

CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

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May 28, 2015
10:00 A.M.
Capitol Annex, Room 125
Frankfort, Kentucky

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MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Karen Angelucci
Sharon Branham
Susie Riley
Susanne Watkins
COUNCIL MEMBERS PRESENT

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1 DR. PARTIN: Let's go ahead and get
2 started. Since we do not have a quorum, we will not be
3 able to approve the Minutes from our last meeting. We'll
4 go ahead and move on to Old Business. And the first item
5 on Old Business is the Workgroup developing common
6 preauthorization form. Do we have any update on that?

7 COMMISSIONER LEE: Good morning. I'm
8 Lisa Lee, Commissioner for the Department for Medicaid
9 Services. And I have with me Dr. John Langefeld who is
10 the Medical Director for the Department. And, so, as many
11 of you may be aware, recently we released an RFP for our
12 MCO process. The responses were due Friday. So, while we
13 can't talk too much about that, we will point you to
14 Section 21.4 in the new contract that was attached to the
15 RFP. That section does state that by or on January the
16 1st of 2016, we will have a prior authorization form for
17 all participating MCOs. So, the common prior
18 authorization form should be in place on or before January
19 1st of 2016.

20 DR. PARTIN: Thank you very much.

21 COMMISSIONER LEE: Do you want me to
22 just keep going down the list ---

23 DR. PARTIN: Sure.

24 COMMISSIONER LEE: --- of the items?
25 Okay. So, regarding provider credentialing and

1 recredentialing, again, the new contract that was attached
2 with the RFP has a specific section in there that deals
3 with credentialing and recredentialing. Managed Care
4 Organizations will have 90 days to credential and
5 recredential providers.

6 In addition, the Department has
7 modified a few of our reporting measures; and we do
8 monitor the MCO credentialing process on a 30-60-90-day
9 and over. When we see any credentialing that has not been
10 completed within 90 days, that alerts us to call that MCO
11 -- that specific MCO and to look at some of those
12 applications so that we can determine what's going on.

13 And, also, Senate Bill 192 that passed
14 in this last Legislative Session requires that MCOs have
15 45 days to credential and contract with providers who
16 deliver substance use treatment services. So, those are
17 some things that we are keeping on our radar and
18 monitoring. And unless you have any questions with the
19 credentialing or recredentialing ---

20 MS. BRANHAM: I have a question,
21 Commissioner.

22 COMMISSIONER LEE: Uh-huh
23 (affirmative).

24 MS. BRANHAM: On the credentialing, I
25 know I've been contacted; and they've had an app in since

1 October. And we talked a little bit about this yesterday
2 in our TAC Meeting. And, so, when this -- on the
3 credentialing and recredentialing within 90 days in the
4 new RFP, what do we do now when it's been hanging out
5 there and we're not getting a response?

6 COMMISSIONER LEE: You alert the
7 Department so that we can check into that and make sure
8 that all the processes are being followed. And we will
9 get with the Managed Care Organization and make sure that
10 that application is expedited.

11 MS. BRANHAM: Thank you.

12 DR. PARTIN: Thank you. That answered
13 my question, too, because I know of one instance where I
14 think an application was held up unreasonably. So that
15 providers will have an avenue, then, to ---

16 COMMISSIONER LEE: Yes. They can
17 contact the Department. That helps us monitor the MCO
18 compliance with the contract and also makes sure that
19 those providers get enrolled as quickly as possible. And,
20 of course, everything is all contingent upon a complete
21 and accurate application. Sometimes there may be missing
22 information that we'll need to get, but at least it alerts
23 us to the fact that an application has been out there
24 longer than 90 days and we can take action.

25 MS. BRANHAM: Yeah, because if we

1 don't have feedback, we don't know what applications
2 aren't complete.

3 COMMISSIONER LEE: Correct.

4 MS. BRANHAM: Or additional
5 information.

6 COMMISSIONER LEE: Dr. Langefeld can
7 talk a little bit about the ER super-utilizer.

8 DR. LANGEFELD: Yes. Good morning.
9 So, I'm not sure exactly what the question was about
10 super-utilizers. I guess I would query the Panel first to
11 see who has heard of the ER super-utilizer initiative.
12 Okay. Well, maybe I should just give a -- I'll give a
13 brief overview of what it is and, then, see if there are
14 any questions about it. And, then, if you would like more
15 detail, we can provide that as well.

16 But this really started in 2013 when
17 the Governor at that time issued a directive. How many of
18 you think ER use is a concern? So, the Governor did, too.
19 So, he issued a directive in 2013 to say we need to figure
20 out a better way or a more efficient and effective use of
21 our Emergency Rooms that meet our community's needs
22 without the ERs functioning really as a de facto primary
23 care resource. And he tasked the Cabinet for Health and
24 Family Services to begin to work initially with our
25 Academic Medical Centers as referral centers but, then,

1 also, all of our acute-care facilities to see what could
2 be done about that.

3 So, when we began to work on this, one
4 of the things we did first was just look at the data. And
5 the data, of course, told us a picture that we anticipated
6 we might see. But, in Medicaid, we have over 350,000 --
7 this was prior to the expansion -- we had over 350,000
8 Medicaid recipients a year who went to the Emergency Room
9 at a cost in excess of \$300,000,000 just in ER costs alone
10 in our Medicaid Program.

11 And many of those -- about half of
12 those visits were only one time, but 45,000 of them were
13 four or more times. And, in fact, almost 4,500 were ten
14 or more times. Now, we had one in the initial analysis
15 who went to 31 different Emergency Rooms within a 12-month
16 period of time; all associated with an ER transport as
17 well. So, I mean, there are obviously some concerns that
18 need to be addressed.

19 Now, the other things in the data that
20 were important, however, is that as we looked at the
21 highest users of the Emergency Room and looked at the
22 diagnosis, for example, that they were presenting with,
23 almost 80% of those who went to the Emergency Room had a
24 behavioral health diagnosis and over 45% had a substance
25 use disorder diagnosis. Now, keep in mind this was even

1 before 2014 where the benefits expanded for behavioral
2 health services and coverage for substance use disorder
3 occurred.

4 So, the work began with a workgroup
5 initially with the University of Louisville and the
6 University of Kentucky. And we expanded that pretty
7 quickly to 15 different hospitals dispersed across the
8 state, urban and rural in character. And one of the other
9 things that occurred concurrent at that time was the
10 opportunity for Kentucky to participate in a National
11 Governors Association sponsored project called
12 Super-Utilizers.

13 And, so, we applied for that; and
14 we're one of six states awarded participation in that
15 project. Now, some states focused on different areas; but
16 we chose to use as our focus, because we were already
17 starting this initiative in ER utilization, to look at
18 super-utilizers of our Emergency Rooms as a place to
19 start. And, so, that's where the term super-utilizers
20 came from. It's really a national initiative, but we're
21 looking at it in Kentucky.

22 So, the workgroup that included in
23 that Phase I 15 different hospitals identified objectives
24 that they set forth. We can't do anything without an
25 acronym and name. So, we called it ER SMART. And the

1 SMART, I think, -- let me see if I can remember it --
2 Supportive Multi-disciplinary Alternatives and Responsible
3 Treatment. So, that's our ER SMART Program.

4 And the essence of that was to
5 identify who these highest utilizers were and how to
6 address their needs at a local, community level. Now, the
7 definition we gave it after looking at the data was ten or
8 more visits in a 12-month period. And the other
9 methodology we used is one that we adopted actually from a
10 group called the Camden Coalition. I'm not sure if you're
11 familiar with that, but you may have heard the term hot
12 spotters. There was an article published nationally. But
13 this really used a methodology that looked at high ER use
14 combined with inpatient admissions. So, ten or more -- or
15 an ER visit with three or more ER visits, essentially,
16 made up the rest of the super-utilizers in addition to
17 just ten visits.

18 And, so, as we began to work with the
19 group, a couple of things emerged. Now, I should say this
20 initiative was led -- is being led by Dr. Stephanie
21 Mayfield, who is the Commissioner of Public Health, and
22 myself working together. As we began to talk with the
23 group, one of the things that we did was to say, you know,
24 at a local community level, there are resources available
25 that may not be being used optimally. And, so, what do we

1 have? We have 120 counties. We have a Health Department
2 in every county.

3 So, one of the initial steps was to
4 say, you know, the Health Departments identify a lot of
5 local resources that are available but maybe not being
6 used for individuals in the community effectively. So,
7 one of the things that the workgroup encouraged was the
8 local Health Department as the active convener, along with
9 the acute-care hospital, in forming a workgroup and all
10 the local resources; the behavioral health providers,
11 particularly housing, transportation.

12 That's one of the things they do is
13 identify local resources. And, so, that began the work to
14 say at a local community level where are the resources
15 that are needed and how do we coordinate and connect those
16 local resources.

17 The other piece that we felt was
18 important was how do we bring tools that the Cabinet might
19 have to support that, besides data which we can help them
20 with. But the other resource in the Cabinet is our
21 Information Exchange. And, so, the Information Exchange
22 was an important foundational piece because it created the
23 capability to transfer information, transfer data to
24 communicate through secure messaging to that care
25 coordination team that's identified at a local level.

1 So, that initiative is ongoing. We
2 actually expanded that last fall and opened it up to all
3 acute-care facilities in the state and are actively
4 continuing to support and promote that.

5 Now, some of the things that are
6 challenges around that. One is that in our system today,
7 people go to the Emergency Room for a lot of reasons that
8 have nothing to do with medical care. Right? So, how do
9 we address that? And on the provider side, what's the
10 incentive not to promote use of the Emergency Room even by
11 providers in a fee-for-service system? So, it's difficult
12 because hospitals are saying, well, we're struggling. We
13 want to have use of our resources; but, at the same time,
14 we want to reduce utilization.

15 And, so, one of the foundational
16 issues that we continue to struggle with is what's the
17 economic model around a different system. And, so, the
18 reason I bring that up is because this initiative -- I
19 think it's important to understand how this initiative
20 actually is parallel to and, in my opinion, convergent
21 with our work around what we now call our State Innovation
22 Model Design. How many of you are familiar with the State
23 Innovation Model work? We can maybe talk about that at
24 the next meeting, if you'd like.

25 But that work is really how do we

1 think about Kentucky -- not just in Medicaid -- but how do
2 we think about Kentucky and what the delivery system looks
3 like, or non-system some people would call it, and how do
4 we redesign that in a more connected way, and what is the
5 economic model around that that moves us from a
6 traditional volume-based system to one that is really
7 focused more on what people call value, which is thinking
8 about it at a population level, with the focus on all
9 individuals, of course, within that population.

10 So, anyway, I'm getting to the point
11 of rambling a little bit. But I'll stop and see what
12 questions you may have.

13 DR. PARTIN: I think that the question
14 related to the super-utilizers came about because of a
15 recommendation from the Behavioral Health TAC wanting to
16 know about behavioral health overutilization -- behavior
17 health patients over-utilizing. And you remarked that 80%
18 were behavioral health?

19 DR. LANGEFELD: Overall, 80% of the
20 highest utilizers had a behavioral health diagnosis and
21 substance use disorder. Of course, it was even higher in
22 some regions. So, what we felt anecdotally was probably
23 true, the data supported. And I think, certainly, it's an
24 area we need to figure out how to respond to and address.
25 It's a lot of our discussion around work, for example, in

1 our health home discussion that I think we've talked a
2 little bit about before. And, so, anyway, did that answer
3 the question?

4 DR. PARTIN: I think I'll have to let
5 the behavioral health folks ---

6 DR. LANGEFELD: Okay.

7 DR. PARTIN: --- say if that addressed
8 the issue. But I would think there might be some overlap
9 between the substance abuse and the behavioral health. Is
10 that right?

11 DR. LANGEFELD: Well, I think, as I
12 described, what would we like to support at a local level.
13 And that's identification of all resources, not just
14 traditional medical resources but things like
15 transportation and housing and other community resources
16 that might be available. How do we think about
17 identifying those and, then, connecting them in a true
18 patient-centric or citizen-centric or community-centric
19 way to respond as needed to that individual's needs.

20 That description is not unique to ER
21 super-utilizers. It's the same discussion we're having
22 with care period. How do we think about moving from kind
23 of this fragmented, one-on-one system to a coordination of
24 resources in a more effective way. So, really, it is a
25 convergent discussion.

1 MS. BRANHAM: I think Dr. Schuster
2 will address some of that today because I recall sitting
3 here at many of these meetings and it's always been
4 behavioral health's position that because MCOs don't
5 approve medications, that relates to that; the number of
6 centers; the medications; and their formularies. And I
7 think she's addressed all of that.

8 And I think if we were to track it
9 back, we might be able to see why we have 80% of the
10 super-utilizers of behavioral health and substance abuse
11 directly tied back to what the contracts are with the
12 MCOs. That might be an easy way to track it. And I'm
13 sure Dr. Schuster can fill us in on that.

14 DR. PARTIN: Well, thank you. Then,
15 so, at our next meeting, you're going to talk about the
16 State Innovation Model?

