service basis an increase in payments for certain
24 preventive items - immunizations and other things - to
25 see if we can improve some of the results there; but the

1 program as it stands today, it ends on December 31st
2 2014.

3 CHAIR PARTIN: And you don't know
4 what those preventive services are at this point?

5 COMMISSIONER KISSNER: We do. The
6 immunizations and a variety of things, but we'll give
7 you a release of all that information. We're trying to
8 figure out if we can do it from a systems perspective in
9 how we actually make the payment from a systems
10 perspective because it would be an increase in the
11 payment for certain items on fee-for-service only and I
12 think will help improve the HEDIS reports, but we're not
13 ready to release all the information yet but we're
14 working on it.

15 DR. NEEL: Will there be some
16 attempt in the Legislature, a bill presented to try to
17 get that in the new budget? Of course, that would put
18 it way down the line as far as when it might happen.

19 COMMISSIONER KISSNER: Right.
20 It's my understanding, and I'm not the political wonk -
21 there are others that are - but this coming Session is a
22 short Session because they don't deal with anything that
23 has to do with budget. In fact, I don't believe they
24 can deal with budget stuff unless it's a crisis or
25 something. They basically deal with budgets every other

1 year. So, I don't believe there can be - the budget is
2 a two-year budget - a budget passed and in statute.

3 DR. NEEL: Well, I'm sure you're
4 aware that Passport has announced that it's going to
5 continue it for one year for the providers that are part
6 of their network. Do you think there's any indication
7 that the other MCOs might follow suit?

8 COMMISSIONER KISSNER: I think you
9 would have to ask them.

10 DR. NEEL: Okay. I intend to do
11 that. Of course, it's not totally dead in the lame duck
12 Congress. We just came back from the AMA meeting and
13 all of the primary care associations, AAP, AAFP and
14 everybody, of course, is lobbying very hard to try to
15 get that.

16 Of course, it can't be in the
17 continuation budget. It has to be voted separately.
18 And, so, I guess it's not totally dead but we're hearing
19 that it's on life support at this point. Is that what
20 you're hearing also?

21 COMMISSIONER KISSNER: Yes, sir.

22 DR. NEEL: Thank you.

23 CHAIR PARTIN: Do we have any
24 representatives from the other MCOs besides Passport
25 that could let us know if you're thinking about

1 continuing these payments to primary care providers?

2 MS. MUNSON: I'm Kelly Munson,
3 Plan President of WellCare, and it is something that
4 we're currently in discussions, and Dr. Neel has agreed
5 to meet with us and take us through the provider case
6 for it and we expect to have a decision soon.

7 CHAIR PARTIN: Thank you.

8 DR. NEEL: Mr. Kissner, will we
9 hear when you institute those changes of an increase in
10 immunization fees, for example? We're the lowest in the
11 nation now, I believe. So, will we hear like as a
12 committee or will we hear publicly when you decide on
13 those fees?

14 COMMISSIONER KISSNER: We're
15 trying to get it done 1/1/15. So, yes, but the
16 committee doesn't meet until January. If we get all the
17 approvals and everything to do it, we will do a formal
18 announcement to all provider types and the world will
19 know.

20 MS. HOWELL: I'm Kim Howell with
21 Humana-CareSource, and we were just meeting yesterday
22 about our agreements. We do have certain agreements in
23 place now that providers should check that stated what
24 the terms would be if the enhanced pay stopped and when
25 it stopped. And then we are also discussing, we were

1 waiting to find out what the State would do to build
2 upon that.

3 So, it's fluid, but providers
4 would want to check their agreement because there would
5 be a term in there that states should enhanced pay stop,
6 this is the term that you are paid at.

7 CHAIR PARTIN: Thank you. Anthem
8 or Coventry.

9 MS. PATTON: Peg Patton from
10 Anthem, and we are currently looking at continuing.
11 Right now we're assessing what that looks like and what
12 the cost would be in order to do that. So, that is
13 currently under consideration and we'll certainly do a
14 communication as we move forward with that.

15 CHAIR PARTIN: Thank you.
16 Coventry.

17 MS. RICHARDSON: Kimberly
18 Richardson with Coventry. This is not an item I'm
19 particularly familiar with myself, but I will certainly
20 take it back and see if the folks that are considering
21 it have an answer for you.

22 CHAIR PARTIN: Thank you very
23 much.

24 The next item under Old Business
25 were some questions that MAC members had that we asked

1 of DMS at the September meeting and we had asked for a
2 response by the meeting today. And, so, I was wondering
3 if we had that response.

4 COMMISSIONER KISSNER: Yes. I
5 believe all of the responses are in the binder.

6 CHAIR PARTIN: Where would they be
7 in the binder?

8 MS. EPPERSON: TAC Meeting Notes
9 and Info.

10 DR. NEEL: Are they in the New
11 Testament or the Old Testament?

12 CHAIR PARTIN: I'll tell you what.
13 We really appreciate getting the response, but what I
14 would request is that maybe we could have the response
15 emailed to us or emailed to me so I could share it with
16 the rest of the committee prior to the meeting because
17 it's going to be really hard for me to conduct the
18 meeting and read the response and respond to it since
19 it's in the binder.

20 So, in the future for responses,
21 if you all could respond to us directly, that would be
22 very helpful.

23 MR. VAN LAHR: I have a question.
24 On number 5, who is that going to go to? Since the
25 Pharmacy TAC has not been allowed to be formed yet, what

1 TAC does that go to?

2 COMMISSIONER KISSNER: We have
3 received the nominations from the Pharmacy Association.
4 So, that's in the process of being formed. In the
5 interim before that TAC is formed, you could send it
6 to----

7 MR. VAN LAHR: But you said all of
8 these have been answered and I'm asking you where number
9 five was answered.

10 COMMISSIONER KISSNER: The
11 concerns about January 1st we'll deal with after January
12 1st. If there's an issue that pops up, we don't
13 anticipate significant changes with the MCOs. We've
14 been open for open enrollment for quite some time and
15 fourteen, fifteen thousand people have changed out of
16 1.1 million. So, I think there's going to be a
17 significant consistency of staying with the MCOs.

18 MR. VAN LAHR: So, this was not
19 answered in the binder then.

20 COMMISSIONER KISSNER: I don't
21 believe it was, no.

22 MS. EPPERSON: There actually is a
23 response. There's a response in the last letter in that
24 section. If you look at number five, there was a
25 response to that.

1 MR. VAN LAHR: Under TAC Meeting
2 Notes and Info?

3 MS. EPPERSON: Yes, the very last
4 document.

5 MR. VAN LAHR: Okay. Thank you.

6 CHAIR PARTIN: So, Barbara, for
7 the future, if you could get the responses to me or to
8 the whole committee prior to the meeting so we have a
9 chance to read them.

10 MS. EPPERSON: And I will; but if
11 you will notice on this letter, this was something that
12 we just got done yesterday and I just had it this
13 morning. So, if I had emailed it to you, you wouldn't
14 have gotten it until this morning, but I will do that.

15 CHAIR PARTIN: Thank you. Next
16 under Old Business, DMS has been working with the MCOs
17 to develop a common preauthorization form. Where are we
18 with that?

19 COMMISSIONER KISSNER: Barbara, is
20 there a tab on this or no?

21 MS. EPPERSON: Pardon me?

22 COMMISSIONER KISSNER: Is there a
23 tab on that, on the prior authorization update? Did we
24 get that in the binder?

25 MS. EPPERSON: Yes, we did.

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DR. NEEL: Where is it?

COMMISSIONER KISSNER: It's in the very last section under Odds and Ends, Miscellaneous. About halfway through, there's a letter dated November 17th from Patricia Davis to me that talks about the process that they've gone through so far.

Having the MCOs do the services the same, we're not finding that as we do our investigation. We're not finding that in commercial, we're not finding that in Medicaid, but we did find in Ohio a common prior authorization form and we continue discussions with the MCOs. And we actually gave you a copy of the form from Ohio's care coordination plans.

CHAIR PARTIN: Great. So, progress is being made. That's good.

Next Under Old Business, we had had some information about Suboxone clinics and we were just wondering about an update on the deeper look that DMS said that they were doing.

COMMISSIONER KISSNER: Yesterday, the Secretary, Audrey Haynes, and Dr. Allen Brenzel and Dr. John Langefeld made a presentation to Health and Welfare and that presentation is available online because once you make it to Health and Welfare, it's online here at the LRC somewhere.

1 We continue to explore the issue
2 and determine what's going on and what the data is
3 telling us. Drug overdose deaths in the State of
4 Kentucky have now exceeded automobile deaths. That's
5 pretty alarming. We're doing a really good job on
6 people wearing seatbelts but on overdoses, we're not.

7 So, we are working with the Office
8 of Drug Policy in the state. We're working with KBML
9 and they have drafted some legislation, KBML has, to try
10 to address this issue because what we're doing does not
11 appear to be working. Just writing a stand-alone script
12 without counseling, without some medication-assisted
13 therapies and treatments, that's not the way to go.
14 It's not what best practice says. It's not what
15 evidence-based health care is pointing to.

16 So, we continue to explore that,
17 but there is more information available that was
18 presented to Health and Welfare yesterday.

19 CHAIR PARTIN: Thank you. We had
20 also asked about psych hospital and IOP denials,
21 admission and readmission rates. Do we have that
22 information?

23 COMMISSIONER KISSNER: We do not.
24 That would be a special ad hoc report that we will need
25 to have the MCOs prepare.

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CHAIR PARTIN: So, can we expect something like that at the next meeting?

COMMISSIONER KISSNER: I will make the request and will try to get it before the next meeting.

DR. NEEL: Can I ask a question, Beth?

CHAIR PARTIN: Sure.

DR. NEEL: We're having a problem. I speak for the pediatricians and family practice docs in my area and I don't know if it's pervasive across the state or not.

In the first place, we don't get information when our children and many of the adults are discharged from those hospitals. We don't even know they were there. So, we don't get that information.

Secondly, the parents and the patients are being told we're going to give you a prescription for your medications when you leave, but we can't see you back for three months, and, so, you're going to have to go to your pediatrician or family practice doc and get your medications refilled.

Many of these are psychiatric drugs that we're not comfortable in prescribing. And a number of phone calls that are starting to come in in my

1 area is huge and we're not willing to do that. I'm not
2 willing to give Prozac to a 15-year-old girl that I
3 don't know what her problem is or anything. So, that's
4 becoming a problem and they're going to be having
5 trouble getting these prescriptions refilled.

6 But these people are telling them
7 at the hospital that you're going to have to go to your
8 private doc to get these refilled and that's going to be
9 a real access-to-care and maintenance problem. Have you
10 all started to hear any of that or is anybody in the
11 room hearing that? It's out there and it's coming.

12 COMMISSIONER KISSNER: The
13 psychiatric hospitals in the state are managed by
14 Behavioral Health, BHDID. So, you guys may want to make
15 a formal request to have them present about that topic
16 because it really becomes a provider data information
17 sharing, right? It's information. I don't know where
18 they stand on KyHI, whether they're uploading their
19 information into the health information records that we
20 have in the state. I don't know. I'm not really
21 involved in that at all, but they're the ones who manage
22 the psych hospitals and would be good to talk to.

23 DR. NEEL: Because a number of
24 mental health providers in our area who even see
25 Medicaid patients is pretty sparse. Is that true with

1 you, Beth?

