

## 1 PRIMARY CARE TECHNICAL ADVISORY COMMITTEE

2 MARCH 12, 2015

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5 TRANSCRIPT OF MEETING6  
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10 APPEARANCES:

11 Lee Guice, DMS  
12 Teresa Cooper, DMS  
13 Charles Douglass, DMS  
14 David Dennis, DMS  
15 Dean Shoftner, Big Sandy Health Care  
16 Chris Keyser, Fairview CHC  
17 Emily Beauregard, KPCA  
18 Marie Rains, Anthem  
19 Stephanie Bates, DMS  
20 Elizabeth Justus, DMS  
21 Yvonne Agan, Family Health Centers  
22 Barry Martin, Primary Care Centers of EKY  
23 Sheila Bowling, Primary Care Centers of EKY  
24 Rachael Fitzgerald, KPCA  
25 Stephanie Wilson, Barbourville Family Health  
Darryl Wilson, Barbourville Family Health  
Richard Carter, Barbourville Family Health  
George Hesfield, CHFS  
Courtney Kelly, Passport Health Plan  
Matt Fitzner, Anthem  
Pat Russell, Wellcare  
Jean O'Brien, Anthem  
Joseph Smith, KPCA  
David Bolt, KPCA  
Ken Groves, Anthem  
Pat Bale, Corbin Pediatrics  
Chris Goddard, Health Point Family Care

1 MS. KEYSER: I will call to order the  
2 Primary Care TAC Advisory Committee, and we do have a  
3 forum present. The minutes of the last meeting were  
4 sent out to all committee members, so I will entertain a  
5 motion to approve the minutes.

6 MS. AGAN: I approve the minutes.

7 MS. KEYSER: Do we have a second? I'm  
8 sorry. Who is the second?

9 MR. MARTIN: I will.

10 MS. KEYSER: Thank you, Barry. Any  
11 questions concerning minutes? There being none, all  
12 those in favor say aye. Those opposed?

13 MOTION CARRIES

14 MS. KEYSER: We'll move on to old business,  
15 the automated wrap payment process, that is the  
16 electronic payments that are happening as of July 1st  
17 and forward. We have had reports of inconsistent  
18 payments that there are some clinics that are getting  
19 wraps and some aren't.

20 MS. BEAUREGARD: Most clinics seem to be  
21 getting wraps on some claims and not on others, and we  
22 haven't found a real consistent trend or pattern that  
23 helps us identify exactly what might be going on. We  
24 have a few examples here, and I know that I've sent you  
25 some others via Sharefile that just show there are some

1 M.D.'s in there, there are some midlevels and we haven't  
2 yet found the pattern. But we know there has been some  
3 work on your side as far as fixing different --

4 MR. DENNIS: Yeah, I know of one edit that I  
5 just approved last week that was letting them come on  
6 through. I forwarded several of these on to Cindy  
7 Arflack, and they've looked into -- looking into what  
8 the issues are, your examples that you've sent me. So  
9 that's good to have examples, and I can just forward  
10 them right on over and we can investigate them.

11 MS. JUSTUS: I'd like to add, also, we have  
12 been working diligently with folks at HP, Cindy  
13 Arflack's division, and we have got a lot of the edits  
14 switched from thresholding to informational to get these  
15 encounters through, and we have been onto the MCO's very  
16 heavily about the FQHC's and RHC's getting the  
17 encounters. We are penalizing them. We have a process  
18 to penalize them, so we are hoping that we will get this  
19 process running real smooth soon.

20 MS. BEAUREGARD: So I guess I have two  
21 questions. If there are other examples that you think  
22 would be helpful, let me know and we can ask  
23 specifically for those types of examples. And then I  
24 know with one group in particular we were told that they  
25 probably wouldn't need to resubmit anything, that they

1 would be reprocessed once an edit was fixed. Is that  
2 going to be the case or do they need to resubmit or just  
3 fill out, put that information on a reconciliation  
4 spreadsheet? It was Monticello that we were talking  
5 about, but I think that the issue would probably still  
6 apply to other clinics.

7 MR. DENNIS: I would need to know about  
8 which issue it was.

9 MS. BEAUREGARD: That they're not getting  
10 wraps on everything. Do they start to fill out a  
11 reconciliation spreadsheet for that, or will they be  
12 processed --

13 MR. DENNIS: This is for after July 1?

14 MS. BEAUREGARD: Yes, for auto wrap, right.

15 MR. DENNIS: I need to determine what the  
16 issue is then I can determine whether fixing it will let  
17 it fix their aims or whether you need to do anything.

18 MS. BEAUREGARD: Do you want me to re-send  
19 you any of those e-mails?

20 MR. DENNIS: Yeah, re-send it.

21 MS. BOWLING: If I could interject, on our  
22 claims at Primary Care Center, we have found a common  
23 thread with our appeal claims, claims that did not  
24 process originally with the MCO with the face-to-face  
25 encounter, but once appealed it did process a payment

1 for face-to-face encounters. And I think that's the  
2 common thread that we have found on our outstanding auto  
3 -- we have the PA issue.

4 MR. DENNIS: See, that would tell me that we  
5 haven't received that encounter, then, and that means we  
6 would need to get the MCO to send that to us and it will  
7 pay them. That is what I need to know.

8 MS. BOWLING: That was our understanding  
9 that the adjustment bill would be processed just like  
10 the original claim, and that payment would be adjusted  
11 on your part as well. Those are the ones we're not  
12 seeing any activity at all.

13 MR. DENNIS: Can we have some examples of  
14 those, some specific claims?

15 MR. SMITH: From your perspective, do they  
16 have to come back to you from the MCO's.

17 MR. DENNIS: Yes, and that's where we're  
18 speculating the problem might lie.

19 MS. KEYSER: So should clinics then just be  
20 in conversation with the MCO's for wrap payments that  
21 they haven't seen for outstanding?

22 MR. DENNIS: In her case, yes, she should be  
23 contacting the MCO and say did you send that encounter  
24 after you've approved my appeal to Kentucky Medicaid.  
25 That would be, you know, I mean, that might fits it

1 right there.

2 MS. BEAUREGARD: So right now we're not on  
3 to a step of anybody filling out a spreadsheet.

4 MR. DENNIS: Not for the automated time  
5 period. I would like very much for it to take care of  
6 it.

7 MR. MARTIN: Is there a pattern?

8 MS. BOWLING: It's appealed claims.

9 MS. GUICE: Which MCO, can I ask?

10 MR. MILLER: But you're saying you have to  
11 appeal it before it will go on to the --

12 MS. BOWLING: There's been a process claimed  
13 from the MCO. They have a partial payment or a no pay.  
14 We will receive correspondence back from Medicaid  
15 regarding that claim whether it be a partial payment or  
16 a no pay. Once we've appealed to the MCO's, they pay  
17 the additional line items and it's many cases and then  
18 we get no further response from Medicaid. So I'm  
19 thinking the --

20 MS. GUICE: Okay. When you say that you get  
21 a response from Medicaid --

22 MS. BOWLING: On the original claim.

23 MS. GUICE: You get a wrap payment on that?

24 MS. BOWLING: I'm thinking these are mostly  
25 zero pays. What we are appealing are most of the time

1 is going to be a face-to-face encounter that got denied.  
2 It's going to be denied --

3 MS. GUICE: I don't know that we would have  
4 sent you anything, we being fee for service Medicaid on  
5 that.

6 MS. BOWLING: We are receiving  
7 correspondence back. We've received correspondence from  
8 the MCO and that you're processing it with no payment,  
9 but we are receiving that.

10 MS. GUICE: Okay.

11 MS. BOWLING: When we appeal it with the MCO  
12 then that process is the MCO paying that line item  
13 that's missing, and then we don't get anything else from  
14 Medicaid. It's showing that it's been an adjusted  
15 claim.

16 MS. GUICE: Sure. Okay. Is it one  
17 particular MCO or is it all of them?

18 MS. BOWLING: I'm finding it's with all of  
19 them.

20 MS. COOPER: If the claim is denied by the  
21 MCO, we don't even see that come into the system to pay  
22 a supplemental payment on that.

