

## BEHAVIORAL HEALTH TAC RECOMMENDATIONS

PRESENTED TO MAC

SEPTEMBER 24, 2015

**RECOMMENDATION:** That DMS clearly communicate to the Behavioral Health TAC which DMS divisions or staff should be contacted in order for the TAC to be actively engaged in the development of the dashboard referenced in DMS' letter of July 21<sup>st</sup> in response to our previous recommendation. If DMS wants our input, we are more than happy to give it!

**RECOMMENDATION:** That DMS share with the MAC, the Behavioral Health TAC and any other interested TAC the newly-revised standardized forms that have been developed under the new MCO contracts.

**RECOMMENDATION:** That DMS share with the Behavioral Health TAC the criteria or "industry standard" it is using in assessing data submitted from the MCOs with regard to: denials and readmissions to Psychiatric Hospitals and Crisis Stabilization.

## BEHAVIORAL HEALTH TAC REPORT TO THE MAC – SEPTEMBER 24, 2015

Good morning. I am Sheila Schuster, serving as Chair for the Technical Advisory Committee on Behavioral Health (BH). Our TAC had its most recent meeting at the Capitol Annex on September 3, 2015. All five (5) of the Medicaid MCOs and their Behavioral Health representatives were in attendance. In addition to the MCO representatives and three of our six TAC members who were present, we had other members of the behavioral health community in Kentucky, including members of the KY Mental Health Coalition and others interested in the topic being presented. We also had a representative from the KY Department for Behavioral Health, Developmental & Intellectual Disabilities, but no staff from the KY Department for Medicaid Services were able to attend.

We reviewed the discussion at the MAC meeting held on July 23, 2015 and the Behavioral Health TAC recommendations. The responses from DMS to the Behavioral Health TAC recommendations from the May, 2015 meeting of the MAC were disseminated and discussed.

In the invitation to the MCOs to attend the July TAC meeting, we noted that we would like to use the TAC meeting to get a current “snapshot” of where we are with each MCO regarding:

\*\*Numbers of credentialed providers by type by Medicaid region

\*\*Numbers of covered lives by Medicaid region (children vs. adult, if possible)

\*\*Numbers of Admissions, Lengths of Stay, and Readmissions for Children and for Adults in Psychiatric Hospitals, CSUs and PRTFs. Please also include the number of authorizations that were denied.

- ✓ If you have already submitted this data for 2014, then we would like to have it for the first six (6) months of 2015.
- ✓ If you have not submitted this data for 2014, please do so and also include a report for the first six (6) months of 2015.

We now have information from four of the MCOs with regard to denials, discharge and readmission data around psychiatric hospitals and PRTFs, based on individuals and not on claims data. Our plan is to have all of the MCOs reporting before the next TAC meeting so that we can ask further questions and make some recommendations. The BHDID representative indicated that the Department is meeting with the MCOs to try to “drill down” on the best way to ask for the data so that issues can be addressed. We have indicated our interest in meeting with BHDID staff around this activity.

We had a brief discussion about the uniformity of forms that should be occurring under the new contracts and indicated our interest in seeing those revised forms as soon as they are available for dissemination. The TAC continues to be interested in obtaining the “industry standard” for readmissions to an inpatient acute hospital setting for a Medicaid population and for a non-Medicaid population. We wonder if this information is available to Medicaid and could be shared with the TAC?

There was an animated discussion around DMS’ activity around Disenrollment Due to Bad Addresses. Consumer and family member representatives, as well as providers and MCOs expressed significant concerns about how this would be done, the disproportionately negative effect that this could have on those members who have behavioral health issues, and whether there are some alternative ways of improving contact information for members.

There was also a brief discussion about the requirement for Parity in all health plans and Medicaid under the ACA. An example from a member of the MAC that sounded like parity was not being experienced was discussed. The TAC was informed that this issue will be discussed at the next meeting of the Behavioral Health Subcommittee of the KY Health Benefit Exchange. Information from that discussion will be shared with the TAC at our next meeting.

Finally – as always – we held a discussion about integrated care and its importance and the difficulties in assessing whether it is happening or not! The MCOs are required under their new contracts to address integrated care as PIP in 2016 and we are hopeful that we will be able to see documentation of outcomes in this area.

The next meeting of the Behavioral Health TAC will be held on Thursday, October 29, 2015 at 1:00 p.m. in Room 125 of the Capitol Annex.

**SEPTEMBER 24, 2015 RECOMMENDATIONS TO THE MAC:**

**RECOMMENDATION:** That DMS clearly communicate to the Behavioral Health TAC which DMS divisions or staff should be contacted in order for the TAC to be actively engaged in the development of the dashboard referenced in DMS’ letter of July 21<sup>st</sup> in response to our previous recommendation. If DMS wants our input, we are more than happy to give it!

**RECOMMENDATION:** That DMS share with the MAC, the Behavioral Health TAC and any other interested TAC the newly-revised standardized forms that have been developed under the new MCO contracts.

**RECOMMENDATION:** That DMS share with the Behavioral Health TAC the criteria or “industry standard” it is using in assessing data submitted from the MCOs with regard to: denials and readmissions to Psychiatric Hospitals and Crisis Stabilization.

Thank you for providing this forum to bring forward behavioral health concerns on behalf of Medicaid members.



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

**Steven L. Beshear**  
Governor

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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

July 21, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Behavioral Health Technical Advisory Committee (TAC)  
Recommendations Presented at the May 28, 2015 MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Behavioral Health TAC recommendations presented at the May 28, 2015 MAC meeting.

1. **Recommendation 201505BH01:** That the DMS dashboard of data from the MCOs regarding: Lengths of Stay in Psychiatric Hospitals and Crisis Stabilization Units; Percentage of Denials for each behavioral health service: inpatient and outpatient; Readmissions to Psychiatric Hospitals and Crisis Stabilization Units be reported by numbers of persons in addition to the claims data now being reported. We request that the data in each instance be separated by children (up to age 18) and adults and be reported on a quarterly basis.

**Response:** The Division for Program Quality and Outcomes has organized a workgroup with all five MCOs to review the required MCO reports to see what or how we can obtain the information requested by the Behavioral Health TAC in a useful and informative way.

2. **Recommendation 201505BH02:** That Dr. Langefeld and/or DMS staff update the MAC on the “Super-Utilizers” of the ER in the near future.

**Response:** Dr. Langefeld updated the MAC on this project at the May 28, 2015 MAC meeting.

3. **Recommendation 201505BH03:** That DMS work with the Behavioral Health TAC and with the MCOs to further discuss appropriate reporting and measures for documenting integrated care and its outcome. We have had no response to date from the Division for Program Quality and Outcomes and are eager to meet with them to hear of progress in developing and reporting these measures.

**Response:** DMS needs to understand our population as holistically as possible, and then be able to respond to those needs. Part of this has to do with data and getting as complete data as possible and then using that data in an effective way. Some of the challenges with obtaining complete data is that we have historically provided a lot of our care, particularly around severe and persistent mental illness through the Community Mental Health Centers (CMHCs), which has been delivered in a different way from a billing standpoint than claims submitted for services provided under our State Plan. Additionally, the designation of Severe Emotional Disturbance (SED) or Serious Mental Illness (SMI) is through an evaluation which is not a data point like a combination of claims in ICD-9. However, now that CMHCs are billing for services provided under the State Plan, we can begin to take this information and incorporate it into a more holistic view. We are actively developing a dashboard that will look at as many of these services and would welcome input from the Behavioral Health TAC on this dashboard. The other challenge is that there is a lack of quality metrics that reflect behavioral health care, whether it's HEDIS or any other metric system. We are looking and actually working with a lot of groups locally and nationally about what some of those things are, what they look like, how they reflect what outcomes we actually want to measure versus just process metrics. We also welcome continued input and active involvement from the Behavioral Health TAC on developing these metrics.