2 CHAIR PARTIN: Yes. Along with
3 that problem, I would like to say that we're also seeing
4 that in the outpatient setting where patients can't get
5 an appointment with outpatient psychiatric providers,
6 and, so, the psychiatric clinics are telling the patient
7 that they need to get a continuation of their
8 psychiatric meds from their primary care provider.

9 So, they're asking us to prescribe
10 some of the antipsychotics and antidepressants and
11 medicines that we wouldn't normally prescribe, but you
12 kind of have to weigh those things and it gets kind of
13 scary because you think, okay, this patient has been on
14 this medicine for three years and now the psych provider
15 is going to be out or not available for three months and
16 this person isn't suddenly going to get their medicine.

17 And, so, you have to think, okay,
18 should I prescribe it even though I don't usually
19 prescribe this medicine but the patient is stable or no
20 because I don't usually prescribe this kind of medicine.

21 COMMISSIONER KISSNER: I
22 understand the severity. Leslie, do you have something
23 to say?

24 MS. HOFFMAN: I was going to say I
25 will be more than glad to follow up with the Department

1 of Behavioral Health related to this issue as well as
2 DMS staff. I can check on it. I haven't heard any
3 complaints but I will be glad to follow up on it.

4 COMMISSIONER KISSNER: Once a
5 month, Mary Begley, the Commissioner of BHDID, has a
6 meeting with the CMHC CEO's, and that's December 5th, I
7 think. So, she has a regularly scheduled, ongoing
8 meeting with them and that's the bulk of outpatient
9 psychiatric services in the state.

10 And, obviously since we've
11 expanded, it's not the entirety, but we can raise the
12 issue there as well and see if we can get some feedback.

13 CHAIR PARTIN: Thank you.

14 COMMISSIONER KISSNER: Changes in
15 enrollment?

16 CHAIR PARTIN: Yes.

17 COMMISSIONER KISSNER: As of right
18 now, it looks like there's been - I'm just ballparking -
19 about 15,000, almost 16,000 changes. It looks like
20 Coventry has lost 7,100-ish and WellCare has gained
21 3,500 and Passport has gained about 3,600. So, they
22 tend to balance each other out. And, then, Anthem and
23 Humana are basically stable.

24 So, that's what we have seen so
25 far, but open enrollment continues until December 12th.

1 DR. NEEL: What were the numbers
2 on Passport?

3 COMMISSIONER KISSNER: About 3,600
4 plus.

5 DR. NEEL: Increase.

6 COMMISSIONER KISSNER: Yes. So,
7 it's pluses, minuses. That's just a net number. So,
8 7,100 and then 3,500, 3,600, and then the other two are
9 basically push.

10 DR. NEEL: We continue to see
11 patients being put on Passport when mothers are having
12 to recertify and it seems to be only Passport. They're
13 on others and they're not initiating the change.
14 They're just being changed to Passport. We've not seen
15 any that were changed to Anthem or to Humana or anybody
16 else.

17 Two months ago, you told us there
18 was a glitch in the computer----

19 COMMISSIONER KISSNER: There was
20 and we have fixed that. We created a fix in the system.
21 It was between the KAMES system which is our eligibility
22 system and the HBE system. When we make a change today,
23 we go into five different systems and make a change.
24 So, when somebody calls us during open enrollment and
25 says I'm changing, we actually change it five different

1 places. That's the system we work today.

2 December of next year, we will be
3 fully integrated into the Health Benefit Exchange system
4 which is integrating the Health Benefit Exchange and our
5 eligibility system into one. So, there's going to be
6 one system, one-stop shop which is what we have on the
7 front end today.

8 If you go to the Exchange and you
9 enter all your data, it tells you whether you're
10 eligible for Medicaid or eligible to buy a Qualified
11 Health Plan, and if you're eligible to buy a plan, your
12 APTC tax credit.

13 So, the system on the front end is
14 completely integrated, but that was only for the new ACA
15 members starting off; and now as we do the recerts, by
16 the end of next year, we'll have one system.

17 So, what we found was when the
18 KAMES system and the Health Benefit Exchange system and
19 in sort of the bridges that we created, there were some
20 glitches and we fixed that so that now the information
21 is back and forth, but we identified about 4,000 people
22 that we had assigned that we should not have--
23 technically, it was looking at them like they were a
24 brand new member and not looking at their old file in
25 the system.

1 responses to all of the written questions that were
2 submitted and that's in the TAC Meeting Notes and Info.

3 We have the good news stories.
4 Those, as always, are definitely worth reading.

5 We did send out a letter right
6 after Good News which is Provider Communications. We
7 did send out a letter per your request to all providers
8 October 1st that said here's the open enrollment period
9 and we got that out to all providers letting them know
10 that was happening.

11 We're being much more transparent
12 on the operational results from our MMIS vendor which is
13 HP. So, we have lots of information there from HP. If
14 you guys go through that and have any questions, just
15 let me know. That's basically the fee-for-service piece
16 and utilization management and a variety of things
17 there.

18 And, then, I would like to see the
19 rest of my time to make sure we have enough time for
20 Kelly to make a presentation from WellCare. My thoughts
21 on this is there's a lot of stuff that WellCare is doing
22 that is unique, important, impactful that have really
23 not come out. And, so, she made a presentation to me
24 and the Secretary and I said I need to get this
25 information to the MAC. I need to get this on the

1 record as to what you're doing. So, I've asked her to
2 do that.

3 And, then, that will set a pretty
4 high bar for the rest of the MCOs because what we'd like
5 to do is have them do a similar presentation one at a
6 time. We just can't do all of them because it would
7 take up the whole meeting.

8 So, WellCare took the initiative,
9 so, they get to go first and set a high bar and we'll
10 have the other MCOs respond as well. I think Passport
11 does a lot of similar stuff. I know Humana-CareSource
12 does and Coventry, but I just want to get it on the
13 record as to what they're doing and how they're doing
14 it.

15 CHAIR PARTIN: Okay. What I'd
16 like to do is do the TAC reports quickly first and then
17 we'll go ahead and do the WellCare presentation after
18 that.

19 And, also, anything that's in the
20 notebook that we received today, if any of the members
21 have comments on these things, please get them to me and
22 then we will put them on the next agenda under Old
23 Business since this was presented to us today.

24 The first one is Behavioral
25 Health. I sent a copy of that to all of the MAC

1 members. Sheila Schuster was not able to be here today
2 but she asked that I note that you all have received the
3 report and the recommendations and that we vote to
4 approve them, although we don't have a quorum today.

5 So, we won't be able to vote on
6 those recommendations, but I'd like to get them into the
7 record so that when we do have a quorum at a subsequent
8 meeting, then, we will automatically approve those. So,
9 you have that.

10 The next one is Children's Health.
11 Consumer Rights and Client Needs. Dental.

12 DR. RILEY: Dental met on
13 September 24th and we had three recommendations coming
14 from that meeting.

15 Number one, that Passport and all
16 the MCO subcontractors be encouraged to send approval
17 letters for service to members as well as denial
18 letters, especially when there has been a reversal of
19 originally denied services.

20 The second is that the KAR
21 language that refers to removal of impacted teeth prior
22 to orthodontic approval be clarified to state tooth or
23 teeth. Because it states teeth, there have been varying
24 interpretations of what's required to be impacted or how
25 many teeth are required to be impacted prior to

1 orthodontic approval.

2 And, thirdly, that DMS closely
3 monitor Humana-CareSource regarding payment rules and
4 payment of interest if guidelines are not met.
5 Throughout the state, there is a complaint of a high
6 level of dental providers about slow payment.

7 And outside the Dental TAC, there
8 was a work group that met with Secretary Haynes on
9 October 28th and further work groups were established to
10 work on policy modifications with DMS, and we're very
11 hopeful about the outcome of that.

12 CHAIR PARTIN: So, a question. Is
13 the dental group going to look for legislation to fix
14 that KRS problem?

15 DR. RILEY: Yes.

16 CHAIR PARTIN: Thank you. Nursing
17 Home Care. Home Health Care. Hospital Care.

18 MR. MILLER: Good morning. I'm
19 Steve Miller with the Kentucky Hospital Association.
20 TAC Chair Carl Herde could not be here today. Hopefully
21 somewhere in your either Old or New Testament, you have
22 the minutes from our meeting back on October 30th.

23 A couple of things I'd like to
24 highlight there is that we continue to work with the
25 Cabinet as it relates to NDC's and whether or not

1 hospitals need to submit those, whether or not
2 especially the 340B hospitals. We believe there should
3 be a process by which they do not need to submit the
4 NDC's for each one of these scripts.

5 We believe that through the 340B
6 pricing, that they're not subject to that, and that's
7 being followed in other states. We thought we had that
8 worked out at one time with the Cabinet but we're
9 revisiting that once again.

10 Also in the minutes you will see
11 where Ms. Eisner, who is the CEO of The Ridge Hospital
12 in Lexington, brought up the issue as to whether or not
13 hospitals could do crisis stabilization on campus.
14 There seems to be some confusion whether or not the
15 psych hospitals are allowed to do that. The Cabinet is
16 going to clarify that for us.

17 We also have a continuing issue as
18 it relates to the credentialing of physicians and the
19 different processes among the different MCOs. I know
20 there's discussion going on right now trying to bring in
21 some sort of uniformity in that process but that still
22 is ongoing.

23 And last but not least, as you
24 know, there was a new DRG reimbursement regulation that
25 was issued last April that has been deferred on a

1 month-to-month basis. We continue to work with the
2 Cabinet on some corrections or at least some
3 improvements there. There has been some movement from
4 our perspective as it relates to the transition of that
5 regulation and the fiscal impact but there are still a
6 number of issues that we still have with it.

7 The Cabinet issued a regulation
8 approximately two weeks ago and has now opted to defer
9 it on a month-to-month basis, but we hope that affords
10 the opportunity to continue to work there.

11 CHAIR PARTIN: Do you have
12 recommendations in your report that we have?

13 MR. MILLER: In the report, no,
14 not at this time.

15 CHAIR PARTIN: Thank you very
16 much.

17 Next up is Nursing Services, and I
18 will give that report.

19 The Nursing TAC met on November
20 7th and we have several recommendations, first related
21 to MCO refund requests. Many practices are receiving
22 notices from the Medicaid MCOs requesting refunds for
23 overpayments. These requests arise after the MCOs audit
24 their records and determine that overpayments have been
25 made on regular visits or that some provider has been

1 paid for more than two level four or five visits. Some
2 of the refund requests are for significant amounts.
3 Practices run on a very tight budget and these
4 unexpected requests for refunds could, in some
5 instances, be enough to cause the practice to close. In
6 that case, no one wins - not the patients, not the
7 providers and not Medicaid.

8 It is almost impossible for
9 providers to determine if they are being overpaid. The
10 MCOs set their rates and the EOBs reflect the rate that
11 the MCO has paid to the provider. The provider does not
12 know that the rate recorded on the EOB is incorrect.
13 Secondly, it is not possible for providers to determine
14 if a patient has had more than two level four or five
15 visits in a year.

16 So, the recommendation under that
17 would be on the repayment of refunds, that the TAC
18 requests that the payback period match the look-back
19 period; that payments retained by payors from future
20 remits be equal to the total percentage of claims paid
21 during the look back; and that payments not be withheld
22 at 100% until fully refunded. This would aid with
23 practice cash flows and not jeopardize the provider's
24 ability to continue services.

