

November 20, 2014 MAC
Binder Section 13 – Miscellaneous Part A
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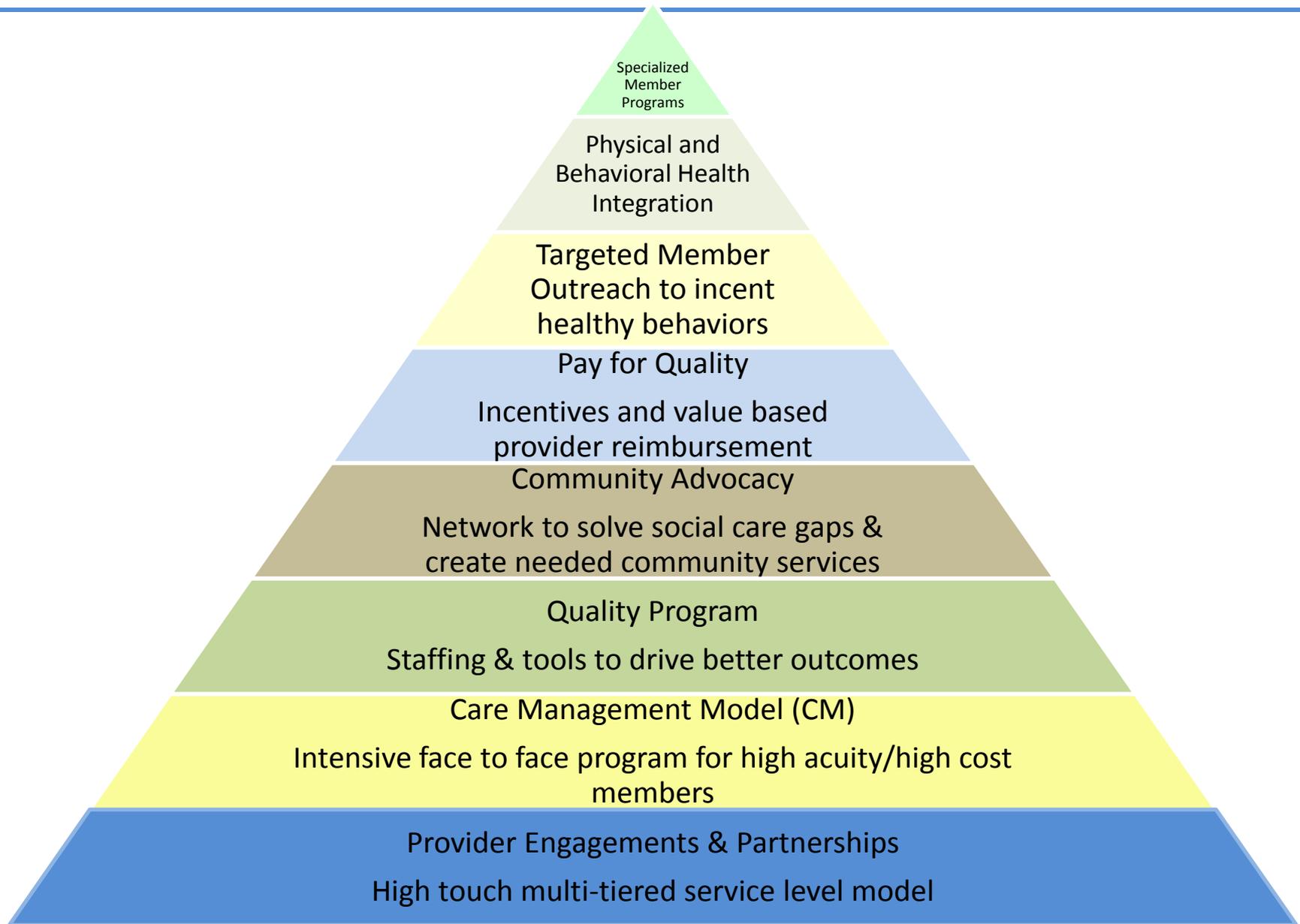
- WellCare Health Plans Presentation to the Medicaid Advisory Council (MAC) dated November 20, 2014
- MCO Medical Director Meeting Notes dated October 2014
- Kentucky CHIP Reauthorization Letter dated October 20, 2014
- The OIG Report - State Standards for Access to Care in Medicaid Managed Care Memo dated September 2014