Kentucky has also been awarded a State Innovation Model Design grant to create a plan for payment reform across multiple payers. One of the workgroups that has been formed as part of the process to elicit stakeholder input is focused on quality metrics and what metrics need to be developed in Kentucky to measure quality. Another workgroup is organized around integrated and coordinated care to explore issues such as these.

Lisa Lee  
Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Steve Bechtel, Acting Director, Division of Fiscal Management  
Patricia Biggs, Director, Division of Program Quality and Outcomes  
Lee Guice, Director, Division of Policy and Operations  
Leslie Hoffmann, Director, Division of Community Alternatives, Behavioral Health Policy Advisor  
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services

## **Children's Health Technical Advisory Committee MAC Recommendations**

Presented on September 24, 2015

The Children's Health TAC met on September 9<sup>th</sup> with attendance from DMS staff, MCO representatives, and a quorum of members. TAC members representing provider groups raised concerns about delays in credentialing with DMS and MCOs that impact the ability for children to receive services in a timely manner. Though potential solutions to this issue seem limited, the TAC is interested in pursuing ideas for speeding up this process.

Another item we discussed at our meeting was implementation of the address change policy being implemented. The members of the TAC had specific questions about how the process will be carried out and sought to ensure that children continue to receive timely care. From this conversation, we developed a recommendation to the MAC requesting further clarification (see below).

The TAC discussed children's oral health issues, including presentations on data from MCO representatives and discussion of DMS-provided data. We discussed child-specific data and will be discussing potential oral health recommendations to address issues raised with the data at the next meeting. The TAC members appreciated the depth of information provided by the MCOs on this important topic.

### **Recommendation:**

The Children's Health TAC recommends that DMS provide further clarification on the change in address rule and disseminate that information to providers and pharmacies regarding the following questions:

1. Will notifications to members include the exact date when disenrollment will occur?
2. What will the lag time be for reenrolling after the client corrects the address?
3. Can members pick-up prescriptions immediately upon supplying a corrected address? If not, then in what time frame would a patient be able to pick up their medication?
4. Can calls from members at a specialist's office be expedited so a child will not have to wait several more months for another appointment?
5. Will coverage be backdated to the first day of the month in which a member corrects the address?
6. What is the plan for monitoring disenrollment of children by key demographics, such as race or ethnicity, language spoken in the household, zip code, and gender?

## Home Health TAC

### Recommendations to MAC

Sept. 24, 2015

1. **Recommendation:** The deadline to transition individuals into MWMA has been extended to August 17<sup>th</sup>. The HH TAC respectfully requests that that deadline be moved to AUGUST 31<sup>st</sup>, 2015 due to the amount of incorrect data which populated the on boarding system, the software glitches of the onboarding and general overall ability to enter patient's demographic information into the onboarding portal.
2. **Recommendation:** That recipients of HCBW who have been identified in the Pickle Amendment receive a written letter from the Cabinet containing information that they have been identified as individuals who should have not been required to pay the liability for their services and their reimbursement would not be calculated and monies reimbursed to them via their service provider.
3. **Recommendation:** Step by Step procedure from the Cabinet in writing to home health agencies on how to respond and to whom to respond to in order to obtain reimbursement for liability charged to HCBW providers. There has been different staff identified as to whom to submit the letters agencies have received as well as no amount placed on that letter which the agency is responsible to reimburse the client.
4. **Recommendation:** That DAIL have in place for on boarding MWMA clients so DAIL, Carewise, and agencies know if the client has been entered and to whose provider number that has begun the contact/demographic information/ provider identification so that the information trying to be submitted through the portal will just not be rejected.



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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

July 21, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Home Health Technical Advisory Committee (TAC) Recommendations  
Presented at the May 28, 2015 MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Home Health TAC recommendations presented at the May 28, 2015 MAC meeting.

1. **Recommendation 201505HH01:** With the changes to HCBW/MWMA the goal was to care for patients with services started by a provider as soon as possible but yet with the roll out of the program there are built in delays. Cautioned Cabinet to watch this time line and beginning of care very carefully as we feel it is time that is not necessary to begin services especially with Presumptive Eligibility HB 144.

**Response:** There are review and approval processes built into the MWMA, which are not intended to delay someone receiving needed services. We expect these processes to speed up as the case management agencies and service providers become more accustomed to the portal.

2. **Recommendation 201505HH02:** Was addressing the EPSDT change and rates to be reimbursed (this is now on hold but the rates and changes with the MCOs have not been discussed).

**Response:** EPSDT Special Services Provider Type 45 applies the rates for each therapy service enumerated on the attached spreadsheet. State Plan PT, OT and SLP services are reimbursed according to rates found in the PT, OT and SLP fee schedules at the

following link: <http://www.chfs.ky.gov/dms/fee.htm>. When State Plan benefit limits for State Plan PT, OT and SLP services have been exhausted, EPSDT Special Services benefit policy will apply for children. Each MCO can develop and apply rates to services that are different from Medicaid rates.

3. **Recommendation 201505HH03:** Upon signing the new contracts with MCO have the penalties for MCO noncompliance in place that has "meat" to it rather than a wrist slap.

**Response:** Medicaid strengthened the penalty section of the MCO contract; and has included a provision to review denials of provider payments.

4. **Recommendation 201505HH04:** Not allowing the MCO to change the process in place when contracts are signed. Example = the change one MCO has made after doing business since November of 2011 now require signed MD orders for starts of care as well as for verbal orders which is not at all possible and without those signed orders will not give Prior Authorization for services. This is an impossibility due to the fact that the conditions of participation with CMS state that orders have to be signed in 21 days and many times ordered are received while the staff are in the patient's home and it is impossible to have that order signed.

**Response:** The MCO's can adjust their PA process to allow for obtaining signatures on verbal orders just so long as CMS signature guidelines are met. The Department encourages providers to communicate directly with the MCO's regarding amendments or changes to their PA process.

Lisa Lee  
Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Steve Bechtel, Acting Director, Division of Fiscal Management  
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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

August 24, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Home Health Technical Advisory Committee (TAC) Recommendations  
Presented at the July 23, 2015 MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Home Health TAC recommendations presented at the July 23, 2015 MAC meeting.

1. **Recommendation 201507HH01:** The deadline to transition individuals into MWMA has been extended to August 17<sup>th</sup>. The HH TAC respectfully requests that that deadline be moved to AUGUST 31<sup>st</sup>, 2015 due to the amount of incorrect data which populated the on boarding system, the software glitches of the onboarding and general overall ability to enter patient's demographic information into the onboarding portal.

**Response:** The deadline has been extended to September 1, 2015.

2. **Recommendation 201507HH02:** That recipients of HCBW who have been identified in the Pickle Amendment receive a written letter from the Cabinet containing information that they have been identified as individuals who should have not been required to pay the liability for their services and their reimbursement would not be calculated and monies reimbursed to them via their service provider.