23 MS. BOWLING: There's paid line item so I'm  
24 assuming that might be the difference.

25 MS. COOPER: But you said the claim was

1 denied. The whole claim can't be denied if there's paid  
2 line items.

3 MS. BOWLING: It's a zero paid claim.

4 MS. COOPER: Okay.

5 MR. DENNIS: What it is, is there's -- the  
6 line item that's being denied is the one face-to-face --

7 MS. BOWLING: That you would recognize.  
8 Once it's appealed and paid, then we don't hear anything  
9 else from it.

10 MS. GUICE: Yeah, if we could get some  
11 specific claims --

12 MS. BOWLING: I've got them.

13 MS. GUICE: Then we can check and see if  
14 it's the system or if we have just --

15 MS. COOPER: If we could have the original  
16 claim and the one --

17 MS. BOWLING: I've got it all.

18 MR. DENNIS: Technically, it should come  
19 through back to us as an adjusted claim. That's what we  
20 need to check into it.

21 MS. BOWLING: I've got your MCO data and  
22 Medicaid data.

23 MS. BEAUREGARD: I know we talked  
24 specifically about the PA claims issue and that seems to  
25 be one that you all have been able to figure out in the

1 process of fixing. Right?

2 MR. DENNIS: Uh-huh.

3 MS. BEAUREGARD: But have since gotten  
4 examples of other things. That's not exclusively the  
5 issue.

6 MS. KEYSER: I think the examples I've given  
7 you here are just regular claims that were submitted in  
8 July, and by September we received a payment from the  
9 MCO, but we've not gotten a wrap on it, and there's a  
10 couple M.D.'s and some nurse practitioners mixed in  
11 there. I do have a lot of those.

12 MR. MARTIN: And are you guys going back  
13 chronologically because it looks like we're not getting  
14 paid anything from November beyond, or back, prior to  
15 November.

16 MS. BOWLING: The oldest dates that I've  
17 seen paid for the PA's are back to November.

18 MS. BEAUREGARD: Are there any current  
19 issues that are still happening? Yeah, okay.

20 MS. KEYSER: So are you getting paid wrap on  
21 some, but not others.

22 MS. BOWLING: Yes.

23 MR. MARTIN: Which ones are we not getting  
24 paid on?

25 MS. BOWLING: Well, current dates of service

1 we're getting paid. Older dates is still outstanding.  
2 We've got one clinic which is a lot of volume for PA's.  
3 We're out almost 8,000 in encounters.

4 MR. DENNIS: So presently it's working?

5 MS. BOWLING: Current claims are coming  
6 through. It's our older ones that are still --

7 MR. MARTIN: That is good news.

8 MS. KEYSER: Does anybody else have anything  
9 in regard to inconsistencies with the auto wrap besides  
10 what have already been mentioned?

11 MR. MARTIN: Besides dental?

12 MS. KEYSER: We'll get to that in a minute.  
13 That's coming up. The next one is the electronic EOB's  
14 for auto-posting. At our work group meeting, David, we  
15 had asked about looking into the possibility of being  
16 able to auto-post. Has there been any progress?

17 MR. DENNIS: Well, we've been working at HP  
18 on that, and we've given our wish list of what we would  
19 like, you know, the information that you all were  
20 wanting to see on the EOB. Now, I haven't gotten any  
21 feedback from them, yet, as of today, but I will get in  
22 touch with them and then get that out to you all as to  
23 where we're at with that.

24 MS. KEYSER: Dental claims. Here we are.  
25 David, I believe you were going to jump --

1 MR. BOLT: Discovered some problems with  
2 reconciling dental claims back to 2014 and even right  
3 now. Working after the last meeting with Avesis, they  
4 jumped on it, they do have a fix in place. It should go  
5 live next week, but we still have the manual situation  
6 to deal with, not only prior to July 1, but July 1 to  
7 next week or whenever they get that in place.

8 So we talked with David and Neville earlier  
9 about the proposition we made with Avesis where they are  
10 going to run claims paid information for all of the  
11 dental providers. In fact, I'm going through an e-mail  
12 that's going out to the dental providers now because we  
13 need to pick up dental providers that may not no longer  
14 be employed, but were employed in 2011.

15 The claims run, and I talked with Pat  
16 Russell at Wellcare asking if they can do a claims run  
17 for the period of time that DentaQuest was their dental  
18 contractor and use that to do the reconciliation for --  
19 provide the information for the reconciliation for you  
20 all and the format. Avesis has asked for the format of  
21 the encounter data that is needed to reconcile. So  
22 we'll get that to them, also. I think they'll work with  
23 us.

24 The other thing that popped up is that both  
25 Neville and David mentioned the Avesis and the other

1 dental vendors correcting their claims, and that's  
2 something I can bring to their attention, but you all  
3 are going to have to talk to them about that. But it  
4 boiled down to, our understanding is they were never  
5 informed. They say that they needed to use anything  
6 other than provider type 60. And I will say, honestly,  
7 their concern was messing up the MCO's and messing up  
8 DMS by pulling those encounters out and resubmitting  
9 them in the new format. So I don't know what the  
10 details on that are, Pat, and some of the other MCO's  
11 might know a little more about that.

12 MS. RUSSELL: I'll have to look at it when I  
13 get back, David. I really don't know, but I'll look at  
14 it.

15 MR. BOLT: I think that's where DMS is going  
16 to have to talk to Coventry and Wellcare on that issue  
17 about the resubmissions. And I did ask David, and  
18 Neville said if we need a little leeway on the  
19 April 13th date because of the run on this, we will -- I  
20 don't think I'm misquoting anybody. They said that was  
21 okay. Right, David?

22 MR. DENNIS: To be honest with you, I didn't  
23 hear Neville's response.

24 MR. BOLT: He said that's okay. You want me  
25 to go get him?

1 MR. DENNIS: That's fine. I really didn't,  
2 but I feel like he probably did.

3 MR. BOLT: Well, you can verify that with  
4 him.

5 MS. KEYSER: Anything else?

6 MR. BOLT: I think that comes close to  
7 cleaning it up.

8 MR. DENNIS: I hope.

9 MS. KEYSER: Barry, did that address what  
10 you wanted to hear?

11 MR. MARTIN: Yes, somewhat. I mean, you  
12 know, they said we have to include the taxonomy. We  
13 included the taxonomy, then Avesis denied the claims  
14 because it has a taxonomy number. So then we have to go  
15 back, start billing it without the taxonomy number to at  
16 least get some money in, and now the claims won't cross  
17 over. So I mean chicken, egg, egg, chicken. We need  
18 everybody --

19 MS. GUICE: MCO's have anything to add to  
20 this?

21 MR. BOLT: Well, I've got Avesis. Avesis is  
22 going to be contacting Barry about that specific issue  
23 and problem. And it may be something they hadn't  
24 recognized or didn't know. I won't judge one way or the  
25 other, but I think if Barry's clinic works with them

1 directly on that issue, they'll move to correct it  
2 pretty quickly.

3 MR. MARTIN: Was any of the other dental  
4 providers having the same issue?

5 MR. BOLT: I haven't heard from any others  
6 that have your particular problem. Chris, are you  
7 seeing it?

8 MR. GODDARD: No. I don't believe that's  
9 our problem.

10 MR. BOLT: Yvonne?

11 MS. AGAN: No, we're not seeing that.

12 MR. MARTIN: We're special. We knew that.

13 MS. KEYSER: We'll move on to 4(d), that  
14 clinics identified to be associated with the wrong  
15 licensure in DMS provider enrollment. Kind of where are  
16 we, what's the status on that? Are you all aware, has  
17 that been cleaned up? Are there any still outstanding  
18 issues in that regard, David?

19 DAVID: George has been researching that and  
20 getting --

21 MR. HESFIELD: I sent you the form.  
22 Provider enrollment found 16 different PCC that had RHC  
23 specialities. All those have been contacted. There's  
24 been three of them to this date that have converted over  
25 to an RHC status. I know there's been second attempts

1 on various people's efforts to get a hold of these other  
2 clinics, but just haven't had a response.