WellCare Health Plans, Inc.
Presentation to the Medicaid Advisory
Council (MAC)
November 20, 2014



Improving Health Outcomes & Access to Care



Improving Health Outcomes & Access to Care

Provider Engagement and Partnerships	Care Management Model (CM)	Quality Program
<ul style="list-style-type: none"> • Dedicated employees serving over 22,000 physicians and hospitals statewide • BH Specialists, Hospital Specialists and Operational Specialists adjusting claims in provider offices • PR representatives quarterback the relationships and have operational and quality resources at their fingertips to attend provider meetings. 	<ul style="list-style-type: none"> • Intensive face-to-face program for high acuity and high cost members • Dedicated clinical associates providing CM/DM to KY members • Over 4,000 high risk and 168,000 low risk members actively enrolled in CM/DM • Preliminary results show a 130% increase in members enrolled in the program, reductions in IP, and ER visits, increases in pharmacy utilization and office visits 	<ul style="list-style-type: none"> • Dedicated associates committed to improving overall Quality Outcomes • Large IPA Quality Summits • Hundreds of individual provider education visits • Increase in the number of providers submitting ERMs • Personalized sites set up to exchange data
Community Advocacy	Pay for Quality Program/Value Based Reimbursement (VBR)	Targeted Member Outreach
<ul style="list-style-type: none"> • Dedicated associates committed to closing social safety net gaps • Over 550 events touching over 620,000 individuals • Numerous programs designed to improve health outcomes (YMCA, Veggie RX, Mama to Mama, Respite Care) • Health Councils across the state designed to create new or replacement social safety net programs 	<ul style="list-style-type: none"> • Program designed to reward providers for improved quality outcomes • Payment for improvement in 6 specific measures • By EOY 2014 WellCare will have paid an additional \$1M over 2013 in quality rewards to providers 	<ul style="list-style-type: none"> • Centralized Telephonic Outreach (CTO) program to close care gaps (preventative and disease state specific) • EPSDT and Post-Partum calls to new moms and babies • Periodicity letters • Home Health Care Gap Closure

Improving Health Outcomes & Access to Care

Physical and Behavioral Health Integration	Specialized Member Programs	Additional 2014 / 2015 Investments
<ul style="list-style-type: none"> • SMI care management program where physical health (PH) and mental health (MH) providers agree to a single treatment plan • Support BH and PH Integration • Interdisciplinary care management team developed & trained to handle PH and BH coordination • BH care managers now have access to our social safety net database to connect members to needed community based services 	<ul style="list-style-type: none"> • COPD, NICU, High Risk OB, Substance Abuse, SMI • Member outreach “feet on the ground” approach to finding those who need help the most 	<ul style="list-style-type: none"> • Corporate investment across WC in 2014 to upgrade and integrate systems (i.e. new IVR, CM Dual integration) • Addition of Utilization Management RN’s in KY serving providers by EOY 2015 • Provider Advocacy Phone Line to connect members to community services • On-Site facility RN’s for UM/CM • Pilot Program to staff on-site social safety net database and RN at ARH, St. E. • Added 68 dedicated KY staff members in 2014, with the addition of 60 staff planned for 2015
Provider Satisfaction Survey		QI Activity Results/Member Engagement Center
<ul style="list-style-type: none"> • Overall satisfaction with WellCare was 74.6% compared to 65.1% overall satisfaction with other Medicaid health plans • In all areas assessed providers indicated higher satisfaction with WellCare of KY than other Medicaid health plans for the same area, with the exception of one • Provider satisfaction with alternative care and community resource options offered by WellCare care managers was 71.2% as compared to other Medicaid health plans at 61.6% • Provider satisfaction with WellCare’s support of provider participation in QI activities was 71.2% as compared to other Medicaid health plans at 62.3% 		<ul style="list-style-type: none"> • WellCare received the highest CAHPs rating for member satisfaction from NCQA (5) • For the adult survey, no measure was below the 50th percentile and only 1 measure was below the 50th percentile for the child survey • WellCare opened the first Medicaid Member Engagement Center in Louisville. The center is used for group care management, educational seminars, general customer service information and a community meeting center for social safety net organizations.

