



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

Division of Program Quality & Outcomes
275 E. Main Street, 6C-C
Frankfort, KY 40621
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www.chfs.ky.gov

Steven L. Beshear
Governor

Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

January 22, 2015

Lawrence Kissner, Commissioner
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621

RE: MCO Provider Network Adequacy Audits Annual Summary

Pursuant to your request, I have compiled the results of the monthly Managed Care Organizations' (MCOs') 2014 provider network telephone and MCO website audits into an annual summary. Audit activities were conducted by Division of Program Quality and Outcomes, Managed Care Oversight – Contract Management Branch liaisons.

Active Provider Telephone Audit Process

MCOs send Provider Network Adequacy files on a biweekly basis. The Office of Administrative and Technology Services (OATS) sends Provider Network Adequacy files to the Department of Medicaid Services (DMS). On a monthly basis the file data are compiled by a liaison for individual MCOs. Once compiled and sorted for "Primary Care Provider", a random number generator is used to select a representative sample of providers to contact.

Liaisons receive a sheet on which they record the results from their telephone audit. During the audit, liaisons dial a provider telephone number; ask whether they are still enrolled in the respective MCO and whether they are taking new Medicaid patients. If they respond in the negative to either question, the liaison checks the MCO's webpage to verify whether that information is accurately reflected. If the liaison is unable to contact a provider, the reason is recorded, i.e. busy signal, wrong number, or voice mail. When receiving a busy signal or voice mail, a second attempt is made no earlier than 30 minutes after the first call and those results are also tabulated. If the reason is a wrong number, attempts to acquire a correct one, e.g. MCO website searches, etc. will be done.

Once all of the information is gathered by the liaisons, the results are compiled for individual MCOs and as an aggregate. Correct telephone numbers for providers who were not contacted due to a wrong number were sent to the Division of Program Integrity, Provider Licensing & Certification Administrative Branch Manager when available.

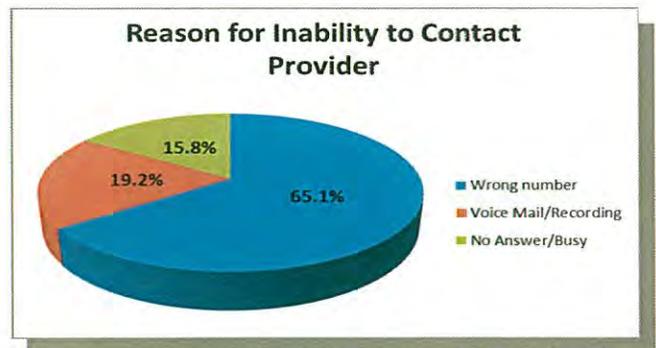
Summary of Active Provider Telephone Audit Results

The summary table below clearly demonstrates that the provider information being audited is largely accurate. During 2014, liaisons attempted to contact a total of 2,386 providers. A sum of 1,403 providers' offices, or 58.80%, answered questions. Of the providers that were questioned, 1,215, or 86.60%, continued their enrollments in the respective MCOs, leaving 188 practices that were no longer enrolled as providers. Of those that continued enrollment, 82.55% were taking new patients.

Active Provider Telephone Audit - 2014						
	ANTHEM	COVENTRY	HUMANA	PASSPORT	WELLCARE	TOTAL
Active Providers						
Sample size	474	473	479	481	479	2386
Unable to contact	163	186	230	235	169	983
Percent Unable to Contact	34.39%	39.32%	48.02%	48.86%	35.28%	41.20%
Number contacted	311	287	249	246	310	1403
Number still enrolled	271	254	219	199	272	1215
Number no longer enrolled	40	33	30	47	38	188
Percent still enrolled	87.14%	88.50%	87.95%	80.89%	87.74%	86.60%
Number not taking new	34	46	47	43	42	212
Percent not taking new patients	12.55%	18.11%	21.46%	21.61%	15.44%	17.45%
Percent taking new patients	87.45%	81.89%	78.54%	78.39%	78.39%	82.55%

In March 2014, the liaisons began documenting the reasons that providers could not be contacted, and the reasons were broken out into three categories: wrong number, voice mail recording, and no answer or busy signal.

As an aggregate, of those that could not be contacted, 65.1% were due to a wrong number; 19.2% had a recorded message; and 15.8% either did not answer or there was only a busy signal. The pie chart on the right presents a visual depiction of those figures.



An analysis was performed in an attempt to identify the root cause for the audit results for 2014. As the audits progressed through the year, a number of process and reporting observations were revealed:

- MCO's send provider files to OATS on a biweekly basis and OATS moves them to a network folder for DMS. The files received on the latest date in each month are used for the auditing process.
- Provider addresses and telephone numbers are not reconciled in the current system(s). When files about providers bump up to claims, etc., the addresses and telephone numbers are unnecessary in the system to pay a claim. As long as the file is formatted correctly, files will clear. The populated field, for example, containing telephone numbers only need to contain ten digits, e.g. 999-999-9999, is accepted.
- The error rates increase as providers move out of state, leave a practice, or move to another provider office or location.
- The audit doesn't accurately reflect when a primary care provider (PCP) practices at another location within the same system, e.g. Norton Health Care. An operator occasionally can provide a new telephone number or sometimes the caller can be transferred to the new location.
- Often PCPs work at multiple locations so they "aren't taking new patients" because it is a clinic, hospital, hospice, or emergency room, but the provider still can accept MCO Medicaid patients at a location other than the location audited. They are counted as not taking new patients.
- When a hospital switchboard number is given rather than a PCP's direct telephone number, that is counted as a wrong number.
- Some doctors want to screen medical records before the patient is accepted into a practice so they are counted as taking new patients. A majority of these providers will not accept patients if they are on chronic pain medication.
- Some family practice doctors do not take new adult patients but do take children. They are counted as taking new patients.

Provider Network Addition & Termination Audit Process

MCOs send provider addition and termination (Adds & Terms) reports¹ directly to DMS staff on a weekly basis. Monthly, the reports are compiled by a liaison and prepared for individual MCO audits. Once compiled and subsequently sorted for state, county, specialty, and provider name, a random number generator is used to select a representative sample of provider information to appraise.

Individual liaisons then research respective MCO websites and search for each provider name. During the search, new provider information is checked to verify that it is reflected on the website and whether terminated providers have been deleted from the site. Once all of the information is gathered by the liaisons, the results are compiled for individual MCOs and as an aggregate.

¹ These reports are also compiled as an aggregate of all of the MCOs' provider additions and terminations to create an additional report.

Summary of Provider Network Addition & Termination Results

The table below plainly shows that provider information on MCO websites does not appear to be updated in a timely manner. New provider information was missing from the online member portal 39.38% of the time. Among individual MCOs, the range was from 17.61% (best) to 62.95% (worst). Humana had the best scores for this audit measure.

Providers terminated for any type of reason should not be posted on MCOs' webpages. Providers were still listed on MCO webpages in the range of 17.09% (best) to 43.71% (worst). The aggregate provider terminations appearing on MCO webpages were 23.55%. The liaisons performed the web searches an average of two weeks after the MCOs' reported the provider additions and terminations to DMS.

Provider Network Addition & Termination Audit - 2014						
	ANTHEM	COVENTRY	HUMANA	PASSPORT	WELLCARE	TOTAL
Providers Added						
Number Audited	416	224	545	524	556	2265
Number not listed on web site	157	141	96	309	189	892
Percent not listed	37.74%	62.95%	17.61%	58.97%	33.99%	39.38%
Providers Terminated						
Number Audited	24	158	168	362	167	879
Number still listed on web site	10	27	29	68	73	207
Percent still listed	41.67%	17.09%	17.26%	18.78%	43.71%	23.55%

Conclusion

The new Provider Portal is anticipated to help resolve some of the issues mentioned above by allowing the individual providers the ability to update any changes to a provider's practice rather than filling out a form and sending it to DMS. Portal testing will begin in March 2015 and will be available to providers by the end of the year.