25 The TAC also requests that there

1 be more transparency on rates paid to providers, with
2 providers receiving a list of the reimbursement that the
3 MCO is paying to that provider. MCOs should be required
4 to honor the reimbursement rate noted on the EOBs sent
5 to providers. The MCOs should not be permitted to
6 decide two years later that the fee paid and posted on
7 the EOP was incorrect.

8 The next item is limitation on
9 Level 4 and 5 visits. Kentucky struggles to meet
10 health standards, and this is especially true with
11 regard to chronic, complex health problems such as
12 diabetes, cardiovascular disease, premature death),
13 obesity and smoking. Patients who have chronic problems
14 require more attention and higher levels of scrutiny at
15 health care visits.

16 Kentucky providers are expected to
17 provide evidence-based care and meet nationally accepted
18 standards of care, or they will be penalized by the
19 PQRS if standards are not met.

20 The Center for Medicaid and
21 Medicare Services has established national standards for
22 level of care, documentation, and reimbursement for all
23 patient visits. These standards are based on extent of
24 history, physical examination, diagnosis, treatment and
25 overall complexity of the visit.

1 As previously noted, many people
2 in Kentucky suffer form diabetes, heart disease, COPD
3 and obesity. Providing appropriate care for these
4 individuals is a Level 4 visit. While providers are
5 required legally and ethically to provide the
6 appropriate level of care to the patient and document
7 that care, the situation created by this limitation
8 continually forces providers to down code visits. The
9 down coding results in inaccurate data on patient
10 visits.

11 And the recommendation is that
12 the TAC requests a legal justification from DMS for
13 limiting level 4 or 5 visits to two visits per patient
14 per year, while at the same time requiring providers to
15 meet nationally accepted standards in the provision of
16 care.

17 If the limitation is to remain in
18 place, the TAC requests realtime notification from DMS
19 or the MCOs that the patient has exceeded the two-visit
20 limitation.

21 And, three, does the two-level 4/5
22 visit restriction apply to any Level 4/5 visits the
23 patient may have had with any provider, or is it per
24 patient, per provider, per year?

25 COMMISSIONER KISSNER: Per

1 patient, per provider, per year.

2 CHAIR PARTIN: The next thing is
3 physical exams. Currently, Medicaid and the MCOs limit
4 participants to one physical exam per year. Many people
5 require more than one physical exam per year. This is
6 particularly true for children who are required to
7 receive school physicals and maybe six months later are
8 may be required to receive a sports physical.

9 Additionally, there are children
10 who are placed in foster care who require a physical
11 exam each time they are placed in a new home. There are
12 a myriad of other reasons that a person may require more
13 than one physical exam in a year's time. The
14 requirements for some of the exams are different, so it
15 is not a matter of providing a one-size-fits-all exam.

16 Further, if the person has had a
17 physical exam performed and billed by another provider,
18 and the second provider is not aware of the previous
19 exam, the second provider's claim is denied.

20 It was interesting to note that
21 Anthem, in a recent DMS publication that compared
22 services of the MCOs, listed free annual sports
23 physicals for members 6 to 18 years old. The
24 advertisement is encouraging parents to bring their
25 child in for a sports physical, for which the provider

1 may not be reimbursed.

2 The recommendation, the TAC
3 requests a report of claims denied for well child annual
4 visits because an exam has already been done.

5 Two, is the limitation per
6 calendar year or is it a rolling date?

7 Three, the TAC requests a minimum
8 of two physical exams per year be permitted.

9 And, four, the TAC requests that
10 providers be notified in realtime if a patient has met
11 their limitation on physical exams for the year.

12 Four: Annual APRN License
13 Renewal. Each year APRNs are required to renew their
14 professional license. Nursing licenses expire on
15 October 31 of each year.

16 Medicaid requires APRNs to mail in
17 notification of their license renewal via the postal
18 service. If the notification is not received by DMS by
19 November 1st of each year, the APRN is considered to
20 have a lapsed license and, therefore, Medicaid patient
21 prescriptions are denied at the pharmacy and payment
22 claims are not accepted.

23 Clearly, there are problems with
24 this system. It is a huge waste of paper; 2000+ extra
25 pieces of mail coming in to DMS in the month of October

1 has to cause some sort of extra work and handling by
2 staff; and mail can get lost. APRNs worry if their
3 medication prescriptions will be accepted at the
4 pharmacy on November 1st and there's no way to verify
5 prior to that date if the license verification was
6 received at the Medicaid offices.

7 So, the recommendation is the TAC
8 requests that DMS reduce paper waste and improve
9 utilization of staff time by accepting a single
10 electronic file from the Kentucky Board of Nursing,
11 within 30 days of the deadline for licensure renewal,
12 that lists all APRNs who have renewed their license each
13 year. The TAC requests that DMS not automatically drop
14 APRNs from Medicaid on November 1st but extend that
15 deadline to November 30th.

16 And, then, finally, reimbursement.
17 Kentucky is one of only four states that reimburse APRNs
18 at 75% of the physician rate. The majority of states
19 pay at 100%. If Medicare is the metric and pays at 100%,
20 then private insurance pays at 110-120% and Medicaid
21 pays physicians at 73%. A 75% reimbursement rate for
22 APRNs translates to 54.75% of the Medicare rate.

23 In order for APRNs to participate
24 in Medicaid, the reimbursement rate must improve.
25 Currently, APRNs receive about \$23.00 for a Level 2

1 visit, \$33.00 for a Level 3 visit, and about \$50.00 for
2 a Level 4 visit which are limited to 2 per year. These
3 fees are not sufficient to cover the overhead costs of
4 running a practice.

5 The physician Medicaid rate of 73%
6 is also a low national rate and hasn't budged since
7 1993. The Primary Care Medicaid Rate Increase, which
8 applies only to physicians, will provide a temporary
9 bump in payment in order to attract primary care
10 physicians to Medicaid but will stop in 2015.

11 In order to avoid a bait and
12 switch fee system that leads to provider withdrawal and
13 care disruption, Kentucky should consider adjusting the
14 Medicaid physician reimbursement rate higher than the
15 currently low 73% rate.

16 Low reimbursement levels have
17 multiple bad effects – providers limit Medicaid patient
18 caseloads, providers choose not to participate in
19 Medicaid at all, or systems compensate by having
20 providers just see more patients.

21 Certainly it is part of the
22 explanation for the fact that 63% of the primary care
23 need is not met in rural settings in Kentucky and that
24 only 22% of primary care provider physicians accept
25 Medicaid.

1 Lack of participation limits
2 patient access. Lack of access to care leads to poor
3 health outcomes and increasing health care costs. We
4 are talking about increased hospitalizations,
5 readmissions and use of the emergency room, which are
6 significantly more expensive than outpatient visits.

7 The recommendation is that DMS and
8 the MCOs provide improved reimbursement for APRNs at 90%
9 of the physician rate and increase the physician rate to
10 90% of the Medicare rate. And that is the Nursing TAC
11 report.

12 The next one is Optometric Care.

13 DR. WATKINS: With our Optometry,
14 we're anxious to hear that WellCare report, but our main
15 concern at this point, we're still referring back to the
16 problem that we're having from our last meeting where
17 the regulation that was placed back into effect in July
18 where one comprehensive eye exam per provider per year
19 is not being paid by Avesis, which is the vision
20 provider that is used by WellCare and Coventry.

21 We're being denied on that by
22 several providers across the state and that's not being
23 addressed at this time and that has not been changed
24 since the last meeting, and we're hoping that WellCare
25 will address that in their response today. Thank you.

1 CHAIR PARTIN: Therapy Services.

2 MS. ENNIS: Good morning. We've
3 met twice since the last MAC meeting. I'm still
4 finalizing minutes. I'm going to email those, so, they
5 will be in your binder next time.

6 We had several questions that we
7 had submitted before that we haven't heard back. So,
8 I'm hoping they're in that mystery section of the binder
9 and I'll get them later, one relating to the 30-day
10 recert issue that we're still seeing mostly for fee-for-
11 service Medicaid that we hadn't heard a followup on.

12 They were still requesting a
13 recert every 30 days for therapy and it was taking three
14 weeks to get it, so, they would only see the child once
15 before they would have to submit again.

16 And then we also were hoping to
17 hear on the differential issue between assistants and
18 therapists and trying to stay out of the whole
19 accusation of a fraudulent billing issue how that was
20 going to be addressed.

21 CHAIR PARTIN: Barbara, do we have
22 a response to those recommendations from the last
23 meeting in our binder?

24 MS. EPPERSON: Anything that was
25 submitted at the last meeting is in the binder, yes.

1 MS. ENNIS: Are they online yet?

2 MS. EPPERSON: They will be
3 shortly.

4 MS. ENNIS: Great. I will look.
5 Thank you. Other than that, we are working through
6 issues. We've had really good attendance from the MCOs
7 and the Cabinet at our meetings which has been very
8 helpful so that we can problem solve some of the other
9 issues that have been going on with coding and those
10 kinds of things being kicked back. So, hopefully we'll
11 keep moving.

12 CHAIR PARTIN: So, no
13 recommendations today?

14 MS. ENNIS: No, other than those
15 two. If I don't see it, I will send it back in again.
16 Thank you.

17 CHAIR PARTIN: Okay. Thank you.
18 Physician Services.

19 DR. NEEL: Physicians TAC met on
20 September 18th and I will not read the entire report.
21 Many of the issues have already been addressed, the
22 enrollment problems that we've already talked about
23 today.

24 The problem that we've continued
25 to have is retroactive card when somebody recertifies.

1 Unless the appropriate box was checked, the card did not
2 go back three months to pick up the time when children
3 or adults were seen during that time and the physicians
4 would not be reimbursed unless that box was checked.
5 I've not seen that as much lately.

6 The other primary issue was
7 reimbursement, and I would echo essentially what the
8 nursing report said is that reimbursement issues need
9 certainly to be addressed.

10 I've talked with a number of the
11 legislators who felt when they passed the APRN bill that
12 they had solved the access-to-care problem; but the
13 problem is that if the APRNs are only reimbursed at 75%
14 of Medicaid, it's going to be impossible for them to
15 solve the access-to-care problems that exist,
16 particularly in rural Kentucky and in some areas of the
17 large cities. So, that's something that does need to be
18 addressed.

19 And I would echo many of the
20 things about the limitation on physical exams, the
21 limitation on the Level 4 and 5's. Those do need to be
22 addressed and we'd certainly like to see that considered
23 in the future. Thank you.

24 CHAIR PARTIN: Thank you.
25 Podiatry Care. Primary Care.

1 MS. BEAUREGARD: Good morning.
2 Emily Beauregard with the Kentucky Primary Care
3 Association. The Primary Care TAC met on Thursday,
4 November 6th. There should be recommendations in your
5 binder as well as minutes. And I also included
6 recommendations from our September 11th meeting because
7 we didn't get them in your binder in time for the last
8 meeting.

9 A majority of our TAC members were
10 present for the meeting along with DMS staff and we also
11 had four of the five MCOs present.

12 Our main concerns continue to be
13 the reconciliation of payments. Since September,
14 significant progress has been made in addressing the
15 automatic wrap payment system or wrap payment process.
16 KPCA facilitated the scheduling of meetings between
17 primary care providers, MCOs and DMS which assisted all
18 parties in identifying and resolving a number of issues
19 that were hindering the submission of clean claims.