**Response:** Member letter dated December 31, 2014, was sent to all members identified as having potentially paid undue co-pays or patient liability payments to their provider. A copy of this letter template is included as an attachment to this response.

- 3. Recommendation 201507HH03:** Step by Step procedure from the Cabinet in writing to home health agencies on how to respond and to whom to respond to in order to obtain reimbursement for liability charged to HCBW providers. There has been different staff identified as to whom to submit the letters agencies have received as well as no amount placed on that letter which the agency is responsible to reimburse the client.

**Response:** Members receiving SCL or Michelle P waiver services with a patient liability were identified. These members were researched in KAMES and the MMIS to ensure eligibility for this settlement. Once confirmed, a letter was sent to the member and to the provider(s).

The letter mailed to members informed them a review of their medical coverage had determined they may have paid copays or patient liability payments to providers in error. Any such payments they may have made to the provider would be refunded to them directly from the provider over the following few months. Deceased members were not notified as any refund would have been recovered through Medicaid's estate recovery program.

As with the member letter, the provider letter explained results of the review and included a listing of affected members to assist them in the refund process. The expectation is that providers would refund the affected member for the total amount of copays and patient liability collected for services rendered during the review period of 2008 to present. Dollar amounts were not included in the member or provider letters because the Department has no way of knowing the exact amount a provider actually collected from the member.

Providers and affected members may direct any additional questions related to this settlement to the DMS Division of Community Alternatives, MH/IDD Branch at (502) 564-1647 ext. 2261.

- 4. Recommendation 201507HH04:** That DAIL have in place for on boarding MWMA clients so DAIL, Carewise, and agencies know if the client has been entered and to whose provider number that has begun the contact/demographic information/ provider identification so that the information trying to be submitted through the portal will just not be rejected.

**Response:** The first initiator to start an application for an individual is associated with that individual (even if the application is in-progress); thus preventing the second initiator from submitting another application. This measure was implemented to avoid multiple applications coming in at the same time for the same individual. However, if the initiator who is supporting the individual is no longer responsive or available, the individual can get the initiator changed by contacting the CHFS Case Management Administrator (CMA). The CMA can do an Application Initiator Transfer (AIT) which will allow the second initiator to view, complete and submit the application for that individual. The CMA is currently DMS personnel, but DAIL personnel will resume this role once the new waiver is effective. To request an AIT please contact (502) 564-7540 ext. 2021 or 2073.

Lisa Lee  
Commissioner

Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

December 31, 2014

«First\_Name» «LAST\_NAME»  
«Address1»  
«Address2»  
«City», «State» «Zip»

Dear Member,

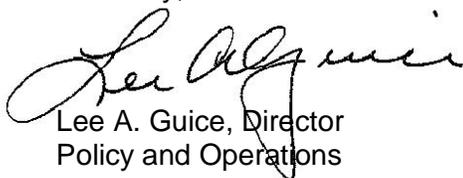
We reviewed your medical coverage case and have determined that from July 17, 2008, to the present you may have paid co-pays or patient liability payments to your providers that you should not have made.

We have notified your provider of the potential overpayments that may have been made. If you made overpayments to your provider for co-pays or patient liability, then you will be getting a check from your provider in the next few months. This check will be a refund of those co-pays made to the provider that you were not responsible for.

Please recall that the asset limit for Medicaid eligibility is \$2000 for an individual and \$4000 for a couple. If you need help or have any questions, please contact your worker.

If you want legal help, call your lawyer. You may be able to get free legal help from your local legal aid office at (800) 888-8189. You may also contact the Kentucky Department of Protection and Advocacy at (502) 564-2967 and (800) 372-2988.

Sincerely,



Lee A. Guice, Director  
Policy and Operations





**CABINET FOR HEALTH AND FAMILY SERVICES  
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**Steven L. Beshear**  
Governor

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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

August 24, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Intellectual and Developmental Disabilities (IDD) Technical Advisory Committee (TAC) Recommendations Presented at the July 23, 2015 MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the IDD TAC recommendations presented at the July 23, 2015 MAC meeting.

1. **Recommendation 201507IDD01:** The IDD TAC recommends that the Department for Medicaid Services immediately stop recoupment for minor documentation errors and examine the monitoring process for traditional providers that are involved in the Money Follow the Person funding and to look at another way to handle the infractions/recoupment.

**Response:** Recoupment cannot be stopped. As a condition of receiving federal dollars to operate the Medicaid Program, the Department is required to ensure that all providers maintain appropriate records documenting the delivery of services to Medicaid members. The Department has the responsibility of reviewing and auditing all records of providers who receive federal and State dollars to provide services to Medicaid members. When the Department conducts an audit and identifies an issue, the Department must take appropriate action to recoup any funds that cannot be linked to the direct delivery of services. In cases where the Department has identified that the documentation required is either lacking or missing, providers are given an opportunity to provide additional documentation to support the services for which they received federal and state dollars. In the event a provider cannot provide documentation to support the services that were billed, the Department is required to recover those funds. Providers who have an overpayment, but the repayment of the funds would result in a financial hardship can request a payment plan.

2. **Recommendation 201507IDD02:** The IDD TAC recommends that the Department for Medicaid Services develop an appropriate tool for evaluation of children's eligibility for the Michelle P. Waiver.

**Response:** As part of its overall review of home and community based waivers, CHFS is reviewing assessment tools for all of the waivers, including Michelle P. Should a new assessment tool be identified, it will need to be approved by CMS as part of a waiver renewal or amendment. If use of a new tool might lead to any difference in eligibility for waiver services, DMS would need to submit an acceptable transition plan to CMS, detailing how current waiver members would be assured of receiving the supports they need.

3. **Recommendation 201507IDD03:** The IDD TAC recommends that the Department for Medicaid Services re-examine the Michelle P. Waiver/Consumer Directed Services (CDO) 40 hour per week limit to allow flexibility within the budgets. Those recipients using more than 40 hours are still within their budget.

**Response:** DMS has received comments regarding this limit and the Cabinet is currently in the process of reviewing. We will notify providers of the decision and will share this notification with the MAC.

Lisa Lee  
Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

August 24, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to MAC Recommendations Presented at the July 23, 2015 MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the MAC recommendations presented at the July 23, 2015 MAC meeting.

1. **Recommendation 201507MAC01:** Kentucky Medicaid take the necessary steps to remove the restriction on 99214/99215 visits.

**Response:** The Department has discovered in our State Plan Amendment language which says the 99214/99215 visits shall be limited to two (2) per member, per provider, per year. Unfortunately, the 'per provider' was inadvertently omitted from the State Regulation. The MCO contract section 31.1 states: "The Contractor shall provide, or arrange for the provision of Covered Services to Members in accordance with the state Medicaid plan, state regulations, and policies and procedures applicable to each category of Covered Services." Therefore, until which time the State Regulation is opened for amendment the MCO may follow the limitation set forth in our State Plan.

As with any recommendation, the Department must first conduct an impact analysis to determine what impact the change would have on the member, the provider, the MCO's and their contract, our system and the Medicaid budget. In the event there is financial impact, additional funds would have to be allocated to the Medicaid budget during the next Legislative Session before the recommendation to remove the limitation could be implemented.

On the fee-for-service side of business, if the limitation has been met for a member the 99214/99215 detail does not deny as a result. Instead, the system is programmed to pay the detail at a reduced rate equivalent to the physician fee schedule rate for CPT 99213. This reimbursement limitation is outlined in the Reimbursement Regulation for Physicians' Services, 907 KAR 3:010(4)(b). This reimbursement limitation ensures the provider is compliant with proper coding guidelines by allowing them to bill and be paid for CPT 99214/99215 level visits beyond the two (2) per year, as appropriate.