17 DR. LANGEFELD: I'd be happy to.

18 DR. PARTIN: Okay, thank you. I'll
19 put that on the agenda. The next item was related to the
20 MCOs retroactively reviewing claims for eligibility.
21 Providers are correctly verifying eligibility at the time
22 of service, but the MCOs are later -- sometimes more than
23 a year later -- making retro-determinations that the
24 patient was not eligible and requesting refunds.

25 At the last meeting, we were told that

1 -- or I think it was in the comments, actually, that DMS
2 has completed the streamlining of eligibility and
3 enrollment systems to prevent this from occurring.

4 COMMISSIONER LEE: Well, what the
5 Department is doing is continuing to update our
6 eligibility systems. So, for example, when we receive a
7 specific example of an individual whose eligibility to an
8 MCO was changed retroactively, we can go in and examine
9 that specific case to find out what happened in the system
10 to prevent that going forward.

11 So, we continually do that and tweak
12 our eligibility system. But we still have several systems
13 that are interacting with each other and communicating.
14 And because of a lag time sometime in passing files back
15 and forth, there's going to be a little bit of an overlap;
16 but we do continue to tweak that system.

17 And we have another release -- we call
18 when we make major changes to the system a release -- that
19 will take place in December. And we feel like that that
20 will alleviate many of the issues that we're having today.
21 So, we do continue to update and tweak our eligibility
22 system to prevent any of those issues going forward.

23 DR. RILEY: I had an experience this
24 month where I was recouped from January of 2014. We had
25 seen a patient, treated a patient. And when our response

1 came from the -- with our Explanation of Benefits, it had
2 a different name on it. So, we advised the MCO back in
3 February of 2014 and forgot about it. Then, in May of
4 2015, I got a recoupment. And we're like, okay, how is
5 this our fault because we have a documented eligibility
6 for the patient with the name and the number.

7 In their investigation, they
8 determined that there were two people with the same
9 Social. Again, I ask how is that the dentist's fault?
10 So, those issues are still ending up on the provider's
11 doorstep as if the provider had done something wrong. The
12 solution to the system should be to fix the system, not
13 penalize the person who has done all the right steps as
14 outlined by DMS.

15 COMMISSIONER LEE: And if you -- after
16 the meeting, if you'd give me or you can email me -- I
17 know you have my email address, Dr. Riley -- that specific
18 example so we can look in the system and make sure that we
19 have fixed it or that we have looked at what caused that
20 duplication in the first place so that we can -- because
21 we want to clean it up in the system, too. I mean, if
22 you've worked it out with the MCO or not, that's between
23 you two. But we want to help by making our system as
24 accurate as it can be. So, if we can get that specific
25 example, we'd be more than happy to ---

1 DR. RILEY: So, each time, we need to
2 send the Department the specific examples?

3 COMMISSIONER LEE: Yeah. And, then,
4 that will help us identify or pinpoint what happened in
5 the system with that specific file.

6 DR. RILEY: Okay.

7 DR. PARTIN: We appreciate the
8 Department helping to smooth out these problems. But I
9 think that the issue still remains that the provider is
10 being required to refund money to the insurance company
11 and the provider did everything they were supposed to do.
12 So, from the provider's perspective, that patient was
13 eligible on that day. So, the providers are being
14 penalized for something that they don't have any control
15 over; and we don't think that that's right.

16 COMMISSIONER LEE: I completely
17 understand. And from the Department's viewpoint, we have
18 to make sure in the event of an audit going forward --
19 let's say, for example, that the Centers for Medicare and
20 Medicaid came in and audited our system and they looked at
21 that. Unless there's some kind of history or trail, we
22 just have to make sure that all of our records line up in
23 the system.

24 And if, for example, an individual
25 member, their eligibility is changed for some reason, the

1 MCO has received a capitation payment for that member.
2 The Department actually recoups that capitation payment
3 from the Managed Care Organization rather than letting
4 them keep that capitation payment. So, they try to clean
5 up their records, too. And we're just trying to make that
6 -- all of those processes and all of the records line up
7 with who actually got paid and things like that. So,
8 again, we understand how big of a hassle this is for
9 providers. It's also a hassle for the Department and the
10 Managed Care companies.

11 MS. BRANHAM: When do you get your
12 money back?

13 DR. PARTIN: We don't. We have to pay
14 the insurance company.

15 COMMISSIONER LEE: And, then, the new
16 Managed Care Organization. So, if an eligibility segment
17 is overwritten with one MCO, the new MCO would be
18 responsible. And going forward -- and we've heard -- in
19 the past, we've heard from our providers that one of the
20 biggest issues was retroactive eligibility and the fact
21 that they didn't a prior authorization for a service maybe
22 that required prior authorization. So, the new MCO was
23 giving them kind of issues about not getting the prior
24 authorization.

25 So, in our new contract in Section

1 27.8, we have included language in the new contract that
2 says the contractor is required to cover all medically-
3 necessary services provided to the member during the
4 retroactive coverage without a prior authorization. So,
5 that will help alleviate some of the issues related to the
6 retroactive eligibility.

7 DR. PARTIN: Okay, good. Thank you.
8 The next item is the Nursing TAC Recommendation on
9 Reimbursement Rate Changes and only part of the
10 recommendation was addressed. While it's understood that
11 the reimbursement rates are proprietary, it would seem
12 that changing rates from those posted on a past EOB and,
13 then, requesting a refund is not a matter of proprietary
14 rates. The provider must be able to accept in good faith
15 that the reimbursement posted by the MCOs is the correct
16 rate. The provider has no way of knowing otherwise. And
17 this part of the issue was not addressed by DMS. So, we
18 respectfully request that that part be addressed.

19 COMMISSIONER LEE: The issue is when
20 you get an EOB, it has one rate on it; and, then, the MCO
21 comes back and changes that rate?

22 DR. PARTIN: Yes.

23 COMMISSIONER LEE: I understand that.
24 Okay. Is that happening on a continuous basis, or was
25 there a specific time frame? I'm aware of a time frame

1 back in 2012 where some errors were on our fee schedules;
2 some rates were in error. And, then, the Department
3 actually changed those codes. And the Managed Care --
4 when we changed, when the Department changed the rates,
5 the Managed Care Organizations went back and changed the
6 rates. But that was for a very specific time period. But
7 you're saying this is ongoing?

8 DR. PARTIN: I may be referring back
9 to that period of time, but the providers are still
10 suffering from those refund requests because of the rate
11 change. And, so, I guess moving forward, we would request
12 that if at the time of service and when the reimbursement
13 was made and the amount paid was documented on the EOB,
14 that the MCOs not be able to go back retroactively and
15 reduce their fees and, then, tell the providers they have
16 to refund the company that money.

17 COMMISSIONER LEE: Is it one
18 particular MCO, or is it all MCOs that do that?

19 DR. PARTIN: I think -- I can't say
20 for sure which one.

21 COMMISSIONER LEE: Well, we can follow
22 up again. But your contract with the Managed Care
23 Organization should spell out those terms. And if they
24 change rates, there should be something spelled out in the
25 contract. But if it's one particular MCO and it's an

1 issue, I'd be more than happy to talk with you about that
2 one-on-one.

3 DR. PARTIN: Okay. I'll have to find
4 out more specifically because it was a general
5 recommendation from the TAC. Okay. Next item is the
6 limitation of Level 4 or 5 visits to two visits per
7 patient per year. And at the last meeting, DMS was going
8 to check about other states. And in the meantime, we have
9 checked with the American Association of Nurse
10 Practitioners; and they can't find any other states that
11 have that specific limitation. And, so, we feel that this
12 rule forces providers to down-code, which we're not
13 supposed to do. But if you don't do it, you can't get
14 paid at all.

15 COMMISSIONER LEE: We have looked into
16 it, and I think the Department does agree that the
17 limitation should at least be spelled out per member, per
18 provider rather than just per member for 12 months. So,
19 until the regulation is changed or amended and because of
20 audit trails, we'll go by what's in the regulation. But
21 the MCOs, of course, serve 90% of our population; and
22 they're free to provide more than those visits if they
23 deem it necessary and it meets medical necessity. They
24 can exceed that limit because the limit in the regulation
25 is specific to the fee-for-service members. And while the

1 MCOs have to abide by our regulations, they can do more.
2 And the Department would look at any of those claims that
3 they pay as encounterable claims.

4 DR. PARTIN: So, the Department is
5 looking at changing it to two visits per provider?

6 COMMISSIONER LEE: Per member or
7 provider per year.

8 DR. PARTIN: Which is still
9 problematic because a lot of our patients -- a lot of the
10 patients that I see have hypertension, COPD, diabetes.
11 That's a Level 4 visit, you know, when you're seeing that
12 patient that day. And particularly in rural areas, you
13 can't bring the patient back. You can't say, okay, today
14 we're going to deal with your diabetes; in two weeks,
15 we're going to deal with your high blood pressure; and,
16 then, in two more weeks, we're going to deal with your
17 COPD because there's transportation issues and other
18 problems. Patients aren't going to come back for those
19 things.

20 Plus, it would be more expensive if
21 you had them come back for three visits to treat three
22 problems. So, I think maybe -- that's a good step I think
23 in the right direction, but I think further consideration
24 should be given.

25 COMMISSIONER LEE: And when that

1 regulation is open and amended, then, there will be an
2 opportunity for public comment period to express your
3 additional concerns.

4 DR. PARTIN: Do you know when that's
5 going to be?

6 COMMISSIONER LEE: I do not at this
7 time. I have no idea. We have lots of regulations in the
8 hopper right now that we're working with. So, ---

9 DR. PARTIN: Okay.

10 COMMISSIONER LEE: --- it's something
11 that is on our radar, but I can't say that it's going to
12 be an immediate change.

13 DR. PARTIN: Okay. Well, I do
14 appreciate that the Department is looking at that and
15 recognizing that it's an issue. Just a second. I have to
16 make my notes. Okay, let's see. The report from DMS on
17 claims denied for well-child annual visit because the exam
18 was already done.

19 COMMISSIONER LEE: The Department did
20 start looking at claims and researching it, of course.
21 This was for a totally different reason. But what we have
22 discovered in our initial run from looking at claims is we
23 have identified something that we believe is a concern,
24 but it's not with the school-age children. It's with
25 children under the age of 15 months who appear to have

1 denied well-child visits. And since the Department's
2 policy relates to -- we deliver annual exams based on the
3 American Academy of Pediatrics Periodicity Schedule. And
4 those children under 15 months should have at least six
5 well-child visits in that first year.

6 So, that is one thing that jumped to
7 our attention that we would like to focus on is digging
8 deeper into that information, finding out what's going on,
9 looking in some very claim-specific detail to make sure
10 our children under 15 are receiving their well-child
11 visits on a routine basis and that they're not being
12 denied services. So, some of those are the ones that we'd
13 really like to dig into before the school-age children.

14 DR. PARTIN: Okay. So, you're going
15 to look at that first; but you may look at the other
16 later?

17 COMMISSIONER LEE: Yes, but the
18 15-month, like I said, when the Periodicity Schedule
19 outlines at least six well-child visits. And, right now,
20 we just have numbers. We don't have a lot of the denial
21 reasons. We do know that the children have had previous
22 well-child exams; but we haven't counted how many they had
23 before one was denied, what was the denial reason, was it
24 a duplicate claim, things like that that we need to search
25 -- research.

1 DR. PARTIN: And another thing that --
2 and I don't know how you measure this or collect that data
3 -- but, again, in order to get around this issue,
4 providers are using other diagnoses. They're doing the
5 well-child visits, but they're calling it something else.
6 And I don't know how you figure that out.

7 COMMISSIONER LEE: Well, that's an
8 issue then. Dr. Langefeld, would you like to address some
9 of those concerns?

10 DR. LANGEFELD: Well, obviously, as
11 you recognized, correct coding means that you're
12 appropriately applying both procedure-based codes as well
13 as ICD-9 diagnosis codes appropriately. I think once we
14 get into the data more and understand it there really -- I
15 mean, the Periodicity Schedule is the recommendation for
16 how often to do a complete, comprehensive exam. And, so,
17 what we don't want to promote is duplication of those if
18 they're, in fact, truly comprehensive exams. But at the
19 same time, we don't want to create a system that can be
20 gamed, where you need to do an exam and can't for whatever
21 reason. So, I think that's the reason we need to look at
22 the data more.

23 DR. PARTIN: Okay. But you understand
24 what I'm saying, though? You know that the child needs
25 that exam. They're supposed to have it. But you can't

1 get reimbursed for it. So, you do the exam; but you call
2 it something else.

3 DR. LANGEFELD: Yeah. So, part of the
4 question, though, is if they've actually had the exam but
5 they had the exam somewhere else and you don't have access
6 to it. Then, part of the answer to that is is there a way
7 we can create or support you being able to access that
8 more effectively. And, so, it's not just a
9 straightforward question. It's ---

10 DR. PARTIN: Right.

11 DR. LANGEFELD: --- how do we support
12 all of the resources. So, if it's been done somewhere
13 else, how do you have access to that. Can you access it
14 through the Information Exchange, for example; are there
15 other ways that you even know that it was done.