20 As part of this process, DMS has
21 asked providers to complete reconciliation spreadsheets
22 for the month of July and also more recently the month
23 of August. This has been an incredibly time-consuming
24 process but we do believe that it should improve the
25 automated system moving forward.

1 Primary care providers have also
2 been waiting for DMS to begin the wrap payment
3 reconciliation process for dates of service going back
4 to November 1st of 2011 through June 30th of 2014.

5 We have been told that providers
6 will begin receiving data on paid claims starting the
7 end of November and will be asked to complete a similar
8 reconciliation spreadsheet to identify what claims are
9 due for a wrap payment.

10 As part of this process, we
11 discussed with DMS staff how they're going to handle the
12 reconciliation of Kentucky Spirit claims and the
13 resubmission process for claims that were incorrectly
14 denied or reimbursed.

15 The issue of dual eligible
16 payments was also discussed. And while CMS has
17 determined that these payments are the State's
18 responsibility, reconciliation has still not occurred.

19 The primary concern here raised by
20 providers is that some claims should have been processed
21 as a zero pay by the MCOs which would then mean that a
22 wrap payment would be provided by DMS but instead some
23 of these claims have been denied and that means no wrap
24 payment. DMS requested that KPCA raise this issue with
25 the MCOs at our monthly operational meetings which we

1 are doing.

2 One final issue that we want to
3 raise before the MAC is the status of recommendations
4 accepted by the MAC. We're concerned that the formal
5 recommendations that the TAC has been making to the MAC
6 have not necessarily been addressed or followed up by
7 DMS. The recommendations that we made at our September
8 11th meeting, there hasn't necessarily been any progress
9 on. So, we just wanted to get some clarification on
10 that process.

11 So, the recommendations in
12 question, the ones from September 11th should be in your
13 binder, and then the recommendations that we have from
14 our November 6th meeting are as follows.

15 The first is that we recommend DMS
16 include additional identifiers on EOBs such as the MCO
17 member ID, claim number, subscriber number and patient
18 name in order to allow clinics to reconcile payments
19 more efficiently. Right now it's a very manual, time-
20 intensive process.

21 The Primary Care TAC recommends
22 that DMS add a legend to the reconciliation spreadsheet
23 to provide clear definitions for the column headers to
24 ensure accuracy when completing the spreadsheet.

25 And we recommend that DMS extend

1 the current time line for providers to complete the wrap
2 reconciliation process from 30 days to 60 days to allow
3 clinics more time to review their data.

4 CHAIR PARTIN: As far as your
5 question goes regarding what the process is, we had
6 requested that DMS respond within 30 days but we don't
7 always get a response. And I understand all the
8 responses are in the binder, and I have requested that
9 we receive them so that we can address that at the
10 meeting. Otherwise, it's four months before we can
11 speak to an issue.

12 MS. BEAUREGARD: So, we should
13 look for those online to be coming out soon, it sounded
14 like.

15 CHAIR PARTIN: Yes. If they're in
16 the binder today, then, they should be online. What is
17 the time frame for this being posted online?

18 MS. EPPERSON: Generally within
19 about a week or so, but the recommendations we responded
20 for the September, they're in the binder. All of them
21 have been responded to.

22 MS. BEAUREGARD: Thank you.

23 DR. NEEL: Let me ask a question
24 before she goes. Clarify this for me. Some of the
25 federally qualified health centers and community health

1 centers have been telling me that since we started
2 Medicaid managed care, the wrap payments are just coming
3 in in bulk. Like they'll get \$500,000. They have no
4 idea what that was for.

5 MS. BEAUREGARD: Right.

6 DR. NEEL: That's what you're
7 looking at and that's what you would like to have
8 changed.

9 MS. BEAUREGARD: Until June of
10 this year, there was an estimated wrap. And, so, those
11 large payments were based on an estimated process. Now
12 the wrap process is automated so that it actually is
13 tied to a particular encounter.

14 And moving forward, we think that
15 the process will be much more accurate and it will be
16 more consistent, but the reconciliation for that
17 estimated period of time which is a significant amount
18 of time is still in process.

19 And, so, that's the part that
20 we're still working on with DMS staff to make sure that
21 we have that reconciliation done correctly, and that's
22 fairly difficult to do because with those estimated
23 payments, there's almost a manual process of going line
24 by line through those encounters.

25 DR. NEEL: Thanks. I just wanted

1 to understand that.

2 CHAIR PARTIN: Also with the wrap
3 payments, wrap payments that I'm receiving are coming
4 automatically deposited into my account and I still
5 can't tell. It's just an amount there and I can't tell
6 what it's for.

7 MS. BEAUREGARD: Right. And that
8 first recommendation that we made about the EOBs and
9 including additional identifiers is really in regard to
10 that because it's very difficult to reconcile something
11 when you can't match the payment up with the claim.

12 MR. VAN LAHR: Madam Chairman,
13 just a real quick question. Reading over some of these
14 responses, I don't know why we're even here today.

15 It says DMS will respond to any
16 forthcoming recommendations from a TAC when brought
17 forth to the MAC at a meeting which a quorum is met
18 which means, when I read this, anything we have
19 recommended today because there's not a quorum present
20 will have no effect.

21 CHAIR PARTIN: What will happen,
22 just like it happened last month, like we haven't had a
23 quorum for three meetings. So, last month, we approved
24 the recommendations from the previous three meetings
25 where we didn't have a quorum.

1 And, so, the same thing is going
2 to happen with this. Those recommendations are there.
3 Once we have a quorum, we will approve all of those
4 recommendations and ask for a response within 30 days.
5 That's why again I urge everybody to attend these
6 meetings.

7 Intellectual and Developmental
8 Disabilities. Pharmacy and Therapeutics.

9 Okay. That's all of the TACs.
10 And I would ask that the various TACs submit written
11 reports if at all possible. And I know sometimes you
12 meet the day of and it's not possible to provide a
13 written report; but if it's at all possible, please
14 provide a written report.

15 And, Barbara, could you also send
16 us those before the meeting because it's really hard to
17 respond or address or speak to any of these issues when
18 we haven't seen them before the meeting. So, it really
19 delays us addressing any of the issues.

20 So, we will pass on the approval
21 and hopefully next meeting in January, we will have a
22 quorum.

23 Then next up on the agenda is the
24 WellCare presentation.

25 MS. MUNSON: Thank you for the

1 opportunity. Again, my name is Kelly Munson and I'm
2 Plan President with WellCare and have been in the market
3 for the last two years.

4 MS. RANDALL: Good morning. I'm
5 Rebecca Randall, Director of Regulatory Affairs. I have
6 spoken before you in the past.

7 MS. ROBERTS: Good morning. I'm
8 Rhonda Roberts, WellCare Senior Director of Quality.

9 MS. MUNSON: So, what we want to
10 go over today, this really grew out of what WellCare has
11 been working on for the last year.

12 One of the things that we knew we
13 had to do was come up with a much more aggressive plan
14 for how we were going to effectively improve health
15 outcomes in the state and also really show a value in
16 partnership with our providers and with our members for
17 ensuring they get the care they need.

18 So, we built an approach and it's
19 been a really aggressive approach and we're actually a
20 pilot project in our WellCare organization for several
21 of the things that I'm going to present to you today.
22 And in that, we are being evaluated to determine proof
23 point how well the programs work and if we need to tweak
24 them going forward.

25 One of the important parts of the

1 program was really there based on partnerships with
2 providers and what we've learned from providers over the
3 last year related to what are the barriers that we're
4 facing for assuring that we are improving health
5 outcomes. So, what are the administrative barriers that
6 the providers are seeing and what are the barriers
7 members have for being able to get the appropriate care
8 that they need.

9 We have had an active care
10 management program since go live, but the care
11 management program that we had, it was a face-to-face
12 program but it wasn't as intensive and we don't think
13 that it always served the members that we really needed
14 to get enrolled.

15 So, we also have made significant
16 efforts to assure that our programs are really
17 pinpointed for those members where we receive the most
18 value in their enrollment, meaning they have impactable
19 conditions that we can work with providers and change
20 the outcomes.

21 Just at level set, we have six
22 offices across the state. We are statewide. We're
23 serving over 400,000 members currently in the state and
24 we have 228 dedicated associates.

25 Also just in the last few months,

1 we have opened our first Member Engagement Center in
2 downtown Louisville, and this Member Engagement Center
3 is geared towards group care management programs and for
4 our health councils with community organizations to
5 allow them to have a meeting place to help solve some of
6 the care gaps and social safety net care gaps that we
7 see across the state.

8 So, we're really excited about
9 that and that's something, as we see how it plays out
10 and works, we'll be interested in adding across the
11 state.

12 Our program initiative is really
13 geared towards a pyramid approach. So, if you go to
14 page 3, you will see this pyramid includes all of those
15 activities that we believe are vital to improving member
16 access and health outcomes.

17 Providers are absolutely holding
18 up the tier, right, because without the appropriate
19 partnership with the providers and really working with
20 them, we can't do what we need to do.

21 So, one of the things that we have
22 done with our provider program, we have 40 associates
23 right now that serve our providers across the state and
24 they were serving our providers on everything. And what
25 we've done is we've really geared them and said we want

1 a facet of those associates that only focus on quality
2 outcomes and building high performance practices.

3 So, what are those attributes you
4 would need to really build a high performing practice
5 that allows you to really bring quality outcomes or show
6 the quality that you're bringing?

7 So, we divided those employees up,
8 and then we also know similar to a member who, if
9 they're not eating, they're not taking their medication,
10 if a provider is not getting paid, they're not as
11 worried about partnering with us on quality initiatives.

12 So, also with that, we have a
13 dedicated operations staff that we have now trained to
14 be able to adjudicate claims. And, so, when they're in
15 a provider's office and there's an issue or a problem
16 with an auth or with a claim, they can adjudicate it
17 right there, take care of it and then they can move on
18 to talking about some of the quality and outcome
19 information that we'd like to be talking about.

20 So, we found that model to be very
21 effective. Our PR reps that are dedicated to quality
22 and building high performance practices, they are
23 visiting and they're focusing a lot on the providers
24 that have 80% of the membership, those top providers, to
25 really move the needle, and then we have another tier

1 that focuses on those providers that may not have as
2 much of our membership.

3 That takes us right into care
4 management. The way we've changed our care management
5 model is we've worked with our algorithms to say let's
6 really look at those members that are highest acuity
7 members that have certain disease states and conditions
8 and also are driving a lot of the costs, those members
9 that are high ED utilizers, those members that we know
10 if they have an impactable condition where, if we can
11 get in there and help the provider get the member to
12 care, see what's going on in the home that's preventing
13 the member from getting the care, partner with community
14 organizations to remove those barriers to care, that
15 those members will really see improvement in their
16 health outcomes.

17 So, we have 110 associates now
18 that are in Kentucky delivering a face-to-face intensive
19 care management program. Since we have developed the
20 new intensive model, which it was fully functional in
21 August, we have seen a 230% now increase in the total
22 numbers enrolled in the care management programs, and
23 that 230% increase is exciting because it's the members
24 you really need enrolled.

25 When we started the program and

1 really looking at it, we found that 60% of the
2 membership was either unable to contact or they refused
3 the program.