3 MR. SMITH: If I understand, basically  
4 those, Bedford is going to have re-enroll as an RHC.  
5 They're going to have to go through the process of  
6 re-enrollment.

7 MR. BOLT: For the record, all of those have  
8 been contacted. I personally contacted all of them over  
9 the last couple three weeks. It's gotten up to the  
10 highest levels of ARH because there are about six or  
11 eight ARH claims on there.

12 Saint Clair Medical Center talks  
13 specifically with Charlotte Walker, and that is in  
14 process. She has been working with provider enrollment  
15 on that issue. Gene So (phon.) had two claims on there.  
16 One's been cleared up. They're still working on the  
17 other.

18 MR. HESFIELD: I haven't heard back if  
19 anybody has got the applications in. They are pending  
20 at this point.

21 MR. BOLT: Gene's got one that's going to  
22 remain a problem for a while because there's a  
23 disagreement with DMS and I didn't get into the dirt on  
24 that. All of them had been contacted and they've  
25 assured me that they either know the problem or working

1 to resolve it.

2 MR. DENNIS: We do have a process to pull  
3 those encounters and convert them over and pay the wrap  
4 on them once they get their RHC. So those won't have to  
5 be resubmitted. We have a process to do those.

6 MS. KEYSER: But did I hear there were some  
7 that you've not had a response from?

8 MR. HESFIELD: Correct.

9 MS. KEYSER: Would we want to know who those  
10 are?

11 MR. BOLT: That's the list he sent us.

12 MR. SMITH: Basically, the ball is in those  
13 clinics' hands at this point in time. We will continue  
14 to prod them. The ball is in their court.

15 MS. BEAUREGARD: This won't continue to be  
16 an issue ongoing where there has to be re-enrollment  
17 for --

18 MR. DENNIS: No. Getting that specialty was  
19 stopped for --

20 MR. SMITH: Except for out of state  
21 providers that provide Medicaid services.

22 MS. KEYSER: Okay. Then we are at Item 5,  
23 the wrap payment current and dual eligible  
24 reconciliation from November 2011 through June 30. Just  
25 curious on a status update. Have you received

1 reconciliation spreadsheets from some already or --

2 MR. DENNIS: Yes, there's been a few that's  
3 trickled in. A few trickled in their spreadsheet, but  
4 since we extended it to the April 13th deadline, I think  
5 most of them are taking advantage and making sure that  
6 it's correct, which I really appreciate because if this  
7 interim or preliminary is done and done correctly, then  
8 the final would be a wash, should be.

9 MS. KEYSER: So if there are some clinics  
10 who are struggling with it in regard to the timeline and  
11 getting it to you on April 13th --

12 MR. DENNIS: Send me a request for an  
13 extension.

14 MS. KEYSER: Okay. I mean, like right now  
15 if they need it or, you know, April 12th, I'm not going  
16 to be able to get it on the 13th to you and ask you --

17 MR. DENNIS: Yeah, that's fine.

18 MS. KEYSER: And, David, the request for  
19 extensions go to you.

20 MR. DENNIS: Yes. I will forward it on to  
21 the right person.

22 MS. KEYSER: Great. Last item under old  
23 business, the status of the Primary Care TAC  
24 recommendations approved by the MAC, it was noted that  
25 there was no quorum at the November or January meeting.

1 We're still in limbo.

2 MS. GUICE: They actually haven't been  
3 approved, yet.

4 MS. BEAUREGARD: Yeah, we put this on before  
5 we found out. I thought that there was a quorum at that  
6 last meeting, so I was --

7 MS. GUICE: Well, I think that there was  
8 confusion about that at the meeting as to what happened.

9 MS. KEYSER: Then moving on to new business.  
10 Can you speak on the timeframe on revisions to edit on  
11 auto wrap for problem areas?

12 MR. DENNIS: I guess what we just talked  
13 about.

14 MS. BEAUREGARD: Yeah, I think it did get  
15 covered. Are there any other edits aside from the PA  
16 that you all are working on?

17 MR. DENNIS: Well, the 3316 which was I --  
18 can't remember the edit name now. That one's already  
19 been implemented, though. No rate on file. That was  
20 the no rate on file edit that the MCO's were sending in  
21 encounters to us and they were being sent back to them  
22 being denied by us, and we fixed that edit where they  
23 would come on through.

24 MS. JUSTUS: And we received the new reports  
25 for the encounters, and since the edits have been

1 relaxed, we have been told that we have gotten a  
2 substantial amount of the old stuff through. HP  
3 informed us yesterday that we have a good turn out of  
4 encounters. So we are in the process now of doing our  
5 monthly calculations, and they said it's looking better.

6 MS. KEYSER: All right. Item no. 8,  
7 requirement for the MCO's to pay FQ's and Rural Health  
8 Clinics according to the DMS schedule.

9 We've noticed that some of MCO's have been  
10 paying --

11 MR. SMITH: And primary care centers.

12 MS. KEYSER: And primary care centers, thank  
13 you. Are paying 90% of the fee schedule for some dental  
14 claims and wondering about the language in the contracts  
15 that the state has with the MCO's.

16 MS. GUICE: There is no requirement that  
17 they pay according to the -- there is no requirement  
18 that they pay according to the Medicaid fee schedule.  
19 If that was a requirement, we wouldn't have needed the  
20 MCO's to manage the care. Yeah, there's no requirement.  
21 That's between you and them, and there never has been.

22 MR. SMITH: If they pay less than the fee  
23 schedule, then Medicaid is going to have to make up the  
24 differential.

25 MS. GUICE: On the wrap payment, yes.

1 That's why we have a lot of the conversations about the  
2 wrap payments, not any other place, only when there's a  
3 wrap payment. We are only required by federal law to  
4 make the FQHC's and the RHC's call. And that's it.

5 MS. KEYSER: Joe, are there some non FQHC's  
6 primary cares that do dental?

7 MR. SMITH: Not many.

8 MS. KEYSER: So for those individuals, then,  
9 they're just to going to have to live with the reduced  
10 reimbursement for their dental services if the MCO  
11 chooses to pay 90% of the fee schedule.

12 MR. SMITH: That's true.

13 MS. KEYSER: Item No. 9 and 12 I think kind  
14 of go hand in hand. We want to kind of talk about those  
15 together. The recruitments for patients based on  
16 eligibility status and then the statute of Medicaid  
17 renewals and issues with retroactive enrollment.

18 I think what we've heard from some clinics,  
19 ours is one of them, that, you know, we'll see a patient  
20 and on that day, based on DMS's website, they are  
21 eligible, we provide the service, and we get paid by the  
22 MCO. And then a year later a letter comes from the MCO  
23 that says, sorry, our records indicate they weren't  
24 eligible. And then we have to undo everything and the  
25 letter doesn't give us much information in regard to

1 have they been -- were they reassigned to somebody else,  
2 did they fall off completely, were they no longer  
3 Medicaid eligible? So you know, where is the  
4 responsibility for, at the time of service, you know,  
5 what do we do? Barry, are you all seeing those same  
6 kind of letters?

7 MS. BOWLING: We've seen the MCO's go back  
8 as far as 2011 and recoup payments.

9 MS. GUICE: Well, okay. The process is that  
10 if there was a miss-assignment to a particular MCO, or  
11 mistake in the eligibility determination, and I don't  
12 think that we would go back four years as far as saying,  
13 oh, they weren't really eligible for Medicaid at all.  
14 Okay? But there's a reconciliation process that  
15 Medicaid and the MCO's go through every month that has  
16 to do with who their assigned members were, were they --  
17 did we pay a cap for them, or do we take it back because  
18 they were miss-assigned and then they've since been  
19 re-assigned.

20 I'm hoping that there won't be many more of  
21 those a-year-later letters and that as we have moved  
22 into Kynect and into a little bit more -- and as we  
23 continue to refine those automated processes, this won't  
24 happen so much. But that's what happens, and once we  
25 take their cap payment back from them for that member,

1 they're going to take your fee back. Okay? You should  
2 be able to see what MCO they were in, but you might not  
3 be able to see what MCO they were in if it was longer  
4 than a year ago. So I would suggest at that point that  
5 you need to contact Medicaid and ask.