In the meantime, the Division of Program Quality and Outcomes, Managed Care Oversight – Contract Management Branch liaisons will continue to monitor MCO statuses with providers by performing the monthly telephone calls and website audits.

Sincerely,



Elizabeth Justus, Branch Manager
Managed Care Oversight – Contract Compliance

Cc: Medicaid Advisory Counsel
Neville Wise, Deputy Commissioner, Medicaid
Lisa Lee, Deputy Commissioner, Medicaid
Dr. John Langefeld, Medical Director, Medicaid



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Steven L. Beshear
Governor

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December 15, 2014

The Honorable Bob Leeper, Senate Chairman
The Honorable Rick Rand, House Chairman Interim
Appropriations and Revenue Committee
Capitol Annex
Frankfort, KY 40601

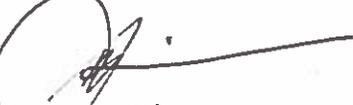
Dear Senator Leeper & Representative Rand,

On behalf of Secretary Audrey Haynes, please find attached the quarterly report for the Medicaid Assistance Program for the first quarter of State Fiscal Year 2015. This report includes the following information:

- Actual expenditures by category of service
- Summary of actual expenditures and eligibles
- Average cost per eligible
- Comparison of actual expenditures to budget
- Separate reports for KCHIP

Should you or your staff have any questions, please feel free to contact Tammy Branham at (502) 564-8196 ext. 2007 or Robin Rhea at (502) 564-7042 ext. 3431.

Respectfully,


Lawrence Kissner
Commissioner
Department for Medicaid Service

CC: Secretary Audrey Haynes
Representative Jimmie Lee
Senator Tom Buford
Robin Rhea, Secretary's Office
Tammy Branham, Medicaid Fiscal Management

DEPARTMENT FOR MEDICAID SERVICES
EXPENDITURES BY CATEGORY OF SERVICES
STATE FISCAL YEAR 2014-2015

Type of Service	BUDGET	July-14	August-14	September-14	TOTAL FIRST QUARTER	2014-2015 TOTAL
Mandatory						
Inpatient Hospital	212,565,400.00	12,573,850.07	18,166,478.54	7,936,224.90	38,676,553.51	38,676,553.51
DSH - Acute Care Hospitals	220,794,100.00	823,444.80	0.00	15,660,823.00	16,484,267.80	16,484,267.80
* Psych Distinct Part Unit - Acute Care Hospitals	6,055,000.00	449,342.33	586,752.31	191,899.62	1,227,794.26	1,227,794.26
* Rehab Distinct Part Unit - Acute Care Hospiats	4,743,400.00	116,356.27	145,950.91	151,046.17	413,353.35	413,353.35
* Supplemental Payments (IOA)	23,578,200.00				0.00	0.00
Outpatient Hospital	127,270,700.00	4,462,159.81	5,800,283.85	6,184,413.99	16,446,857.65	16,446,857.65
Physicians	41,482,900.00	15,748,240.52	2,777,115.63	2,049,767.02	20,575,123.17	20,575,123.17
Nursing Facilities	1,081,948,500.00	138,643,862.78	80,525,227.30	83,554,578.86	302,723,668.94	302,723,668.94
Home Health	20,841,800.00	1,228,140.32	1,649,361.92	1,239,919.04	4,117,421.28	4,117,421.28
Durable Medical Equipment (DME)	22,405,300.00	1,465,564.92	1,771,706.90	1,515,873.19	4,753,145.01	4,753,145.01
EPSDT - Screens	460,300.00	62,520.97	112,223.32	390,154.44	564,898.73	564,898.73
EPSDT - Related	18,791,400.00	1,320,201.08	2,231,543.97	1,687,027.35	5,238,772.40	5,238,772.40
Laboratories	1,834,400.00	129,332.17	144,678.44	120,720.37	394,730.98	394,730.98
Dental	2,882,400.00	737,900.53	249,313.02	176,994.34	1,164,207.89	1,164,207.89
Non-Emergency Transportation	3,147,400.00	232,638.14	261,119.00	189,569.89	683,327.03	683,327.03
Ambulance	2,644,200.00	133,111.93	203,539.05	124,916.17	461,567.15	461,567.15
Vision	958,400.00	58,259.01	91,108.87	59,669.70	209,037.58	209,037.58
Hearing	33,900.00	1,345.69	942.11	548.41	2,836.21	2,836.21
Primary Care (FQHC)	79,441,900.00	3,834,668.40	2,477,347.68	2,591,182.86	8,903,198.94	8,903,198.94
Rural Health	57,637,900.00	4,499,912.32	1,273,659.26	2,654,007.58	8,427,579.16	8,427,579.16
Qualified Medicare Beneficiaries (QMBs)*	490,200.00	25,375.50	41,506.53	35,804.53	102,686.56	102,686.56
Nurse Practitioner/Midwife	1,888,000.00	229,666.48	153,116.47	114,240.30	497,023.25	497,023.25
Subtotal:	1,931,695,700	186,775,894.04	118,662,975.08	126,629,181.73	432,068,050.86	432,068,050.86

Optional						
ICF-MR	184,540,000.00	21,049,944.74	11,868,520.58	12,069,265.73	44,987,731.05	44,987,731.05
Pharmacy	76,822,800	5,679,770.86	5,626,505.55	5,938,443.16	17,244,719.57	17,244,719.57
Community Mental Health Centers	6,153,800	318,429.66	422,007.39	537,814.70	1,278,251.75	1,278,251.75
Mental Hospital	1,553,300	37,160.09	42,386.62	46,355.01	125,901.72	125,901.72
DSH - Mental Hospital	40,846,300				0.00	0.00
Psychiatric Residential Treatment Facilities (PRTF)	922,100	84,192.80	8,855.62	37,589.43	130,637.65	130,637.65
Renal Dialysis	6,223,400	484,954.14	479,882.20	525,550.46	1,490,186.80	1,490,186.80
Podiatry	546,900	28,328.68	43,931.93	46,583.16	118,843.77	118,843.77
Support for Community Living	358,236,600	20,183,041.68	29,906,592.10	19,888,924.48	69,976,558.26	69,976,558.26
Ambulatory Surgical	1,394,200	89,115.26	81,454.71	95,575.89	266,145.86	266,145.86
Home & Community Based Services	106,810,300	1,367,970.27	1,701,643.23	1,338,953.54	4,406,567.04	4,406,567.04
Adult Day Care		5,323,810.43	6,923,757.80	5,782,208.72	18,029,776.95	18,029,776.95
Model Waivers	7,003,200	442,559.39	364,077.02	478,531.11	1,285,167.52	1,285,167.52
Hospice	32,327,300	1,526,887.81	1,636,615.01	1,359,002.28	4,522,305.10	4,522,305.10
Preventive	417,300	16,511.16	20,104.18	30,901.79	67,517.11	67,517.11
Children with Special Health Care Needs	0	5,243,515.09	12,911.90	18,244.35	5,274,671.34	5,274,671.34
Targeted Case Mgmt. - Emotionally Disturbed Child	799,600	49,702.67	56,786.11	99,935.53	206,424.31	206,424.31
Targeted Case Mgmt. - Mentally Ill Adults	1,103,600	55,987.33	93,450.23	57,979.25	207,416.81	207,416.81
Other Lab/X-Ray	888,700	63,422.25	72,894.68	72,403.29	208,720.22	208,720.22
Nurse Anesthetist	559,600	28,411.12	39,580.16	28,766.61	96,757.89	96,757.89
Title V/DCBS	135,174,200	10,892,975.22	11,794,722.40	8,827,644.93	31,515,342.55	31,515,342.55
School-Based Services	7,098,800	672,406.66	434,699.94	131,828.06	1,238,934.66	1,238,934.66
Early Intervention - First Steps	14,819,600	891,056.30	1,386,383.38	903,659.34	3,191,099.02	3,191,099.02
Brain Injury	34,235,000	2,216,933.12	2,448,862.74	1,985,469.63	6,651,265.49	6,651,265.49
Brain Injury Long Term Care	18,221,500	1,247,383.38	1,517,994.95	1,304,758.96	4,070,137.29	4,070,137.29
HANDS	25,265,000	1,523,330.00	1,612,400.00	1,698,850.00	4,834,580.00	4,834,580.00
Michelle P. Waiver	263,387,700	20,184,228.09	30,887,562.87	21,845,125.37	72,916,916.33	72,916,916.33
Money Follows The Person Post-Transition	5,604,500	388,575.28	430,133.41	328,022.70	1,144,731.39	1,144,731.39
Money Follows The Person Benefits	120,700	51,296.48	8,222.39	(5,378.75)	54,140.12	54,140.12
Chiropractic	208,700	11,574.34	15,444.07	9,048.39	36,066.80	36,066.80
Impact Plus	2,742,300	140,500.31	168,471.94	146,585.46	455,557.71	455,557.71
Subtotal:	1,334,827,800	100,293,774.61	110,116,655.89	85,622,642.58	296,033,072.26	296,033,072.26