16 MS. ANGELUCCI: I have a question.

17 DR. PARTIN: Yes.

18 MS. ANGELUCCI: Just yesterday I took
19 my child, 16-year-old, to have her wellness checkup for
20 school and asked for the sports physical at the same time.
21 So, I got two pieces of paper; and I filled them all out.
22 They did nothing different. So, I'm trying to think why
23 can't we just merge the two forms and have the children
24 get checked out for once a year. They literally ran her
25 finger down her spine to make sure she didn't have

1 scoliosis, and they pricked her finger. They did nothing
2 as far as making her run a mile or anything like that.
3 So, it just makes parents have to go to the doctor twice
4 to take their kids; and, then, that second time they won't
5 get covered.

6 DR. PARTIN: The exams for school and
7 for sports are different.

8 MS. ANGELUCCI: Well, they weren't
9 yesterday. It was very, very simple.

10 DR. PARTIN: If you know that a child
11 is going to need a sports physical, then, you can do the
12 sports physical and that will count for the school
13 physical. Are you agreeing with me or no?

14 DR. LANGEFELD: What I would say is
15 this. If you have a complete, periodic exam, very
16 comprehensive exam, all of the components that you need
17 for this sports exam are part of that comprehensive exam,
18 which is what you experienced. The other fact is that
19 according to -- I guess the questions we've had, for
20 example, with the Kentucky High School Athletic
21 Association is that these exams are required not for each
22 sport but once a year for all sports for that individual.

23 So, again, part of this is how do we
24 get access to the information. But to your point and the
25 guidance by most organizations -- the American Academy of

1 Family Practice, the American Academy of Pediatrics -- all
2 the guidance around this says that sports physical
3 components can be extracted from a comprehensive physical
4 exam if done correctly during the year and, then, the form
5 completed. And that's really the essence of the whole
6 discussion around other physicals is that absolutely you
7 want to support that completion, but the other exams can
8 be completed with that information.

9 DR. PARTIN: Right. The sports
10 physical is just a little more detailed than the other
11 physical. For instance, with a school physical, we're not
12 going to have the child duck-walk, which is a new thing
13 that's been added to the sports physical. But if you do
14 the sports physical, then, it covers everything else.

15 MS. BRANHAM: I thought we were going
16 to get with the Kentucky Athletic Association to see what
17 we could glean from their requests versus the ---

18 COMMISSIONER LEE: We did contact the
19 Athletic Association -- Kentucky Athletic Association.
20 And they basically just said we require one physical per
21 year for the sports. We did ask if they had any sort of
22 program that would assist individuals who had lower income
23 to pay for the exam if they had to have a second one.
24 They did not have such a program. But the Department has
25 been in contact with them.

1 DR. PARTIN: So, I guess if we know
2 that they have to have that, we can ---

3 MS. ANGELUCCI: I'm just a simple
4 person. I think a child goes to -- if you're going to get
5 an exam once a year, just do it all at one time and go on.
6 I just don't see why you have to go back again. Whether
7 your child is playing sports or not, we should check them
8 out. A sport could just be kickball in recess or
9 something. It doesn't have to be an organized sport. My
10 child is going to play golf. So, it's not like it's a
11 physical sport. So, I'm just thinking why don't we just
12 converge -- make it easy on everybody. That's just my
13 thoughts.

14 DR. PARTIN: Okay. The last item is
15 the license verification. And in the last recommendations
16 from the Nursing TAC, the TAC requested DMS not to
17 automatically drop APRNs on November 1st as October 31st
18 is the date of the -- the deadline for relicensure but
19 provide a 30-day time period to allow APRNs to submit
20 their license renewal verification.

21 And, also, I have talked with KBN to
22 ask them if they would submit an electronic list. And
23 they're looking into whether or not they can do that. So,
24 if they could do that, they still would not be able to get
25 that list to DMS for DMS to review it by November 1st.

1 So, the second part of the recommendation was to ask for a
2 grace period to allow DMS to review the list from KBN if
3 they send it and not automatically block the providers on
4 the first.

5 COMMISSIONER LEE: And I apologize.
6 Veronica Cecil, who is the Director of Program Integrity
7 and Provider Enrollment, was unable to join us today. So,
8 I'm not prepared to speak to this. So, I will go back and
9 discuss that issue with her. And she may, Dr. Partin,
10 contact you just by email or telephone to discuss ---

11 DR. PARTIN: Okay.

12 COMMISSIONER LEE: --- some of those
13 issues.

14 DR. PARTIN: Okay. So, that's all of
15 our Old Business, unless anybody else can think of
16 something else that I missed. Okay. Then, the next item
17 is updates from the Commissioner.

18 COMMISSIONER LEE: We have just a
19 couple of updates. Of course, you know, we have issued an
20 MCO RFP. The responses were due on Friday. We do
21 anticipate having contracts in place on July 1st. That's
22 about all I can say about that right now.

23 And the other topic we'd like to talk
24 a little bit about is ICD-10. As we know, ICD-10
25 implementation is set to start October 1st of 2015. And

1 we are looking for providers to test, and we want to get
2 some idea -- we want to gauge the ability of the providers
3 to comply by October 1st. And in your binder in the
4 Miscellaneous tab, there is just a one-page document
5 talking about ICD-10 testing. It tells what providers can
6 do to be a beta tester, who they can contact and what they
7 will need. Because, again, ICD-10 is going to involve
8 some major changes come October 1st, 2015; and we want to
9 make sure that our providers are ready and that we're
10 giving them the information that they need to be ready.
11 So, that's one thing. If you could pass that along to
12 your provider groups or your associations to see if there
13 are some providers who would be willing test with us, that
14 would be great.

15 The other issue or topic that I would
16 like to talk a little bit about -- unless you have
17 questions about the ICD-10?

18 DR. PARTIN: I do have a question. I
19 was just trying to write down so I don't forget things.
20 Will DMS be ready? Because we've been counseled by our
21 billing companies -- and not just my own but others --
22 saying that you need to have a month or two of funds set
23 aside because reimbursement may be slowed up because of
24 this change.

25 COMMISSIONER LEE: Well, you know,

1 ICD-10 was supposed to have been implemented in 2014. And
2 we did not stop working on our system when the date was
3 pushed out. So, we do anticipate that we'll be fully
4 ready for ICD-10 on October 1st, 2015.

5 DR. PARTIN: Okay, great, great.

6 Thank you.

7 COMMISSIONER LEE: The other topic I'd
8 like to talk a little bit about is therapies;
9 specifically, physical therapy, occupational therapy and
10 speech therapy. So, prior to January the 1st of 2014, our
11 State Plan did not have a large -- those services weren't
12 spelled out specifically in the State Plan. For example,
13 occupational therapy was not covered in our State Plan.

14 Those services were provided to
15 individuals in Waivers by Waiver providers. Children were
16 receiving those therapies through the EPSDT benefit. And
17 beginning January the 1st of 2014, we included those
18 therapies in the State Plan, which means that providers
19 delivering those services must comply with the State Plan
20 requirements for providers. They would also get paid from
21 the fee schedule that is attached to the State Plan.

22 During the course of this time, we've
23 been meeting to get all those providers ready, get them
24 enrolled to deliver those services beginning July 1st of
25 2015, this year. We've heard from many of those providers

1 that deliver services to the Waiver population. The rates
2 attached to the State Plan are a little bit different than
3 what the Waiver providers are receiving now to deliver
4 services. They have some concerns about their ability to
5 continue to provide those services at the rates outlined
6 in the State Plan.

7 The Department has heard their
8 concerns. We are working with CMS right now to see if we
9 can develop some sort of rate schedule based on level of
10 care for the individual needs in order to continue to take
11 care of our Waiver members, because the last thing that we
12 want is any disruption in services. We are listening to
13 our providers. And, so, the letter that we sent that
14 specified those services beginning July 1st all those
15 therapy providers would have to meet the criteria in the
16 State Plan has been postponed.

17 As soon as we work something out with
18 CMS to get more information detailing what we can do going
19 forward, we will issue more provider guidance. But for
20 now, those therapy providers delivering services to Waiver
21 members can continue to provide and bill as they are today
22 until they have further information from the Department.

23 MS. BRANHAM: At the reimbursement
24 level of prior to, not the one ---

25 COMMISSIONER LEE: Yes.

1 MS. BRANHAM: --- attached to the
2 State Health Plan?

3 COMMISSIONER LEE: Yes. They will
4 receive the reimbursement that they are currently
5 receiving to provide those services. And, again, this is
6 for Waiver members only. It does not affect the therapies
7 that the Managed Care companies are delivering. It's for
8 our Waiver members. So, any Waiver member.

9 MS. BRANHAM: What about EPSDT?

10 COMMISSIONER LEE: If they're in a
11 Waiver and that ---

12 MS. BRANHAM: Okay.

13 COMMISSIONER LEE: --- Waiver provider
14 was billing under the EPSDT benefit, they will continue to
15 bill that same way for the Waiver member.

16 MS. BRANHAM: Okay. So, this brings
17 up a question we had at our Technical Advisory Meeting
18 yesterday. On the transition from EPSDT Special Services
19 under home health with a separate provider number, that
20 provider number goes away as of July 1. So, the
21 transition for getting those folks into either traditional
22 home health, following traditional home health rules, or
23 under outside therapies and those rates associated with
24 it. And MCOs, you know, they haven't posted their rates
25 as well. And we don't have any kind of training or

1 transition period or billing codes.

2 So, we see this -- is this whole thing
3 going to be on delay, Commissioner? Because that was one
4 of my questions today is, you know, the Special Services
5 -- EPSDT Special Services changes July 1. No provider
6 numbers for home health agencies. So, we don't have the
7 codes to bill EPSDT under. And MCOs are not ready for
8 those codes as well. So, what is the transition period
9 for all these kids because here's hundreds of kids in
10 these programs?

11 COMMISSIONER LEE: So, for Waiver
12 children, it's going to stay the same. For any child
13 that's in a Managed Care Organization, they should have
14 their fee schedule because we do have the therapy fee
15 schedules posted online with the rates associated for the
16 fee-for-service population. Of course, the Managed Care
17 companies can develop their own rates for those services;
18 but the fee schedules for Medicaid are posted online with
19 the codes and the rates.

20 But if it's a Waiver member, those
21 services will stay the same for now. So, if you have a
22 specific child, for example, that's receiving services
23 under EPSDT and it's a Managed Care Organization that
24 would be delivering those services, if that child is in
25 the Managed Care Organization, those rates and those codes

1 are posted online. But if it's a Waiver member, the
2 billing for those services for the Waivers will remain the
3 same as it is today and the rates.

4 MS. BRANHAM: Well, this was a large
5 part of our conversation yesterday. So, the MCOs said
6 they didn't have the codes to transition these or for us
7 to not have the provider number to bill EPSDT under.

8 COMMISSIONER LEE: So, if you have a
9 Managed Care child ---

10 MS. BRANHAM: Uh-huh (affirmative).

11 COMMISSIONER LEE: --- that's in a
12 Managed Care organization, you should be able to bill with
13 your home health number -- your traditional home health
14 number. The rates are posted -- or the codes are posted
15 on our website, on the Medicaid website, with the rates
16 for the fee-for-service population. Now, if the Managed
17 Care Organizations -- they can come up and speak to this
18 if they want to, but they should have all the codes and
19 corresponding rates that we've posted. If they develop
20 their own rates for those codes, then, ---

21 MS. BRANHAM: That was one of my
22 recommendations. So, we're going to be delayed if they're
23 under ---

24 COMMISSIONER LEE: The Waiver ---

25 MS. BRANHAM: --- Waiver.

1 COMMISSIONER LEE: Waiver only.

2 MS. BRANHAM: And will there be a
3 provider letter that goes out for this?

4 COMMISSIONER LEE: Yes. We had one
5 conversation with CMS earlier this week, and we're trying
6 to get as much information as we can. We don't want to
7 bombard our providers with letter after letter until we
8 have a good plan in place to say exactly what steps are
9 next.

10 MS. BRANHAM: Okay, thank you.

11 DR. PARTIN: Anything else?

12 COMMISSIONER LEE: I don't have
13 anything. But if you have any questions, I'd be more than
14 happy to address ---

15 MS. BRANHAM: I do. I have a couple
16 of recommendations. And I just will make them, and I
17 guess we'll follow up. This is just overall on the RFPs.
18 You know, they've been here on the RFPs for MCO -- they've
19 been here since November '11. And we've gone through a
20 lot of growing pains. And we're in a pretty good place
21 now compared to where we were then. But now that those
22 contracts are ready to be signed again, something you
23 addressed, Commissioner, I was glad to hear is about the
24 prior authorization that is in Section 21.14 that starts
25 January '16 and, then, the credentialing component which

1 is very good.

2 And I guess I would recommend --
3 something we're experiencing right now that makes me want
4 to recommend this is suddenly -- you can be a provider
5 with a Managed Care contract and suddenly, without any
6 conversation, it is changed to where you can't provide
7 services without a signed physician's order because
8 they've decided to change it.

9 And regulations in Kentucky allow for
10 verbal and telephone orders under our regulatory boards,
11 whether it's Nursing or Therapies, to receive verbal
12 orders. Just like they're in a hospital, you know, we
13 have them in the community provider world. And we're
14 having a delay in services because of a change that just
15 happened mid-air.