Member Service Enhancements

	NUTRITION/PHYSICAL ACTIVITY INITIATIVES	REGIONS
Veggie RX Initiative	During HEDIS nutritional counseling, PCPs can offer “prescription” vouchers for fresh produce at local farmers markets. Partnership with community farm programs and 9 FQHC sites. Programs evaluated by the University of Kentucky	Regions 3 & 5
Pediatric Obesity Initiatives	<ul style="list-style-type: none"> ▪ Statewide YMCA Partnership - Sponsoring successful local YMCA programs with demonstrated positive health outcomes, focused on both improved nutrition and increased physical activity. ▪ Team Ultra - Partnership with Marshall County elementary schools and Health Department, sponsoring a free after-school program for physical activity and healthy nutrition. 	Statewide & Region 1
	PRENATAL AND POSTNATAL PEER SUPPORT	REGIONS
Mama to Mama Peer Support (Substance Abuse)	Partnership with providers, WIC, HANDS, and Mama to Mama, a Kentucky non-profit providing perinatal educational. Our state and community partners offer weekly peer support classes and provide community resources to teens and young women who are pregnant and may have substance abuse issues. Programs evaluated by the University of Louisville.	Regions 3 & 5
	ACCESS TO CARE INITIATIVES	REGIONS
Site-Based Respite Program	WellCare provided a grant to offer daily site-based respite care for children up to 14 years old in Eastern KY. The three-hour respite care program is intended to reduce parent and caregivers’ stress levels, particularly when children may have special needs or MH/BH issues.	Region 8
MH/BH HCC Meetings	HealthConnection Councils are community meetings held statewide that target specific issues, these MH/BH meetings will focus on continuum of care issues and suicide prevention.	Regions 2 & 5

Community Relations and Focused Giving

WellCare strives to help our members, and their communities, lead better and healthier lives. The WellCare Community Foundation, our employee volunteerism and community relations efforts help to support this mission.

The WellCare Community Foundation

Established in 2010, it is a non-profit, private foundation with a mission to foster and promote the health, wellbeing and quality of life for the poor, distressed and other medically underserved populations – including, those who are elderly, young and indigent – and the communities in which they live.

Employee Volunteerism

WellCare encourages volunteerism to support children and seniors, and those who are low-income or underserved. Employees work in their local communities to raise much-needed funds and to support organizations that offer valuable support to those in need.

Community Relations

The Community Relations program educates and advocates for WellCare members and the community. Through it, we proactively facilitate communications with providers, members and the community to inform, educate, address health issues and encourage preventive health care.

In Kentucky, WellCare supports the work of community organizations and initiatives, including:

American Diabetes Association

American Red Cross

Coalition for the Homeless

HOTEL INC Homeless Outreach

The Lincoln Foundation

Pediatric Asthma Pilot Program

Workforce Diversity: Community Liaisons & Social Work Practicum



**At WellCare, our members
are our reason for being.**



**We work each day to
enhance our members'
health and quality of life.**



October Meeting Notes

MCO Medical Director Meeting

Kentucky Medicaid Managed Care Plans

Tuesday, October 21, 2014

8:30 a.m. – 12:00 p.m.

Location

CareSource/Humana

10200 Forest Green Blvd

4th Floor Board Room

Attendees (MCO's): Dr. Vaughn Payne (Humana/CareSource), Dr. Stephen Houghland (Passport), Dr. Fred Tolin (CoventryCares/Aetna), Dr. Jerry Caudill (Avesis), Dr. Peter Thurman (Anthem), Kenneth Soloman (WellCare), Alan Daniels (WellCare), Leann Magre (WellCare)

Attendees (CHFS): Dr. Allen Brenzel (BHDID), Andrea Adams (OHP), Patricia Biggs (DMS), Judy Baker (DMS), Adi Mittrache (UKMC), Dr. John Langefeld (DMS), Dr. Connie White (DPH), Sue Thomas-Cox (DPH)