6 MS. BOWLING: And we have.

7 MS. GUICE: Then you should be able to bill.

8 MS. BOWLING: And at some point they have  
9 been able to help us with the eligibility and who it  
10 needs to go to, and in many cases there was no coverage.  
11 There was issues of validations or just total lapses in  
12 coverage that we -- we have nowhere to bill other than  
13 the patient and that's usually --

14 MS. GUICE: Total lapses in coverage?  
15 Because they didn't re-certify?

16 MS. BOWLING: What my girls have learned is  
17 through their contacts at Medicaid that they have had a  
18 total lapse in coverage. Now, not every case is that,  
19 but -- and we are able to confirm coverage with another  
20 MCO at times and re-bill that. Obviously, that's going  
21 to be timely, and we'll have to fight that battle. In  
22 many cases, we are seeing no coverage whatsoever.

23 MS. GUICE: You shouldn't be fighting any  
24 battle if you can show that the date of -- even if it  
25 was out of, you know, if you're more than a year late

1 filing a claim, I don't mean late, but if it's more --

2 MS. BOWLING: It just becomes a mountain of  
3 work when, you know, we've already confirmed coverage,  
4 we've already, you know, billed the claim, got paid, and  
5 having to do deal with current issues along with issues  
6 through --

7 MS. KEYSER: Is there not a way to be  
8 notified, you know, who they actually should have been  
9 covered under instead of the clinics having to chase  
10 that down? Because that's what we're having to do.

11 MS. BOWLING: Those conversations that  
12 Medicaid turns into half an hour of the day and it's not  
13 so much, you know, they're very willing in trying to  
14 help us. It's just that it's very time consuming on  
15 both sides.

16 MR. MARTIN: We've found that it's been two  
17 and three years --

18 MS. BOWLING: Yeah, I mean, I'll go and get  
19 you some examples. We do have --

20 MR. MARTIN: I wouldn't think -- if we can't  
21 bill past a year, why would they be come back and be  
22 able to take it back two years ago?

23 MS. GUICE: MCO's?

24 MR. MARTIN: Because you can?

25 MS. GUICE: Just speak.

1 MR. MARTIN: I guess, that's the question  
2 we're having is, you know, we understand if it's a month  
3 ago or two months ago, catching up, but I mean if it's  
4 two or three years ago, I mean --

5 MS. KEYSER: As you said, within the same  
6 year, but --

7 MS. BOWLING: And a lot of the instances  
8 that we discovered had to do with the KY Kynect. They  
9 were always an issue with the KY Kynect it seemed like,  
10 being a common thread with what we were seeing. So I  
11 don't know if they weren't retro in the card like it  
12 should have been or if the lapses were an issue and the  
13 common thread was with KY Kynect.

14 MR. MARTIN: We can give you examples.

15 MS. BEAUREGARD: Sheila, I know you did send  
16 me an example, and that was one that it was a  
17 conversation with DMS staff. Did that include that the  
18 patient was in the end not eligible at all --

19 MS. BOWLING: Yes. That was the 2011 one I  
20 do believe.

21 MS. GUICE: That happens. That happens  
22 today. Right?

23 MR. MARTIN: I mean, I guess my question  
24 is --

25 MS. BOWLING: It just seems like we get

1 stuck holding the ball.

2 MR. MARTIN: I mean three years ago? I  
3 mean, we can't bill. If we find out we didn't bill for  
4 something three years ago, that seems like that  
5 shouldn't be taken from us.

6 MS. GUICE: MCO's. This is an MCO issue.

7 MR. FITZNER: With that, though, I mean the  
8 way we operate is, you know, if we get received -- going  
9 back to the date that eligibility -- so if they  
10 retrospectively enroll a member with us, the date that  
11 member retrospectively enrolled with us, that's when the  
12 time clock starts counting, is my understanding with  
13 them.

14 As far as your question on why we didn't go  
15 back three years, you know, we go back to the state and  
16 go, well, why can't I go back to three years and take a  
17 cap payment? So we're in the same situation you are  
18 where that recovery occurs. So I would say that always  
19 notify that that has happened, you know, with Anthem, we  
20 would start counting that clock from the time that that  
21 eligibility is notified to us. So if they go back  
22 two years, let us know in February, that's when it  
23 starts going back even though the service occurred --

24 MS. KEYSER: But is there a way to make  
25 it --

1 MS. GUICE: That's what we do, too. That's  
2 what I was going to say before. There's no timely  
3 filing issue if you re-file the claim or, with us, from  
4 the date of recoupment, not from the date of service.

5 MS. KEYSER: So, Sheila, when you get the  
6 recoupment letter, then what do you do as far as -- so  
7 you then notify the MCO and say take the money,  
8 whatever. And then do you try to find who you want to  
9 bill or who you can bill if that's possible?

10 MS. BOWLING: We'll research what websites  
11 we have access to and try to confirm where the coverage  
12 was, and in those instances a lot of times we've had to  
13 -- our contact at Medicaid has been real helpful, but in  
14 many cases we're finding that the coverage was a true  
15 lapse in coverage and there's nothing to bill other than  
16 the patient. And we all know that if they were eligible  
17 for Medicaid, then they're really not in the position to  
18 pay us.

19 MS. BEAUREGARD: If they're considered  
20 eligible on DMS's website when you check, if that's an  
21 error of DMS, I mean, what is the solution there?

22 MS. BOWLING: Our system checks eligibility  
23 for us automatically when we're registering the patient.  
24 You know, we can prove electronically that we did check  
25 and it was verified. I don't think that's even being

1 the question. I think at the time there was coverage  
2 and they found out later that there wasn't.

3 MS. GUICE: Have you tried to send us any  
4 old claims?

5 MS. BOWLING: Yes.

6 MS. GUICE: Have we denied them?

7 MS. BOWLING: We're sending to the MCO's,  
8 obviously. We're correcting those and trying to prove  
9 timely. I'm not real sure how successful we have been.

10 MS. AGAN: So if you get a recoupment and  
11 it's 24 months old or three years old, you get to start  
12 your timely filing period over from that date of that  
13 recoupment letter? Is that what I just understood you  
14 to say?

15 MR. FITZNER: It's from when we're notified  
16 of that eligibility. So let's say date of service  
17 occurred on January 5, 2014. Well, February 1st of  
18 2015, we get notified by the state that our retro  
19 eligibility goes all the way back to the date of service  
20 from the previous year. The date that we're notified by  
21 the state through our reporting systems, that is the  
22 date in which our timely filing should start. If you  
23 have issues with that, I recommend you contact us and  
24 let us know. A lot of times with these retro  
25 eligibilities, there can be hiccups because dates of

1 service, different things like that. There's usually a  
2 fair amount of back and forth with that, too, because  
3 just as confused as you are with member's eligibility,  
4 and they're confused, the member, and we're confused,  
5 too, until all those dates of service get worked out  
6 when the data comes across. So we'll work with you on  
7 that. So from that point of our notification on  
8 February 5th is when your timely filing will start.

9           And then also with any sort of authorization  
10 requirements if there were something like that, you  
11 would need to get retrospect of authorization. You may  
12 have gotten one from Wellcare. Just because you got one  
13 from Wellcare you're going to need to notify us, send us  
14 some of those clinical records so we can verify because  
15 it's going to be different, and vice versa, a lot of  
16 times.

17           So, you know, you may get a rejection. How  
18 could I know you got an authorization? Well, just let  
19 us know and we'll do a retrospective review for that and  
20 take that into consideration.

21           MS. KEYSER: I guess I'm just wondering  
22 should there be an improved line of communication to the  
23 clinic when something like this happens? Because all we  
24 get is a letter saying they weren't eligible or they had  
25 another -- they were eligible with another MCO and

1 they're going to take our money, but we don't know who  
2 they are currently eligible with. Sheila, I mean, would  
3 that be helpful? Your billers probably spend a lot of  
4 time tracking down, well, now, who do I bill? I've got  
5 five MCO's. It could be this, this, this or --

6 MS. BOWLING: Well, actually, once we've  
7 been notified that there's been a recoupment in process,  
8 that's when we start our investigation, and, you know,  
9 we have access to their websites to confirm that  
10 coverage. It's available to us. I don't see that that  
11 -- any other correspondence is going to help us other  
12 than knowing that, that they're going to take their  
13 money back and why. I mean, the eligibility was there  
14 originally. If it's accurate today, we'll have to count  
15 on that.