On the Managed Care side of business, the MCO's may exceed the service limitation outlined in the KAR as long as the service meets medical necessity as defined by the MCO.

## 2. Recoupments due to Retro-eligibility

**Recommendation 201507MAC02:** DMS disseminate a formal communication to all providers regarding recoupments due to retro-eligibility. Specifically, we recommend that the communication be in writing and include the following: 1) an explanation of the issue; 2) a description of how retro-eligibility is being addressed in the new contract; and 3) step-by-step instructions for how providers should handle these recoupments, including those that are outside the timely filing window and/or those that are being denied payment due to prior authorization requirements.

**Response:** DMS is currently drafting a letter to address this issue. The letter will be shared with the MAC upon completion.

## 3. Disenrollment

**Recommendation 201507MAC03:** DMS disseminate a formal communication to all providers regarding disenrollment of Medicaid members due to inability to contact or returned mail (as described in section 27 of the new MCO contract effective 7/1/15). Specifically, we recommend that this communication be in writing and include the following: 1) a summary of the new contract provisions regarding disenrollment and how this will effect members, providers and MCOs; 2) an explanation of how disenrollment will be communicated to members. Providers and MCOs; 3) a description of the disenrollment and re-enrollment process, including the warning period, who is authorized to update member information, and when updated information will go into effect; and 4) any recommendations DMS has for avoiding disenrollment of transient members that would be helpful for kynectors, providers and MCOs to know. One example of this would be letting the member know that they have the option of authorizing a local DCBS office, shelter, church, etc, to collect mail on their behalf.

**Response:** Please find attached the provider letter dated, August 12, 2015, which discusses the new member statuses that are outside of Medicaid eligibility and includes a list of FAQs.

Lisa Lee  
Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

August 12, 2015

**Important Information for all Medicaid Providers**

PL #A-101

Dear Medicaid Provider:

Beginning this month, you may see something new and different when checking for member eligibility in KyHealthNet. We are implementing three new member statuses that are outside of Medicaid eligibility. These status are Incarcerated (I), Warning (W), and Address Mismatch, eligible but disenrolled (A). Previously, Medicaid terminated eligibility for an incarcerated individual (I). Now these members will have their Medicaid eligibility suspended while incarcerated. During the suspension period, the Department is prohibited by federal rules from paying claims for these individuals.

All members with an (I) will be able to have their benefits re-instated when they are no longer incarcerated by simply logging onto their kynect account at [kynect.ky.gov](http://kynect.ky.gov), contacting the DCBS call center at 855-306-8959, calling the kynect call center at 855-459-6328, or working with a kynector. A list of available kynectors can also be found at [kynect.ky.gov](http://kynect.ky.gov). If a member has self-attested to being incarcerated, they may self-attest to being released. If not they will need to provide documentation but once verified they will be entitled to enroll in an MCO right away.

The Warning and Address mismatch status (W) is attached to a member when the Department receives undeliverable mail for these individuals. The W status only alerts the member and all providers that a member needs to log into kynect, call the DCBS call center, or the kynect call center and update their mailing address. Their eligibility status will remain unchanged while they are in the (W) status.

All members with a (W) status code will be dis-enrolled from the Medicaid program if they do not update their address prior to the last day of the month following the month in which they received the (W) status code. The (W) status code will be changed to an (A), indicating the member has been dis-enrolled and must update their address by simply logging onto their kynect account at [kynect.ky.gov](http://kynect.ky.gov), contacting the DCBS call center at 855-306-8959, calling the kynect call center at 855-459-6328, or working with a kynector. A list of available kynectors can also be found at [kynect.ky.gov](http://kynect.ky.gov).



The Department is making the address verification change to ensure that members are located and engaged in their healthcare delivery. The change also ensures that all individuals receiving services through Kentucky Medicaid actually live in the state, which is a condition of eligibility. Please encourage and assist those members in either the (W) or (A) status to make the necessary contact to update their address.

It is still important to remember that changes do not appear in real time across all systems so please check the system again if you are unsure of member status.

The Department remains committed to providing quality health care services to our members and this cannot be accomplished without our provider partners. Please contact Medicaid Provider Services at 855-824-5615 if you have specific questions on these new member statuses.

Sincerely,

A handwritten signature in black ink, appearing to read "L. Lee", written in a cursive style.

Lisa D. Lee, Commissioner  
Department for Medicaid Services

LL/LG/kl

## Frequently Asked Questions: Address Mismatch Disenrollment

- When does this process become effective?
  - The process becomes active August 19, 2015 and includes Address Mismatch as well as Incarcerations suspension.
- Are there specific returned notices that trigger the Address Mismatch Disenrollment?
  - No, any piece of undeliverable mail will trigger this disenrollment.
- Who may update or change a member's address?
  - The member or authorized representative may update the address.
- How can an address be updated or changed?
  - Self Service Portal in kynect, DCBS call center at 855-306-8959 or kynect call center at 1-855-4kynect (459-6328).
  - MEDICAID MEMBER SERVICES DOES NOT HAVE ACCESS TO MAKE THESE CHANGES
- If a member officially notifies the United States Postal Service (USPS) of an address change and ask mail to be forwarded will DMS recognize this change by receipt of the forwarding notice?
  - The member has a duty to inform DMS through DCBS Call Center, kynect Call Center, or the Self Service Portal of any change in address. There is no authority to accept a change of address from a third party. Only if the mail is returned as undeliverable the warning record will be created.
- How long is the warning period for an address mismatch?
  - The warning period runs until the end of the second month after the record is created. For example if a warning record is created on August 20, 2015 the warning period runs till September 30, 2015.
- Will the member be allowed to re-enroll once the address is updated?
  - Yes. The member will be re-enrolled with their former Managed Care Organization (MCO) automatically if the disenrollment period was no longer than 60 days. If the disenrollment period was longer than 60 days, the member will be allowed to either choose an MCO or be auto-assigned an MCO.
- Will all DMS partners be able to handle a potential increase in call volume? Most of these changes will be brought about by members accessing care, so they will be time sensitive to both member and their providers.

- DMS is working with all partners, including providers, to implement this process as efficiently as possible.
- Can the member be notified upon enrollment of the need to notify if their address changes with the consequences if they don't comply?
  - Members are currently notified they have a duty to inform DCBS or kynect of any change in circumstances within 30 days or they may be terminated.

## Frequently Asked Questions: Incarcerated Individuals

- Can a currently incarcerated individual apply for and receive Medicaid after August 19, 2015?
  - Yes. Incarceration alone will no longer be a bar to eligibility. Federal regulations prevent Medicaid from paying for the health care of incarcerated individuals except in very limited circumstances. Previously, our eligibility systems were unable to implement this requirement and incarcerated individuals' Medicaid eligibility was terminated in order to comply. The new eligibility system can now accommodate this option.
- What does suspension for an incarcerated individual mean?
  - An incarcerated individual is not entitled to enrollment in an MCO or Fee For Service (FFS) claims payments except for admissions to hospitals for 24 hours or more.
- Does incarceration suspension disenroll the individual from their MCO until release?
  - Yes
- How will the incarceration suspension be lifted?
  - If the individual self attested to being incarcerated, they can also self attest to being released from incarceration. If the incarceration indicator was created by other means (Federal Hub for example) the individual must provide verification, i.e. release paper work, by uploading information in SSP, calling DCBS call center or kynect call center. Also see below for potential automation options.
- How will the system be informed the person has been released?
  - DMS is working with several partners in the corrections community to implement electronic information sharing. This could automate both incarceration and release.