16 And my recommendation is that they're
17 not allowed to do those kinds of things when what has been
18 working under contract has been working for a period of
19 time. So, when you're looking to sign these contracts, I
20 would urge you to have some stipulation in there that, you
21 know, there has to be guidance and discussion with the
22 Cabinet if they want to change the component of delivering
23 services.

24 We discussed this very intently
25 yesterday at our TAC Meeting. But, I mean, the first

1 contracts that were put out, I mean, there's so many
2 loopholes you can drive buses through them. And I believe
3 you're going to be tidying up a lot of that, again, as
4 you've referred to today. But, you know, they should have
5 consequences when they do those kinds of things to
6 providers who are just trying to hum along and provide
7 care and provide the documentation and the request; and,
8 then, everything stops suddenly because they want
9 something different.

10 And if that's not been communicated by
11 them, then, we don't know that's what they want; and it
12 leaves patients without care. So, that would be -- and,
13 you know, of course, I'm speaking to the home health side;
14 but, you know, we do it in the home. And most of us are
15 electronic. And if we find a situation in a patient's
16 home and we need a prior authorization -- or we need to
17 prior authorize a visit because we need to come back
18 tomorrow because of a wound or because of administration
19 of antibiotic, we cannot have that signed order because
20 that staff member hasn't been back to the office to upload
21 or download or whatever. And we cannot always print that
22 off.

23 But we talked a little bit about that.
24 But, suddenly, this is happening; and it's been happening
25 for a couple of months. And we can't allow these kinds of

1 changes to happen that precludes providing care,
2 particularly in the home, or anywhere else.

3 DR. PARTIN: Yeah, I can see that. I
4 didn't know that was happening. But a lot of times, you
5 know, the home health nurse will call the clinic and say
6 this is what I've seen today. This is new; what do we
7 need to do; and you tell them what to do. But if they
8 have to get a signed order, you know, ---

9 MS. BRANHAM: To get that
10 authorization visit.

11 DR. PARTIN: --- to get that done,
12 that could take two days sometimes.

13 MS. BRANHAM: And CMS Conditions of
14 Participation, as well as the Office of Inspector General,
15 Kentucky has 21 days for an order to be signed --
16 generated and signed. So, I think that, you know, when we
17 look at and we read through the contracts, I mean, that's
18 all fine and dandy; but don't just suddenly say this has
19 to occur when it supersedes Conditions of Participation.

20 So, that's one of the recommendations
21 that I would make that we're running into in regards to
22 the new RFPs that were out there Friday. And when we have
23 issues that come along like it's not the provider's fault,
24 that relates to the fact that somebody else had -- or the
25 same person had the same Social Security number, but it's

1 always on the provider. It's not on who we've contracted
2 with in good faith and provided the service with in good
3 faith.

4 COMMISSIONER LEE: Thank you.

5 DR. PARTIN: I have one more question
6 about the ICD-10. If you do the beta testing, obviously,
7 you'll be using the ICD-10 coding. Will you also have to
8 submit the ICD-9 coding so you have to do it twice?

9 COMMISSIONER LEE: I'm not sure. I
10 can follow up with you on that. I would have to
11 double-check.

12 DR. RILEY: I've got a couple of
13 questions. You referred to specific sections of the new
14 contract. Does that exist online?

15 COMMISSIONER LEE: Yes, it does. It
16 was released with the -- it was attached to the RFP that
17 was released.

18 DR. RILEY: Is it in the CHFS website,
19 or is it a different website?

20 COMMISSIONER LEE: It was a different
21 website. It's the finance website.

22 DR. RILEY: Okay. And the second is
23 do you have a timeline for how long the dental regs will
24 be open?

25 COMMISSIONER LEE: Not at this time.

1 I know that we were finalizing those regs to get ready to
2 file. So, I can check on that; but I don't know exactly
3 where they are in the filing.

4 DR. RILEY: Okay. Thank you.

5 COMMISSIONER LEE: Uh-huh

6 (affirmative).

7 DR. PARTIN: Okay, thank you very
8 much. We'll move on to reports and recommendations from
9 the TACs. First off is Behavioral Health.

10 DR. SCHUSTER: I'm always glad to hear
11 that behavioral health is being talked about; and I
12 appreciate, Sharon, your sharing. Good morning. I'm
13 Sheila Schuster, serving as Chair of the Behavioral Health
14 TAC. We had our meeting on May 7th. All five of the
15 Medicaid MCOs and their behavioral health reps were in
16 attendance. In addition, four of our six TAC members were
17 present. We had members of the behavioral health
18 community and also folks from the Children's Health TAC
19 and others because of the presentation that was being
20 made.

21 We had staff from the Kentucky
22 Department for Medicaid Services, including the Medical
23 Director, Dr. John Langefeld, and representatives from the
24 Kentucky Department for Behavioral Health Developmental
25 and Intellectual Disabilities, including its Medical

1 Director, Dr. Allen Brenzel.

2 A copy of the recommendations that we
3 had made in November of '14, January and March of '15 were
4 disseminated and briefly reviewed. We had asked the MCOs
5 to come prepared to tell us about their Performance
6 Improvement Plan which has been assigned to them; and that
7 is in the area of psychotropic medications with children
8 and adolescents.

9 In response to a request from the
10 Behavioral Health TAC, Dr. John Langefeld and Dr. Allen
11 Brenzel made a presentation of their findings to-date.
12 And that's something you all may want them to do here to
13 the MAC because it is disturbing data is all I can say.

14 Fourteen percent of Kentucky children
15 had a prescription for at least one psychiatric medication
16 as compared with the national rate of 7% of children. The
17 increased number of prescriptions is particularly evident
18 in the data for Kentucky's foster children where the
19 Kentucky rate is 42% of foster children are on psychiatric
20 medications versus the national rate of 26%.

21 DR. PARTIN: Twenty-six percent of
22 foster children nationally?

23 DR. SCHUSTER: Of foster children
24 nationally, but in Kentucky 42%. And these are the kids
25 that are most at risk, as you know. My guess is, as a

1 child psychologist, is that they get moved. We've heard
2 of stories of kids being moved 20 and 30 and 40 times in
3 the course of a year. And as soon as there's a behavior
4 problem or some difficulty with sleeping -- you can
5 imagine how upsetting this is to a child.

6 The data is also very disturbing
7 because the FDA does not approve any of these medications
8 below the age of eight: and, yet, we have polypharmacy
9 with kids from zero to five years of age. So, more than
10 one psychiatric medication being prescribed. There also
11 is a high number of kids for whom there is no psychiatric
12 diagnosis; and, yet, they're on psychiatric medications.

13 So, the data that Dr. Brenzel and Dr.
14 Langefeld presented was -- as I say, was disturbing. I
15 mean, I'm delighted and I thank Dr. Langefeld because he's
16 really taken on this problem with the assistance of Dr.
17 Brenzel, who is both a pediatrician and a child
18 psychiatrist. But we have really got to get a handle on
19 this.

20 One of the parts of the study that's
21 interesting, they had four medical researchers from U of L
22 -- psychiatry, ER, pediatrician, and I'm not sure what the
23 specialty of the other -- maybe infectious medications --
24 are doing follow-up interviews with prescribers trying to
25 get at the why. Is it because we don't have resources?

1 Is it because there hasn't been appropriate education of
2 providers?

3 We know that most of the psychiatric
4 medications are not being prescribed by psychiatrists or
5 by psych mental health NPs. You know, we certainly have
6 had this discussion, I think, about resources and lack of
7 resources. Is there pressure from parents to get a quick
8 fix? Is there pressure from schools? We've heard this
9 over and over again. When I was in practice, never have
10 had prescriptive authority; never wanted it. You know, we
11 had a lot of schools saying your kid can't come back until
12 they're controlled by some medication. So, there are lots
13 of factors out there; and it's an area of great concern.

14 As you can imagine, there was a robust
15 question-and-answer period with those present with
16 concerns about the use of medications without FDA
17 approval, extensive use of polypharmacy, disproportionate
18 use of these medications with foster children, and the
19 concern of how many were being written without a
20 psychiatric diagnosis.

21 Dr. Brenzel's description, too young,
22 too much, too soon, too often, was echoed by those
23 present. The TAC thanked the presenters and asked for
24 follow-up from Drs. Langefeld and Brenzel and the U of L
25 research team as more data is gathered.

1 Each of the MCOs briefly discussed
2 their Performance Improvement Plan. And they are in the
3 first data-gathering stage. But I'm delighted that that's
4 a requirement now for all the MCOs to look at this issue.
5 Each of them is taking a somewhat different approach in
6 terms of how to address the problem once they have the
7 data in-hand. And, again, we asked for regular updates
8 from the MCOs on their studies.

9 Drs. Langefeld and Brenzel expressed
10 the hope that the approaches that the MCOs tried, -- they
11 described it as a kind of laboratory, if you will. You
12 know, once we know what the problem is, we're going to try
13 this approach, this approach and so forth. Would yield
14 models that could be applied across the Medicaid and KCHIP
15 population.

16 Two of the MCOs have provided the
17 Behavioral Health TAC with denials, discharge and
18 readmission data, which has been a persistent, as you
19 know, request for data on our part. And I got a third one
20 today. The data that's being reported to DMS is in terms
21 of claims. In other words, amounts of money paid, which
22 gives us no information. And, so, I appreciate the MCOs
23 stepping forward and saying we can actually give you the
24 data in terms of people; how many people were admitted,
25 how many were readmitted, how many were denied admission,

1 what was the average length of stay. And I think that
2 will get us much better information.

3 So, our recommendation is that the DMS
4 Dashboard of Data from the MCOs regarding length of stay,
5 percentage of denials, inpatient and outpatient for psych
6 hospitals, crisis stay units, PRTFs be reported by numbers
7 of persons in addition to the claims data. And we request
8 that the data be separated by children up to age 18 and
9 adults and be reported on a quarterly basis so we can
10 really follow this. This is where also the Children's
11 Health TAC is also very, very interested in that data for
12 kids and trying to find out what's happening with kids.

13 We had asked that Dr. Langefeld and
14 DMS staff update the MAC on super-utilizers, and that
15 happened today. We also continue to be concerned about
16 the documentation of integrated care. And, again,
17 behavioral health was included in the managed care
18 approach in the state so that there would be integrated
19 care. We don't think it's happening. Or if it's
20 happening, nobody seems to be able to know how to report
21 that data.

22 I would like to comment on the super-
23 utilizers. And, actually, Sharon did a great job of
24 anticipating what I was going to say. When our folks with
25 severe and persistent mental illness do not have access to

1 medication, bad things happen. And if you couple that
2 with the closing of the therapeutic rehab programs, -- the
3 TRPs we call them -- these folks not only are not on their
4 medications, they don't have anyplace to go to get the
5 support, the education, the camaraderie, quite frankly,
6 that they need.

7 There is a very productive, positive
8 thing. And Valerie Mudd, who is a member of our TAC, has
9 been instrumental in helping to establish a peer-run
10 center in Lexington. There are eight more of these
11 peer-run centers opening around the state. Some of them
12 have opened and even more are opening. And these do
13 become places where our consumers can go get some advice
14 from their Peer Support Specialists, get GED classes, get
15 tasks of daily living kinds of classes, and get support.

16 But people end up in the ER, as Dr.
17 Langefeld noted, for a variety of reasons; one of which is
18 because literally they have no other place to go when
19 something doesn't feel right. And, so, they end up there.

20 We also know that severe and
21 persistent mental illness is often highly correlated with
22 co-occurring substance use disorder. So, I would be
23 interested in looking at that data in terms of how many of
24 those are co-occurring and how many are kind of separated.
25 My guess is that most of the SUD, the substance use

1 disorders, are also co-occurring with mental illness where
2 people are off their meds and are self-medicating with
3 alcohol or other drugs.

4 The isolation and stigma prevents
5 people from having someplace to go and some group to
6 support them. And, again, I would remind you that people
7 with severe and persistent mental illness -- and this has
8 been documented over and over again -- die on average 25
9 years earlier than their same-age peers. So, if we don't
10 figure this out and get integrated care and get them the
11 physical care that they need, we're going to keep losing
12 people. And it's a terrible way to die. You're dying in
13 isolation with no support. And, you know, it's just very
14 sad. Any questions?

15 MS. BRANHAM: Dr. Schuster, what is
16 your recommendations for the MAC?

17 DR. SCHUSTER: Well, the
18 recommendation, again, I'm still struggling with what does
19 this integrated care look like and what are -- you know,
20 if the HEDIS measures aren't getting at that, then, let's
21 come up with something that ought to be reported on this
22 dashboard. I mean, I have not sensed that the MCOs are
23 opposed to it; but I think we're all out here struggling.
24 And we have this discussion over and over again at the
25 TAC, which I know the MCOs are like I can't believe we're

1 talking about this again.

2 I don't know what else to do with it
3 but to say how do we track folks that we know have a
4 severe and persistent mental illness and actually track
5 what kind of physical healthcare they're getting. And
6 part of it is co-location because our people are reluctant
7 to go anyplace else.