Attendees (Guests): Dr. Charles Woods (U of L Pediatrics), Dr. Julia Richardson (FHC, Louisville)

Agenda Discussion Items

- **Update from past meetings**
 - **Behavioral Health – Update**
 - **Impact Plus**

Dr. Brenzel updated the group regarding transition which occurred August 1. There have been no significant issues that have occurred during the transition and the process with MCO's has been "smoother" than with FFS.
 - **AG Grant Funds update**

The committee made final decisions and awarded 19 programs for Adolescent Substance Abuse services. The list of awards is below. The web address for more detail is: <http://kykidsrecovery.ky.gov/Pages/default.aspx>

Boys & Girls Haven, Louisville — \$267,084

Children's Home of Northern Kentucky — \$1,500,000

Communicare — \$1,200,695

Cumberland River Behavioral Health — \$959,775

Four Rivers Behavioral Health — \$315,876

KVC Behavioral Health Care Kentucky, Inc. — \$2,032,998

Kentucky River Community Care — \$686,165
 Maryhurst — \$932,928
 Methodist Home of Kentucky — \$542,628
 Mountain Comprehensive Care Center — \$192,720
 Necco — \$1,371,283
 Our Lady of Peace — \$1,471,143
 Pathways — \$841,655
 Pennyroyal Center — \$1,075,131
 Ramey Estep Homes — \$1,521,744
 Rivendell Behavioral Health Hospital — \$24,905
 Specialized Alternatives for Families and Youth of Kentucky, Inc.
 (SAFY)— \$1,089,271
 The Ridge Behavioral Health System/Bluegrass.org— \$1,350,008
 WestCare— \$600,982

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

The BH project team workgroup continues ongoing meetings. Next meeting is scheduled Monday October 27.

- **Institutional De-certifications**

Work continues on reducing the number of institutional de-certifications. Meeting have now occurred with all MCO's.

Summary as of 7/10/2014

CoventryCares:	11
WellCare:	6
Passport:	1
Humana/CareSource:	1

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

- Public Health Hygienist: An oral health provider designed to deliver preventive services, oral health education and patient navigation to primarily school children who are not receiving dental care. With the intended goal of reducing the disease burden in the population and reducing the need for more complex care.
- Fluoride Varnish delivered by primary care Physicians, This service is for children 0 to 5 yrs. and is covered in FFS Medicaid but there have been problems in reimbursement.
- ECC program /preventive initiatives: This disease management program attempts to address dental disease by involving the parents/caregivers in an accelerated home hygiene program.
- Mobile Dental Delivery systems. There was much discussion about the effectiveness and regulation of the mobile dental delivery systems operating in the states and how to assure that they operate synergistically with the established Dental health workforce in the state. This conversation will continue as the Board of Dentistry is looking into this also.

➤ New Discussion Items

▪ **Psychotropic Medications in Children Initiative and common PIP**

Dr. Langefeld began the discussion with confirmation that the Medicaid Advisory Committee (MAC) voted to adopt the recommendation of ***Appropriateness of Psychotropic Medications in Children*** as the common Performance Improvement Plan (PIP) for quality improvement for the MCO's for the upcoming year. The HEDIS-proposed technical specifications (6 measures) have been distributed. All 5 MCO's have submitted initial draft proposals outlining their respective program proposals. They have also been reviewed by IPRO with preliminary questions and comments. Judy Baker gave an update on the current status. The next step will be for all 5 MCO's to meet individually with U of L Pediatric team for discussions. Dr. Charles Woods was at the meeting and reiterated that his team was there to support and provide input into the process. The next step will be for the U of L pediatric team to meet with IPRO regarding discussion and coordination of efforts. Dr. Woods also gave the group an overview of recent discussions at the AAP meeting around psychotropic use in children.

▪ **Task Force on Childhood Asthma**

Dr. Connie Gayle White from the Department for Public Health (DPH) introduced to the group the Kentucky-Asthma Integrated Resources (K-AIR) pilot project for the group's consideration. Development of this program was a collective effort of Local Health Departments, DPH (School Health, Lead, Chronic Disease and Environmental Services) and Medicaid.