DEPARTMENT FOR MEDICAID SERVICES
 EXPENDITURES BY CATEGORY OF SERVICES
 STATE FISCAL YEAR 2014-2015

Type of Service	BUDGET	July-14	August-14	September-14	TOTAL FIRST QUARTER	2014-2015 TOTAL
Managed Care						
MCO's	4,115,178,900	992,706,808.06	497,692,152.60	547,733,636.62	2,038,132,597.28	2,038,132,597.28
Empower Transportation	73,473,700	0.00	14,963,722.91	8,321,173.26	23,284,896.17	23,284,896.17
Subtotal:	4,188,652,600	992,706,808.06	512,655,875.51	556,054,809.88	2,061,417,493.45	2,061,417,493.45

Special Expenditures/Offsets						
Intergovernmental Transfer Payments (IGT's)	11,973,800	0.00	0.00	0.00	0.00	0.00
Cost Settlements	84,483,300	0.00	0.00	0.00	0.00	0.00
Supplementary Medical Insurance (SMI)	245,631,700	17,427,897.80	17,365,995.30	17,242,458.30	52,036,351.40	52,036,351.40
Part D Medicare Clawback	99,022,500	7,091,109.42	7,108,334.91	7,154,571.97	21,354,016.30	21,354,016.30
Non-Provider Payments		109,443.48	131,215.63	109,940.06	350,599.17	350,599.17
Drug Rebate	(289,658,900)	(22,058,421.58)	(6,448,049.00)	(13,575,917.81)	(42,080,388.39)	(42,080,388.39)
QI1 Payments	18,841,000	888,025.40	673,260.00	665,469.00	2,028,754.40	2,028,754.40
Health Information Technology (HIT)	85,904,600	1,335,275.77	832,492.80	306,000.00	2,473,768.57	2,473,768.57
Redeposits and Other Adjustments	(3,400)	(2,989.37)	0.00	178.08	(2,811.29)	(2,811.29)
Subtotal:	256,194,600	4,590,340.92	19,665,249.64	11,902,699.60	36,158,290.16	36,158,290.16

TOTAL MEDICAID:	7,710,569,900	1,284,366,817.63	761,100,755.32	780,209,333.79	2,825,676,906.75	2,825,676,906.75
TOTAL KCHIP:	229,207,300	24,394,744.88	12,006,849.46	12,259,610.95	48,661,205.29	48,661,205.29
GRAND TOTAL:	7,939,777,200	1,308,761,562.51	773,107,604.78	792,468,944.75	2,874,338,112.04	2,874,338,112.04
MEDICAID	6,294,385,600	876,405,498.91	553,905,138.81	547,737,312.35	1,978,047,950.08	1,978,047,950.08
ACA EXPANSION	1,416,184,300	407,961,318.72	207,195,616.51	232,472,021.44	847,628,956.67	847,628,956.67
KCHIP:	229,207,300	24,394,744.88	12,006,849.46	12,259,610.95	48,661,205.29	48,661,205.29
TOTAL:	7,939,777,200	1,308,761,562.51	773,107,604.78	792,468,944.75	2,874,338,112.04	2,874,338,112.04

MONTHLY ELIGIBLES:		1,128,097	1,168,048	1,193,180	1,163,108	1,163,108
MEDICAID		771,407	793,626	807,886	790,973	790,973
ACA EXPANSION		305,860	325,166	337,419	322,815	322,815
KCHIP		50,830	49,256	47,875	49,320	49,320

AVERAGE COST PER ELIGIBLE PER MONTH:		1,160.15	661.88	664.17	823.75	823.75
MEDICAID		1,136.11	697.94	677.99	833.59	833.59
EXPANSION		1,333.82	637.20	688.97	875.25	875.25
KCHIP		479.93	243.76	256.08	328.88	328.88

Department for Medicaid Services
Budget to Actual Expenditure Comparison
July 1, 2014 through June 30, 2015

Expenditure Category	Budget	Expenditures	Unexpended Balance	% Unexpended
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Administration:

1 -Personnel Costs:	\$ 102,167,300		\$ 72,958,233	71.41%
Salaries		\$ 4,027,502		
Other		\$ 25,181,565		
3 - Operating Expenses	\$ 1,191,600	\$ 610,306	\$ 581,294	48.78%
4 - Grants, Loans, Benefits	\$ 24,037,200	\$ 2,707,160	\$ 21,330,040	88.74%
5 - Debt Service		\$ -	\$ -	
6 - Capital Outlay		\$ -	\$ -	
7 - Capital Projects Outlay		\$ -	\$ -	

Total Administration	\$ 127,396,100	\$ 32,526,534	\$ 94,869,566	74.47%
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Benefits:	\$ 7,939,777,200	\$ 2,874,338,112	\$ 5,065,439,088	63.80%
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**DEPARTMENT FOR MEDICAID SERVICES
SUMMARY OF EXPENDITURES AND ELIGIBLES
STATE FISCAL YEAR 2015**

	Expenditures	Eligibles	
Jul-13	\$ 1,308,761,563	1,128,097	Actual
Aug-13	\$ 773,107,605	1,168,048	Actual
Sep-13	\$ 792,468,945	1,193,180	Actual
Oct-13	\$ -	-	Actual
Nov-13	\$ -	-	Actual
Dec-13	\$ -	-	Actual
Jan-14	\$ -	-	Actual
Feb-14	\$ -	-	Actual
Mar-14	\$ -	-	Actual
Apr-14	\$ -	-	Actual
May-14	\$ -	-	Actual
Jun-14	\$ -	-	Actual
Closing Period	\$ -	-	Actual