8 So, we're trying to get the regs in
9 place to implement House Bill 527 that was passed in 2014
10 to put a non-psychiatric physician or primary care
11 provider -- it could be a nurse practitioner -- in the
12 Comp Care Centers so that when I see you and I see your
13 blood pressure is out the wazoo or your blood sugar more
14 likely because of the medications, I can send you right
15 down the hall and not out to someplace else where you're
16 not going to go because you don't know the people. And
17 you may not be real welcome there because you're acting
18 strange.

19 So, I guess the two -- the constant
20 reporting, I think, we've got to keep our eye on the ball
21 in terms of these kids that are being -- and we don't know
22 what the long-range effect of that kind of medication is
23 on the developing brain. Pretty scary. And if they're
24 not getting the behavioral health services they need, why
25 not? We've got more providers out there. We've got more

1 resources.

2 It's a longer fix. I think it's a
3 better fix than medication. In fact, I think medication
4 should never be given for a psychiatric problem without
5 therapy along with it. All the research shows that's that
6 the most effective approach. So, I guess it's the
7 constant monitoring. I don't know what else to recommend
8 to the MAC.

9 DR. PARTIN: Well, you said you
10 recommended that you wanted the data in people instead of
11 claims.

12 DR. SCHUSTER: Yes, the data in
13 people. You know, when you get this ---

14 MS. BRANHAM: --- behavior health in
15 terms of people, not just numbers. And you have three of
16 the MCOs have given you some data.

17 DR. SCHUSTER: Yes, and the other two
18 have told me that they're going to do that. So, we ---

19 MS. BRANHAM: So, we can make the
20 recommendation; but we don't have a quorum. But we can
21 put it on the table that the DMS data report the number of
22 persons and they're separated out of age 18 and it's
23 reported quarterly?

24 DR. SCHUSTER: Right.

25 MS. BRANHAM: Okay. Then, what about

1 this lack of integrated care?

2 DR. SCHUSTER: Well, I would like to
3 sit down -- and I know Dr. Langefeld meets with the
4 Medical Directors of the MCOs. And maybe I'm just dense,
5 but I have yet to figure out how DMS is monitoring that
6 there's integrated care going on and if there are measures
7 that we ought to be able to know. But when I talk to the
8 MCOs and some of them had little PIPs -- Performance
9 Improvement Projects -- about small numbers, but I'm still
10 trying to figure out what is it that we're looking at.

11 You know, there aren't bazillions of
12 people that have an SPMI, a severe and persistent mental
13 illness. We can't track them through the system? I don't
14 get it. I don't want to put a homing device on them, but
15 I'd sure like to know what happens to them on a day-to-day
16 basis when they have physical health needs. We don't want
17 them to show up at the ER. But who's addressing those
18 physical health needs?

19 MS. BRANHAM: Well, that's why we have
20 the super-utilizers on there.

21 DR. SCHUSTER: It may be.

22 MS. BRANHAM: So, how can we track
23 this lack of integrated care? How can the Cabinet give
24 the information to the MCOs, make it a component of what
25 needs to be provided so that we can, really, it looks

1 I like, you know, cut in to a -- or break the circle.

2 DR. SCHUSTER: Right. And we call
3 that circle -- we typically call it the revolving door,
4 which is the circle in and out of the psych hospital.

5 MS. BRANHAM: Right.

6 DR. SCHUSTER: So, now the label is
7 super-utilizers.

8 MS. BRANHAM: Okay.

9 DR. SCHUSTER: Not necessarily a bad
10 thing or a good thing. But how do we get a-hold of those
11 people and really get them all of the care that they need?

12 MS. BRANHAM: Dr. Langefeld or,
13 Commissioner, do you have any suggestions that we can make
14 today that we can give from the Cabinet -- your behalf in
15 the Cabinet to the MCOs and let's try to -- it's been --
16 this has been a constant theme since '11, I know.

17 DR. SCHUSTER: And, as I say, there
18 may be things that are happening out there that ---

19 MS. BRANHAM: Well, we all need to
20 know what they are. Otherwise, we can't improve anything.

21 DR. SCHUSTER: The TAC does not have
22 its arms around it is all I can say.

23 DR. LANGEFELD: Absolutely. I
24 appreciate the comments. And it reflects what all of us
25 have been struggling with. And there's no doubt that we

1 have to understand our population as holistically as
2 possible and, then, be able to respond to those needs.
3 And part of this has to do with data and getting as
4 complete data as possible and, then, using that in an
5 effective way.

6 Some of the challenges with that, for
7 example, we have historically -- a lot of our care,
8 particularly around severe and persistent mental illness,
9 has come through our CMHCs.

10 DR. SCHUSTER: Right.

11 DR. LANGEFELD: Right. And that care
12 had been delivered in a different way from a billing
13 standpoint. So, a lot of those services had not been part
14 of the State Plan. They hadn't been billable as a claim
15 -- traditional claim. And the designation of SED/SMI, for
16 example, as an evaluation. It's an important evaluation
17 with that designation. It also is not a -- it is not a
18 data point like a combination of claims in ICD-9.

19 So, part of this is as we move forward
20 -- and now CMHCs, for example, are billing because these
21 are State-Plan-covered services -- we can begin to take
22 that information and incorporate it into a more holistic
23 view. And we are actively developing a dashboard that
24 will look at as many -- you know, pharmacy, oral health,
25 behavioral health services generally. And, so, that's

1 something we're actively working on. And I would welcome
2 your input into that.

3 The other thing is that in behavioral
4 health, you know, one of the challenges is around what
5 metrics do we use to measure.

6 DR. SCHUSTER: Right.

7 DR. LANGEFELD: There's been a paucity
8 of what we call quality metrics that reflect behavioral
9 health care, period, whether it's HEDIS or any other
10 metric system. And, so, we're actively looking and
11 actually working with a lot of groups locally and
12 nationally about what some of those things are, what do
13 they look like, how do they reflect what we actually want
14 to measure as far as outcomes, not just process metrics.
15 And, so, we welcome your continued input with that and
16 active involvement.

17 DR. SCHUSTER: And my continued
18 questions pestering ---

19 DR. LANGEFELD: And continued
20 questions.

21 DR. SCHUSTER: Is it possible for --
22 and I don't know what the forum would be. We've got good
23 representation on the Behavioral Health TAC across brain
24 injury, SPMI and so forth. To sit down with you and
25 whomever to really drill down on some of these things?

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DR. LANGEFELD: Sure.

DR. SCHUSTER: Because I feel like we keep asking these questions and we keep coming here and asking them. And, then, I'm never quite sure ---

MS. BRANHAM: And never get anywhere.

DR. LANGEFELD: The other thing I'll put a plug in for -- because, again, when we're talking about Kentucky, ---

DR. SCHUSTER: Right.

DR. LANGEFELD: --- I know this is a Medicaid forum -- but Kentucky is more than just Medicaid; and there are people that come on and off. And when we deal with these issues, we want to deal with them at a community level and an individual level. So, the other initiative that I think you've participated in and ---

DR. SCHUSTER: I sat in the front row.

DR. LANGEFELD: --- is the State Innovation Model Design. And one of the workgroups -- one of the five workgroups is actually around quality metrics and what are the quality metrics we need to develop and use at a population basis in Kentucky.

DR. SCHUSTER: And one of those is on integrated care.

DR. LANGEFELD: Absolutely.

DR. SCHUSTER: So, I go to a lot ---

1 DR. LANGEFELD: Integrated coordinated
2 care is ---

3 DR. SCHUSTER: --- of those; and I sit
4 in the front row; and I keep reminding them that
5 behavioral health and Raynor Mullins keeps reminding them
6 that oral health needs to be included.

7 DR. LANGEFELD: Absolutely.

8 DR. SCHUSTER: Okay, thank you.

9 DR. PARTIN: Thank you very much.

10 Children's Health.

11 MS. GRIESHOP-GOODWIN: Hello, good
12 morning. Tara Grieshop-Goodwin with the Children's Health
13 TAC. We met on May 13th, and we had DMS staff in
14 attendance and representatives from all the MCOs and most
15 of our members as well. Before I jump into what we
16 discussed at the meeting, I would just add that integrated
17 care is an issue of interest, I know, for a lot of the
18 members of the Children's Health TAC as well. Not
19 specifically with that population that Dr. Schuster
20 described but more broadly. We are one of the TACs that
21 has representatives from a number of the different groups
22 on our committee.

23 So, at our May meeting, we heard
24 information from a lot of the MCOs -- from every one of
25 the MCOs, actually, about behavioral health claims and,

1 actually behavioral health data on issues like length of
2 stay, rehospitalizations, and the use of psychotropic
3 meds. We are going to be hearing from Dr. Langefeld in
4 July. He's going to come and share the presentation that
5 was given to the Behavioral Health TAC with our TAC as
6 well. We're grateful for his time for that and look
7 forward to that discussion.

8 We also spent a good deal of time
9 talking about dental data and focused much of that on
10 denials of services and had some conversations about
11 possibly collecting more information from providers on
12 forms so that MCOs would have more information before
13 making the determination on whether to approve or deny a
14 service to try and address some of the denials that are
15 occurring. So, that is slated for our July meeting as
16 well.

17 Finally, we've been talking about data
18 for a number of months as well. And I don't have a
19 recommendation today because we have gotten another
20 commitment from Medicaid staff to try and work with us on
21 getting the data broken out for children under 18 on a
22 number of the indicators that we haven't been able to
23 secure so far. So, I hope that that continues to move
24 forward and that we are able to secure that information
25 since a lot of the reports that are standard reports are

1 for the entire population. We've been very grateful to
2 the MCOs to provide that detailed information on children
3 when we've asked for it, though.

4 So, that is what we have been
5 covering. And we are going to be addressing behavioral
6 health more fully and dental in our next meeting.

7 DR. PARTIN: Great, thank you. I'll
8 look forward to hearing about that.

9 MS. GRIESHOP-GOODWIN: Thank you.

10 DR. PARTIN: Consumer Rights and
11 Client Needs. Dental.

12 DR. RILEY: The Dental TAC has not met
13 since the last MAC meeting. So, there is no report. We
14 have people working on -- a couple of workgroups regarding
15 the change in the dental regs.

16 DR. PARTIN: Thank you. Nursing Home.
17 Home Health.

18 MS. BRANHAM: Okay. We had our
19 Technical Advisory Meeting yesterday. And some of the
20 take-aways I've addressed a little bit earlier on the new
21 RFP contract when they're signed about the changes for
22 signed orders. And we discussed also EPSDT Special
23 Services, which we had some concern about the transition.
24 And now that's informed today of the delay.

25 Then, the other thing that we have

1 going on that has all providers somewhat anticipatory of
2 what changes are going to occur is with Home- and
3 Community-Based changes, as well as MWMA changes. And,
4 yesterday, Tanya Wells came to the TAC; and Lynn was there
5 -- Lynn Flynn was there as well. And we talked a little
6 bit about the processes and getting people before July 1
7 reassessed in those; after July 1, how it's going to
8 occur.

9 But I really have given this some
10 consideration through the evening last night. And I
11 understand that Kentucky is not consistent with
12 conflict-free case management, and this is why we're
13 moving to conflict-free case management which is part of
14 the MWMA. But, also, the conversation for well over a
15 year now has evolved around the nursing home budgets and
16 people getting care appropriately rather than having to go
17 to the nursing home to get the care. Because in order to
18 qualify for the Waiver Services, you have to have level of
19 cares that are deficient that would qualify you for Waiver
20 Services.

21 And we've had conversations around
22 what, then, can we do so that when a patient is discharged
23 from a facility, i.e., an acute-care facility, then, how
24 can they receive the services so they can go directly home
25 rather than to a facility. And yesterday it was brought

1 to our attention that there's going to be a couple of
2 different levels that are going to occur on this Waiver
3 component, which I see on the MMMA side, which I see is
4 not going to expedite that care.

5 So, working closely with Commissioner
6 Anderson and Lynn yesterday and, as I said, I see some
7 issues that are coming to light as we're moving in and
8 gearing up for July 1 and the changes that revolve around
9 this. So, I do urge the Cabinet and Dale to look very
10 closely and monitor how these kinds of already written in
11 time lines on approval of services are going to affect
12 what they thought was going to be this smooth transition
13 and getting somebody in the home and getting them cared
14 for.

15 The other component of that is, you
16 know, it's been opened up to other providers. We're
17 outside of Certificate of Need. And there's been, you
18 know, the Area Development Districts and adult day, home
19 health. And Public Health Departments have been recruited
20 to do case management and those kinds of things. But one
21 of the components of care is what used to be called
22 personal care and minor housekeeping and those kinds of
23 things and, now, an additional component involved in that
24 that keeps patients home is the ability to go to the
25 grocery or to go to doctor's appointments and those kinds

1 of things.

2 And I know in rural areas, we have
3 transportation issues. And part of the reimbursement per
4 day of someone receiving the services would involve them
5 getting in the vehicle with a person 18 or older,
6 non-certified, and then transporting them to do this. And
7 I really think that this is going to be a hindrance to
8 those services that could be provided a different way.
9 So, I urge the Cabinet to look closely at how this lays
10 out -- how it's laid out. We're going to start it. And,
11 really, you know, black-and-white is one thing; but doing
12 it is another. So, I think we might have bigger holes
13 than we do now. And I have some great concerns about
14 this. And I made my recommendation earlier about the RFPs
15 and those kinds of things.