16 MS. KEYSER: So then you resubmit a claim to  
17 the current MCO, whatever that is. And then we have to  
18 -- what do you do with the wrap payment that's occurred  
19 with -- you've got to undo all that, right?

20 MS. BOWLING: Exactly. And we've been told  
21 that that process, the adjustment claims will process  
22 through Medicaid the same as our original claims which  
23 we identified a few issues with that.

24 MR. MARTIN: Why would it take a year for  
25 DMS to figure out --

1 MS. GUICE: I don't know.

2 MR. MARTIN: I guess that's a big question  
3 because you know what that patient is -- if they're not  
4 eligible at all, so that it's pretty much -- we've done  
5 all the billing and we're not going to get paid for it.

6 MR. SMITH: Lee, is eligibility still in  
7 social services or whatever it's called these days --

8 MS. GUICE: DCBS is still the agent. Most  
9 of them are now moved to -- everything but waiver and  
10 long-term care has been moved to Kynect, and Kynect is  
11 -- DCBS is still the agent, but Kynect is now the  
12 system. So right now we have two eligibility systems.

13 MS. KEYSER: So that kind of leads into item  
14 No. 10, the eligibility discrepancies between DMS and  
15 Kynect. Emily, what have you heard?

16 MS. BEAUREGARD: Just that it does seem like  
17 that is where part of the problem lies. There is a  
18 discrepancy sometimes in how Kynect has determined  
19 eligibility and then what DMS recognizes. I think David  
20 might have more information about this. This is  
21 something you brought to my attention.

22 MR. BOLT: I mean, calling the MCO's just  
23 seems to, again, we need DMS and the MCO's to sit down  
24 and talk to one another because we're putting the  
25 providers in a very precarious position of having people

1 come back on them two and three years later over  
2 something that can't control them.

3 MS. GUICE: Kynect has only been live since  
4 October 2013. So we're not two years into that part of  
5 it, yet. But could you be a little bit more specific  
6 about this disconnect between DMS and -- are there  
7 discrepancies between Kynect and DMS?

8 MS. BEAUREGARD: I think there may also be  
9 some discrepancy in just when eligibility is official, I  
10 guess. With Kynect a person thinks that they're covered  
11 maybe immediately and then there's lag time.

12 MS. GUICE: Timing.

13 MS. BEAUREGARD: I think that's part of it.  
14 I'm not sure if there's more to it than that. That's  
15 one of the things that I've heard as an example.

16 MS. GUICE: Well, okay. Just at a very high  
17 level, let me talk about what the timing is with this.  
18 Okay? I can go onto Kynect and submit my application,  
19 okay, and when I hit submit, the system will run  
20 eligibility. And if all of the stars are aligned, it is  
21 possible for me to be notified in a minute and a half  
22 that I am Medicaid eligible. Okay?

23 However, even when the stars align for that  
24 person, okay, so I see it, and I think, oh, I've got  
25 coverage, call a doctor, call a clinic, make an

1 appointment. The problem is, though, that while -- and  
2 Kynect will feed that information back to Medicaid for  
3 MMIS purposes, but MMIS loads that information once a  
4 day, and then we send a file to the MCO's once a day.  
5 Most of these things occur at night so that all of the  
6 other processes can happen. You know, claims can get  
7 paid and MCO's can run their whatever their business  
8 processes are which is a lot of claims getting paid. So  
9 and then they have to send that file down to their  
10 pharmacy administrator, the same as we have to send it  
11 to our pharmacy administrator and then to their  
12 behavioral health subcontractors if they have them, and  
13 to their dental subcontractors.

14 So it is entirely possible that it could be  
15 as long as three days from the time that I hit my submit  
16 button until I show up on everybody's system as  
17 eligible. Entirely possible. But because I've hit my  
18 submit button and I believe that I now have coverage,  
19 I'm going to -- and I will, but I'm going to go out and  
20 make appointments and see doctors. Okay? And that has  
21 become an issue for us from the very first time, from  
22 January 1, 2014.

23 MS. KEYSER: And that individual is waiting  
24 for a letter of communication with their cards and  
25 things like that from the MCO.

1 MS. GUICE: Well, the MCO has three or  
2 five days to get the new membership -- some single digit  
3 number to get the communication back out to a new member  
4 that they've received from us.

5 MS. KEYSER: Okay.

6 MS. GUICE: Currently, DMS is still issuing  
7 a separate card. So there are two cards, one from DMS  
8 and one from the MCO.

9 MS. KEYSER: And when they present to the  
10 clinic, we've got that, that shows that they were  
11 eligible. Right. And then a year later comes the  
12 letter that says --

13 MS. BEAUREGARD: So I don't think all of  
14 this recouping is happening because of Kynect which is  
15 why they are different items. We're not sure what the  
16 issues are and how they're related and which ones may  
17 not be related, but these are all issues that have been  
18 coming to our attention recently. So I think there are  
19 still areas where we need to dig down a little bit more  
20 to figure things out so they don't keep affecting those  
21 providers.

22 MS. GUICE: Well, once again, specific  
23 examples of somebody that has been recouped from a year  
24 ago or two years ago will help us take a look and see  
25 what the issue is.

1 MS. BEAUREGARD: I can share Sheila's  
2 examples with you.

3 MS. GUICE: Yes. It's impossible to solve a  
4 problem unless we know specifically what it is.

5 MS. AGAN: So is it possible that you go  
6 on-line and it says they're eligible today?

7 MS. GUICE: Yes. Then it made a mistake?

8 MS. AGAN: And then 60 days later you find  
9 out that today they're not eligible? Because we've seen  
10 that. We file a claim and it comes back denied by the  
11 MCO's as no coverage, and you go back on-line, and it  
12 still says they're eligible.

13 MS. GUICE: Then they're probably just with  
14 another MCO.

15 MS. AGAN: Well, we have that, too, but I'm  
16 talking about when it goes all the way back to the DMS.

17 MS. BOWLING: I think when the patients have  
18 to revalidate --

19 MS. AGAN: There's confusion going on.

20 MS. GUICE: A re-certification period,  
21 there's an annual re-certification period, and when that  
22 happens, you know, eligibility does not continue as just  
23 because one -- at one particular time you were eligible.  
24 You have to be re-certified every year. So it is  
25 possible, certainly, to be eligible today, but I don't

1 know why I would be eligible today and not 60 days later.

2 MS. AGAN: So if they did not recertify and  
3 do it in their time, do you backdate their eligibility,  
4 or does it go from -- I mean, is there a time that DMS  
5 ever backdates and says not eligible?

6 MS. BEAUREGARD: Retroactively.

7 MS. GUICE: Says retroactively not eligible?

8 MS. BEAUREGARD: Yes.

9 MS. GUICE: Not that I'm aware of. So  
10 that's why I would like to see some examples of that.

11 MS. AGAN: So if we see those, we should get  
12 the copies to you?

13 MS. BEAUREGARD: If you could send me more  
14 examples or directly to Lee, but I think it would be  
15 good to have examples of different types of issues that  
16 all are around eligibility because it seems like  
17 they're --

18 MR. MARTIN: Is there a timeframe during  
19 that re-certification process or revalidation process  
20 that they could show up as being eligible, but they  
21 could retroactively not be?

22 MS. GUICE: No.

23 MS. BEAUREGARD: Item 12 actually goes right  
24 along with this. I know that during this whole open  
25 enrollment period, there have been reports coming out

1 with newly enrolled members and not of the -- I put  
2 renewals, but you said recertification, I guess. I'm  
3 not sure what the correct term is. But for all of those  
4 folks that signed up and were eligible January 1st of  
5 last year or February 1st, whenever it was, got Medicaid  
6 coverage and then had to re-certify, what are those  
7 numbers looking like? Are there going to be a lot of  
8 folks who didn't get recertified within that one year?