4 So, some of the things we started
5 doing was working with the providers and saying can we
6 partner with you; and if we give you a list of the
7 members that are assigned to your practice that we
8 really need in care management, would you be able to (a)
9 let us know when they're in so that we can meet them at
10 the point of care and talk to them about how this could
11 be a valuable program to them, or (b) could we also get
12 you to encourage? Could we have a staff member in your
13 office that makes calls and encourages members who we
14 really need enrolled?

15 The reason why this is so
16 important, we ran a pilot project recently where we
17 looked at members who had serious mental illness plus
18 five comorbidities, and we said what happens if we put
19 them in an intensive program with a BH care manager and
20 a physical health care manager and we get the physical
21 and behavioral health provider to agree on a single care
22 treatment plan, what would that do?

23 And we saw such significant
24 improvement in the member outcomes and the quality of
25 their life and such reduced costs to the point of almost

1 44% in terms of costs that we saw. So, a very
2 significant program.

3 Now, that was an extremely high
4 intensive program that you may not be able to scale
5 across the whole organization; but certainly when you
6 look at that top 2% of high acuity, high cost members,
7 we can certainly make a difference by bringing programs
8 that are that intensive to the members. So, we're proud
9 of that program.

10 One of the other things to note
11 about the program is we currently now have a community
12 advocacy database. Right now it stores about 8,000
13 organizations that have about 110 different services in
14 them.

15 So, when a care manager has a
16 member on the phone and the member is experiencing a
17 barrier to care or they're in the member's home and they
18 have their laptops and the member is experiencing that
19 barrier, they can actually pull up in the database all
20 of the programs that are available to that member.
21 Perhaps it's heat, perhaps it's food or something else
22 that the member needs - it could be housing - and hook
23 them up with an organization that can help remove that
24 barrier.

25 In doing that, that's where we've

1 really seen the success of the program because if you're
2 not helping the member solve that social issue and
3 problem and removing that barrier, then, they're not
4 going to focused on their health.

5 So, also in this advocacy program,
6 we are able to work in health councils across the state.
7 And what we do with those health councils is when we
8 have identified through the database that there is a
9 gap, meaning there is not a social program that is
10 currently serving that particular area, we can pull
11 community organizations together and talk about how we
12 might be able to fill the gap.

13 There have been two success
14 stories that we've had over this past six months. We
15 had a homeless shelter that shut down that was serving a
16 lot of the population. And, so, we were able to partner
17 with a Christian church and they were able to not
18 develop a full homeless shelter but they were able to
19 develop a place where those who were homeless could come
20 and seek shelter for the night, and we were able to hook
21 up with organizations that could get them full training
22 to let them know how to run such a program.

23 We were also able to bring a
24 medical program to that particular spot so that members
25 who weren't getting the care that they need that were

1 WellCare members, there would be physicians that came in
2 and met them at that point of care and could take care
3 of their needs there. So, we're really happy about that
4 program.

5 We had another one where we had a
6 food bank shut down that was serving a three-county area
7 in the Bowling Green area and we were able to work with
8 community organizations to get that set up. It was
9 serving a lot of our members. It was going to be
10 devastating to their care because we knew that we
11 weren't going to be able to get them to adhere to
12 medications when they're not able to get their food and
13 basic needs met. And, so, we were able to work with
14 them and set those up.

15 So, that's part of our health
16 council initiative, and so far we've been able to set up
17 I think 329 to solve those gaps across the state that
18 we've been working on.

19 So, it's really looking at the
20 total member and diving in. It's much more than just
21 saying, hey, you're in a care management program.
22 Here's a brochure on how to manage your condition and
23 make sure you get to your doctor's appointment. It's
24 going with them to the doctor's appointments. It's
25 offering translation if they need it and seeing them in

1 the home to find out what the barriers are in the home.

2 On top of that and what we're
3 really excited about because we're seeing the biggest
4 lift with this initiative is the quality programs and
5 the quality outcome that we have.

6 So, right now we have 21
7 individuals that are located in Kentucky that are
8 dedicated solely to quality, and this is outside of the
9 provider relations reps that are focusing on quality and
10 high performance networks.

11 Rhonda runs our area and those 20
12 individuals. We have a group of people internally that
13 are doing data mining and analysis for each provider and
14 getting very comprehensive about where we're seeing
15 their data is falling short on quality, where we see
16 their members are having care gaps and not getting in
17 for needed care, but also what are the administrative
18 barriers that are not showing the good care that the
19 providers are bringing.

20 We've conducted 800 visits across
21 the state. Our clinical HEDIS advisors go out, visit
22 with providers and bring out this information to them to
23 say here is where your medical records aren't showing
24 some of the documentation, here is where there's so many
25 data disconnects.

1 So, here is where you think that
2 your EMR is including the BMI measurement and it is not
3 because it's a zero-billed item, and, so, it gets
4 stripped off your EMR. It never comes to us. You think
5 it comes to us but it never does.

6 And, so, there's a lot of
7 administrative burdens with providers on some of those
8 reporting codes where how do you get those to the
9 managed care plans to actually show that you are
10 delivering those services and you are performing them,
11 and we have really been able to tackle that issue.

12 We have set up 40 individual FTP
13 sites with providers where we allow them to send us the
14 medical record, not an electronic medical record, but
15 post it to an FTP site and we can share that data. We
16 can actually go in and pull that data down for the
17 provider and load it into the pseudo claims system so it
18 takes away some of the administrative burden.

19 And that's what we've heard over
20 and over again. I want to comply with quality but I
21 don't have the staff and I don't have the funding in
22 order to comply. So, we said, well, what about if we
23 have someone come out to your office two days a week and
24 would pull the charts down for you and would input for
25 you, or what about if we have a specific FTP site that

1 would allow you to share data.

2 The other great thing about the
3 sharing on those sites with providers that we have is we
4 have been able to share high-risk members that need to
5 get case management. So, we also can share your
6 membership that has had ED visits in the last month and
7 what the reasons were for those visits so that the
8 providers can act on that.

9 One of the reasons why we saw a
10 230% increase in members getting enrolled in case
11 management is because we were able to get the providers
12 these high priority lists and we had them calling. I
13 mean, we literally--there was a few really high ED
14 utilizers in the state that everyone has been trying to
15 get enrolled in care management including several
16 providers, and we have a hospital system who is really
17 partnering with us that called us and said, hey, your
18 member is here now.

19 I think it was five in the morning
20 and we had a call chain going and we got a care manager
21 out to that member and we got the member enrolled. I
22 mean, literally, people were clapping when we got back
23 because it's just so exciting to see that in this
24 partnership, we can actually get the member enrolled.

25 And the success stories around

1 that are I suddenly know where to go. I mean, when we
2 looked at the care management program for the members
3 that needed to be enrolled, we did see reductions in
4 cost but we saw increases, too.

5 We saw an increase in pharmacy
6 spend, we saw an increase in professional spend which is
7 exactly what we want members to do. We want them to
8 adhere to their medication and we want them to get to
9 their doctor.

10 We saw decreases in inpatient,
11 outpatient and emergency spend which is what we want to
12 see is the reduction in those high cost areas which
13 isn't really the right point of care for them. So, in
14 that respect, it's really been a great program.

15 I talked a little bit about
16 community advocacy.

17 I'll go into pay for quality. So,
18 we, of course, brought a pay-for-quality program. Pay
19 for quality is not new to providers here. As a matter
20 of fact, in some respects, it's just your way in for a
21 provider to even pay attention to your care gap report.

22 But the magic is when our HEDIS
23 advisors are going in to the providers, they are now
24 going in and saying, here are ways that you can maximize
25 your dollars. So, we have a pay-for-quality program.

1 Here's where you sit on the spectrum. If you can get to
2 here and here are all your barriers that are preventing
3 you from getting to here, this is the way you can
4 maximize your dollars.

5 So, we paid over \$1 million more
6 than we did last year and this year and our P-for-Q
7 program is going to be much more robust next year, but
8 it encourages providers to get to that three-star, four-
9 star mark in which case we know, as we have gold star
10 providers, we'll be able to lessen administrative
11 requirements for them because we know that we're
12 partnering with them. They're following good clinical
13 guidelines. They're administratively getting the
14 information we need in order to show that we're bringing
15 the quality in order to show that the members are having
16 services, in which case we would expect that they would
17 have less administrative burden on the back end. So,
18 that's really one of the value-adds of the program that
19 we're excited to bring.

20 But the feedback from the provider
21 community on our clinical HEDIS advisors has been the
22 most positive feedback I've ever received here so far in
23 that they're now actually saying, you know what, go
24 ahead and embed a case manager in our practice where
25 they may have been resistant to it before because they

1 can see the lift that they're getting and the additional
2 pay-for-quality dollars that they're eligible for simply
3 because they have a partner that's helping them remove
4 those barriers and administratively get the data in in
5 the systems.

6 We have always run a targeted
7 member outreach program to incent healthy behaviors but
8 never found that members take us up on those as much as
9 we would like them to.

10 So, one of the things we're doing
11 this year is really trying to evaluate what's the most
12 effective program to choose. We've done dental in the
13 past, and only about 1,500 of our members have taken
14 advantage of it. Now, it's 1,500 members that otherwise
15 wouldn't have received services.

16 So, we're happy about that, and
17 that's one of the things we're talking about with
18 providers as well, like what ideas do you have that you
19 think would really incent a member or what specific
20 measures do you think would be most appropriate for us
21 to incent members. And we're looking on adding eye
22 exams for diabetics. So, that's what is going to go
23 into effect next year.

24 I talked a little bit about our
25 SMI population and how we got the providers to agree on

1 single care treatment plans. One of the other things we
2 realized early on, we've always had integrated
3 behavioral health at WellCare, but we really took time
4 to train our physical health care managers and our
5 behavioral health care managers so they're all cross-
6 trained because we realized that so many of the issues
7 that were coming in on the physical health side really
8 had a behavioral health component behind it. It's so
9 common.

10 So, we have very specific experts
11 in BH that partner with our physical health providers--
12 I'm sorry, our physical health care managers but they
13 also are completely trained in the behavioral health
14 world. We have found that that component has gotten
15 members to agree to enroll with us in the care
16 management programs much more frequently and has been a
17 big value add.

18 And, then, finally, specialized
19 member programs. So, we've always had a few specialized
20 member programs, but now we're to the point where we're
21 evaluating what are the actions that we took that really
22 had the biggest effect on changing member behavior.

23 So, in that respect, is it a face-
24 to-face program for a member with COPD where you visit
25 them every two weeks and then eventually go off to every

1 month? So, is it the face-to-face component that
2 changes behavior, or is it something little or certain
3 that we're not thinking of, some encouragement that can
4 get them to manage their care?

5 And, so, we're really looking into
6 those cases where we were successful, why we were
7 successful and how we can streamline the program to make
8 more of a difference. So, we're really excited about
9 those programs.

10 We do all of the things in the
11 quality world that you would expect. We do all the
12 telephonic outreach to members to tell them they have a
13 care gap. We send them letters to tell them that they
14 have a care gap. We're looking to partner in other ways
15 with some technology to try to let members know that we
16 need to get them in for certain services, but we still
17 find that face-to-face component to be one of the most
18 impactful. And the face-to-face component at the point
19 of care I would say would be even higher than that in
20 terms of the impact that we can bring.