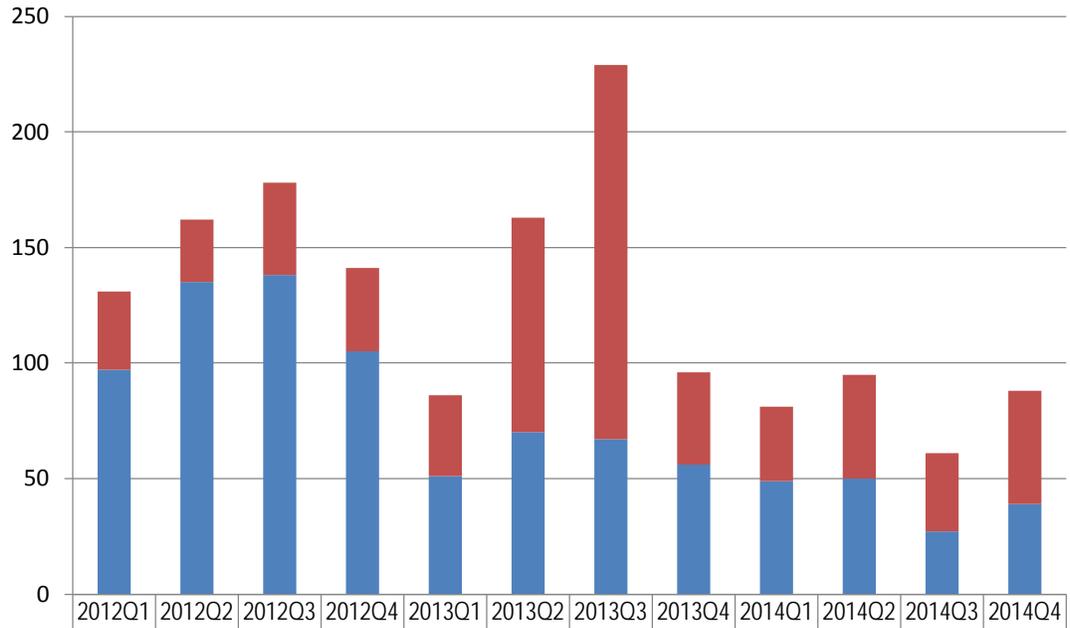
TOTAL PROGRAM
PMPM

Total Actual Cost	\$ 2,874,338,112	3,489,325	\$ 823.75
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State Fair Hearing Report

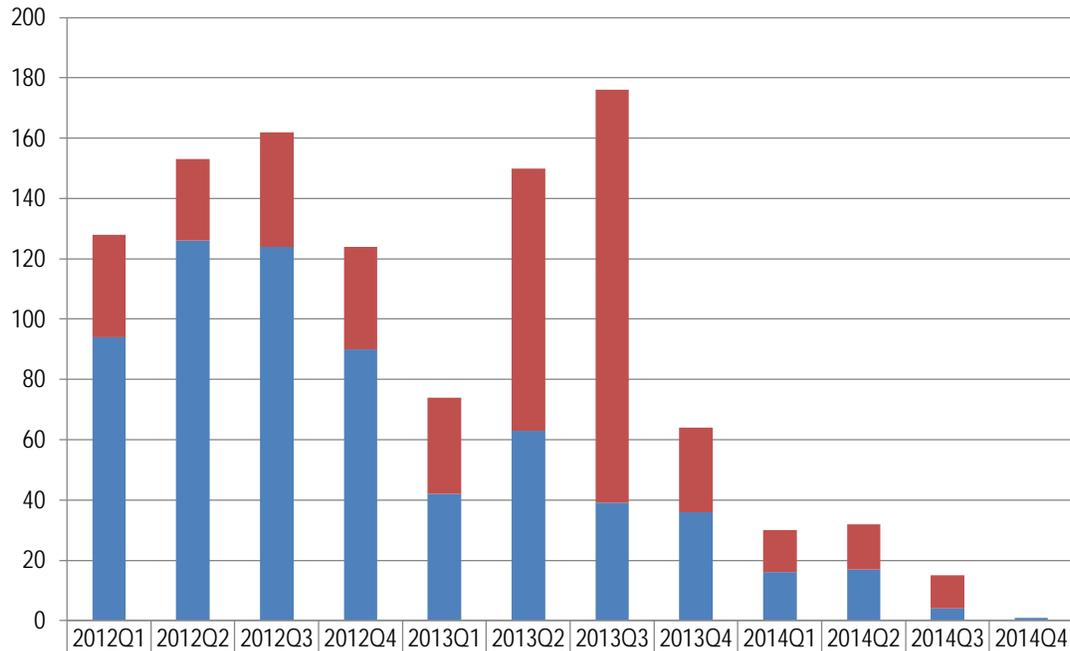
Case Summary - All	2012Q1	2012Q2	2012Q3	2012Q4	2013Q1	2013Q2	2013Q3	2013Q4	2014Q1	2014Q2	2014Q3	2014Q4
CASES RECEIVED REPORT QTR	131	162	178	141	86	163	229	96	81	95	61	88
PREVIOUS QTR IN PROCESS CASES	0	3	12	28	45	57	70	123	155	206	269	315
TOTAL CASES	131	165	190	169	131	220	299	219	236	301	330	403
CASES FINALIZED	128	153	162	124	74	150	176	64	30	32	15	1
Case Summary - Managed Care	2012Q1	2012Q2	2012Q3	2012Q4	2013Q1	2013Q2	2013Q3	2013Q4	2014Q1	2014Q2	2014Q3	2014Q4
CASES RECEIVED REPORT QTR	97	135	138	105	51	70	67	56	49	50	27	39
PREVIOUS QTR IN PROCESS CASES	0	3	12	26	41	50	57	85	105	138	171	194
TOTAL CASES	97	138	150	131	92	120	124	141	154	188	198	233
CASES FINALIZED	94	126	124	90	42	63	39	36	16	17	4	1
Case Summary - Fee for Service	2012Q1	2012Q2	2012Q3	2012Q4	2013Q1	2013Q2	2013Q3	2013Q4	2014Q1	2014Q2	2014Q3	2014Q4
CASES RECEIVED REPORT QTR	34	27	40	36	35	93	162	40	32	45	34	49
PREVIOUS QTR IN PROCESS CASES	0	0	0	2	4	7	13	38	50	68	98	121
TOTAL CASES	34	27	40	38	39	100	175	78	82	113	132	170
CASES FINALIZED	34	27	38	34	32	87	137	28	14	15	11	0

CASES RECEIVED



■ FFS CASES RECEIVED	34	27	40	36	35	93	162	40	32	45	34	49
■ MCO CASES RECEIVED	97	135	138	105	51	70	67	56	49	50	27	39

CASES FINALIZED



■ FFS CASES FINALIZED	34	27	38	34	32	87	137	28	14	15	11	0
■ MCO CASES FINALIZED	94	126	124	90	42	63	39	36	16	17	4	1

November Meeting Notes

MCO Medical Director Meeting

Kentucky Medicaid Managed Care Plans

Monday, November 24, 2014

8:30 a.m. – 12:00 p.m.

Location

WellCare Health Plans

13551 Triton Park Boulevard, Suite 1800

Louisville, Ky. 40223

Attendees (MCO's): Dr. Vaughn Payne (Humana/CareSource), Dr. Stephen Houghland (Passport), Dr. Fred Tolin (CoventryCares/Aetna), Dr. Jerry Caudill (Avesis), Dr. Peter Thurman (Anthem), Dr. Howard Shaps (WellCare), Rick Schultz (CoventryCares/Aetna)

Attendees (CHFS): Dr. Stephanie Mayfield (DPH), Andrea Adams (OHP), Patricia Biggs (DMS), Adi Mitrache (UKMC), Dr. John Langefeld (DMS), Dr. Connie White (DPH),

Attendees (Guests): Dr. Charles Woods (U of L Pediatrics), Dr. Gil Liu (U of L Pediatrics), Dr. Michael Smith (U of L Pediatrics), Dr. Mark Williams (UKMC), Dr. Roger Humphries (UKMC), Rob Sprang (UKMC)

Agenda Discussion Items

- **Update from past meetings**
 - **Behavioral Health – Update**
 - **Behavioral Health Project Plan Team/Workgroup**

The BH project team workgroup continues ongoing meetings. Next meeting is scheduled Monday December 1.
 - **Dental Items - Dr. Rich and Dr. Caudill updated group:**
 - **Public Health Hygienist:** An oral health provider designed to deliver preventive services, oral health education and patient navigation to primarily school children who are not receiving dental care. With the intended goal of reducing the disease burden in the population and reducing the need for more complex care. These services are now covered by MCO's.
 - The **CMS Oral Health Initiative** was presented: The Oral Health initiative consists of:
 - 1) Increasing by ten percentage points, from FY 2011, the percentage of children ages 1-20 enrolled in Medicaid for at least 90 continuous days that received a preventive dental service. Target date for this goal is FY 2015

- 2) Increase by ten percentage points the percentage of children 6-9 enrolled in Medicaid for at least 90 continuous days that received a sealant on a permanent molar.
- ❖ After a CMS presentation on a “CHIP All-State Call” which reviewed the current status on *CMS and Children’s Oral Health*; Commissioner Kissner sent a communication to *all* MCO CEO’s as inserted below:

Dear MCO CEO,

Attached you will find the presentation from yesterday’s CMS presentation on Oral Health. The country has made steady improvement in dental care. This was due in part by **CMS setting state specific goals** of an increase of 10% in the proportion of Medicaid and CHIP children ages 1 to 20 (enrolled for at least 90 days) who received a preventive dental service over a 5 year period. CMS also set a goal of increasing by 10% the proportion of Medicaid and CHIP children ages 6 to 9 (enrolled for at least 90 days) who receive a sealant on a permanent molar tooth.