Asthma in children is a major issue in the Commonwealth resulting in missed school days (poor test scores and less graduation), missed work days for parents (loss to the economy), and considerable medical cost for unmanaged asthma in ED visits and in-house stays. This pilot would involve four Local Health Departments (LHDs) chosen for their asthma burden in children and their ability to provide the necessary personnel to implement this program. NIH's Expert Panel report recommends not only patient self-management education of asthma, but the importance of reducing exposure to inhaled indoor allergens, a component of asthma care that is often overlooked. With K-AIR, the patient will be evaluated by both an asthma educator and a Healthy Homes Specialist with an in-home evaluation to determine potential causes of the asthma severity and make appropriate adjustments for the child. Community Health Workers (CHWs) trained in Asthma 1-2-3 and CHW Healthy Homes will also participate with the team in home visits, phone calls and education on asthma self-management and asthma triggers in the home. The program will be managed through the MCO Disease Management Specialist with monthly progress reports on the family's goals and DPH providing quarterly reports on the financial returns from the program. Payment would be on a per member per month basis with continued evaluation by the MCO Disease Manager.

The program was well received by the CMOs with request to increase the number of children served in the pilot. The proposal and power point will be revised and sent to the CMOs along with a link to the Healthy Homes video developed by KET. This video had been viewed by Dr. Vaughn Payne who was impressed with the Healthy

Home project. Once these changes are made, the CMOs will review and send questions to Dr. White for clarification. Initiation of the project by all five MCOs could begin at the first of the calendar year.

- **Health Home Update and Program Proposal**
Overview/Background

ACA Section 2703 gives states the option to submit one or more State Plan Amendments (SPAs) to create Health Homes for Medicaid patients with: two or more chronic conditions; one chronic condition and at risk for a second; or, serious mental illness. States must show how they will use Health Information Technology to support six required services: comprehensive care management; care coordination; health promotion; comprehensive transitional and follow-up care; individual and family support; and, referral to community and social support services. States receive a 90/10 match for Health Home services during the first eight quarters after the SPA is active. The expansion population receives the federal expansion match rate. States may create more than one SPA and may have geographic limitations.

Fifteen states have at least one CMS approved Health Home SPA and another six states have SPAs in the approval process with CMS. While most states have paid for Health Home services on a per member per month basis, states have flexibility in designing the reimbursement mechanism. Payments may flow: directly to Health Home providers outside of Medicaid MCO contracts; through MCOS who act as “lead entities” that contract with Health Home Partners to provide some or all of the six required Health Home services; or, to the MCO that serves as the Health Home. States must address issues regarding the role of MCOs, the distribution of savings, data governance and data sharing, practice transformation, stakeholder communication, and HIT and supporting infrastructure. (Urban Institute)

Kentucky received a Health Home Planning Grant in early 2014 under the leadership of Dr. John Langefeld from DMS, Dr. Allen Brenzel from DBHDID, and Emily Parento from the Office of Health Policy. An Interagency Work Group representing eleven agencies within the Cabinet for Health and Family Services was created to reach internal consensus on populations of focus and to design one or more health home programs for Kentucky. The Work Group reviewed analyses of Calendar Year 2013 Medicaid claims data grouped into 27 chronic condition categories defined by CMS with added indicators for SMI/SED and hepatitis C.

Recommendation

After thorough analysis, review, and consideration of all available information, the Health Home Leadership Team and Interagency Work Group recommended that Health Home development initiative focus *first* on the Medicaid population identified with **Substance Use Disorder** (SUD). Other chronic diseases which are high priority for consideration subsequently are asthma/COPD, SMI/SED, Heart Disease, Diabetes, and Chronic Kidney Disease.

SUD rose to the top of the list of chronic conditions due to the public health crisis that Kentucky is experiencing around substance use, particularly opiates. SUD has broad implications for child welfare, corrections, communicable disease and rising

incidence of Substance Exposed Infants and Neonatal Abstinence Syndrome. Because SUD is a new covered service with new Medicaid providers and an expanded Medicaid patient population, Health Homes can provide needed continuity of care.