21 Finally, we are seeing positive
22 and good results. I will tell you, last year, we had
23 five providers that were working with us on electronic
24 medical records. We have 140 this year. So, we're
25 starting to see such a lift and everybody getting on the

1 bandwagon.

2 I think last year at this time, we
3 had 3,000 pseudo claims in the system for providers.
4 This year, we're up over 18,000 already and this is just
5 doing information and the administrative work for the
6 provider so that we can all show that we're bringing
7 value and good quality outcomes.

8 We saw it on our provider
9 satisfaction survey. We are required to deliver a
10 provider satisfaction survey and we have an outside
11 vendor that does this on our behalf and then gives us
12 the results, but what we were seeing in every case is
13 that the providers were happy with what WellCare was
14 bringing. And when asked to be compared to other
15 managed care plans, what the percentages were, WellCare
16 ranked higher in our survey in every area except one.

17 So, we do feel like providers are
18 noticing. We're getting good feedback and we are
19 certainly seeing, based on some of our results, really
20 good outcomes. Our CAHP scores this year were very
21 high. We received a five in member satisfaction which
22 is the highest score we could get which is somewhat
23 atypical in Medicaid managed care. I've been in this
24 business a long time and you don't always get fives
25 there, but we also had several, all but one measure of

1 sitting above the 50th percentile.

2 So, all of these actions that we
3 are bringing are showing value and improving member
4 outcomes, and, to tell you the truth, reducing costs.

5 I'll take you to the last page. I
6 talked about our community advocacy program. We are
7 getting several of our programs evaluated now. The
8 University of Kentucky is helping us in particular on
9 some of them, but I just wanted to give you a flavor of
10 some of the programs that we're bringing.

11 We do have a Veggie RX program
12 where members can get produce. So, providers can have
13 vouchers in their offices and those members that they
14 believe should need additional help can get a voucher to
15 go to a farmer's market and get additional produce. The
16 University of Kentucky is valuing that for us to say did
17 those members, indeed, eat healthier and did they,
18 indeed, take advantage of the program.

19 We have other ones where the
20 actual farmer's market is mobile and it will come to the
21 neighborhoods of our members and make sure that the
22 members can then utilize the benefit there.

23 We're really excited about our
24 YMCA pediatric obesity initiative where we are
25 partnering with the YMCA getting members enrolled in the

1 obesity project to help control their weight and health
2 outcomes and also allows the family to have full
3 memberships. So, we have 300 members that have full
4 memberships to the YMCA through that program, so, it
5 encourages the entire family to get healthy which is
6 important.

7 The Mama to Mama peer support
8 program is one of my favorites because it really focuses
9 on teens that have substance abuse problems and are
10 pregnant. And, so, that's one of those where we're
11 doing it a group setting. Obviously teens in a group
12 setting, there's better outcomes with them partnering up
13 with some of their peers and feeling that they're
14 supported in different ways, but that program is being
15 evaluated by U of L.

16 And, then, we do have - and all
17 parents will like this one - we did bring on a site-
18 based respite care program in Hazard where our members
19 can have up to 3,000 hours of service of respite care
20 for children. So, after school, they get up to three
21 hours and during the Christmas holidays up to eight
22 hours where they can have a break and go out and do some
23 things they need to do.

24 So, these are just some of the
25 things that we're bringing. We're on board in 2015 to

1 have twelve projects that we'll be doing and proof-
2 pointing to see how they add lift, and we're strategic
3 about it. Of course, we pick the communities where we
4 think these are going to have the most value and effect,
5 but also the communities where we're serving a large
6 part of the membership in those communities because we
7 know that it's only going to flow in and help the health
8 outcomes of the members ultimately.

9 Did I forget anything, anybody?
10 Do you have any questions for me?

11 DR. RILEY: I have one. You
12 mentioned that your dental incentive only attracted
13 1,500 members. Do you have any familiarity with the
14 design of that program?

15 MS. MUNSON: Yes. The design of
16 the program was a \$10 gift card that members could get.
17 And I know that the \$10 gift card was at Lowe's. Where
18 else?

19 MS. ROBERTS: At Lowe's, J.C.
20 Penney and Subway, which those had to be approved by
21 DMS. And because it had to be retailers that had access
22 in all counties and all areas of the State of Kentucky,
23 we were limited to those three by approval from DMS.

24 DR. RILEY: Was that for the exam
25 and preventive services or was that for treatment?

1 MS. MUNSON: Preventive services.

2 DR. RILEY: Have you considered
3 expanding that?

4 MS. MUNSON: We're open to all
5 ideas. We are. We want to bring programs that are
6 going to properly incent and bring the value.

7 DR. RILEY: Especially if you're
8 focusing on outcomes. And I don't know if you were
9 trying to target the children or if you were trying to
10 target the expansion population, but certainly you need
11 two different mechanisms to go after those two very
12 different populations.

13 MS. MUNSON: Noted. Thank you.

14 CHAIR PARTIN: You spoke about
15 representatives coming and working with the providers.
16 Are you doing that in all areas or just some areas?

17 MS. MUNSON: We have a clinical
18 HEDIS advisor that is assigned to every region, and then
19 they assess from the providers the needs. And, so, it
20 is really wherever a provider has identified a need or
21 we have gone in and identified a barrier and the
22 provider is telling us, I can't remove this barrier
23 without help.

24 So, it's not only us going in.
25 Sometimes we go in to the practice two days a week,

1 sometimes it's one day a week and sometimes it's simply
2 doing just calls on behalf of the provider and other
3 things within our office. With 21 people, there's a
4 whole wealth of information or services that we can
5 offer providers in this respect.

6 CHAIR PARTIN: So, the provider
7 has to make the initiative to contact you?

8 MS. MUNSON: No. Go ahead,
9 Rhonda.

10 MS. ROBERTS: The provider does
11 not have to initiate this at all. We have HEDIS
12 advisors in every region of the state. They are tasked
13 to seeing and supporting providers that are making up,
14 seeing 80% of the membership. So, whether they contact
15 us or not, they're on our radar. We are watching and
16 monitoring because we want to reach out and help that
17 particular practice.

18 So, we go in and work individually
19 with the practice office, with the providers, with the
20 office administrators and it's whatever their needs are.
21 Some practices have resources within their providers and
22 need very limited assistance from you. Others don't.

23 And, so, that's the example that
24 Kelly has. They would like us to come in two days a
25 week, help them identify patients, pull these records,

1 bridge the gap of the data exchange, so on and so forth.
2 So, it's available throughout the entire State of
3 Kentucky.

4 CHAIR PARTIN: Thank you.

5 MS. MUNSON: And one thing I will
6 say is where we do face challenges in that sometimes is
7 that some of the larger IPA's and groups that are
8 affiliated with hospitals don't allow us to go in at
9 that individual group level.

10 So, we knew that we could bring so
11 much value and providers are so happy with this program,
12 but we're not able to get to some of the providers we
13 really want to get to because they're held very close to
14 the vest with the IPA through those hospital systems.

15 So, that's our next barrier to
16 break to say how can we show you that this is a big
17 value and this is really only meant to help us all and
18 not to be something where we're in your business or
19 causing staff time which that's a lot of provider
20 concern is you're just going to eat up my time and I'm
21 not getting paid enough for this. We hear a lot of
22 that. So, we say, well, how can we help remove that
23 burden.

24 CHAIR PARTIN: Thank you.

25 DR. NEEL: I'm delighted to see

1 that you're doing the partnership idea. I've preached
2 for 30 years or more that this is not - and it was with
3 DMS before - this is not us versus you. It's got to be
4 a partnership.

5 We started years and years ago in
6 our state with a model program with KenPAC where we did
7 a per member/per month and it was to be a quality
8 improvement plan. That was the whole idea.

9 And some of us worked very hard
10 years and years ago to try to make that--it was before
11 we could spell HEDIS, but quality was the idea, and we
12 were to invest in the providers with extra money for
13 them to have them help do quality.

14 We never, though, were able to
15 develop the partnership with the Department of Medicaid,
16 not through their fault or our fault. It was still a
17 kind of adversary kind of thing. So, we were not able
18 to do that.

19 I had hoped that when we started
20 Medicaid managed care, that we would develop a
21 partnership because if it's going to work, and we're
22 still only two years into it and we still don't know for
23 sure if it's going to work, but it's got to be a
24 partnership, and I think some of that is what you're
25 doing.

1 organizations and 110 services, we'll be able to say for
2 that member in this area, here are the places you can
3 connect them to and here are the phone numbers.

4 And, so, you can actually have the
5 member leave armed with that which is really going to
6 help increase that, and that is a pilot that we're doing
7 in February that will be available to all Kentucky
8 providers.

9 DR. NEEL: Thank you.

10 DR. WATKINS: You mentioned when
11 you were talking about the incentives that next year it
12 was going to involve the diabetic eye exams. Was that
13 right?

14 MS. MUNSON: We're going to seek
15 approval on diabetic eye exams.

16 DR. WATKINS: So, what would that
17 involve?

18 MS. ROBERTS: It would involve
19 offering the diabetic members who are in need of having
20 that annual diabetic retinal exam, if they go and they
21 get that service, then, we will then offer them a gift
22 card for them obtaining that preventive service for
23 management of their diabetes.

24 CHAIR PARTIN: Any other
25 questions? Thank you.

1 Next up on the agenda are meeting
2 dates for next year. And in order to help facilitate
3 attendance at the meetings, I was wondering if it would
4 be helpful to change our meeting date to the third
5 Thursday of each month or perhaps the fourth Wednesday
6 instead of Thursday. I've gotten some feedback from
7 members saying that those dates might be more helpful
8 for them if it's not a problem for others.

9 DR. RILEY: Not the fourth
10 Wednesday. We moved the Dental TAC from Thursdays to
11 get away from this meeting and now we have the fourth
12 Wednesday. So, if you follow us, then, we have to move
13 again.

14 MR. VAN LAHR: I have a question
15 on attendance. Commissioner, is there any requirement
16 or any flexibility as far as a member being on a
17 conference call? Do they have to physically be present
18 at this meeting to have a quorum?

19 COMMISSIONER KISSNER: This is all
20 linked into the open records and open meetings laws in
21 the State of Kentucky. So, you can't do a conference
22 call unless the conference call is published in advance
23 and open to the public, and we don't have the resources
24 to do that.

25 MR. VAN LAHR: So, a member of the

1 committee could not be on a conference call for those
2 here basically, then?

3 COMMISSIONER KISSNER: That's
4 right. There's no proof that the person is the person.
5 You could recognize their voice but they're not
6 physically present. There are some issues associated
7 with the current laws that say this is how open meetings
8 have to be done and it just doesn't work.

9 DR. NEEL: Can you Skype them or
10 something or bring in one of the robots like we do in
11 the hospital and know who they are?

12 COMMISSIONER KISSNER: You could
13 if you could Skype the whole world because you've got to
14 be able to let everybody have the same access and we
15 just don't have the technical capabilities to do that.

16 CHAIR PARTIN: What about the
17 third Thursday of each month?

18 DR. NEEL: Is there just one
19 person that has a problem with the fourth? Is it the
20 hospital representative or who is it because I know he's
21 having a hard time?

22 CHAIR PARTIN: The hospital person
23 has meetings that he's obligated to at his facility on
24 the fourth Thursday of each month and also the first and
25 third Wednesday, and then some other people wanted the

1 fourth Wednesday.