9 MS. GUICE: We have a rolling -- every month  
10 there's a rolling 25 to 35,000 members that drop off and  
11 come back on. Is that about right? Right. Every month  
12 that happens. Because re-certs don't happen just on  
13 January 1st. I mean, we have a large number that  
14 occurred January 1, 2014, and then January 2015, but not  
15 -- you know, all of the rest of the members roll, and it  
16 depends on their calendar month.

17 MS. BEAUREGARD: Yeah. So I'm just  
18 wondering if you've seen that there's a big number of  
19 people who didn't recertify in time.

20 MS. GUICE: No, I have not seen anything  
21 different than what has usually occurred. The  
22 traditional 25, 35,000 people rolling in and out every  
23 month.

24 MS. BEAUREGARD: Somehow I feel the outreach  
25 enrollment workers could, if they knew who needed to

1 re-certify could do a little bit more proactive outreach  
2 there, and that's one thing that has just come to mind  
3 with all of this conversation about eligibility and  
4 re-certification, making sure that people aren't in that  
5 gap of coverage, and what we could maybe do for  
6 educating patients and just more outreaching to them.

7 MS. GUICE: Who do you mean by outreach  
8 enrollment workers?

9 MS. BEAUREGARD: The connectors. We have a  
10 lot of connectors that are housed at clinics that are  
11 part of our membership.

12 MS. GUICE: Well, everybody gets noticed for  
13 45 days before the end of their certification period,  
14 and then 15 days and then 10 days.

15 MS. BEAUREGARD: The individual does?

16 MS. GUICE: Uh-huh. Absolutely. You can't  
17 terminate Medicaid --

18 MS. KEYSER: Letters and --

19 MS. BEAUREGARD: Right. But is that  
20 information going to the person who enrolled them, too?

21 MS. GUICE: No.

22 MS. BEAUREGARD: That's where I'm thinking  
23 there could be some more proactive outreach and  
24 education to the patient if we were aware of what that  
25 date was and could get to them a little sooner. But

1 that might be more of a Kinect conversation maybe.

2 MS. KEYSER: Thank you, Emily. Then we'll  
3 go back up to item 11. Just a little bit of discussion  
4 on -- I guess it's come to our attention that the MCO's  
5 have the ability to bundle codes with the E&M code which  
6 is the office visit, lab, and other services recognized  
7 in DMS's fee schedule, and we've given an example here.  
8 And I guess our question is, is that do they have the  
9 authority to bundle?

10 MS. GUICE: Are you asking Medicaid?

11 MS. KEYSER: Yes, and their contractual  
12 language with the MCO's, is there language that gives  
13 the MCO's the ability to bundle codes with the office  
14 visit?

15 MS. GUICE: That contract does not talk  
16 about that at all. The MCO's have to follow correct  
17 code, the NCCI, right, and some, you know, whatever the  
18 laws and rules are about that. But they are not  
19 required to pay as Medicaid paid.

20 MS. KEYSER: Emily, any examples?

21 MS. BEAUREGARD: I think that Sheila may be  
22 able to speak to this.

23 MR. BOLT: Actually, the MCO's were pointing  
24 to the SPA that was approved.

25 MS. GUICE: That says?

1 MR. BOLT: I don't have it right off the top  
2 of my head. The MCO's might be able to mention it.

3 MS. GUICE: A SPA that was approved that  
4 said? What was it about?

5 MR. BOLT: They could bundle certain --

6 MS. GUICE: That the MCO could bundle  
7 certain codes?

8 MS. BEAUREGARD: We think that it was  
9 related to drug screening and that this has gotten --  
10 the urinalysis has somehow gotten mixed up in that.

11 MR. BOLT: They're bundling the microscopic  
12 urinalysis with the E&M code. I think there's an issue  
13 on clinical relevance. I admit it probably is overused  
14 in certain situations, but in a clinical setting it's,  
15 in some instances it's an absolute necessity for  
16 appropriate diagnosis by a PCP, not related to drug  
17 screening.

18 MS. GUICE: I think this is an issue for the  
19 MCO and the providers.

20 MR. BOLT: But they're pointing us back to  
21 you all saying approved a SPA.

22 MS. GUICE: You need to tell me exactly what  
23 it is.

24 MR. BOLT: We'll get it to you.

25 MS. KEYSER: Item no. 13, MCO corrections to

1 member addresses. We would like the MCO's to correct  
2 member addresses. And once again, Emily, can you  
3 elaborate for me?

4 MS. BEAUREGARD: Yeah. I think there's just  
5 been an issue with the addresses.

6 MS. GUICE: Let me just say this. The MCO's  
7 can correct their addresses, their member addresses in  
8 their systems all day long, but we don't keep that  
9 information at DMS.

10 MS. BEAUREGARD: Right. And what our  
11 understanding is that it actually gets overwritten.

12 MS. GUICE: That's correct.

13 MS. BEAUREGARD: And so whenever you gather  
14 a correct address, it gets overwritten with the  
15 incorrect address. We're wondering if there's a way to  
16 correct that, improve the system so that we get better  
17 addresses.

18 MS. GUICE: Not with our current system,  
19 there is not. We have investigated that possibility  
20 last year, and it just is not possible with our current  
21 system. So I would advise you providers and your  
22 connectors, your member has the ability to correct their  
23 address in the system on-line now. So you can make that  
24 change on-line. You don't have to send anything in.  
25 You don't have to do anything else, but if you go to

1 Kynect and you make that change, that goes in our  
2 system, and it gets shot back out to the MCO's.

3 MS. AGAN: If they have a wrong date of  
4 birth or a wrong gender in there, can they correct that  
5 on-line now?

6 MS. GUICE: Yes.

7 MS. KEYSER: So then, again, if it's  
8 corrected on Kynect, then that gets sent to Medicaid?

9 MS. GUICE: Uh-huh, that goes into the MMIS.

10 MS. BEAUREGARD: Now, if the address was  
11 significantly incorrect as having them in a different  
12 county or something, would they ever be re-assigned or  
13 something happen to their coverage because they go in  
14 and correct it? Because we have seen --

15 MS. GUICE: Yes.

16 MS. BEAUREGARD: -- people listed with just  
17 counties away from where they actually live.

18 MS. GUICE: Yes.

19 MS. BEAUREGARD: So it could cause them  
20 trouble to correct their address?

21 MS. GUICE: Well, it could cause them  
22 trouble because of if the MCO that they're assigned to  
23 is not offering services in that area, that would be an  
24 issue. Otherwise, I don't know that --

25 MS. BEAUREGARD: Otherwise, they would not

1 be re-assigned.

2 MS. GUICE: They shouldn't be, but they can  
3 choose to reassign themselves when they go do that, but  
4 they shouldn't be. That would only be the reason. That  
5 would be the only reason.

6 MS. BEAUREGARD: If an MCO was not covering  
7 that area.

8 MS. GUICE: Right.

9 MS. KEYSER: Item 14, the lock-in program  
10 notification, there seems to be some problems, Emily,  
11 how with the --

12 MS. BEAUREGARD: So we know that a provider,  
13 if their patient assigned to them is locked in, the  
14 provider gets notice of that. But other providers don't  
15 get notice of that. So, you know, that patient could go  
16 to another PCP or other type of provider, and whenever  
17 they go to check eligibility, it says that they're  
18 eligible, but there's no real indication there that  
19 they're in a lock-in program and that you're not going  
20 to get paid to see them.

21 MS. GUICE: You're talking about MCO  
22 patients? I don't know what their member screen shows.

23 MS. BEAUREGARD: This is on DMS's website  
24 for eligibility. It shows that they're eligible, but  
25 then my understanding is, and I don't check eligibility,

1 so someone may need to correct me, but there's a whole  
2 other screen that you have to go to. It's not something  
3 that you would typically go to look to see lock-in  
4 status.

5 MS. GUICE: I don't know that. I don't know  
6 the answer to that.

7 MS. BEAUREGARD: And so the end result is  
8 that a locked in patient can go to a non locked in  
9 provider, get services, and then that provider is not  
10 going to get paid.