**KyHealthNet Address Warning Message Example**

**KENTUCKY**  
**CABINET FOR HEALTH AND FAMILY SERVICES**  
KY MEDICAL MANAGEMENT INFORMATION SYSTEM (KYMMIS)

[Provider Home](#) | [Member](#) | [Claims](#) | [PA](#) | [Provider References](#) | [Trade Files](#) | [RA Viewer](#) | [EFT](#) | [Logout](#)

Member Eligibility Verification

Tuesday 14 July 2015 08:50 am

Provider:  - 282N00000X

Select Lookup Type:  Service Type:

Member ID:

From Date of Service:  To Date of Service:

**Member**

Current ID:  Last Name:  First Name:  Date of Birth:

Old ID:  Check Digit: 4 Gender: F Date of Death:

Other IDs Phone Number:

SSN:  County Code: 076 County Name: Madison

Address:

City: BEREA State: KY ZipCode: 40403-9717

Hospice Election Date:

Medicare A:  Medicare B:

Case Number:  Case Name:

**Suspensions/Disenrollments**

Address Mismatch Warning! Please call the Department for Community Based Services (DCBS) at 855-306-8959 or kconnect at 1-855-4kconnect (459-6328) to update your address.

Suspension/Disenrollment Type	Date Effective	Date End
W-ADDRESS MISMATCH WARNING	07/01/2015	07/30/2015

**Eligibility**

Eligibility 5 Year History

Eligibility Group	Program Code	Program Status	Pov Ind	From Date of Service	To Date of Service
KY Managed Care Organization without Co-Pay	XC - Child	P1 - Child at least 6 and under 19, Attending School if 18	N	07/01/2015	07/30/2015
Copoly Indicator		From Date	To Date		
N		07/01/2015	07/30/2015		

**Note: POV\_IND - An 'N' in this field indicates that the member is at or below 100% of the federal poverty level. If the indicator is 'N' you may not refuse to provide services for no**

**KyHealthNet A – Eligible but Disenrolled and I – Incarcerated indicator Message Example**

Suspensions/Disenrollments		
Suspension/Disenrollment Type	Date Effective	Date End
I-SUSPENDED - INCARCERATED	07/10/2015	07/12/2015
A-ELIGIBLE BUT DISENROLLED - ADDRESS MISMATCH	07/01/2015	07/30/2015

**Alert! Individuals with an incarceration suspension (Ind - I) or an address hold (Ind - A) will not be eligible for claims payment or MCO enrollment. If this information is incorrect, please call the Department for Community Based Services (DCBS) at 855-306-8959 or kconnect at 1-855-4kconnect (459-6328).**

Eligibility					
Eligibility 5 Year History					
Eligibility Group	Program Code	Program Status	Pov Ind	From Date of Service	To Date of Service
<u>KY Managed Care Organization without Co-Pay</u>	XC - Child	P1 - Child at least 6 and under 19, Attending School if 18	N	07.01/2015	07/30/2015

## **Optometric TAC Recommendations for MAC – September 2015**

The Optometric TAC met September 16. Representatives of the Department, Vision plans and MCOs were present.

An amendment to add optometrists to the list of providers on the proposed regulation on Acquired Brain Injuries was discussed. There are doctors of optometry who specialize in working with stroke and head injury victims.

The TAC emphasized that all providers of eye/vision care be treated the same by all the MCOs. ODs and MDs should submit claims to the same place and be credentialed the same.



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

**Steven L. Beshear**  
Governor

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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

July 21, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Optometric Technical Advisory Committee (TAC) Recommendations  
Presented at the May 28, 2015 MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Optometric TAC recommendations presented at the May 28, 2015 MAC meeting.

1. **Recommendation 201505OPT01:** The Optometric TAC would request that Medicaid receive confirmation from all MCO's vision subcontractors that they are following CPT guidelines/definitions for coding?

**Response:** Please see response #5 below.

2. **Recommendation 201505OPT02:** The Optometric TAC would request that Medicaid ask all MCO's vision subcontractors how a provider is supposed to bill cataract co-management. Request specifics codes & modifiers to bill; as well if the claim needs to be billed directly to MCO instead of the vision subcontractor?

**Response:** Please see response #5 below.

3. **Recommendation 201505OPT03:** The Optometric TAC would also request the department receive a list of any codes that need to be billed directly to MCO instead of vision subcontractors? Do ophthalmologists bill the exact same way on any code that is found on the vision fee schedule?

**Response:** Please see response #5 below.

4. **Recommendation 201505OPT04:** The Optometric TAC would request that Medicaid receive confirmation from all MCO's vision subcontractors that they are following the Medicaid Vision Fee Schedule service of on routine exams of "1 exam, per year, per provider"?

**Response:** Please see response #5 below.

5. **Recommendation 201505OPT05:** The Optometric TAC would request that Medicaid receive explanation from all MCO's vision subcontractors on how to apply for a prior authorization if requested? As well as instructions on how to appeal a denied claim?

**Response:** Each vision subcontractor attended the Optometric TAC meeting to present responses to these questions. If the Optometric TAC finds that some recommendations have not been addressed, please submit those to the Optometric TAC coordinator to send to the vision subcontractors for a written response.

Lisa Lee  
Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Steve Bechtel, Acting Director, Division of Fiscal Management  
Patricia Biggs, Director, Division of Program Quality and Outcomes  
Lee Guice, Director, Division of Policy and Operations  
Leslie Hoffmann, Director, Division of Community Alternatives, Behavioral Health Policy Advisor  
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services



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DEPARTMENT FOR MEDICAID SERVICES**

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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

August 24, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Optometric Technical Advisory Committee (TAC) Recommendations  
Presented at the July 23, 2015 MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Optometric TAC recommendations presented at the July 23, 2015 MAC meeting.

1. **Recommendation 201507OPT01:** Regarding Medicaid EHR incentive qualification, some optometrists experienced a problem qualifying after the MCOs took over. The doctors know that they have a high percentage of Medicaid patients in their practice. The first year when the data was provided by the Department, they had no problem meeting the encounter numbers to receive their money.

However, once they were dependent on the MCOs for data, they could not qualify. Evidently, the problem had to do with whether the numbers were reported by an individual or group NPI numbers. The TAC would request that Department require uniformity in methodology in the MCO reporting of provider data to qualify for their EHR incentive payments. Due to this issue, doctors were not able to get their incentive payment for the year.

**Response:** The Department enlisted the assistance of the Office of Administration and Technology Services (OATS) staff to research this issue. Preliminary results of their review indicate a potential issue with the MCO billing practices for Optometrists claims. The Department will continue to work with OATS staff to finalize the research and will provide the Council with a final report when it becomes available.