16 DR. PARTIN: Thank you. Hospital
17 Care. Intellectual and Developmental Disabilities.

18 MS. DEMPSEY: Hello. I'm Patty
19 Dempsey with the Kentucky statewide advocacy organization
20 and member of the IDD TAC group. We don't have any new
21 recommendations for today, but I do want to report that we
22 did meet. Our TAC group met on May the 16th, much to
23 everybody's dismay for two-and-a-half hours; but it was a
24 very informative meeting. Like I say, we don't have any
25 new recommendations; but we still -- and I'm probably

1 going to sound like a broken record here. We did revisi t
2 our recommendations that we had made previously because
3 there are lingering issues that are continuing as new
4 Waivers are written, and we're in the middle of the
5 rewrite for the Supports for Community Living Waiver
6 that's right now in the 30-day response period. It
7 actually ends today.

8 And there's pi eces on sel f-di rected
9 servi ces or parti cipant-di rected servi ces that are
10 actually in the new Waiver that are some problems that are
11 in the current Waiver already. And that being -- and this
12 is where I'm going to sound like a broken record here --
13 and that's where people that want to parti cipant-di rect
14 their servi ces -- some people cannot do that because of
15 the process that they have to go through to be able to do
16 that.

17 First of all, there's a MAP 532 that
18 has to be done -- that has to be completed if it's an
19 immediate family member. Those forms can be denied.
20 They're denied twice. A person can apply twice. If
21 they're denied twice, they have to go through an appeal
22 process which involves costs to get through that whole
23 process and actually can be loss of servi ces that people
24 are getting.

25 The other thing is people that are

1 self-directing their services that are participant-
2 directed, there's a Supports for Community Living Waiver
3 currently which is probably about 200 people, which is a
4 small number, are having to pay an unfunded mandate for
5 hiring employees. So, for the background checks that are
6 required through the Waiver process or through the
7 regulations -- for the background checks and for training,
8 that can cost -- that costs the person that's doing the
9 hiring that's receiving the services -- that's out-of-
10 pocket money because it cannot be in a person's budget
11 paid by Medicaid. So, that's a continuing concern that we
12 have. Don't have a solution for that yet, but that's
13 continuing.

14 The other thing that we looked at,
15 too, was we had also made in our original recommendation
16 an assessment tool for children that are actually
17 receiving Michelle P. Waiver Services that there be some
18 sort of assessment tool; a separate individual's tool for
19 that.

20 We did hear in our meeting because --
21 actually, there was several people there. There was the
22 Department for Medicaid Services, the Department for
23 Behavioral Health, the Department for Aging and
24 Independent Living. And we did have a lot of questions;
25 so, we did get some answers. And, actually, Division of

1 Community Alternatives Branch out of Medicaid and the
2 Division of Program Quality and Outcomes. So, we did have
3 a lengthy discussion; because, like I say, in the middle
4 of the Waiver rewrites, we did have some concerns. So, we
5 did have a lot of questions.

6 On the assessment tool, we did hear
7 that on the Home- and Community-Based Waiver that involves
8 people that are aging and children with special needs,
9 that on that Waiver rewrite, there is an assessment tool
10 being looked at by the Department for Medicaid Services;
11 an assessment tool that possibly could be an assessment
12 tool for children; and that Medicaid may look at that for
13 the other Waivers as well. So, we were pleased to hear
14 that.

15 The other issue that we had is another
16 that's been discussed was the EPSDT services because a lot
17 of children were receiving therapy service through
18 Michelle P. Waiver Services and through the EPSDT Program.
19 And with that being switched over to the state -- to the
20 State Medicaid Program, there looked like there was going
21 to be some families that were without therapy services.

22 So, we did hear, too, about the
23 Deloitte online reporting system that's actually -- it's
24 our understanding that providers -- through the Waiver
25 Programs, providers have received training on. And we did

1 ask about if that's -- if families are going to have to
2 also go through that process. And, so, at our next
3 meeting that will be held in the near future, we've
4 invited someone from Deloitte or the Department of
5 Medicaid is going to have someone from Deloitte to attend
6 our meeting. So, we do have a request on that.

7 Some of the other issues that we had
8 was we had requested an update on the final rule. And,
9 so, we were able to get information on the final rule as
10 it also impacts the Waiver Programs, the Supports for
11 Community Living Programs, and the Michelle P. Waivers.
12 And we had requested -- family groups had requested that
13 the Department for Medicaid Services and the Department
14 for Behavioral Health actually attend some of those
15 meetings and let family members and self-advocates know
16 about -- kind of more information on what was going on
17 with those programs from across the state. And those
18 meetings did happen, and we thank the Department of
19 Medicaid and the Department for Behavioral Services for
20 actually attending those meetings. Actually, I think that
21 that's pretty much it. I think that's it.

22 DR. PARTIN: Okay. Well, thank you
23 very much.

24 MS. DEMPSEY: You're very welcome. No
25 questions?

1 DR. RILEY: Have you received a
2 response from DMS on your previous recommendations?

3 MS. DEMPSEY: We did. We did. And
4 thank you and the Department of Medicaid very much. We
5 did receive a response. And, unfortunately, it wasn't the
6 news that we wanted to hear; but we did get a response.
7 And we thank the Department of Medicaid very much for
8 that. But they are continuing issues. So, yeah. So,
9 thank you.

10 MS. BRANHAM: I have one comment.
11 Lynn, are these -- in PDS-directed services, are their
12 time sheets going to be submitted electronically for their
13 services?

14 MS. FLYNN: In the future, they will
15 be. I'm actually being told that by the lady sitting to
16 my left. I guess it will be the December release?

17 AUDIENCE: Yeah, in the December
18 release.

19 MS. BRANHAM: Well, you know, the PDS
20 services that they're talking about -- you know, that
21 criminal background check, the CPR certification, and any
22 trainings that they have, which would involve how do they
23 submit their time sheets -- probably ought to be something
24 that these folks have addressed to them individually
25 rather than as part of a bigger group, like a provider

1 under these public forums that you all have.

2 And, then, they probably need to know
3 about the fiduciary component that relates to that on who
4 has the ability to disperse their checks. So, I know
5 under this TAC group, that's where most of these
6 components would affect them. And it doesn't sound like
7 they have all the answers that they need just yet.

8 MS. DEMPSEY: Well, actually they
9 don't. I don't think the family -- I think family members
10 and people that are actually participating in the
11 participant-directed services, I don't think they have --
12 that's a concern that we are hearing; that they heard
13 about the online services for participant-directed
14 services from the providers, but they personally have not
15 gotten the information.

16 MS. FLYNN: I think there's a training
17 plan, and it's phased in time. And I think that that's
18 going to be prior to when they actually have access to
19 that service. I'm sorry. I'm just talking from the
20 audience.

21 MS. DEMPSEY: I think maybe that the
22 response was maybe for that plan for families members and
23 stuff -- advocates to get the information. Leslie, was it
24 like December?

25 LESLIE: I thought it was prior. I

1 want to say November.

2 MS. DEMPSEY: November or December?

3 MS. FLYNN: Prior to the release,
4 yeah.

5 MS. DEMPSEY: Prior to, okay. Thank
6 you. Yeah. Well, that was some of the concerns we were
7 getting from some of the family members. So, we did have
8 a lengthy TAC meeting. It was an informative meeting.

9 MS. BRANHAM: It sounds like you need
10 more information.

11 MS. DEMPSEY: We do need more ---

12 MS. BRANHAM: Well before ---

13 MS. DEMPSEY: --- information.

14 MS. BRANHAM: --- November to December
15 transition.

16 MS. DEMPSEY: Yeah, and I don't think
17 there's ---

18 MS. BRANHAM: Maybe you can contact
19 the (inaudible) Commissioner's Office and talk to them
20 about a training because those folks ought to be easily
21 identifiable that are consumer-directed which are not
22 switching to personal -directed services.

23 MS. DEMPSEY: Yeah. And one of the
24 big -- one of the issues right now with participant-
25 directed services right now through the Supports for

1 Community Living Program, that's probably 200 people. If
2 the Michelle P. Waiver and other Waivers actually end up
3 going to participant-directed services instead of
4 consumer-directed services, that's a lot of people. That
5 will be a lot of people. So, like you said, don't have
6 all the information, yeah, or don't -- they'll have some
7 of the information they need, especially with some of it
8 being streamlined online. Yeah; pretty much, yeah. Thank
9 you.

10 DR. PARTIN: Thank you. The Nursing
11 TAC did not meet. Optometric Care.

12 DR. WATKINS: Well, for the first time
13 in -- the Optometric TAC finally did meet. And we
14 gathered several of our members, many of us driving from
15 two to three hours from different ends of the state. So,
16 we did have a lengthy TAC meeting as well. And we opened
17 it up to the public; although, none of the MAC members
18 joined us. We did not make a personal invitation to them.
19 We just posted it on the website. So, next time we will
20 make sure that they are aware.

21 We've already posted when the next
22 meeting is going to be. And we are having it at the
23 Transportation Department so we'll make sure we have
24 plenty of room for all of the MCOs as well as their
25 subcontractors to have room to join us there because I'm

1 sure that will be a lengthy meeting as well because we
2 found that there were several discrepancies on things that
3 we were being told by the different MCOs, as many of the
4 doctors voiced at that meeting.

5 You'll find in your notes today the
6 minutes from our meeting there. We try to be as brief on
7 those as possible. And I'll go over with you the
8 recommendations that we had. We are just asking that the
9 MCOs try to give us their take in written form since the
10 doctors were telling us that they were receiving different
11 answers from the MCOs.

12 The Optometric TAC would request that
13 Medicaid receive confirmation that the MCO vision
14 subcontractors -- that they are following CPT guideline
15 definitions for coding. In an audit, the provider would
16 be held to CPT. So, we are making sure that the
17 subcontractors are also doing that. We are finding that
18 when we file for a code that we have performed, say, an
19 office visit and a visual field, which tests a person's
20 peripheral vision, or if we file for an office visit and a
21 photograph of the inside of the eye -- what we call a
22 (inaudible) photo -- the subcontractor might tell us that
23 is included in an office visit. It's lumped together.

24 CPT does not define it that way. But
25 the subcontractor is telling us, oh, yes, you would

1 normally do that in that office visit. So, it's just one
2 code. That's all we're going to pay you for. So, it's
3 like they're setting their own definitions for CPT. And
4 by an audit, we would not be held to those definitions.
5 So, we are asking for confirmation that the MCO and their
6 subcontractors are being held to CPT.

7 The Optometric TAC would request that
8 Medicaid ask all MCO vision subcontractors of a provider
9 -- how are they supposed to bill their cataract co-
10 management. When an ophthalmologist performs cataract
11 surgery, oftentimes they allow the optometrist to take
12 over the follow-ups of the cataract surgery afterwards.
13 So, they bill only maybe the first day after cataract
14 surgery. And the rest of those office visits after
15 cataract surgery, the optometrist is allowed to bill.

16 And we need to know how that is to be
17 billed. Is it to be billed to the medical MCO, or is it
18 to be billed to their subcontractor? Are they wanting us
19 to use the modifier at the end or not? And we're getting
20 different answers from different MCOs and different
21 subcontractors, and we need to have that in writing so our
22 providers know what to do.

23 The Optometric TAC would also request
24 the Department receive a list of any codes that need to be
25 billed directly to the MCO instead of the vision

1 subcontractors. And we also would ask do the
2 ophthalmologists bill the exact, same way on that code if
3 it's a code that is found in the vision fee schedule.
4 This is in reference to if the ophthalmologist sells
5 eyeglasses, if they do refractions, meaning the tests that
6 we say which is better, one or two, this is not. And,
7 also, too, if they do surgeries.

8 As an optometrist, I can pluck an
9 eyelash from your eye if you have an eyelash that is
10 turned inwards to your eye. That's considered -- that's a
11 surgery code. I get paid for that. So does an
12 ophthalmologist. And if you get a foreign body in your
13 eye, if you get a piece of metal in your eye, that's a
14 surgery code. I get paid for that and so do they.
15 Typically, that code is paid the same across the board by
16 any insurance company coming and going; and we bill it the
17 same. And we are just trying to make sure that they know
18 how to bill it and we know how to bill it and who you bill
19 it to and to make sure we're all getting the same answers.

20 The Optometric TAC would request that
21 Medicaid receive confirmation that (inaudible) vision
22 subcontractors that they are following the Medicaid vision
23 fee schedule service of routine exams of one exam per
24 provider per year. I know you've heard this from me 100
25 times. We're still not getting it done, people. We're

1 still getting denials; and it's still happening that even
2 though it's been -- it's on the website, the reg is there,
3 we're still getting denials. We want to make sure that
4 they're paying it correctly.

5 The Optometric TAC would request that
6 Medicaid receive explanation from all MCO vision
7 subcontractors that they -- on how to apply for prior
8 authorization and how it's requested and what it's
9 requested for and also how to bill as a (inaudible) claim.