2 MR. VAN LAHR: Madam Chair, may I
3 suggest sending out an email or a questionnaire to all
4 the Board members and see what date would work best for
5 the group.

6 CHAIR PARTIN: That's fine with
7 me. We'll have to do that rather quickly. I'll send
8 out an email to everybody. I'll give you some choices.

9 MR. VAN LAHR: Don't put free
10 space in there. You have these choices to choose from.
11 Which would be best for you.

12 CHAIR PARTIN: I'll send that out.
13 Let me write that down.

14 COMMISSIONER KISSNER: I'm sorry.
15 what were the choices you're giving them?

16 CHAIR PARTIN: It's the third
17 Thursday of the month or the fourth Wednesday are
18 suggestions.

19 MR. VAN LAHR: Or the current
20 fourth Thursday. So, we have three choices basically,
21 then.

22 DR. NEEL: Does that create a
23 problem for you all?

24 COMMISSIONER KISSNER: It might
25 create a problem here in the room, especially when you

1 get into Session, it gets pretty crowded. All these
2 rooms are taken. If LRC has already scheduled their
3 meetings, I don't think we could bump like a Health and
4 Welfare or one of those meetings, especially these rooms
5 in this section here. But I don't think from our
6 perspective whether it's the third or fourth. Wednesday
7 is Health and Welfare.

8 So, if we get called into one of
9 those meetings--it was yesterday. We'll make it work.
10 It's just there could be some scheduling conflicts with
11 Health and Welfare on a Wednesday, but go ahead and ask
12 the question because I'd rather you get a quorum every
13 time. That would be my preference and then we'll make
14 it work on the Medicaid side.

15 CHAIR PARTIN: All right. Thank
16 you.

17 And then we have a couple of items
18 of New Business. One item was a question from a member
19 that came to me after I submitted the agenda. So, that
20 question was what dates will the next contracts or the
21 extensions be negotiated for the MCOs or will there be a
22 request for a bid placed?

23 COMMISSIONER KISSNER: We're in
24 the first year of a four-year cycle. We did a 32-month
25 contract and then we did a 12-month contract. We

1 actually did 18 months. So, anyway, effective 7/1 of
2 '15, that would be the second one and then there will be
3 two more after that.

4 So, we're at the one-year
5 extensions at this point. So, all of the contracts get
6 negotiated on a one-year cycle from now on with an
7 effective date of July 1st.

8 MR. VAN LAHR: So, if we had
9 changes or things we wanted to see involved in the new
10 renewals, when do you negotiate those contracts, then?
11 Are you doing them now?

12 COMMISSIONER KISSNER: Yes. We're
13 in the process of gathering information. We've got a
14 bunch of stuff that we've identified that we would like
15 to see in the new contracts. So, if you have
16 suggestions on that, you can submit them.

17 MR. VAN LAHR: ASAP.

18 COMMISSIONER KISSNER: Yes.

19 CHAIR PARTIN: Thank you. And,
20 then, the last thing was we had received copies of some
21 brochures that I think DMS put out - I sent these out to
22 the MAC for your comments - but I think we had some
23 questions about those.

24 This one is a Member's Guide to
25 Choosing a Health Care Plan and then it has stars rating

1 the different plans. One of the questions that
2 committee members raised was are these stars related to
3 billing information? Is that how that's obtained?

4 COMMISSIONER KISSNER: It's all
5 HEDIS-based.

6 CHAIR PARTIN: How do you get that
7 information?

8 COMMISSIONER KISSNER: Through the
9 HEDIS survey that's done every year. We get member
10 information. We get provider information. It's the
11 HEDIS survey, and it goes through IPRO, our external
12 quality review, our EQRO.

13 CHAIR PARTIN: I don't know what
14 that is.

15 COMMISSIONER KISSNER: It goes
16 through IPRO. We have a contract with IPRO, which is
17 Island Peer Review organization, and their
18 responsibility is to make sure that we are improving
19 quality and lowering costs, and they audit, in essence,
20 the MCOs and gather that information. So, we do the
21 HEDIS surveys. They provide the information. That gets
22 rolled up into that report card.

23 They designed the report card and
24 they said we've used this in other states. We think
25 this is a good way. It's simple to understand and

1 you're trying to get it out to a population that you
2 want to try to simplify the information because you
3 could give percentiles and different things like that
4 and (a) it gets busy to illustrate it and (b) it may not
5 be so understandable.

6 So, they designed that and we
7 approved it and that's what we used. In all the open
8 enrollment, we used that exact format.

9 MR. VAN LAHR: Is that the same
10 thing as the star ratings that Medicare uses?

11 COMMISSIONER KISSNER: No, no, no,
12 not at all. That's completely different.

13 MR. VAN LAHR: Why not?

14 COMMISSIONER KISSNER: Because
15 Medicaid, you have a lot of kid stuff. Medicare has
16 mostly old people stuff and it doesn't link up as well
17 in terms of the star ratings. The star ratings are
18 quality initiatives--they just don't align and it's just
19 a little tougher to do that.

20 CHAIR PARTIN: So, like the
21 cervical cancer screening, that's not like claims-based.
22 They obtain that information someplace else.

23 COMMISSIONER KISSNER: It is. All
24 the information there is actually claims-based. Let me
25 try to explain this.

1 HEDIS says has the person been
2 covered for a year with no changes in enrollment because
3 if you're in and out, they don't want to use it in a
4 sample survey. So, they say, okay, so, here's a block
5 of people. How many men or people over the age of 50
6 have had their colorectal screening and they'll say, so,
7 have they been continually covered. Let's say you had
8 5,000 people that were eligible and should have had it
9 done.

10 They'll go through and they will
11 do a random sampling of the claims file and they will
12 say here's 300 people and they will extrapolate the
13 result and say this is the result for that health plan.
14 They're not looking at like all 12 million claims for a
15 specific MCO.

16 They just do a sample and they
17 designed a sample to say this is representative plus or
18 minus three standard deviations, blah, blah, blah,
19 whatever that is that makes it statistically valid and
20 they pull a survey and they say how many women had a
21 mammogram and how many people had a hemoglobin A1c and
22 did the diabetic screenings and all that and they will
23 just pull it.

24 So, it is very factual. It's just
25 based on a sample size.

1 CHAIR PARTIN: Okay. And is some
2 of this coming from--like, I get forms from the
3 different MCOs and they want me to fill it out on the
4 patients who have had the hemo cult screenings or
5 mammograms or whatever and I have to put in the dates
6 when they had those things done and fax them back. Is
7 that part of this?

8 COMMISSIONER KISSNER: Yes. That
9 will definitely help their scores and their results
10 because you have to have the finding and they could talk
11 to the member and get confirmation that, yes, I had it
12 done on this date or they could talk to the provider.

13 I think Kelly could give a good
14 example of her 21 HEDIS people and those are the kind of
15 activities that they focus on to say, hey, we've
16 identified we have a bunch of women who should have had
17 a mammogram that haven't. And what they have is they
18 may have been under Coventry for six months and then
19 transferred to WellCare and while they were under
20 Coventry, they actually had a mammogram.

21 So, if you want to go ahead and
22 give us a little bit of information, that would be
23 great.

24 MS. ROBERTS: I'll help you out on
25 the methodology. It is all based on HEDIS and KAHP's.

1 HEDIS is the mechanism for how we measure our clinical
2 practice outcomes. KAHP's is the source for the
3 customer satisfaction. So, that's all the members'
4 perception, how satisfied are they with their provider,
5 with the plan, so on and so forth.

6 So, for HEDIS, it's all based on
7 claims information. And for a subset of measures, it's
8 also based on information that we don't get on claims
9 that may be contained in the medical record.

10 So, for a subset of those
11 measures, you can use the attestations like you're
12 speaking of or medical record documentation. All of
13 that information is sent in to DMS annually. It's
14 audited by the plan's HEDIS auditors. Each of the MCOs
15 are required to have a HEDIS auditor. They audit your
16 entire process for your claims submissions, your
17 encounters, the way that you conduct medical record
18 review. You also have to have a certified KAHP's survey
19 vendor that's approved by NCQA. All of those things are
20 audited.

21 They also are submitted to DMS and
22 to the EQRO organization, IPRO as well. That
23 information all feeds in together, then which the EQRO
24 uses to develop that MCO comparison and guide. That way
25 all of the plans are comparing their--they're using the

1 same measurement for their outcomes.

2 Everyone is required to use the
3 HEDIS for their clinical outcomes and everyone is
4 required to use KAHP's for your member satisfaction
5 pieces, and that piece is made up of both of those
6 components.

7 CHAIR PARTIN: Thank you.

8 DR. NEEL: If I were a parent or a
9 member looking at these stars, I would be kind of
10 confused. I probably wouldn't choose Coventry if you
11 look at this; but if you look at overall satisfaction,
12 everybody got two stars. So, I don't know that it
13 really helps a whole lot but that's fine.

14 CHAIR PARTIN: I had one other
15 issue, and that was on this other paper that came along
16 with the brochures that list the--it's sort of like an
17 advertisement for the different plans and compares the
18 benefits for each of the plans.

19 And under the Anthem, and I
20 alluded to this in my TAC report, but the free annual
21 sports physicals for members, for one thing, everything
22 is free because there's no copay. And, then, the other
23 thing is, we're going to have patients coming wanting
24 this free sports physical and it's not free for us
25 providers. We need to get reimbursed for it.

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MS. PATTON: I can speak to that.
Peg Patton with Anthem.

Actually, we expanded the benefit to cover the sports physicals and we are paying for those in addition to the normal annual physical. So, it is an expanded benefit and we are not applying a copay to it.

CHAIR PARTIN: So, how do we code for that?

MS. PATTON: It should be in the communication. If you don't have that, I will get it sent out to you, but there's a specific code and a specific diagnosis code to put on there.

CHAIR PARTIN: I would appreciate that. Thank you.

DR. NEEL: I still don't think we've solved the problem of these physical exams. We've been over this fifty times. You only provide one well child per year. I get it. I understand, but we still have to do it. So, we're still doing school physicals. We're still doing sports physicals. We're still doing all these and we're sort of committing fraud when we put it down as something it's not. We're getting paid on a well worry, we're getting paid on something else.

It just seems to me we ought to

1 come to some sort of agreement, and Dr. Langefeld had
2 talked about that a bit and I don't think we've really
3 solved that yet, Commissioner.

4 COMMISSIONER KISSNER: We have not
5 solved that issue, and my recommendation is not to
6 commit fraud.

7 CHAIR PARTIN: So, what do you do?
8 Do you just tell the patient, no, I can't do it?

9 COMMISSIONER KISSNER: If you've
10 identified that they've already had their well visit, I
11 would not do that. They've already had it.

12 MR. VAN LAHR: I think part of
13 that goes back to the KHSAA is they should accept the
14 physical. If you did it three months earlier, they
15 shouldn't require another one. My issue, if a physical
16 is legally required by a state agency, a second physical
17 is legally required, then, I think it should be covered.

18 COMMISSIONER KISSNER: I
19 understand that, but there's lots of stuff that is
20 covered under insurance and Medicaid. There's lots of
21 issues where just because somebody says you legally are
22 required to do this doesn't mean it has to be covered by
23 Medicaid. It doesn't change our benefit structure nor
24 does it change medical necessity.