11 MR. MARTIN: Because before DMS, you would  
12 know if they are a lock-in patient.

13 MS. GUICE: How?

14 MR. MARTIN: Because when you looked at  
15 their eligibility or their card, it would have lock-in.

16 MS. GUICE: If you looked at eligibility  
17 previous to MCO's, if you looked at the eligibility  
18 screen of DMS, you would see it was locked in. I see  
19 the issue is here that we don't -- the MCO's are locking  
20 them in now. DMS is not. So it's not going to probably  
21 -- probably doesn't show up there. So one of my  
22 questions would be is are you only checking eligibility  
23 for your members on DMS website, or do you go to the MCO  
24 website?

25 MS. AGAN: We actually do both.

1 MS. GUICE: Does it show up on your all's  
2 websites, MCO's?

3 MS. KEYSER: If a patient is locked into a  
4 certain provider, if I go to your all's websites to  
5 verify eligibility, will I see that that patient is  
6 locked in?

7 MR. FITZNER: Anthem will have that  
8 functionality on our portal. We have just begun the  
9 lock-in process. We just now reached a period where our  
10 membership is eligible to be locked in because of the  
11 amount of records you have to have in order to do that,  
12 but we should have that in place by the time that  
13 members are being locked into our services.

14 MS. KEYSER: So the other MCO's that are  
15 here, what about something on the member's ID card that  
16 addresses that they are locked into a provider?

17 MR. FITZNER: We are not allowed to do that.

18 MS. BEAUREGARD: That's what we wanted to  
19 really request that there be some notification that's  
20 much simpler than what it currently seems to be. If  
21 there's just some way to say that the patient must see a  
22 particular provider and indicate it, I think that would  
23 really solve this issue.

24 MS. GUICE: Passport I know requires you to  
25 see the primary care physician that's on your card.

1 MS. BEAUREGARD: That's a policy for all of  
2 their --

3 MR. MARTIN: We have that issue after hours.

4 MS. KEYSER: So if a Passport patient comes  
5 in, we get prior authorization, we have to call and get  
6 approval to be seen. So that happens. But I guess the  
7 issue is, as you said, not knowing who they're locked  
8 into.

9 MS. BEAUREGARD: Right. And I don't believe  
10 that the ways that the individual portals work with the  
11 MCO's are necessarily always providing that information  
12 because we've discussed that. David, do you remember  
13 specifically?

14 MR. BOLT: No. I was busy trying to find  
15 the answer to the other question.

16 MS. BEAUREGARD: It's not necessarily that  
17 the correct information is on DMS's website or the  
18 provider portal of the MCO always that shows lock-in  
19 status.

20 MR. BOLT: That's what we heard, yes,  
21 essentially.

22 MR. SMITH: Well, what Lee is saying is that  
23 it's never going to show up on DMS's site. It's always  
24 going to have to come from the MCO.

25 MS. GUICE: I don't think that it's going to

1 show up on our site. I don't think we hold that  
2 information.

3 MS. BEAUREGARD: We were told there was  
4 another screen, but that it was hard to get to, and but  
5 you wouldn't typically go there. And then I know just  
6 from a practicality standpoint, checking, you know, four  
7 or five different MCO portals is just something that  
8 doesn't happen always. I'm not saying that that's  
9 something that DMS can necessarily be responsible for,  
10 but it just -- checking DMS's website, I think, is a  
11 preference because it's a one-stop place to check  
12 eligibility and why would you check two places every  
13 time you have a patient come in.

14 MS. GUICE: DMS isn't paying you anymore.  
15 DMS is not paying you for that patient anymore. That's  
16 why I would not check that.

17 MS. BEAUREGARD: And that there are times  
18 when there's a discrepancy between eligibility on the  
19 portal versus DMS's website and which one do you go  
20 with.

21 MR. SMITH: But DMS is telling you whether  
22 you're eligible or not.

23 MS. BEAUREGARD: Eligibility is DMS's  
24 responsibility.

25 MS. BOWLING: A lot of systems nowadays does

1 that electronically. There's not a physical person  
2 looking at that screen. It's done electronically, and  
3 that information isn't transferred electronically.

4 MS. BEAUREGARD: But the part about lock-in,  
5 yeah. So I think one thing that we had discussed is  
6 that if there were, one, a notification that was simpler  
7 on the card would be best. And then, two, if there was  
8 just more consistency between the MCO's on how the  
9 lock-in was established, that also, and then how that  
10 information is shared, even more so with providers, that  
11 would be helpful because it's a little bit different  
12 with each.

13 MS. GUICE: Do you want to ask the MCO's  
14 anything about that because I don't know that I can  
15 answer anything on that at all.

16 MS. BEAUREGARD: Well, I think the  
17 notification on the card part is DMS's -- that would be  
18 your role to determine whether you could give the MCO's  
19 the authority to put something on the card because right  
20 now they're not allowed to.

21 MS. RUSSELL: The reason we're not allowed  
22 to is that's PHI. That has nothing to do with Medicaid.

23 MS. BEAUREGARD: Saying somebody has to go  
24 to a provider?

25 MS. RUSSELL: Sure.

1 MS. BEAUREGARD: Their whole card is PHI.  
2 The card has their name and it has their number on it.

3 MS. RUSSELL: The lock-in on the card  
4 indicates there is an issue with your healthcare. It  
5 doesn't say specifically what it is, but we cannot put  
6 that on the card.

7 MR. FITZNER: Another question I'll also ask  
8 you all, we hear from the providers all the time that a  
9 member coming in with their card is also slim to none in  
10 a lot of areas. So, again, we fall back to what good is  
11 it putting it on the card, you know, also disclosing  
12 that information because a lot of times it is around  
13 drug-seeking behavior or utilization patterns that the  
14 pharmacist, you know, another doctor, another pharmacist  
15 doesn't need to know, which is why we can't notify  
16 anybody when a member is in lock-in.

17 MS. BEAUREGARD: Well, if a provider is not  
18 going to get paid to see the member and the whole point  
19 is to try to direct that patient back to their locked in  
20 provider, I mean, there needs to be some way that  
21 everyone is informed and is able to work together here  
22 so that --

23 MR. MARTIN: DMS --

24 MS. BEAUREGARD: Patients can very easily  
25 get around being locked in.

1 MR. MARTIN: The card from DMS prior to  
2 MCO --

3 MS. BEAUREGARD: Right, did say something on  
4 it.

5 MR. MARTIN: -- actually had lock-in and who  
6 they were locked into.

7 MS. COOPER: HIPAA going into effect too.  
8 But I mean even when DMS had the lock-in program,  
9 providers were still responsible for checking who they  
10 were locked into and make sure that information is  
11 current. I still think this falls back on the provider  
12 to check the web portals of the MCO that they are  
13 assigned to, and it's the provider's responsibility to  
14 do that.

15 MR. MARTIN: I think we're not trying to get  
16 out of that. We're just trying to find it in a  
17 consistent pattern.

18 MS. COOPER: I think the best option would  
19 be for that to be on the portals for the MCO's because  
20 we don't have that information.

21 MR. MARTIN: Does all the portals have that  
22 the patient's locked in?

23 MS. BEAUREGARD: And does it come with  
24 eligibility, or do you have to check it somewhere else?

25 MS. RUSSELL: I don't know the answer. I'd

1 have to go look.

2 MR. BOLT: What if we just ask for the MCO's  
3 to give KPCA in a secured format the locked in patients?

4 MS. BEAUREGARD: We need to know the  
5 patients that aren't locked in for our numbers. That's  
6 the problem is the people --

7 MR. MARTIN: I'll tell you what, we'll go  
8 back -- various MCO's and see if we can find --

9 MR. SMITH: We need to sit down with each of  
10 the portals and see what it says.

11 MS. BEAUREGARD: If you all could do that  
12 for us because we don't see those portals, that would  
13 help. We have heard that it's not as simple as just  
14 going to each MCO portal.