Slide 5 illustrates the progress over a two-year period. As you can see, **KY went BACKWARDS with a slight decline** in preventive services. We are also low (6th worst) in sealant use for kids ages 6-9.

The purpose of this email is to alert you that we really need to improve our scores in this regard. This is part of our state Medicaid initiative and also part of the Governor’s health now initiatives. Since 90% of our membership and results rests with you, we need you to be creative in designing programs that encourage increased utilization of these services. Please have your teams follow up with Patricia Biggs on your specific plans to improve dental outcomes.

Sincerely,

Lawrence Kissner - Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
(11/20/2014)

- The medical director group was made aware of this request and the related time-line and follow up.
- **Mobile Dental Delivery systems.**
Dr. Caudill of AVESIS reported on issue regarding potential substandard care being provided by some dental providers and reviewed his notes from an on-site visit to two different “for profit” dental buses operating in KY.
- Overview of Mobile / Portable dental units in KY
 - Kentucky has many/multiple mobile and portable dental units going to schools
 - Many of these programs go to schools, perform more easily administered exams, x-rays, prophylaxis, and fluoride treatments and then leave. Some also do sealants. Very few do any restorative.

- The children usually receive no definitive treatment. The parents are sent a sheet saying the child needs restorative care and here is a list of Medicaid providers in the area. Go find one.
- When the children do find a dentist, the new providers often cannot gain access to any x-rays previously taken and end up doing another exam and re-taking the x-rays thus exposing the children needlessly to additional radiation and costing Medicaid additional expense.
- Dr. Sharpe and Dr. Caudill have been working on a proposed set of guidelines to help make sure the children receive needed care, not just a lot of diagnosis and no treatment.
- Dr. Caudill had a meeting with the KY Board of Dentistry regarding this on 9/13/14 and a much longer meeting on 11/22/2014. The board is sympathetic but need an actual complaint against a provider in order to take action. They suggested they felt it would be more effective if DMS put guidelines in place and went after the fraud.
- We also have the backing of the majority of KY pediatric dentists.
- Below are DR. Caudill's notes from on-site visits:
 - i. Doctor was only doing a screening, not a true exam. Doctor NEVER picked up an explorer during the 2 ½ hours I was there. Medicaid is being billed for exams when children are only receiving screenings.
 - ii. Doctor never did any kind of scaling on any of the children.
 - iii. Doctor was not wearing any kind of protective clothing. Just mask and gloves.
 - iv. Doctor was seen on several children not even looking at the member's panoramic x-rays that had just been taken.
 - v. I never saw the doctor wash or disinfect his hands between patients. He just slipped on new gloves and looked around with a mouth mirror.
 - vi. Even though bus has a BWX tube head, they only take bite wings on children 11 and over. All children 10 and under only receive a pano.
 - vii. I noted that pano's were being taken with the door to the room closed and no window where the technician could observe these very young children during exposure using a moving tube head.
 - viii. Children were being treated in the chair with no protective eyewear on. Rubber cup prophylaxis were done that could propel pumice into child's eyes. Also, 37% phosphoric acid was being used on teeth and over patients' faces where it could have possibly be dropped or splashed into child's eyes.
 - ix. Current CDC guidelines are that the straight nosecone on a slow speed headpiece be sterilized between patients. This was never done, just wiped down.
 - x. Last week I visited another for-profit dental bus in south-central KY operated by a different company. I again found the doctor doing only screenings, not true examinations. The doctor never picked up an explorer the whole time I was

there. However, they are fraudulently billing Medicaid for comprehensive examinations and recall examinations.

- xi. This office also did not have any protective eyewear on the children while doing prophylaxis or applying dental sealants using phosphoric acid over the child's face.
 - xii. Also, like the previous bus, they are not taking any bitewing x-rays to discover active dental caries at an early stage where it can be treated easier and with less expense to Medicaid.
 - xiii. I plan to go do additional site visits to dental vans and portable units to gather additional documentation for recoupments for fraudulently submitted exams.
 - xiv. Finally, according to our FWA flowchart, I will be providing specific names and charges to our three partners, Passport, Coventry, and WellCare.
- There was discussion around potential next steps including:
 - Follow up within CHFS/DMS regarding quality concerns
 - Continued discussion with Dental Board

- **Update on Psychotropic Rx's in children: PIP update**

DR. Woods & Dr. Liu from U of L Pediatrics provided an update -> "We have had multiple contacts now with IPRO staff and understand their roles with the MCO PIPs. We believe we have a way to work together and not duplicate effort. Here is current thinking:

- IPRO will continue to play its contractual role for the state for each MCO.
- UofL CAHRDS roles re IPRO and the PIPs are:
 - We will review the next draft of each PIP along with IPRO--with our role being to focus on the listed interventions. We have confirmed with IPRO that the interventions can be tweaked/changed over the next year or two (since these are 3 year PIPs) as we get better data analysis from our own work—and whatever the MCOs are able to do on their own—in terms of informing the types of interventions that may be effective.
 - One or more of our group will participate in the current round of conference calls with IPRO staff and each MCO staff group.
 - We will follow-up these calls with a separate call with each MCO to discuss intervention options and the likelihood that these will change over the next 12-18 months.
 - We will discuss the possibility of additional outcomes measure if our data analyses suggest something that is reasonable and feasible—and that can be defined to the level coding specificity of the various HEDIS measures.
 - Our other role will be to work with the MCOs to define the magnitude of change in each HEDIS measure that represents an effective intervention. This will entail more data analysis and some guesswork.

Logistically, phone calls will probably be sufficient at this point, with some expected flexibility built into the PIPs as we learn more together in the next 6 mo or so."

There was a question has been raised regarding how much would be shared between MCO's. Clarification from DMS was that this would be a common PIP, meaning that the metrics utilized would be common, however the MCO's would have discretion regarding flexibility for different models. There was some discussion at the meeting and an agreed thought that the more alike the programs were (or the same) the less confusion by providers. There was encouragement to attempt to reduce significant variation.

There was also some additional information provided regarding further analysis, with the next iteration to focus on the sub-class of atypical antipsychotics. Specifically, there are ~300 children below the age of 5 that had received an Rx for antipsychotic in the analyzed period. It is felt that this may represent the best group to focus on initially. There is also some additional data elements that are needed around demographics that were not include as well as additional time period.

Will plan to continue work and dialog.

- **Update Health Home**

Group was informed that the initial focus of our Health Home was most likely going to be Substance Use Disorder. DMS has submitted application to the Innovation Accelerator Program (IAP) for participating in CMS initiative around SUD.

- **Update on Task Force on Childhood Asthma**

Dr. White reminded the group she has sent an update of a proposal for this project and asked for a response.

➤ **New Discussion Items**

- **Dr. Mark Williams**

Dr. Mark V. Williams, the new director for the University of Kentucky Center for Health Services Research at the University of Kentucky Medical Center, was introduced to the group and first gave an overview of his background and current areas of focus at UKMC:

The Center for Health Services Research (CHSR) is focused on creating, testing and scaling next-generation solutions to improve the efficiency and effectiveness of health care delivery and the overall health of people within Kentucky and beyond. A primary objective of the center is to accelerate the discovery of new knowledge concerning clinical effectiveness and cost-effectiveness of health care delivery, particularly in rural and limited-resource settings. Health services and outcomes research is an evolving priority area for UK. With the addition of Dr. Williams and his research team, UK adds significant clinical informatics expertise and depth to the biomedical informatics capacity already housed within the UK Center for Clinical and Translational Science. The CHSR will strive to translate research findings into improved decision-making in the clinics, conference rooms and administrative offices of UK HealthCare.