Next steps include:

- ✓ Defining criteria for Health Home providers
- ✓ Developing a payment methodology
- ✓ Defining Health Home services and dealing with potential overlap
- ✓ Developing HIT support, and planning for sustainability beyond the eight quarters of the 90/10 match

➤ **Miscellaneous Items**

▪ **Suboxone Update**

The updated draft for DMS Prior Authorization (PA) criteria was given to the group. It was also noted that KBML is in process of issuing guidelines with an initial approval by their governing committee. We will continue to monitor and discuss, with agreement that this was an issue we should all move in concert.

- It was also noted that Sec. Haynes, along with Commissioner Begley (DBHDID), Commissioner Kissner (DMS), Dr. Brenzel and Dr. Langefeld, will be on the November Health and Welfare agenda to discuss the issues and concerns around scheduled drugs and particularly opioids in Ky.

Next Meeting: Scheduled for November 18 will need to be re-scheduled because of a conflict. Tentatively this was rescheduled to Tuesday November 25th.



COMMONWEALTH OF KENTUCKY
OFFICE OF THE GOVERNOR

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October 20, 2014

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2183 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
2204 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Upton, Chairman Wyden, Ranking Member Waxman, and Ranking Member Hatch:

I am writing in response to your letter of July 29, 2014, seeking state input on the Children's Health Insurance Program (CHIP).

I am incredibly proud of the work we have done to provide access to affordable health insurance through kynect, the state's health insurance exchange, and the national attention we have received for so dramatically reducing our uninsured rate. However, before we began these efforts through kynect, I worked to greatly lower our rate of uninsured children. I strongly believe that it is shameful and shortsighted to deny children with the health care they need and deserve.

In 2008, I launched a plan through the Kentucky Children's Health Insurance Program (KCHIP) to dramatically cut the number of children without health coverage by removing barriers to enrollment, retaining more children once they are enrolled and significantly increasing education and outreach. The steps we took to get more eligible children enrolled in KCHIP were fiscally responsible, economically smart, and an unqualified success. Since the launch of our efforts, the number of Medicaid-covered children has increased by 97,251, a 22 percent increase, which includes an increase of 10,563 children in KCHIP. In addition, we eliminated a six-month waiting period to enroll in KCHIP that had been required for children whose private insurance was dropped voluntarily and whose family income was between 150 percent and 200 percent of the federal poverty level. Finally, earlier this year, we removed the five-year ban for lawfully present residents under the age of 18 to enroll in KCHIP.



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KCHIP has been essential to ensuring that quality health coverage for Kentucky's children is affordable and accessible. As you know, children with health coverage have improved health outcomes throughout their childhood and are more likely to receive preventive care, treatment when they are ill and for recurring illnesses; get sick less frequently; have better attendance and performance at school; and have parents with better attendance and performance at work. Quite simply, KCHIP is a vital piece of the health care landscape for Kentucky's children and I urge its immediate reauthorization.

Below are answers to your specific questions:

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

Currently, 21,159 children are enrolled in the Medicaid Expansion portion of CHIP and 25,988 children are enrolled in the separate portion program.

As a result of the new MAGI income calculation methodology, children may be enrolled in KCHIP if household MAGI is at or below 159% of the federal poverty level (FPL), and they may enroll in the separate portion program at income levels up to 218% FPL. The previous thresholds were 150% and 200% respectively.

Children receiving disability benefits are not generally enrolled in KCHIP, but are eligible through programs for the disabled, though there may be some children with disabilities who do not qualify for disability payments that are enrolled in the program. Generally, both KCHIP and the separate portion program are comprised of children without disabilities.

The demographics of the combined group are below. These children are 51.08% male and 48.92% female (table 1). More than 97% of the children identify as non-Hispanic (table 2). Almost 60% do not list a standard federal racial category at the time of application, while 35% identify as white and 4.6% identify as black (Table 3). The enrollment by age group is shown in table 4.