15 MR. MARTIN: I think the prevailing thing  
16 here we found is DMS's website should be meaningless.  
17 Right?

18 MS. KEYSER: Is not the go to in regard to  
19 eligibility.

20 MR. MARTIN: We need to go the MCO's because  
21 they don't --

22 MS. BEAUREGARD: MCO's also rely on what DMS  
23 is sending them. So it could be just as incorrect from  
24 the MCO side.

25 MR. MARTIN: Well, I mean, we're sitting

1 here confirming that they don't send information. The  
2 correct information they send gets overwritten so why  
3 would we expect DMS to give us anything that's really  
4 clearcut. Right?

5 MR. SMITH: It is going to be the MCO  
6 portal.

7 MS. KEYSER: Go to the source.

8 MR. MARTIN: We need to go the MCO's. We  
9 just need you guys to help enforce that that information  
10 is there for us.

11 MS. BEAUREGARD: I think that's true. I  
12 guess I thought that there was an another reason that  
13 providers check the DMS portal, that there was some  
14 other --

15 MS. BALE: I think originally, a lot of the  
16 MCO's, originally, the data was inaccurate, and we went  
17 to the Medicaid side because we got much more accurate  
18 information.

19 MS. BEAUREGARD: But now you think that the  
20 MCO's data is accurate? I mean, because that's the  
21 thing, you might have to check, too, because they might  
22 say different things, and then which one do you  
23 ultimately rely on?

24 MS. KEYSER: Well, since the MCO is paying  
25 us, I think what Lee is saying is that's where it goes,

1 that's who we should rely on.

2 MS. BEAUREGARD: But if it's related to  
3 eligibility, it goes to back to a discrepancy with DMS  
4 over eligibility?

5 MR. MARTIN: Doesn't matter if they showed  
6 that they're eligible or not, they can still come back  
7 two years and take it away from us.

8 MS. AGAN: We actually check both. We go  
9 and we first check DMS, and that's actually where we're  
10 going to verify the Medicaid number and all that to make  
11 sure that we match up to our wrap. Then it tells us  
12 exactly what MCO the patient is with. Then we go to the  
13 MCO site to go get all the details. In the case of  
14 Passport, that's where we're going to find our PCP  
15 information. So I have found that we can't do without  
16 checking both because there's information on both sides.  
17 We have to check both on every single patient on every  
18 single visit.

19 MS. GUICE: What is it that you're finding  
20 on the Medicaid member site that is not on the MCO  
21 website?

22 MS. AGAN: Sometimes the patients, they  
23 don't know who they're with. They just say they have  
24 Medicaid. So you go to the Medicaid, and it will tell  
25 you.

1 MS. GUICE: And find out who the MCO is.

2 MS. KEYSER: Don't you also see dual  
3 eligible information to see if they have Medicare as  
4 well? You see that on DMS as opposed to the MCO's  
5 website, too.

6 MS. AGAN: Right. It is different. And  
7 then if you want to secure your wrap payments coming  
8 through, we want to make sure we have the right Medicaid  
9 number because that's the only identifier we get back on  
10 our EOB is that Medicaid number. So that's how we have  
11 to make sure that's correct in our systems, and that's  
12 where we get the correct information because the patient  
13 often does not carry a card. I think everybody --

14 MS. KEYSER: I know we'll find other  
15 insurance information on DMS that they have Medicare or  
16 they'll have a commercial something or another out  
17 there, and we won't see it on the MCO, but it flags and  
18 we're like, oh, patient, you've got something else.

19 MS. AGAN: Right.

20 MS. KEYSER: So there are reasons.

21 MS. AGAN: We don't rely just on the MCO.

22 MS. GUICE: Well, I think that this is --  
23 I'd like to just offer this to you, this your  
24 opportunity to speak to several of the MCO's to ask them  
25 about maybe putting some more information on their

1 website.

2 MR. MARTIN: You have that information to  
3 put on there of other insurance?

4 MS. RUSSELL: Yeah, I mean, pull up the  
5 other insurance, as well.

6 MR. MARTIN: Is that available on your  
7 portal?

8 MS. RUSSELL: I'll have to go look.

9 MS. BOWLING: It is on Wellcare's.

10 MS. BEAUREGARD: I think we should come up  
11 with a list of information that we would like to request  
12 all MCO's have available on their portal in some format.

13 MS. KEYSER: Moving to any other item that  
14 is not already on the agenda, anybody?

15 MR. MARTIN: On 4(b), did I miss something  
16 on that? Did we talk about it?

17 MS. KEYSER: Auto posting? They're checking  
18 into the parameters that they need to make that happen.  
19 They're still working on that.

20 MR. DENNIS: We're working with HP on that  
21 to see -- I've got a list. It's in my office. I didn't  
22 bring it, the things you all would like to see on the  
23 EOB and breaking it out by MCO, different things like  
24 that.

25 MS. AGAN: Do you think that's a doable

1 thing and do you have a timeline on that?

2 MR. DENNIS: I don't know and they  
3 haven't -- we met with them here a week or so ago and  
4 gave them -- they haven't gotten back with us on it.

5 MS. GUICE: One of the things just to  
6 mention is that changes to our system generally will  
7 cost money, and that will be a consideration for  
8 Medicaid.

9 MR. MARTIN: We know that.

10 MS. GUICE: Just want to mention that.

11 MR. MARTIN: But, I mean, is it something  
12 that's going to be doable?

13 MR. DENNIS: Well, I've got to touch base  
14 with them and see because they were looking into it. We  
15 gave it to them and they said they'd look into it.

16 MR. MARTIN: Because not having electronic  
17 posting is costing us a lot of money.

18 MS. KEYSER: Medicaid has that system in  
19 place for regular Medicaid. We get auto remits for our  
20 regular Medicaid patient. So it's being done on their  
21 side in one circumstance. We're just wanting them to  
22 figure out how we can have it done for the others, a  
23 wrap.

24 MS. GUICE: So is it doable? Probably. But  
25 I'm speaking for somebody who thinks all that stuff is

1 smoke in mirrors, the technical part. It's magic to me.

2 MS. KEYSER: David will keep us abreast on  
3 that. And then Emily is going to wrap on the  
4 recommendations to the next MAC, which I'm sure will  
5 include the previous recommendations from the other  
6 meeting.

7 MS. BEAUREGARD: Right. While I'm looking  
8 back at the previous recommendations, one was around the  
9 EOB's. Well, just revise that to include the electronic  
10 piece of it. We had asked for some additional  
11 information to be included on the EOB's, some  
12 identifiers that would make it easier to do the posting,  
13 but for auto posting purposes, we'll include the  
14 electronic piece. And then around eligibility and  
15 recoupment, I think we need to come up with a  
16 recommendation about figuring out what some of those key  
17 issues are that are causing these eligibility issues and  
18 the really delayed recoupment and potentially -- I don't  
19 know if that is a worker that we need to request, get  
20 together, or if it's just some -- I'm not sure yet.

21 MR. SMITH: Let's articulate the problem  
22 before we get --

23 MS. BEAUREGARD: Well, we know that the  
24 problem for our providers is that they're not always  
25 aware of eligibility --

1 MR. SMITH: We need to be able to articulate  
2 it. We're just articulating the consequences rather  
3 than --

4 MS. BEAUREGARD: Well, to articulate the  
5 problem, we either need to have a work group meeting or  
6 get more information from DMS and the MCO's about what  
7 is happening in their system.

8 MS. KEYSER: So we'll do that. Yeah.

9 MS. BEAUREGARD: That could be a  
10 recommendation. And then I think around the lock-in  
11 piece, I know that there's a possibility that it can't  
12 be on the card for PHI, but I think that that could be  
13 an interpretation of HIPAA. I would like to know if DMS  
14 could actually look into that and see if there is  
15 something that could be done to make more of a visible  
16 and immediate sort of indicator on the card. I think  
17 that that would be helpful.

18 Aside from that, we also will be working  
19 more directly with the MCO's on what information we'd  
20 like to see on the provider portals, and that I don't  
21 think needs to be a recommendation.

22 Is there anything else here that --

23 MS. GUICE: Are you going to make the  
24 recommendation to MAC that we look into the lock-in  
25 issue?