Lisa Lee  
Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Steve Bechtel, Acting Director, Division of Fiscal Management  
Patricia Biggs, Director, Division of Program Quality and Outcomes  
Lee Guice, Director, Division of Policy and Operations  
Leslie Hoffmann, Director, Division of Community Alternatives, Behavioral  
Health Policy Advisor  
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services

## PHARMACY TAC RECOMMENDATIONS

PRESENTED TO MAC

SEPTEMBER 24, 2015

The Pharmacy Technical Advisory Committee makes the following recommendation to the MAC:

1. **Recommendation in regard to Coverage of Naloxone Kits to address the Heroin Epidemic in Kentucky in compliance with SB 192:** The Pharmacy TAC requests that the MAC ask the Department of Medicaid Services to identify a mechanism to get reimbursement authorized for Naloxone Kits in order to make them available to certified Pharmacists as soon as possible to assist patients concerned about their family members at risk of an opioid overdose. The Pharmacy TAC has discussed the formation of subcommittees in partnership with the MCOs to help work through any distribution issues.
2. **Recommendation on Medicaid Member mailings:** The Pharmacy TAC requests that the MAC encourage the Department of Medicaid Services and the Cabinet for Health & Family Services to initiate a media campaign to reach as many Medicaid Members as possible about the impending dis-enrollment issue due to their having moved and/or not having a valid mailing address on file.
3. **Recommendation in regard to coverage of vaccines other than flu:** The top three vaccines that the Pharmacy TAC would like to see addressed and added to coverage consistently throughout Medicaid are vaccines for TDAB, Zoster and Pneumonia. Another one to look at is the HPV. Many patients get the first dose with their pediatrician, but do not follow up with their healthcare provider for doses 2 and 3, which are outside of the Pediatrician's care.

# **Pharmacy Technical Advisory Committee (PTAC) Recommendations to the MAC and Meeting Notes Friday, September 18, 2015**

Kentucky Pharmacists Association, 1228 U.S. 127 South, Frankfort, KY 40601

The Meeting of the Pharmacy Technical Advisory Committee (PTAC) was called to order Friday, September 18, 2015 at 9:30 a.m. by Chair Jeff Arnold. Those present for the meeting were as follows: Jeff Arnold, Cindy Gray, Chris Betz, and Suzi Frances: PTAC Members; Tom Kaye representing Aetna/Coventry; Owen Neff representing Humana CareSource; Alan Daniels representing WellCare; Andrew Rudd representing Anthem; Thea Rogers and Carrie Armstrong representing Passport Health Plan; Trista Champman, and Laura Cannon, Jasmine Overfelt, Samantha McKinley and Leeta Williams representing DMS; Chris Clifton, KPhA President, KPhA Trish Freeman, President Elect, Bob McFalls, KPhA Executive Director and Angela Gibson KPhA Director of Membership and Administrative Services; and, Shannon Stiglitz from KRF on behalf of KPhA. Guests included: Mike Arnold, Alex Brewer, Lan Nguyen, Andrea Thompson and Thi Huynh.

The minutes and report from the July 10, 2015 meeting were reviewed by Jeff Arnold. Chris Betz moved to approve the minutes and report as presented. Motion was seconded by Cindy Gray and carried with all PTAC members in agreement.

The PTAC committee then conducted a drawing under the purview of Executive Director McFalls in order to establish random terms for the Committee Members. The terms were drawn as follows: Jeff Arnold: 4 years; Rob Warford: 4 years; Cindy Gray: 2 years; Chris Betz: 3 years; and, Suzi Frances: 3 years. Individual members will be eligible for reappointment by KPhA.

The PTAC discussed the following topics—

- Heron Epidemic & Coverage of Naloxone Kits—Dr. Trish Freeman, UK College of Pharmacy & President-Elect KPhA
  - The provisions of Senate Bill 192 passed in the most recent Legislative Session and went into effect with an Emergency Order in March has really afforded Pharmacists a greater impact to help with the overdose epidemic in Kentucky. The Coalition for Advancing Pharmacy Practice Coalition has worked with KPhA, KSHP and the Kentucky Board of Pharmacy, to prepare Pharmacists to take on a new leadership role in terms of helping to reduce deaths from Opioid overdoses in Kentucky.
  - The greatest obstacle has been getting the reimbursement for the Naloxone and the atomizer devices that are necessary to convert the Naloxone syringes for nasal administration. We are finding out in the field that the coverage for the Naloxone syringes is very inconsistent in terms of denials on coverage, not being approved in the health plans and/or not being included on the formularies.
  - Another obstacle that has been identified has been the need for a Billing Code for a Naloxone Kit which would include reimbursement for the Naloxone syringes and the atomizer that is needed to convert the syringes to nasal administration.
  - MCOs and DMS spoke to the technical issues that need to be addressed in order to address consistent Medicaid coverage. After detailed discussion, the MCOs provided great feedback and spoke to the need of issues that need to be clarified for

reimbursement in working work a solution to the issue. All ideas and discussion were taken into consideration for the PTAC's recommendation.

- MCO New Contract Provisions/Opportunities
  - Overall, most MCOs have been compliant with the 24 hour turnaround ruling. Some have not noticed a decrease in approvals; others have noticed a slight increase in denials due to the time frame. Several reported that have not seen any changes due to having an internal 24-hour turnaround time already in place as an internal control.
  - Some medications have required a few MCOs to put together special teams to review those specific medications quickly.

MCOs were present at the meeting and were given the opportunity to provide any updates at this time.

- New Contract Implementation
- Flu/Vaccine Coverage
  - MCOs reported claim processing issues have been cleared up as of September 17, 2015
- January 2016 Formularies
  - Most Formularies have stayed fairly similar to previous year.
  - All formularies will have a link on the State's Website that Pharmacies can view for changes in compliance with the new DMS contract provision.
- Pharmacy Dispensing Rates
  - These rates are set directly with the individual Pharmacy according to their PBM or PSAO contract. The MCOs do not have any influence or input on this issue.
- Medicaid Bad Address Listings
  - This issue was discussed extensively in terms of the requirement for Medicaid Members to have a correct mailing address on file. When mail from Medicaid is returned, the address is then flagged. The addressee has 31-59 days, depending upon the date of that flag, to get into contact with Medicaid to update his/her address. Unfortunately, because the Medicaid Member does not get the actual mailing, s/he may not know that they need to do anything.
  - The first place that their coverage may be denied very well may be the Pharmacy. The Pharmacists will see a denial notice. Discussion centered around the need to educate Pharmacists on how to help fix this situation. The Medicaid Member will have a short 31-59 day warning period to get his/her address fixed.
  - Medicaid Members will be able to take steps to have their address information updated and to be reinstated. But there may be a "gap in coverage" in terms of being eligible for services during the period in which s/he has been dis-enrolled.

The Committee also discussed the need for a number of vaccines to be consistently covered by Medicaid and decided to make a recommendation to this effect.

The Pharmacy Technical Advisory Committee makes the following recommendation to the MAC:

1. **Recommendation in regard to Coverage of Naloxone Kits to address the Heroin Epidemic in Kentucky in compliance with SB 192:** The Pharmacy TAC requests that the MAC ask the Department of Medicaid Services to identify a mechanism to get reimbursement authorized for Naloxone Kits in order to make them available to certified Pharmacists as soon as possible to assist patients concerned about their family members at risk of an opioid overdose. The

Pharmacy TAC has discussed the formation of subcommittees in partnership with the MCOs to help work through any distribution issues.

2. **Recommendation on Medicaid Member mailings:** The Pharmacy TAC requests that the MAC encourage the Department of Medicaid Services and the Cabinet for Health & Family Services to initiate a media campaign to reach as many Medicaid Members as possible about the impending dis-enrollment issue due to their having moved and/or not having a valid mailing address on file.
  