Table 1. KCHIP Enrollment by Gender

Gender	Percent
F	48.92%
M	51.08%

Table 2. KCHIP Enrollment by Ethnicity

Ethnicity	Percent
Hispanic	2.23%
Non-Hispanic	97.73%
Not Listed	0.04%

Table 3. KCHIP Enrollment by Race

Race	Percent
E - Other Race or Ethnicity	59.45%
O - White	35.10%
B - Black	4.62%
A - Asian or Pacific Islander	0.50%
7 - Not Provided	0.04%
I - American Indian or Alaskan Native	0.18%
J - Native Hawaiian	0.11%

Table 4. KCHIP Enrollment by Age Group

Age Group	Percent
0 – 5	20.95%
6 – 12	43.54%
13 – 18	35.51%

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

As I mentioned above, Kentucky lifted the five-year waiting period for lawfully residing immigrant children. We have also added a substance use treatment benefit as a Medicaid covered service and amended cost-sharing requirements for children. Kentucky utilizes the existing Medicaid infrastructure to administer KCHIP; therefore, implementation of PPACA had a minimal impact on KCHIP, outside of the small impact of the MAGI calculation methodology on income thresholds.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost-sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Kynect adopted the KCHIP vision and dental benefit package, which makes the two benefit packages more comparable. However, cost sharing in KCHIP is limited. Kentucky does not have a monthly premium or enrollment fee for KCHIP, while the monthly premiums, co-payments, deductibles, and cost-sharing in kynect are higher for families with children, depending on the income of the family.

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- 4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?**

CHIP funding must be extended until all Kentucky families' income no longer necessitates the need for this assistance. It is short-sighted to deny children health care coverage – sick children cannot be successful students; sick children cannot thrive in our workforce; and sick children will not lead the happy, productive lives that they deserve. I cannot urge strongly enough for you to continue funding for CHIP.

If a decision is made NOT to fund CHIP after FY2015, as many as 50,000 Kentucky children will lose health care coverage.

- 5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?**

The restructuring and retargeting of allotments in 2009 have been adequate and sufficient for Kentucky; so far, Kentucky fully expends its annual CHIP allocation. Congress could easily address the issue of unspent allotments by reducing a state's next scheduled allotment by the unspent amount. The state would retain the unspent allotment from the previous period along with the modified new allocation, which would ensure the state retains the allotment necessary to maintain its CHIP program for the new period.

- 6. Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?**

KCHIP and PPACA have been instrumental in reducing the number of uninsured in Kentucky. As mentioned in the answer to question 4, CHIP serves as a vital transition point for children who may eventually move to a qualified health plan through kynect. Therefore, Kentucky recommends that the federal government fix the "family glitch" that exists in PPACA today. Since the affordability test for individuals who have access to other insurance is based on the cost of a single plan and not the cost of a family plan, the only options currently available to families who

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cannot afford the cost of a family plan through their employer are either enrolling in CHIP or not insuring their entire family. This unfortunate glitch must be addressed.

I greatly appreciate the opportunity to provide my perspective on this critical program. Continued funding of this program is the right thing to do and Congress should view it as a moral obligation.

Sincerely,

A handwritten signature in black ink, appearing to read "Steven L. Beshear". The signature is fluid and cursive, with the first name "Steven" and last name "Beshear" clearly legible.

Steven L. Beshear



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Steven L. Beshear
Governor

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Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

*Copy for
- Staff MTG
- MAC*

MEMORANDUM

TO: Lawrence Kissner, Commissioner

FROM: Patricia Biggs, RN *PB*
Director, Division of Program Quality & Outcomes

DATE: November 10, 2014

SUBJECT: Office of Inspector General (OIG) Report September, 2014
State Standards for Access to Care in Medicaid Managed Care

I have reviewed the report and agree with the analysis by the OIG that national standards would benefit the states with full risk Medicaid managed care and the states which have expanded Medicaid.

I look forward to a collaborative effort with CMS. By strengthening the standards of access we insure our membership is receiving the services they need to maintain optimal health.

Three standards that the report identified involved limiting the distance or amount of time enrollees should have to travel to see a provider; require appointments to be provided within a certain timeframe; and standards that require a minimum number of providers in relation to the number of enrollees. Measures such as implementing a standard number of enrollees per specialist and a standard related to the time a member waits to see a provider for services would give us a more robust monitoring mechanism directed toward access. We currently have standards defined for travel distance.