Dr. Williams brings to the Center a wealth of clinical and research expertise. He most recently served as the chief of the Division of Hospital Medicine at the Northwestern University Feinberg School of Medicine in Chicago. A graduate of the University of Florida and Emory University School of Medicine, Williams completed an internship and his residency in internal medicine at Massachusetts General Hospital. He also completed postdoctoral training at the General Medicine Faculty Development Fellowship Program of the University of North Carolina - Chapel Hill, the Woodruff Leadership Academy, the Harvard Palliative Care Education Program, the Advanced Training Program in Quality Improvement at the University of Utah, and obtained a Lean Certification from Simpler Consulting Inc.

One of Dr. Williams first initiatives is PCORI. Patient-Centered Outcomes Research Institute (PCORI), is an independent, non-profit organization authorized by Congress as part of the Patient Protection and Affordable Care Act. In October (2014) approval was given for Dr. Williams to lead a three-year (\$14.9 Million) contract for one of PCORI's priority projects, "Effectiveness in Transitional Care."

The study, entitled Project **ACHIEVE** (**A**chieving Patient-Centered **C**are and **O**ptimized **H**ealth **I**n Care Transitions by **E**valuating the **V**alue of **E**vidence), combines the expertise of patients, caregivers and stakeholders with national leaders in care transition research.

It's focus will be to identify which combination of transitional care services improve outcomes that matter most to patients and their caregivers as they leave the hospital and return to their homes. Patient characteristics, care settings, and other factors will be incorporated in the analysis to determine which transitional care services work best for whom and under what circumstances.

This three-year study is divided into two phases. During the first phase, Project ACHIEVE will use focus groups and site visits to identify the transitional care outcomes and service components that matter most to patients. During the second phase, the team will evaluate the comparative effectiveness of multi-component care transitions programs occurring across the U.S. The project team will evaluate studying historical and current and future groups of patients, caregivers and providers using site visits, surveys, and clinical and claims data.

Dr. Williams also introduced for the discussion the concept of "paramedicine". Paramedicine is a new and evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations. "CP" (Community Paramedicine) programs typically are designed to address specific local problems and to take advantage of locally developed linkages and collaborations between and among emergency medical services (EMS) and other health care and social service providers and, thus, are varied in nature. Interest in community paramedicine has substantially

grown in recent years based on the belief that it may improve access to and quality of care while also reducing costs.

Some of the delivery system problems targeted by CP programs include overuse of the 911 system for social or psychological problems; the need for alternative means to manage patients who do not require transport to a general acute care hospital emergency department; repeat ED visits or hospital readmissions due to gaps in care between hospital and outpatient primary care or specialty management; limited or no capacity for short-notice home visits, especially during off hours; and supplementing primary care shortages in underserved areas.

Several other countries and states around the U.S., including North Carolina, Colorado, Minnesota, Maine, and Texas, have implemented variations of Community Paramedicine or a comparable Advanced Practice Paramedic (APP) program. A full Community Paramedic training curriculum approximately 200 hours in length has been developed by Community Healthcare Emergency Cooperative (a multistate and multinational collaborative) and the North Central EMS Institute in Minnesota. These programs have demonstrated that paramedics can be trained to safely and effectively perform an expanded role.

Dr. Williams finished with asking the group to be receptive to continued dialog and identification of collaborative working opportunities.

■ **Telemedicine ED initiative**

Dr. Roger Humphries (ED director, UKMC) and Rob Sprang (Director, Kentucky TeleCare) presented an overview of UK Tele-Emergency Network (UK-ATEN) Grant Project.

Description: The purpose of this program is to support implementation and evaluation of broad telehealth networks to deliver Emergency Department consultation services via telehealth to rural and community providers without emergency care specialists.

- Initial interest by UK as a result of the NGA-funded ED Super-utilization initiative
- Recruited 18 “rural” hospitals to participate
 - SCRMC, Manchester, 8 KY ARH, 8 LifePoint
 - 6 CAH
- UK is one of 6 national grantees
- Randomized **9 intervention and 9 control**
 - based on distance, number of referrals, CAH status
 - Incremental implementation due to limited funding each year (Y1 = 4/4, Y2 = 7/7, Y3 = 9/9)
- Y1 intervention sites – ARH Hazard, St. Claire RMC, Manchester Memorial, Ephraim McDowell/Fort Logan
- Y1 control sites – ARH Harlan, Rockcastle RMC, Harrison Memorial, Marcum & Wallace

Goals:

- Assist with **emergent care** when requested
- Improve coordination and better **tailor the arrangements with the patients’ need**
 - Outpatient F/U, ED-ED transfer, direct admit, keeping patient at rural facility
- Study the differences in **costs of care, patient/provider satisfaction** between the traditional referral methods and telemedicine referrals

They also presented other Telehealth projects for MCO's to consider:

- **HRSA funded \$742K Diabetes Retinopathy Screening project**
 - 11 primary care clinics in the St. Claire and White House clinic system (FQHC and RHC) Y1=4, Y2=7, Y3=9
 - DR screening of Diabetic/traditionally non-compliant patients
 - Images are automatically uploaded to Ophthalmologist to be read within 7 days
 - Reports are placed in patient's EMR
 - 1st 6 months – 407 DR screenings, 9.1% have referable DR pathology, 9.6% have referable non-DR pathology
- **Remote Patient Monitoring for chronic disease patients**

The group expressed desire to continue an open dialog and explore opportunities.

➤ **Miscellaneous Items**

- **Suboxone Update**

The updated draft for DMS Prior Authorization (PA) criteria was given to the group. It was also noted that KBML is in process of issuing guidelines with an initial approval by their governing committee. We will continue to monitor and discuss, with agreement that this was an issue we should all move in concert.
- It was also noted that Sec. Haynes, along with Dr. Brenzel and Dr. Langefeld, will be on the November Health and Welfare agenda to discuss the issues and concerns around scheduled drugs and particularly opioids in Ky.

❖ **Next Meeting: The next meeting will tentatively be scheduled for January 20, 2015.**