3. **Recommendation in regard to coverage of vaccines other than flu:** The top three vaccines that the Pharmacy TAC would like to see addressed and added to coverage consistently throughout Medicaid are vaccines for TDAB, Zoster and Pneumonia. Another one to look at is the HPV. Many patients get the first dose with their pediatrician, but do not follow up with their healthcare provider for doses 2 and 3, which are outside of the Pediatrician's care.

The meeting ran more than two hours, and the next PTAC meeting will be announced as soon as members can be polled. It will be held at the Kentucky Pharmacists Association headquarters located at 1228 U.S. 127 South, Frankfort, KY 40601. As soon as the date is finalized, all regular attendees and other interested parties will be notified via email and posting by DMS staff on the CHFS web site. All interested parties are welcome to attend and representatives from each MCO are participating on a consistent basis.

Respectfully submitted,

Jeff Arnold, Chair, PTAC  
Chris Clifton, President, Kentucky Pharmacists Association

## **PHYSICIANS TAC RECOMMENDATIONS**

### **PRESENTED TO MAC**

**SEPTEMBER 24, 2015**

#### TAC Recommendations

1. All covered physician and other healthcare providers should be enrolled into an MCO within 45 days. Any missing information should be conveyed back to the physician within 5 days.
2. At the last Medicaid Advisory Council (MAC), Commissioner Lee indicated that DMS would begin the process of reviewing 907 KAR 3:010(4)(1) to see if it still has relevance. While this is good news we would recommend that DMS immediately review the “edit” process when CPT® 99214 and 99215 exceed the limits outlined in 907 KAR 3:010(4)(1) and ensure that MCOs are in compliance with the regulation and services are not denied but reduced to the payment of a CPT® 99213.
3. The TAC understands that the MCOs are not able to provide ICD-10 coding advice, we would recommend that MCOs offer some type of ICD-10 portal or immediate assistance for help specific to ICD-10. This would help with identifying, tracking and problem resolution.



## Technical Advisory Committee on Physician Services (Title XIX) Meeting Notes and Recommendations

Date: August 5, 2015

Location: KMA Headquarters, Louisville, KY

### TAC Members:

Donald R. Neel, MD, Owensboro, Chair – Present by telephone  
Renee Girdler, MD, Louisville – Absent  
Richard S. Miles, MD, Russell Springs – Absent  
Naren James, MD, Stanford – Present by telephone  
Ira Potter, MD, Lackey – Absent

Managed Care Organizations represented: Anthem, CoventryCares, Humana CareSource, Passport and WellCare, appropriate DMS staff, GLMS and KMA staff.

### **Medicaid Enrollment – Timeliness and Annual Disclosure Ownership (ADO)**

DMS staff confirmed that the ADO is no longer required annually, although it is required when a major change occurs i.e. the physician moves, etc. The physician TAC applauds DMS for all the steps taken to improve the credentialing process (MCOs are currently required to use NCQA standards as the standard credentialing entity.)

The enrollment process is often where the biggest delays occur. Depending on what occurs (missing information, etc.) the enrollment process can take months to complete. A regulation that requires a forty five (45) day enrollment for mental health specialties was enacted last year. A regulation to extend the timeframe for all specialties should be considered.

### **Medicaid Managed Care – Preauthorization Standardization**

DMS staff indicated that this initiative is moving forward and soon we will have one standard form for *all* pre authorizations.

### **CPT Codes 99214 and 99215**

KMA continues to receive reports that when a physician bills for more than 2 complex visits CPT® 99214 and 99215 per provider/per patient/per/12 month period the service is denied outright by the MCO instead of the reimbursement being reduced to that of a CPT® 99213 as required by 907 KAR 3:010(4)(1). To add to the problem, MCOs are advising physicians to “recode” the service to that of a CPT® 99213 in order to receive reimbursement, which as the TAC has pointed out is not in accordance with evaluation and management documentation guidelines.



### **Sports Physical Update**

The TAC would like to thank the MCOs that currently reimburse for sports physicals as well as the annual well-child preventive visit. The TAC and the Coding sub-committee will continue to work with the KMA Sports Committee, KHSAA, and other groups to develop education and promote awareness about using the comprehensive well-child preventive visit as proof for the sports physical.

### **Other – ICD-10**

The TAC is concerned because we have seen very little education from the MCOs about ICD-10. We understand that DMS is not using the same guidelines that Medicare will be using, which means any claim transmitted electronically or filed via paper October 1, 2015 and after must have a complete and valid ICD-10 listed in order to be considered for payment. The TAC would like the following question addressed by the MCOs and DMS:

1. If a claim is submitted *without* a valid ICD-10 on October 1, 2015 will the claim be denied or rejected by the MCO? Depending on the response this could severely impact payments for a practice. A *rejection* would allow the physician to correct the claim and re-file at once. A denial may involve appeals, etc. Would DMS and the MCOs clarify this issue? To reduce administrative burden, and costs the TAC recommends the same process for all the MCOs.

### **TAC Recommendations**

- All covered physician and other healthcare providers should be enrolled into an MCO within 45 days. Any missing information should be conveyed back to the physician within 5 days.
- At the last Medicaid Advisory Council (MAC), Commissioner Lee indicated that DMS would begin the process of reviewing 907 KAR 3:010(4)(1) to see if it still has relevance. While this is good news we would recommend that DMS immediately review the “edit” process when CPT® 99214 and 99215 exceed the limits outlined in 907 KAR 3:010(4)(1) and ensure that MCOs are in compliance with the regulation and services *are not denied* but reduced to the payment of a CPT® 99213.
- The TAC understands that the MCOs are not able to provide ICD-10 coding advice, we would recommend that MCOs offer some type of ICD-10 portal or immediate assistance for help specific to ICD-10. This would help with identifying, tracking and problem resolution.

The meeting adjourned promptly at 12:30PM with a reminder the last meeting for 2015 meeting will take place on at KMA Headquarters in Louisville, Kentucky on October 22, 2015 at 11:00AM



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

**Steven L. Beshear**  
Governor

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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

July 21, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Physician's Technical Advisory Committee (TAC) Recommendations  
Presented at the May 28, 2015 MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Physician's TAC recommendations presented at the May 28, 2015 MAC meeting.

1. **Recommendation 201505PS01:** Provide Medicaid reimbursement for all KYHealthNow priorities.

**Response:** DMS is actively involved with initiatives to identify what quality metrics reflect kyhealthnow priorities and to measure these on an ongoing basis and are working with the MCOs to share this information with them.

2. **Recommendation 201505PS02:** Use standardized quality measures for all MCOs.

**Response:** DMS utilizes the standardized HEDIS to measure quality outcomes for the MCOs. This is the third year that HEDIS metrics have been used.

Lisa Lee  
Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Steve Bechtel, Acting Director, Division of Fiscal Management  
Patricia Biggs, Director, Division of Program Quality and Outcomes  
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Leslie Hoffmann, Director, Division of Community Alternatives, Behavioral  
Health Policy Advisor  
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services

**Recommendations to the MAC**  
**Submitted by the Primary Care Technical Advisory Committee**

The Primary Care TAC met on Sept. 10, 2015 and requests the MACs consideration of the following recommendations.