Appendix A which states "no standard" for a specialist in Kentucky is incorrect. It should state 60 miles as the standard distance for travel.



DMS response to the recommendations in the report:

Strengthen its oversight of State standards and ensure that States develop standards for key providers.

The Kentucky Department for Medicaid Services (DMS) has set standards through the Provider Network Adequacy report which monitors several different requirements. The Provider Network Adequacy report provides DMS with a listing of all specialist and primary care that are currently contracted with the Managed Care Organization (MCO) on a monthly basis. The MCO must meet a 95 % standard on the distance a member must travel to see a provider. Specialists are allowed to be within 60 miles and a Primary Care is required to be within 45 miles for rural areas and 30 miles for urban. The data is used to determine if the MCO is in compliance with the contract. The Managed Care Oversight Branch (MCOB) staff review this report to determine if the member to provider ratio is in accordance with the contract.

Future plans:

- Develop a contract monitoring process to include an on-site visit by MCOB staff for each MCO to walk through their provider enrollment process to determine the differences in our provider file.
- Work with Provider enrollment staff to allow more than 22 specialties on our provider file. This will allow monitoring of all specialists currently enrolled with DMS.
- Create a minimum requirement of 1 specialist per region per specialty type assuming a Medicaid enrolled provider exists in the region.

Strengthen its oversight of states methods to assess plan compliance and ensure that States conduct direct tests of access standards.

DMS has developed a method to assess plan compliance by conducting "secret shopper" audits. DMS receives a monthly list of network providers from each of the 5 MCO's from which the MCOB staff developed a random sampling. Staff contacts the providers on the list and inquire if they are taking new patients and if they are contracted with the specific MCO being reviewed. The staff makes the inquiry as if they were a member asking for information. These findings are compiled into a report and reviewed by the MCOB to determine any issues with access. This report will become a part of the MAC reporting binder in March, 2015. Audits of the MCO are performed to validate the accuracy of their data.

The Island Peer Review Organization (IPRO) performs an annual audit of the network validation data. Currently IPRO is conducting an audit of the Behavioral Health network providers. They have received a file from the MCO of providers in the network and are contacting providers to see how long it takes to get an appointment for these services. This audit will determine inadequacies in the network and access issues that may be barriers to members getting these services in a timely manner.

DMS requires the MCO's to submit a monthly report of additions and terminations to their provider network. The MCOB staff performs a check of the website to validate that the MCO has added or removed the providers on the list. This validation process determines if the MCO's are removing providers in a timely manner. MCOB staff review the website as if they were a member trying to find a PCP and have made recommendations to the MCO's on making the websites more user-friendly.

Future Plans:

- Continue to call providers from a random sample monthly and notify provider enrollment when phone numbers are incorrect, physical location has changed and the provider is no longer participating with the MCO or accepting new patients.
- Work with Provider Enrollment staff to suggest changes to current process to allow updating of provider information. It is expected that the new provider portal to be active in late 2015 will address this issue by providing self-service for provider entry of the information.

Improve States' efforts to identify and address violations of access standard.

DMS has developed processes that address violations of the MCO contract. When the reports show a specialist out of the 60 mile range a Corrective Action Plan/Letter of Concern process has been developed that enables DMS to notify the MCO in a timely manner and get the deficiency corrected. Once a CAP or LOC has been issued the MCOB monitors the MCO's plan to insure compliance. If the MCO does not follow the plan approved by DMS, sanctions can be applied.

Future Plans:

- MCOB staff will develop a query by county to get encounter data to determine what specialties members are utilizing and whether the specialty is below the 95% standard.
- MCOB staff will continue the direct test of access utilizing the "secret shopper" audit.
- The MCO Quality staff will collaborate with MCOB staff to address provider access issues identified through the disenrollment for cause letters.

Provide technical assistance and share effective practices

We have begun discussions with other states regarding the encounter process, validating the provider file and other issues facing the department after the implementation of ACA.

Future Plans:

- Implement a contract monitoring process to include an on-site visit by MCOB staff with each MCO to review network access.
- Work with CMS technical assistance staff to further develop network access standards.