10 And we already heard from Lisa on --
11 you know, about the preauthorization forms that we're
12 going to be having for medicines. And the prior
13 authorization that we're referring to here is on where
14 we're running into that on certain tests that we do. Some
15 of the subcontractors are telling us that we need a prior
16 authorization in order to do that visual field or in order
17 to do that photo. Other companies are telling us, no,
18 you're the doctor; if you think they need it, do it.

19 And I'm telling you right now, the
20 reason that they came out with these five different MCOs
21 was to provide choices to the constituents. But what
22 you're going to come up against is, people, we're not
23 going to have choices when it comes to providers if they
24 keep it up. Because I'm hearing from the doctors that I'm
25 working with we're not going to be able to put up with

1 this.

2 I'm working in a small town in
3 Southern Kentucky. There are two optometrists in that
4 town. Well, my office, I have another doctor that works
5 with me two-and-a-half days a week. There's another
6 optometrist in that town that's there two days a week.
7 That other optometrist in that town has quit taking all
8 Medicaid. They are calling my office everyday making
9 appointments for their patients to come see me because I'm
10 the only doctor in the town now that takes any Medicaid of
11 any kind. And, currently, I take every kind there is.

12 I was already taking 40% of the
13 patients in my office. Medicaid. Okay? How much time do
14 I have to see other patients if the amount of Medicaid
15 keeps going up and up and up and up. And I can't make it
16 on just seeing Medicaid alone. When you're having to hire
17 an extra staff person just to keep straight, oh, hey, is
18 this one a prior auth or not and, then, have I already --
19 you know, I'm going to have to go online with eyeQuest to
20 file for this person's glasses; and I'm going to have to
21 go on a Visa to file for this person's glasses because I
22 can't file it directly through the WellCare site. I'm
23 going to have to go over here to file on CareSource.

24 And I'm hearing this from doctors
25 everyday. So, this doctor is choosing that they're just

1 going to take WellCare or this person is not going to take
2 Medicaid at all. So, you're not giving the constituents
3 more choices of providers. It's not working. You're
4 doing nothing but giving them less choices and giving the
5 providers more headaches. I think you're doing nothing
6 but shutting doors.

7 I'll continue to help out anyway I
8 can. And the optometrists will take this up with all of
9 the MCOs at our next meeting, which will be at the
10 Transportation Cabinet on July 16th at 1 p.m.

11 DR. PARTIN: Any questions? Okay.
12 Pharmacy TAC.

13 MR. ARNOLD: Good morning. My name is
14 Jack Arnold, and I'm a practicing pharmacist in the State
15 of Kentucky. And I'm here to introduce the new Pharmacy
16 TAC. The Kentucky Pharmacy Association recently appointed
17 five members from the Pharmacy Association to serve on
18 this advisory committee; a long-term-care pharmacist, a
19 340B pharmacist who works with access -- rural access
20 clinics, an educator and a hospital pharmacist, a chain
21 pharmacist who deals with patient education, and an
22 independent, community pharmacist. So, we have five
23 pharmacists from throughout Kentucky.

24 We had our orientation session on
25 Friday, May 15th, about two weeks ago, at the Kentucky

1 Pharmacy Association offices and had a very good
2 conversation, by the way, with both our pharmacy
3 representatives from the Managed Care Organizations as
4 well as DMS. And the tenor of the conversation dealt with
5 a lot of issues that we heard today.

6 I heard Ms. Schuster talk about 42% of
7 foster children on psychotropics. And we've heard the
8 issue of non-compliance. And it really was a very
9 constructive meeting, talking about the pharmacist's
10 involvement and the need of the pharmacist's involvement.
11 If you think back to years ago when you'd go to your
12 corner drug store and walk up to the pharmacist and many
13 times you would call him "Doc" and say, hey, I've got an
14 issue with my child or I've an issue here or I've got an
15 issue there, I don't feel good. So, the modern term for
16 that is called pharmaceutical care.

17 You know, today the Colleges of
18 Pharmacy put out pharmacists; and they have been for
19 several years. It's not just a dispensing practice. It's
20 really about the pharmaceutical care for your patient,
21 your friend in the community that you're caring for.

22 And along that way, by the way,
23 federally they're looking at giving the pharmacists what's
24 called provider status through the Medicare Program, to
25 use their advice and counsel as educators. So, we did

1 have an excellent meeting. We had good input with
2 representatives from all the Managed Care Organizations.
3 And, again, Samantha McKinley was a very significant
4 contributor from DMS with our discussions.

5 So, Dr. Langefeld, I wanted to comment
6 also. In our discussion, we did talk a bit about the
7 Kentucky Healthcare Transformation Grant, the State
8 Innovative Model. I think as you correctly pointed out
9 it's a volume to value; going from just having medicine as
10 volume to what's the value. And pharmacy -- our point,
11 and it was well-received by everyone in the room -- it's
12 not just a commodity business. It's really a business
13 about dispensing, education with the medicine, which
14 strives to deliver compliance.

15 It's been said that up to 10% of the
16 hospital admissions are a result of drug non-compliance.
17 It may be higher in Kentucky. It's also been said that up
18 to almost 50% of the medications may not be taken
19 correctly. It could be as simple as taking it with food
20 or ahead of food and not complying with those directions.
21 So, through our discussion, it really centered around what
22 can we do and personalize patient care for the 1.2 million
23 Kentuckians -- 1.2 million who are supported through the
24 Medical Assistance Program in the State of Kentucky.

25 I think everybody has a stake in that.

1 No matter what area you're in, if it's behavioral, if it's
2 home health, if it's nursing, optometrics, we all have a
3 stake in medication compliance that really transcends into
4 all areas of healthcare.

5 So, we're excited to be back; the
6 Pharmacy TAC Committee. We will be putting some
7 information together and some creative thoughts, some
8 innovative solutions on how to help drive better drug
9 compliance.

10 And just to recap, we talked about
11 areas such as medication therapy management and the
12 pharmacist's involvement as a provider to help with that.
13 We talked about simple public service announcements
14 regarding the contribution of pharmacists and how they
15 serve the whole Commonwealth of Kentucky as well as our
16 Medicaid beneficiaries. About being an integrated part in
17 the home health team and about the economics of what is
18 happening with generic drugs.

19 And we're going to have -- that's an
20 action item that we'll be talking about at our next
21 meeting; about what is happening with the conversion from
22 brand to generic drugs. In some instances, it's a great
23 value. In some instances, we're starting to see generic
24 prices escalate. So, we want to talk about those
25 important points.

1 But, again, I wanted to state that we
2 are aware of the State Innovation Model. Dr. Langefeld,
3 we think we're going to have you come visit with us
4 sometime and see what role we can play to help with that.
5 Beyond that, we did talk about an item that came up from a
6 previous MAC meeting here involving prior authorization.
7 And, really, to boil it down, it involved who is the data
8 point, who is the point of contact on the prior auth and
9 what role can the pharmacy play in helping with that prior
10 authorization to get the medication timely to the patient.

11 And we'll have more to discuss on
12 that. And as I said, this was our first meeting. It was
13 organizational, and it was an excellent meeting. We had
14 good input. Again, I want to thank the MCOs for
15 attending. Not that we don't have issues we want to work
16 out with the MCOs on certain areas of reimbursement and
17 recognizing price changes in the industry, but I think it
18 started off on a very good note. And we can address those
19 issues and at the same time we can work hand-in-hand, I
20 think, to bring pharmaceutical care to Kentuckians and
21 really try to help in each of the areas here by stepping
22 in to help with the area of drug compliance, which I think
23 is a significant -- if I had to pinpoint one area, it's
24 complying with taking the medicine as the physician orders
25 the medication.

1 But I respectfully submit that as our
2 report. It's brief. It's our first meeting. But we do
3 look forward to being active participants. And it's good
4 to be back and have pharmacy back on this to advise --
5 this Medicaid Advisory Council.

6 DR. PARTIN: Thank you.

7 MR. ARNOLD: Thank you all very much.

8 DR. PARTIN: Physician Services.

9 MS. LADY: It's good afternoon now.

10 Lindy Lady, staff member at Kentucky Medical Association
11 and TAC member. The Physician TAC met on April 23rd. All
12 MCOs were represented, as well as some DMS staff and most
13 of our TAC members. We have three recommendations. The
14 first one is provide Medicaid reimbursement for the
15 kentuckyhealthnow priorities. As detailed by KMA
16 President, David Benson, M.D., in a recent Op-ed in both
17 The Courier-Journal and Herald-Leader, KMA conducted a
18 survey of its members to determine barriers to achieving
19 the state's health priorities as set out in the Governor's
20 KYhealthnow initiative. Based on the findings of this
21 survey, along with additional comments from members of the
22 Physician TAC, it appears that systematic barriers do
23 exist in achieving these goals. And we believe they
24 should be addressed in order to help all Kentuckians
25 achieve better health.

1 Since most MCOs, with the exception of
2 Passport, chose not to continue with the primary care
3 payment increases provided under the ACA in 2013 and 2014,
4 something needs to be done to further incentivize
5 treatment for Medicaid recipients, and addressing the
6 barriers to the KYhealthnow goals could be a cost-
7 effective way to do so.

8 So, what are these barriers? As we
9 discussed previously, one barrier concerns smoking
10 cessation. Currently, if a physician bills for an
11 evaluation and management visit and also bills for smoking
12 cessation counseling, the MCOs will not pay for the
13 evaluation and management visit but will pay the smoking
14 cessation counseling which is a substantially less fee.

15 This sends a clear message to the
16 provider that the payors do not care about what is
17 actually done with the patient. They only want to pay the
18 cheapest service performed. We also found numerous
19 examples of smoking cessation drugs not being covered.
20 Such a policy not only appears to run counter to the
21 state's goals, but also sends a message to the patient
22 that the insurer doesn't care about smoking cessation.

23 Other examples identified in our
24 survey included refusing to pay for prescriptions that are
25 prescribed by physicians who may not choose to be a

1 Medicaid provider, not covering medical nutritional
2 therapy which has proven beneficial for diabetics and
3 people with pre-diabetes.

4 Sports physicals was one of the top
5 items commented on in the survey, despite the fact that
6 children taking part in school sporting activities goes a
7 long way to fighting obesity, one of our KYhealthnow
8 goals. So, we would ask for help from the state to
9 standardize the sports physical forms, the timing and
10 requirements. We need to -- kind of need to adjust that.
11 And this would go a long way to help promote good health
12 and wipe away a significant barrier.

13 The state should be commended for
14 prioritizing its health goals. We believe progress on
15 these goals can be achieved through the elimination of
16 barriers within our current healthcare system, including
17 Medicaid, and can be done with little cost to anyone.

18 Our second recommendation, something
19 you've heard over today discussed in other TACs, we would
20 recommend the use of standardized quality measures.
21 Payment based on quality criteria are being -- they're
22 being implemented at all facets of the healthcare system,
23 including discussions currently being held within the
24 Cabinet through its State Innovation Model Initiative.
25 While we believe much work still needs to be done in

1 creating appropriate quality measures, we also believe
2 such measures should be as uniform as possible among
3 third-party payors, including the MCOs.

4 Currently, commercial payors have
5 implemented varying types of quality measurement programs;
6 but all of them use different measurements and have
7 different -- they have different criteria. This has put
8 an undue burden on providers to the point that many, if
9 not most, simply ignore them and treat the patient as they
10 normally would. This, once again, creates disincentives
11 for providers.

12 If one plan uses one set of criteria
13 and another plan uses a second set, which criteria truly
14 measures quality? Providers don't know. The public does
15 not know. And it simply provides meaningless burdens on
16 the providers; at least, that's certainly how they see it.
17 But if there are differing measurements for quality, how
18 can the state adequately measure which plans and which
19 providers are actually providing quality care? It's
20 already been pointed out that we really don't have the
21 ability to do that right now.

22 It seems important to have consistency
23 across the payors so that their work can be monitored to
24 ensure quality of care. Currently, most of the MCOs have
25 clinical staff review the patient's medical record to see

1 if a specific HEDIS goal has been met. Manual review of
2 the record, whether it's paper or electronic, takes
3 considerable time and cost for both the physician and
4 MCOs, often necessitating on-site visits where physician
5 offices have to provide working space for the reviewer and
6 access to the patient records.

7 The primary component of quality
8 measures is data collection. That's the number one
9 purpose of quality is data collection. For example, the
10 use of existing CPT tracking codes to report quality
11 measures would decrease the need for record abstraction
12 and chart review, minimize the burden on physicians and
13 other healthcare professionals, and improve data
14 collection by accurately describing clinical components
15 associated with the quality measure. It would be a
16 cost-efficient way for the state and MCOs to track
17 specific quality measures and identify where patients have
18 made improvements in their health.

19 The final recommendation, -- you've
20 already heard this today, too, -- simplify provider
21 enrollment. Building on the Legislative changes made this
22 year, the TAC also discussed the need to further reduce
23 the time it takes to enroll into the Medicaid Program.
24 This would also assist with any potential gaps in
25 workforce shortages if it took more than 30 days to be

1 enrolled and have MCOs use the same standard enrollment
2 platform to make the enrollment process simpler. The
3 current system of sometimes long waits and various kind of
4 platforms has not shown to increase quality or access to
5 care, at least that we are aware of. Thank you, and I am
6 happy to answer any questions that you have.