1. DMS reports that changes are being made to the automated wrap process, but the administrative burden has not been lessened, to date. Electronic EOBs are critical in allowing clinics to use the management tools that EMRs have provided. Clinics are having to add time, personnel and use scarce resources on non-medical costs to work through a process that is cumbersome and time consuming. More rapid deployment of an electronic EOB is an imperative.
2. While DMS and the clinics are moving forward with the manual reconciliation of claims from 11/1/11 to 6/30/14, the automated wrap process implemented effective July 1, 2014 still has major flaws that impairs smooth operation and timely reimbursement from DMS to clinics. We ask that DMS convene a workgroup of TAC membership and the MCOs to determine root cause issues and develop an understanding by all parties of what is needed and how the solution will be deployed to the benefit of all parties.
3. And finally, the TAC recommends that DMS consider adding the Transitional Care Management Codes to the Medicaid Fee Schedule as a way to arm clinics and others to affordably approach reduction of readmissions, lowering down-stream costs and improving the health of our patients.



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

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**Audrey Tayse Haynes**  
Secretary

**Lisa D. Lee**  
Commissioner

July 21, 2015

TO: Medicaid Advisory Council (MAC)

RE: Responses to Primary Care Technical Advisory Committee (TAC) Recommendations Presented at the May 28, 2015, and re-submitted at the July 23, 2015, MAC Meeting

Dear Medicaid Advisory Council:

The following is provided in response to the Primary Care TAC recommendations presented at the May 28, 2015 MAC meeting.

1. **Recommendation 201505PC01/201507PC01:** To improve the automated wrap payment process and decrease administrative burden on providers, the Primary Care TAC recommends that DMS upgrade their system in order to have the capability to provide all EOBs electronically. For auto-posting, EOBs should contain at least the following identifiers: MCO Member ID, claim number, subscriber number and patient name.

**Response:** DMS has previously submitted a change order to our Fiscal Agent for design and impact analysis to determine if there is currently enough information to satisfy this recommendation. DMS continues to work with its Fiscal Agent, the MCO's and the Association to determine the best solution to this issue.

2. **Recommendation 201505PC02:** In addition, the Primary Care TAC recommends that DMS meet with the MCOs to determine the best way to reprocess claims for dates of service after 7/1/14 that have not received a wrap payment due to MCO or DMS errors. We recommend these be reprocessed in a way that will be least burdensome on providers.

**Response:** DMS has worked with its Fiscal Agent and the MCO's to develop a process with minimal involvement by the provider.

- 3. Recommendation 201505PC03/201507PC02:** To avoid placing the burden of eligibility-related recoupments on providers, the Primary Care TAC recommends that DMS's provider portal should be considered the official record for member eligibility. As such, any service provided to a patient who is listed as "eligible" on DMS's portal on that particular date of service should be subject to payment by DMS or an MCO.

**Response:** Eligibility reflected on DMS's provider portal, KyHealthnet, does not assure claims payment. If an error or unforeseen change occurs in a member's eligibility resulting in an individual's ineligibility or a change in MCO assignment, DMS is required to reconcile the system retroactively. Therefore, even if the provider checked eligibility on the date of service and there was a subsequent change, DMS or the MCO has no choice but to recoup the incorrect payment. DMS has advised the MCOs to work with providers when another MCO has recouped because of an incorrect assignment. The appropriate MCO should waive timeliness. Provider with questions on a specific case may call the Division of Provider and Member Services at 1-800-635-2570. DMS is making improvements to its system to reduce situations involving retro-eligibility.

- 4. Recommendation 201505PC04/201507PC03:** Additionally, the Primary Care TAC recommends that DMS implement a "statute of limitations" for eligibility-related recoupments. Specifically, we recommend that the timeframe for recoupments should be the same as timely filing for claims.

**Response:** Federal guidelines require that if an overpayment is identified, it must be recouped. DMS is authorized to look back five (5) years in an audit. Therefore, DMS cannot institute a statute of limitations in conflict with this authorization. DMS must ensure that individuals meet eligibility and that MCOs are paid appropriately including recouping a capitation payment if paid incorrectly.

- 5. Recommendation 201505PC05/201507PC04:** In order to improve the effectiveness of the MCOs' various lock-in programs and avoid unnecessary denied claims to providers for unknowingly treating patients who are locked-in to another provider, the Primary Care TAC recommends that DMS work with the TAC and MCOs to adopt a more consistent and effective approach to lock-in notification.

**Response:** Each MCO's lock-in program must be approved by DMS and meet certain standard requirements and Kentucky Regulations. If a member is in a lock-in program, it is reflected on the member's file viewable to the provider through KyHealthnet. If the member is transferred to a new MCO, the lock-in status is transferred with the member's file. DMS recently clarified that if a member is in the lock-in program in one MCO and transferred to another MCO, the new MCO should keep the member in lock-in until it can reassess whether the member needs to remain in the program. If a member has a period of ineligibility during a lock-in period, when the member returns any remaining lock-in period is imposed. DMS will welcome any suggestions to improve the process.

6. **Recommendation 201505PC06/201507PC05:** Finally, in order to improve the MCOs' and providers' ability to effectively outreach to members and provide appropriate care based on patient demographics, the Primary Care TAC recommends that DMS develop a form that will allow providers and MCOs to collect corrected or updated information with the patient or guardian's approval. We suggest a form that collects the following information: Name (correct spelling and hyphenation), full address and zip, phone number, email address, date of birth, sex, residency status, citizenship status, immigration status, relationship status. This form can be faxed to the local DCBS office to update the system. Local offices will need to be informed by DMS at the State level that this method of updating demographic information is officially sanctioned.

**Response:** This issue is currently under review by DMS. DMS will communicate the outcome to the MAC at a future MAC meeting.

Sincerely,

Lisa Lee, Commissioner  
Department for Medicaid Services

cc: Neville Wise, Deputy Commissioner, Department for Medicaid Services  
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity  
Dr. Langefeld, Medical Director, Department for Medicaid Services  
Steve Bechtel, Acting Director, Division of Fiscal Management  
Patricia Biggs, Director, Division of Program Quality and Outcomes  
Lee Guice, Director, Division of Policy and Operations  
Leslie Hoffmann, Director, Division of Community Alternatives, Behavioral Health Policy Advisor  
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid Services

## THERAPY TAC RECOMMENDATIONS

PRESENTED TO MAC

SEPTEMBER 24, 2015

1. Speech Therapy graduates in their CFY cannot be credentialed; therefore, cannot bill Medicaid for rendered services. Additionally, Speech Therapy grads in their CFY may not bill Medicaid under their supervising clinician's provider number, at this time. These CFY practitioners are utilized widely and not being able to bill for their services will impact access drastically. Services provided by students, interns and residents are generally billed under the supervising clinician's provider number (as long as they are credentialed). **Recommendation: We are asking the Department to reconsider this policy.**
2. HP/Carewise have been telling providers that visit based codes must be billed in a unit based manner to give them an indication of utilization. Essentially, this becomes billing fraud as CPT codes are defined as per-visit or timed. **Recommendation: HP/Carewise have said they will change this when told to by the cabinet. We are asking that this occur.**
3. Therapies have been in discussion with the cabinet on the therapist/assistant differential. However, we have not had any feedback over the last two months. **Recommendation: We are asking that this differential be removed as it is not feasible to be billed, cannot be billed in the hospital setting, and will also drastically limit access as providers will not enroll if this is in place. No other state uses this, it will not increase cost as it has not been able to be billed over the last 18 months that therapists have been providing services, and we want more providers to be able to share the burden of providing to this population.**