PASSPORT

HEALTH  PLAN

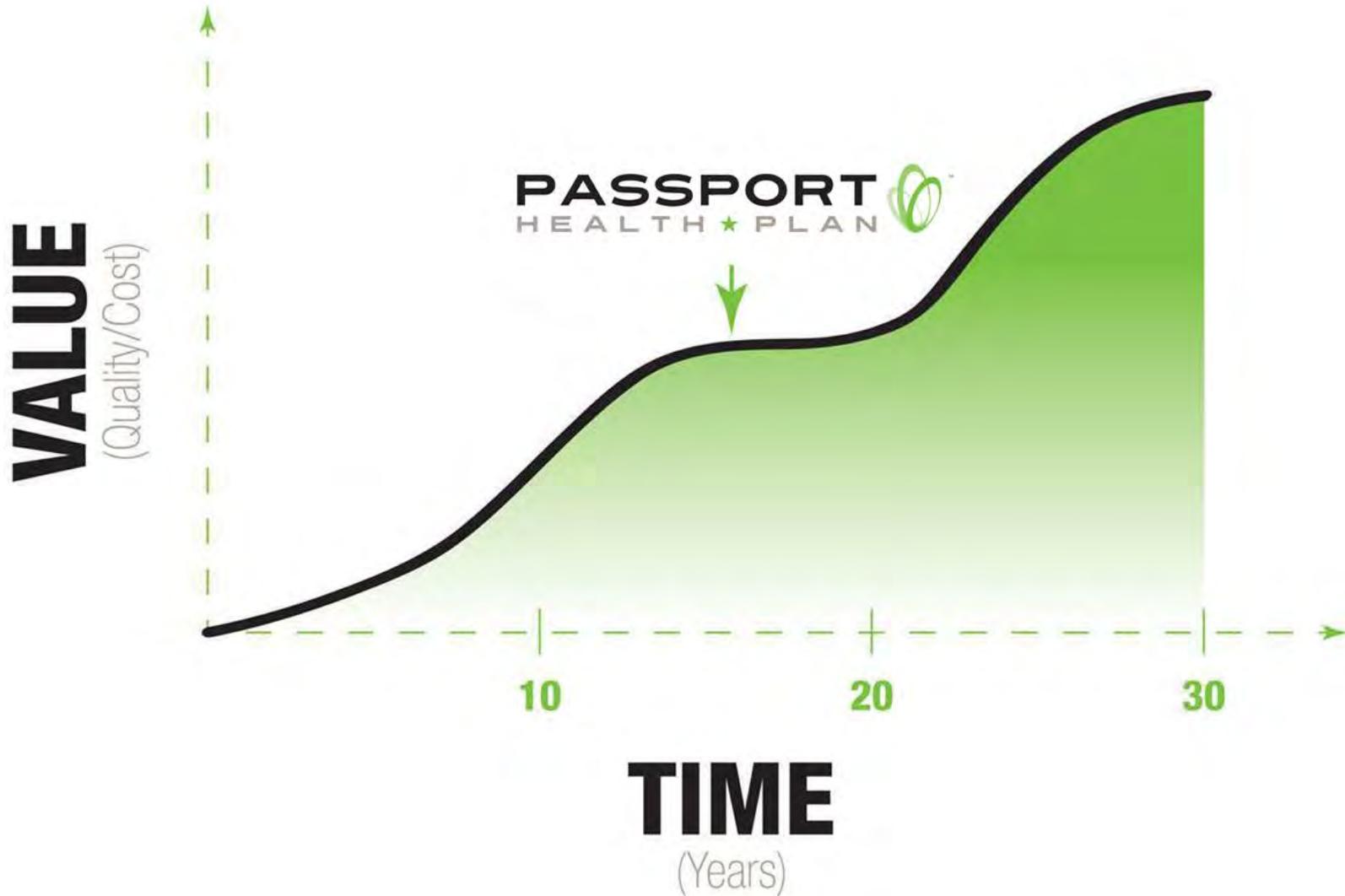


Presentation to the Medicaid Advisory Council

January 22, 2015



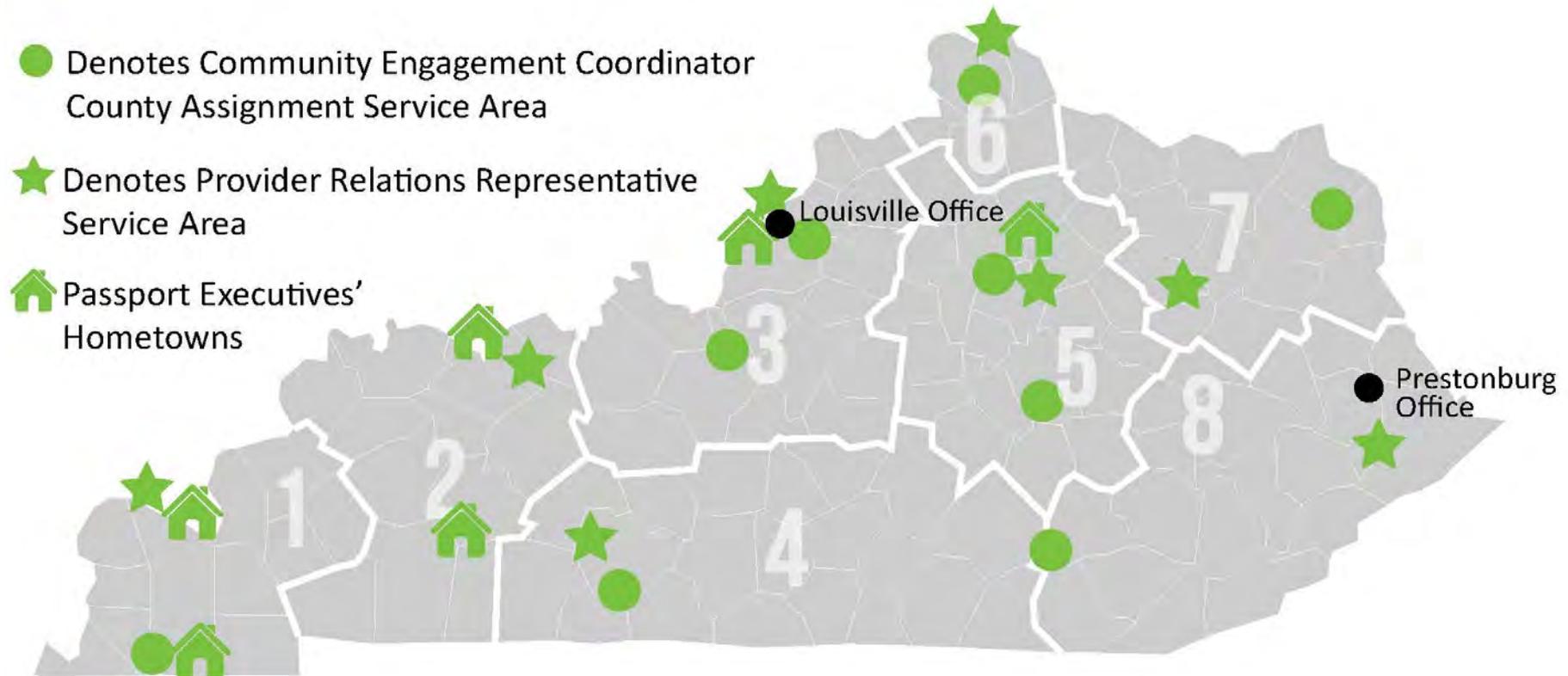
Potential Value Over Time...