7 DR. PARTIN: Any questions.

8 MS. LADY: Thank you all.

9 DR. PARTIN: Thank you. Podiatry
10 Care. Primary Care.

11 MS. BEAUREGARD: Good afternoon.
12 Emily Beauregard with the Kentucky Primary Care
13 Association and representing the Primary Care TAC. We met
14 on Thursday, May 14th. We had a majority of our TAC
15 members as well as some other primary care providers
16 there; DMS staff and representatives from all of the MCOs
17 attending. And I believe that you have the report and
18 recommendations in your binder. I don't think that you
19 have the minutes. We didn't receive those from the court
20 reporter in time. So, we'll just get those to you
21 whenever we can.

22 DR. PARTIN: That's fine.

23 MS. BEAUREGARD: Since our last report
24 to the MAC, we've continued to work on issues related to
25 completing the Wrap Conciliation process. And I know I

1 talk about this every time that I come and report to you
2 all. Luckily, that is really starting to wrap up. No pun
3 intended.

4 But we are seeing that really start to
5 come to the final stages; and we're very close to the
6 process going into the next phase which is going to be the
7 spreadsheets being processed, audited, and then the final
8 decisions being made by DMS reported to the primary care
9 providers and then either payment or repayment being
10 processed.

11 And, so, one thing, I think the most
12 significant update since our last report to the MAC, is
13 that DMS no longer plans to do an additional, final
14 reconciliation. We were told last year that there would
15 be a final final reconciliation just because, you know,
16 it's really a moving target as claims that are old and for
17 whatever reason didn't make it through the system
18 initially continue to be reprocessed. But because this
19 has gone on since -- you know, the automated system went
20 into effect July 1st of 2014. And, so, the reconciliation
21 is 11-1-11 through June 30th of 2014.

22 The plan right now is to start
23 processing the reconciliation in June. So, that's a full
24 year. They think that that will be a sufficient time
25 frame for capturing the vast majority of claims that were,

1 you know, date of service prior to July 1st, 2014. And I
2 think that that's probably correct. Any claims that are
3 processed after that will have to be dealt with on a
4 case-by-case basis, but that should be pretty minimal.

5 We were also told that the process
6 would include a mini-audit to ensure that no duplication
7 of payments are being made; and, then, the findings would
8 be provided to the provider. There is a 30-day appeal
9 process and, then, finally payment or repayment. So, it's
10 still going to be a lengthy process; and we do have some
11 concerns about that. Mainly for the practices that have
12 not been getting a full Wrap payment since 2011 and have
13 really -- they're going to be due quite a significant
14 payment.

15 Some of them are owed in excess of
16 \$1,000,000. They've been taking out lines of credit to
17 meet payroll. And, so, for these practices, we really
18 would like to see an expedited process. You know, that
19 their spreadsheets and their claims be processed first and
20 payments made to them before some of the others.

21 In addition to the Wrap reconciliation
22 time frame, we've received clarification from DMS on how
23 licensed primary care centers are supposed to proceed with
24 the reconciliation. While they're not getting Wrap
25 payments anymore, they were up until February of 2013.

1 So, there is quite a bit of reconciliation that has to be
2 done for them as well. And because there's been an
3 ongoing lawsuit, the same information hasn't necessarily
4 gone out to all of the licensed primary care centers. And
5 we've been told that regardless of whether they're
6 participating in the lawsuit, because many are not, they
7 still have to request their claims disc through the law
8 practice that's handling that case. And, so, we're pretty
9 certain that most of these primary care centers aren't
10 aware of that. We've been trying to get that information
11 out to them.

12 And in regard to the automated Wrap
13 payment process, which is really where we're spending more
14 of our time now trying to make sure that that works
15 smoothly going forward because that is the current process
16 that should continue in the future for Wrap payments,
17 we've been working with DMS and the MCOs to identify and
18 resolve issues with this system. There have been a lot of
19 corrections that DMS and the MCOs have been able to make,
20 especially to system edits that were incorrectly kicking
21 out paid claims that they were paid by the MCO but they
22 got kicked out of DMS's system and, therefore, they didn't
23 generate that Wrap payment.

24 So, while a majority of these issues
25 seem to be improving, we still see issues with crossover

1 payments. That would be for dual-eligible patients. And
2 appealed claims that aren't receiving consistent Wrap
3 payments. So, we're collecting examples of these issues
4 so that we can facilitate that resolution.

5 And there also is some disagreement on
6 how claims that did not initially make it into DMS's
7 system are supposed to be reprocessed for the period of
8 post-July 1st. So, any claims that weren't Wrapped after
9 July 1st when the automated system was put into place.
10 So, we suggested to DMS that they meet with the MCOs and
11 determine the most efficient process for doing this
12 without creating an additional burden on providers. And
13 that burden that we assume could be put on providers is
14 that they be asked to reprocess those claims, which we
15 just would like to see that not be the case.

16 Another ongoing problem that continues
17 to be an issue with the automated Wrap process is that
18 DMS's system currently only provides electronic EOBs for
19 fee-for-service patients. I've mentioned this at least
20 one, if not two, of our previous MAC meetings; but we
21 still haven't gotten resolution on it. So, all patients
22 or all members enrolled through an MCO, their EOBs are on
23 paper. And, so, it's a manual process.

24 The staff at the practices have to
25 enter those manually. And some practices have actually

1 had to hire people to do that. So, this has created a
2 tremendous amount of work for practices. And we have
3 requested to DMS that they do these electronically. Their
4 system doesn't currently allow for that. So, they're
5 going to have to look into ways that they can update the
6 system. They are seeking a solution for auto posting;
7 and, hopefully, we'll have more to update you on at the
8 next meeting; but that's been pretty important to our
9 members.

10 In addition to the Wrap payments,
11 another important issue that has been affecting primary
12 care providers is the patient eligibility and retroactive
13 enrollment, which you all mentioned earlier. So, I won't
14 go into that too much. But I think that it's important to
15 understand that when -- if patients are getting
16 re-enrolled retroactively, providers can get paid
17 eventually. They may have to resubmit to another MCO.
18 It's a hassle, but you can get payment.

19 But if the members just disenrolled
20 for that time period, the burden is on the provider; and
21 they won't get paid for that service. And, so, I think
22 that even though there have been corrections made to
23 Connect and we've been told by DMS that most of these
24 issues have been resolved, but disenrollments are still
25 going to be an issue.

1 And, so, we do think that if a
2 provider's office verifies eligibility on the date of
3 service using both the DMS and the MCO portals, that that
4 should really stand as the final word on eligibility as
5 far as the provider is concerned.

6 And, then, another issue that we
7 touched on briefly was improve notification regarding the
8 walk-in program. Again, this is something that I've
9 mentioned before. The response that we got back from our
10 last recommendation wasn't very specific, but it did say
11 that DMS would address this through the new contracting
12 with MCOs.

13 If you have had a chance to read
14 through the new contract that came out with the RFP, it
15 isn't specific at this point. There's no real detail on
16 how walk-ins should work or how notification should be
17 handled. And, so, we just want to make sure that DMS, the
18 MCOs and providers are working together to figure out how
19 that should work; because it's not going to be an
20 effective program if providers aren't aware of who is and
21 isn't in the walk-in program.

22 And, finally, we discussed options for
23 correcting or updating member information to ensure that
24 providers and MCOs have the right information with which
25 to contact patients effectively. But even more

1 importantly, the right information to treat them
2 appropriately.

3 You've probably had times in your
4 practice where you've had a patient present that had the
5 wrong date of birth or some other incorrect information
6 that you had to make a decision -- a clinical decision to
7 treat them differently than you necessarily would using
8 the information that's in the system. But this affects
9 billing in some ways, and it affects the practice's
10 ability to get a hold the patient, and sometimes it can be
11 a safety issue for patients.

12 So, currently, patients have the
13 ability to correct this information; but they don't always
14 have the time to do it, certainly not always the
15 motivation or really the understanding of why it's
16 important. And, so, we requested before that there be
17 another way for providers and MCOs to correct this
18 information without it just being the responsibility of
19 the patient. The response that we got from DMS wasn't
20 very -- didn't exactly respond in the way that we were
21 anticipating. So, we're just requesting more specifically
22 that DMS create a form that can be completed by the
23 provider or the MCO and authorized by the patient or
24 guardian.

25 So, our recommendations, some of these

1 may sound similar to ones that we've made before; but
2 based on the responses that we got from our November,
3 January and March recommendations, we've had to revise
4 some of these to be more specific.

5 So, the first is that related to the
6 automated Wrap payment process to decrease administrative
7 burden and to improve the process, we're recommending that
8 DMS upgrade their system in order to have the capability
9 to provide all EOBs electronically. For auto-posting, the
10 EOB should contain at least the following identifiers:
11 The MCO member ID, claim number, subscriber number and
12 patient name.

13 And, then, in addition, we're also
14 recommending that DMS meet with the MCOs to determine the
15 best way to reprocess claims for dates of service after
16 July 1st, 2014, those claims that have not received a Wrap
17 payment due to MCO or DMS errors, and that this be done in
18 a way that is least burdensome to providers.

19 Our third recommendation is to avoid
20 placing the burden of eligibility-related recoupments on
21 providers; that their provider portal be considered the
22 official record for member eligibility. And, as such, any
23 service provided to a patient who is listed as eligible on
24 DMS's portal on that particular date of service should be
25 subject to payment by DMS or an MCO.

1 Additionally, we would recommend that
2 DMS implement a statute of limitations for eligibility-
3 related recoupments. Specifically, we would recommend
4 that the time frame for recoupment should be the same as
5 timely filing for claims. I don't think a recoupment two
6 years later is really appropriate, and it just is very
7 difficult for providers.

8 In order to improve the effectiveness
9 of the MCOs various lock-in programs and avoid unnecessary
10 denied claims to providers for unknowingly treating
11 patients who are locked in to another provider, we would
12 recommend that DMS work with the TAC and MCOs to adopt a
13 more consistent and effective approach to lock-in
14 notification.

15 And, then, finally, in order to
16 improve the MCOs' and providers' ability to effectively
17 outreach to members and provide appropriate care based on
18 patient demographics, we recommend that DMS develop a form
19 that will allow providers and MCOs to collect corrected or
20 updated information with a patient or guardian's approval.
21 And we suggest that the form include information that is
22 collected when a member essentially is applying for
23 Medicaid. So, through Connect Now. And I've specified
24 all of those points of information. And, then, that form
25 could then be sent to a local DCBS office to update the

1 system so that that information is official. That's it.

2 DR. PARTIN: Any questions? Thank
3 you. We have one more TAC report, Therapy Services.
4 Okay. We are supposed to have a presentation today by
5 Humana, but we have run out of time. And, so, I'm going
6 to have to ask the Humana folks to do their presentation
7 at our next meeting if that's okay.

8 At our next meeting, I will ask that
9 the TAC reports -- they went kind of long today. That
10 when we have another presentation, that the TACs just
11 stick to giving their recommendations when we have a
12 presentation to do on that day so that we can fit
13 everything in on our schedule.

14 Then, finally, I had one other order
15 of business. And I think that this has already been
16 partially addressed. But way in the past when the MAC had
17 a question for DMS, DMS would provide the information to
18 the MAC and there weren't any problems. But let's say in
19 the past year, maybe, or for a little bit longer back,
20 somehow along the line, there was a policy instituted that
21 we had to have a quorum in order to get information from
22 DMS. And I don't think as far as -- I'm not an attorney
23 -- but as far as I can research into the statutes and
24 regulations, there is no prohibition to DMS providing us
25 with information that we request if we don't have a

1 quorum.

2 And, Commissioner Lee, you've already
3 sort of changed the whole tenor of things. And I really,
4 really appreciate that. And, so, I think that what I'm
5 asking is that when the MAC has questions or requests
6 information or -- basically, requests information, that
7 DMS provide that to us even though we don't have a quorum.
8 But like I said, you've already instituted that. You've
9 made that change. And, so, I appreciate that. Thank you.

10 Is there any other business? It's
11 been brought to our attention that possibly attendance was
12 down today because of the holiday. And, so, when we look
13 at scheduling our meetings for the future in the coming
14 year that we look at where the meeting falls in relation
15 to a holiday so that maybe we might have better attendance
16 at the meeting.

17 MS. EPPERSON: We can definitely do
18 that. But to comment on that, some of the ones that
19 actually responded to me and said they weren't going to be
20 able to be here, it was because they had another meeting
21 they had to attend that took priority.

22 DR. PARTIN: Okay. Is there any other
23 business? Thank you very much.

24 (END OF MEETING)

25

STATE OF KENTUCKY

COUNTY OF FRANKLIN

I, Rita Susan Moore, a notary public in and for the state and county aforesaid, do hereby certify that the foregoing ninety-eight pages are a true, correct and complete transcript of the above-styled meeting taken at the time and place set out in the caption hereof; that said meeting was taken down by me in shorthand and afterwards transcribed by me; and that the appearances were as set out in the caption hereof.

Given under my hand as notary public aforesaid, this the 29th day of June, 2015.

Notary Public
State of Kentucky at Large

My commission expires January 8, 2016.