25 So, a judge who rules and says you

1 have to provide your ex-wife with coverage, you have to
2 buy them insurance, you have to get them insurance
3 doesn't mean the insurance company has to provide that
4 coverage. It's the responsibility of the--the judge is
5 saying you have to provide it to--let's say a husband
6 saying, I just got divorced, you have to provide
7 insurance.

8 MR. VAN LAHR: I understand that,
9 but if it's state law that requires the physical exam to
10 be done, if state law requires it to be done maybe as a
11 foster child, to me, that's different than a judge
12 requiring it or somebody else requiring it.

13 COMMISSIONER KISSNER: We do cover
14 the ones on the foster care. When there is a change and
15 a foster kid changes and they're classified and they're
16 in that, we do cover that physical. That's covered and
17 Medicaid does pay for that, but other ones, it would
18 require a change in our State Plan Amendment. It would
19 require additional funding.

20 CHAIR PARTIN: So, how do we code
21 that for the foster kids?

22 MS. LEE: Just the same.

23 CHAIR PARTIN: But it will get
24 rejected if it's a second exam because there's no way
25 for us to denote that it's a foster child. It's just an

1 exam.

2 COMMISSIONER KISSNER: We know
3 they are a foster child. We have that in our system.
4 Let us get back to you exactly how that's done.

5 AUDIENCE: It would require a
6 prior authorization.

7 CHAIR PARTIN: If it did, you
8 wouldn't be able to because they just show up at your
9 door. You can't get that preauthorized. They're there.

10 COMMISSIONER KISSNER: Let us get
11 back to you on that. I'm not exactly sure what the
12 answer is on how to code it. I know that it's covered,
13 though, because we have covered that for sure for foster
14 kids.

15 CHAIR PARTIN: Okay. And, then,
16 the other thing on the physical, you're saying don't do
17 the physical. We've done their school physical. The
18 sports physical is a different exam. There's different
19 things that you examine.

20 COMMISSIONER KISSNER: Sports
21 physicals are not covered under our current program. We
22 don't cover sports physicals.

23 CHAIR PARTIN: But it could be an
24 annual exam and you did it.

25 COMMISSIONER KISSNER: We cover

1 one annual exam a year. That's correct.

2 CHAIR PARTIN: So, are you saying
3 that we should charge the patient for the exam if
4 they've already had their one annual exam six months ago
5 and now they need a sports physical?

6 DR. NEEL: It sounds like we need
7 to get the school systems, the sports people, the
8 Medical Directors, the MCOS and some of us together to
9 try to solve this problem. We've been talking about it
10 for at least two years.

11 CHAIR PARTIN: It was in one of
12 our recommendations.

13 COMMISSIONER KISSNER: Right, and
14 it's funding, State Plan Amendment.

15 Ultimately if we make a change,
16 other than an MCO stepping up and saying I want to
17 attract members by providing an additional service,
18 Anthem is an example that said I want to do this, I want
19 to actually provide coverage for this. They have the
20 ability to go higher than our benefits. They have to do
21 our benefits but they can provide more than our
22 benefits. They can do that.

23 CHAIR PARTIN: I think we need
24 some guidance, though, on what to do, if we're supposed
25 to just turn the patient away and then they can't play

1 sports or we charge the patient and you're saying don't
2 code it differently. Don't say they have allergies when
3 they're really getting a sports physical.

4 COMMISSIONER KISSNER: Don't
5 commit fraud. That is fraud. You can't provide one
6 service and then bill it as another. I definitely think
7 that remain a concern.

8 CHAIR PARTIN: So, I guess the
9 bottom line is how do we take care of these people who
10 need this?

11 MR. VAN LAHR: Can you legally
12 charge a patient?

13 COMMISSIONER KISSNER: Yes.

14 CHAIR PARTIN: You can bill the
15 patient?

16 COMMISSIONER KISSNER: Yes. It's
17 a non-covered service. You can bill the patient.

18 CHAIR PARTIN: Well, that's part
19 of the answer, I guess. You have to be in a room
20 sometime with a child when you've done a sports physical
21 and they failed the exam and you tell them they can't
22 play sports. You have to be in the room there with them
23 and see them crying. It's no fun. So, if you're
24 telling him you can't do the exam, that's not pleasant.

25 DR. NEEL: Not only that. The

1 coaches give them their sports physical exams at five
2 o'clock one afternoon and you don't get to practice
3 tomorrow if you don't have yours and they forgot to
4 bring out the physical, plus they don't know there are
5 now two sports physical forms, one for middle school and
6 one for high school, and a lot of coaches don't even
7 know that.

8 That's all right. That's our
9 problem but we'd like to meet with some of them
10 together.

11 CHAIR PARTIN: Yes, and get some
12 clarification.

13 Is there any other business?

14 MR. VAN LAHR: I've got two things
15 real quickly. First of all, I really, really appreciate
16 getting the minutes of the meetings as an email prior to
17 the meetings. That is super. It's so nice.

18 To help save some additional trees
19 and plastic, is there a portion of this we could get the
20 same way? Like we had the TAC reports and the responses
21 from DMS on the issues----

22 COMMISSIONER KISSNER: It will
23 basically be a month delayed. So, we could take like
24 the network adequacy and that would be the October
25 network adequacy that we ran. We could do that online

1 and say it's available online. In here, we have the
2 most current information. So, if you guys want us to
3 not provide in paper form some of these sections, we can
4 post it online in the normal cycle and it will just be a
5 month old.

6 CHAIR PARTIN: I think I'd rather
7 get the most current.

8 DR. RILEY: Do we have
9 connectivity in this room?

10 MR. VAN LAHR: Yes. I mean, I
11 think the only thing is, for example, any materials that
12 were available as of November 1st, if it's available 20
13 days ago, again, as the problem we had today with some
14 of the TAC reports and responses----

15 CHAIR PARTIN: Well, that's what
16 I've asked to have ahead of time. So, we will have that
17 ahead of time.

18 MR. VAN LAHR: A lot of things
19 like the dashboard, a lot of these things, if I had them
20 at home, I might sit down at night with a glass of wine
21 and review them rather than this morning.

22 And my last point, my question for
23 you is, going back to the pharmacy concerns I've kind of
24 expressed earlier, one of the issues that I see coming
25 somewhat and we have on a semi-regular basis because of

1 the insulation between Medicaid, the MCO, PBM and the
2 pharmacy, we've had this happen and my concern is that
3 it will happen the first of the year again is when there
4 is a change, the MMIS shows it's changed to a different
5 company, the MCO shows it has changed to a different
6 company, but the PBM doesn't know.

7 And, so, what happens is we're
8 stuck. I would like maybe some communication, something
9 out there to ensure that at the point in time that the
10 MCO knows this patient is eligible, that the PBM is also
11 going to know that the patient is eligible.

12 COMMISSIONER KISSNER: You could
13 ask all of the MCOs to come up and tell you I believe
14 it's within three days. So, when we tell them, here is
15 your roster for 1/1, they downstream cycle that
16 information I believe within three days to all of their
17 vendors because they've got to get it to Avesis and to
18 Delta Dental and Beacon, and whoever they have contracts
19 with, they have to get that information out. And I
20 believe that they are cycling that information out
21 within three days.

22 So, that's why open enrollment
23 closes on the 12th so we can get it to them with plenty
24 of time to generate ID cards because when they're
25 generating ID cards, it's in their system. They know

1 them and that information is communicated
2 electronically to their vendors.

3 So, I believe it's all within
4 probably 24 or 48 hours. I'm just using three days as
5 an outside. Does anybody not do it within three days?

6 MR. DANIELS: Alan Daniels,
7 Pharmacy Director with WellCare. I do know that
8 Catamaran, our PBM, from the time the roster--the roster
9 comes nightly for patients and for pharmacies and those
10 are loaded within 72 hours. It's usually less than
11 that.

12 There's also a process through the
13 Medicaid Department for emergency updates that go
14 through them. We get an email from them and those are
15 usually updated within hours but we have to validate it
16 through the Department.

17 MR. VAN LAHR: That's 72 Monday
18 through Friday hours.

19 MR. DANIELS: Correct.

20 MR. VAN LAHR: So, if somebody
21 comes in on Thursday, it could be Monday or Tuesday.

22 MR. DANIELS: That is probably
23 correct. Specifically Friday. If something comes in on
24 Thursday, it's probably updated----

25 MR. VAN LAHR: To my knowledge,

1 pharmacy is probably the only realtime provider. So,
2 when the patient comes in and they bring the letter in
3 and say I'm covered as of this date and we've got
4 nothing, it is a problem for us.

5 I don't know how to address that
6 but it's usually the nightmare from you know where the
7 first of the year for us because people will say we're
8 covered and there's been a change some place or the
9 doctor, be it a PA, APRN or MD, is not on a particular
10 plan and it's a weekend.

11 MR. DANIELS: As far as pharmacy
12 goes, whether they are contracted with WellCare or
13 whatever, as long as they appear on the State roster as
14 effective, with an effective date in the future, those
15 claims will adjudicate.

16 MS. RANDALL: And that's what I
17 wanted mentioned. I'm Rebecca Randall, Director of
18 Regulatory for WellCare.

19 We do utilize the State portal
20 quite frequently, Kentucky HealthNet, because we do
21 recognize that there is a data lag and we've seen that
22 happen in some cases. And as long as they're showing on
23 the State portal, we can do manual adjustments in our
24 system to make sure whatever that member needs, whether
25 it's to go see their physician or to go to the pharmacy

1 to get medication, we can utilize that information to
2 process it.

3 MR. VAN LAHR: So, who do we
4 contact, then?

5 MS. RANDALL: All of the managed
6 care plans have access to the State portal. So, the
7 plans can view that, yes.

8 MR. VAN LAHR: But the PBM won't
9 do it.

10 MR. DANIELS: No. The PBM will
11 not do it. They will have to act under our direction.

12 MR. VAN LAHR: So, the pharmacy
13 needs to know the contact information for the MCO.

14 MR. DANIELS: Yes, and then we
15 would verify it through the portal and then update the
16 PBM, yes. And you're correct. Pharmacy is the only
17 realtime adjudicator of claims. So, yes, it is probably
18 a bigger problem on the pharmacy side than elsewhere.

19 COMMISSIONER KISSNER: I will send
20 a memo out to the CEOs and ask them to provide the
21 hotline that a PBM would call. On 12:01 January 1st,
22 somebody has got an issue and they're trying to get a
23 prescription filled and there's a disconnect somewhere
24 because, you're right, it's not calling necessarily the
25 PBM. It's calling the MCO, but I will put out and say

1 do a communication out to your contracted pharmacies to
2 tell them how to do it and that should resolve that.

3 MR. VAN LAHR: Awesome. Thank you
4 very much.

5 CHAIR PARTIN: Anything else?
6 Commissioner, I think this presentation from WellCare
7 was beneficial. I think there was some good
8 information. Should we plan on another MCO presenting
9 at the next meeting?

10 COMMISSIONER KISSNER: Yes. I'd
11 like to cycle one in every time until we get through
12 them. I would probably push Anthem to the back since
13 they're the newest and have Passport go next. So, you
14 guys are up. You've seen the presentation. So, you can
15 go back and talk to Mark and then we'll figure out
16 Coventry and Humana.

17 CHAIR PARTIN: Thank you. If
18 there's no other business, then, we're ready to adjourn.

19 MEETING ADJOURNED
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