PASSPORT
HEALTH ★ PLAN



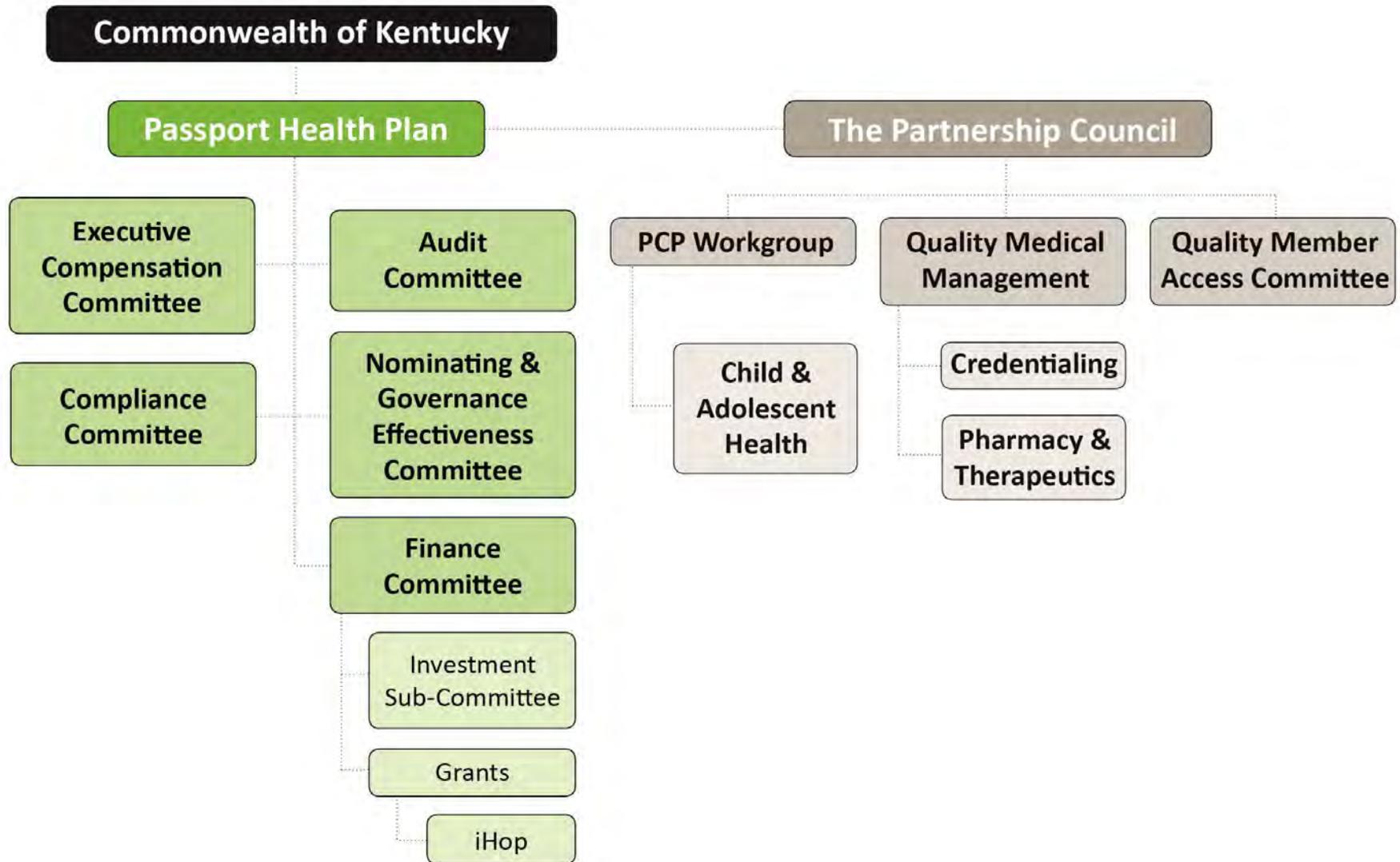
The Passport Difference



Keys to Success: Passport Health Plan

- Operates ONLY in Kentucky
- Non-profit and mission driven
- Provider sponsored

Passport Health Plan Organizational Structure



Established Programs

- Care Connectors (Rapid Response Team) – initiated in 2010
- Case Management
 - Prenatal (2000)
 - Neonatal (2001)
 - EPSDT (2010)
 - ER navigators (2013)
- Disease Management
 - CHF (2013)
 - Asthma (2001)
 - COPD (2006)
 - Diabetes (2000)
 - Obesity (2013)
 - Cardiovascular (2014)
- Community Engagement
- Wellness Programs



Rapid Response Team

Rapid Response Activities

- **Connect members to Passport programs**
 - Case management
 - Disease management
 - Quit smoking
 - Mommy Steps
- **Continuation of care**
 - Health screenings
 - Transportation for Provider visits
 - Community resources for electric, food, housing
- **Reward healthy behaviors**

2014 Connections

- **299,302 Outgoing calls**
 - Complete Health Risk Assessments
 - Reminders that Physical Exams, EPSDT, other screens/care gaps are due
- **41,551 Incoming calls**
- **Passport Support Staff: 14**
- **1,721 referred to Community Resources**
- **719 referred to a Provider**

Leigh Ann Jones, a Passport Case Management Technician, was able to assure a medical equipment company of coverage and a frantic father of a 7-month-old peace of mind. She assisted in acquiring a blood pressure cuff within 24 hours to monitor the child for seizures and hypertension through our EPSDT benefit management program.



Disease Management

Disease Management Activities

- **Disease Management**
 - Assist with Provider appointments
 - Coordination between Providers & Specialists
 - Obtain supplies
- **Education**
 - Unhealthy behavior modification
 - Identify community resources
 - Member rewards for healthy behaviors

2014 Connections

- **33,000 members Participated**
 - Diabetes
 - Asthma
 - COPD
 - Congestive Heart Failure
 - Obesity
- **Passport Support Staff: 9**
- **2014 Improvement (sampling of results):**
 - 55% more given BMI assessment
 - 21% more nutritional counseling
 - 15% more physical activity counseling
 - 19% more healthy weight counseling

Passport Disease Manager, Sharon Owens worked with Sherry* for several years who lost 60 pounds and was able to stop using insulin. However, it did not stop a nearly fatal heart attack. While her diet and exercise were still monitored, PHP provided education regarding Sherry's heart disease and specialized medicines to promote compliance with her post heart attack regimen.

*Name changed for privacy

Case Management

Case Management Activities

- **Assessment & Planning**
 - Daily living activities
 - Physical & Mental Health status
 - Physician Comprehensive Care
 - Cultural, linguistic needs & limitations
 - Individualized case plans
- **Education**
 - Benefits from community resources
 - Self-management plans
- **Development**
 - Prioritize goals
 - Follow-up communication
 - Life-planning activities

2014 Connections

- **Case Management for 15,046 members**
 - Catastrophic
 - Embedded
 - Prenatal & Neonatal
 - Behavioral Health
 - Emergency Room
- **Passport Support Staff: 37**
- **100% Adherence to 2014 Goals in Case Management**
- **24-hour Nurse-line answered 18,219 calls**

Susie* was pregnant for the 10th time after 7 miscarriages and 2 preterm deliveries. At 12 weeks during a hospital stay, Passport High Risk OB Case Manager, Melissa Stahl became her coach and support. Susie experienced several issues throughout her pregnancy including re-admittance to hospital, missed medicine injections and OB appointments. Melissa oversaw the instillation of the Mommy Steps program to support Susie who delivered a full-term, healthy baby.

*Name changed for privacy.

Community Engagement & Wellness Programs

Community Engagement activities

- **Community Engagement Coordinator**
 - Benefits, Providers and PHP services education
 - Special population identification
 - Homeless
 - Special needs
- **Health Equity Educator**
 - Cultural diversity education
 - Language assistance services
- **Health Educator**
 - Back to School * Healthy Hoops * Teen Institute * Inspire Kentucky
 - Zoo events for homeless and grandparents as guardians
 - Oral health * Smile Kentucky * Kentucky Refugee Ministries
 - Partnerships with YMCA & Catholic Charities

2014 Connections

- **1,500 educational sessions**
 - Involving 380 community advocates
 - 37 county schools
 - 335 community health fairs
 - 452 Chamber of Commerce offices
 - 80 Homeless shelter visits
- **Passport Support Staff: 13**
- **Member rewards = exceed \$250,000/year**

Passport foster child Todd's* braces were bothering him. Jessi Clements, a Passport Behavioral Health Team Member worked with Passport's Out of Home Placements Team and Passport's Dental Management Team. Together they were able to locate the prior orthodontist Todd had seen. As a result of this quick communication and collaboration across departments, Todd had continuity in his dental care and health.

*Name changed for privacy.

Investment Beyond a Traditional Medicaid Health Plan

- 94 cents of every dollar goes to providers in claims payments
- Investment into KY economy
 - 400+ Kentucky employees
 - Opening Eastern Kentucky office in an area with a struggling economy
- Investment into the KY Primary Care
 - Pay for Performance program since 2006 has paid over \$46 Million. Last year alone we paid \$5,662,000 to PCPs.
 - NP AND PA's paid at 100%
 - ACA enhanced payment extension will pay an additional \$7 million in 2015
- Investment in innovative delivery in KY
 - Since 2007, Passport Health Plan has awarded over \$1.7M in grants



Looking Ahead: 2015 and Beyond

- Certified Health Educators
- Coalitions across Kentucky
- Foster Care Children Pilot
- Home based initiatives
 - Biometric tele-monitoring
 - Telehealth
 - EMS
- PCMH initiatives
 - aICU concept program
- Network Optimization
 - Behavioral Health levels of care



Thank you for your time today and your service on the MAC