



**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

April 27, 2015

TO: Dr. Beth Partin, Chair, Medicaid Advisory Council (MAC) and MAC members

RE: Action Items from the January 22, 2015 MAC Meeting

Dear Dr. Partin and MAC members:

The following are responses from the Kentucky Department for Medicaid Services (DMS) to action items recommended by the MAC at the January 22, 2015 MAC meeting

1. Finalize the psych hospital and IOP denials, readmission rates

Response: This was provided to the MAC at the March 26, 2015 MAC meeting.

2. Work with the MCOs on sports physicals.

Response: DMS follows the American Academy of Pediatrics periodicity schedule for preventive exams. Any preventive exams that are requested outside of the periodicity schedule must meet medical necessity criteria and be covered by EPSDT. Please see <http://www.aafp.org/fpm/2006/1000/p39.html> for further clarification.

3. Explore possibility of doing away with the Unbridled Spirit card for MCO members.

Response: Some services are not covered under MCOs such as some waiver services or long-term care services. Members need to show the Kentucky Unbridled Spirit card to receive these services. In addition, MCO member identification numbers are not consistent with Medicaid member identification numbers. The additional card allows providers to search for member eligibility in both MCO and FFS systems.

4. Present on the new HCBS rules at the March MAC meeting.

Response: Representatives from the Division for Community Alternatives presented at the March MAC meeting.

Erin Hoben
Chief Policy Advisor
Office of the Commissioner
Department for Medicaid Services

cc: Lisa Lee, Commissioner, Department for Medicaid Services
Neville Wise, Deputy Commissioner, Department for Medicaid Services
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity,
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TO: Dr. Beth Partin, Chair, Medicaid Advisory Council (MAC) and MAC members

RE: Recommendations from the MAC at the March 26, 2015 MAC Meeting

Dear Dr. Partin and MAC members:

The following are responses from the Kentucky Department for Medicaid Services (DMS) to recommendations made by the MAC at the March 26, 2015 MAC meeting

1. The MAC recommends that pharmacies should be notified when pre-authorizations for medications are approved; this is currently not being done.

Response: Due to the research required and the potential variation in operational processes and IT systems – DMS respectfully request that this recommendation be submitted to the Pharmacy Technical Advisory Committee (PTAC) for consideration and agenda placement. Allowing the PTAC to properly investigate this issue will render a more actionable recommendation for the MAC to consider.

This recommendation will require in depth research and operational analysis for FFS as well as each MCO and all participating pharmacy benefit administrators, to include, but not limited to the following considerations:

- How would the processing entity know with certainty what pharmacy to address the response when the PA is submitted by a physician? This raises potential PHI/HIPAA violations.
- Does the requirement as stated unjustly put the responsibility on the prescriber to provide a pharmacy fax number when they complete the PA form and submit? If the prescriber was to enter an incorrect number this could actually cause unnecessary

delay in the member's ability to obtain medication, as well as, introduce additional PHI disclosure and HIPAA risks for the prescriber.

- Currently and regardless of the health plan, most prior authorization request forms include an area for return number. The requestor may include more than one number for response notification. However, many prescribers are not willing to include a pharmacy; most do not know which pharmacy to include when submitting the request. How would this hinder the flexibility that a member has to fill a prescription at a location of choice?
- All pharmacies have processes in place today to determine the status of a PA request. In addition, the pharmacy that initially attempts to dispense may not be the pharmacy that ultimately fills the prescription for the member. Our member population has great flexibility and variability in their fill patterns – inconsistency is often the only consistent trait among members.
- Any changes that would need to take place to accommodate this requested change would require in depth analysis and review. Testing would also need to be completed with pharmacy and prescriber submittals. These changes would also require possible Call Center and other P&P revisions, extensive time, and may be financially restrictive.

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TO: Dr. Beth Partin, Chair, Medicaid Advisory Council (MAC) and MAC members
RE: Response to Behavioral Health Technical Advisory Committee (TAC)
Recommendations Presented at the November 20, 2014 and January 22, 2015
MAC meetings

Dear Dr. Partin and MAC members:

The following are responses from the Kentucky Department for Medicaid Services (DMS) to recommendations presented to the MAC on November 20, 2014 by the Behavioral Health TAC:

- 1) That DMS work with the BH TAC and with the MCOs to further discuss appropriate reporting and measures for documenting integrated care and its outcome.

Response: Please see response to #4 below.

- 2) That the NCCI billing edits issues be resolved quickly.

Response: Please see response to #1 below.

- 3) The Hospital recommendations were reviewed and the Behavioral Health TAC is endorsing these recommendations: To waive the IMD exclusion; To have the MCOs report on admissions to psych hospitals, re-admissions, Lengths of Stay in psych hospitals, and denials of IOP and Partial Hospitalization.

Response: Federal guidance prohibits federal contributions to the cost of treating Medicaid beneficiaries for medically necessary inpatient care when receiving care in

certain institutions that fall within the definition of an “institution for mental disease.”¹ DMS continues to research the possibility of allowing MCOs to reimburse for services not normally covered such as those provided in an IMD “in lieu” of one or more services specified in Medicaid law through a CMS waiver.

Recommendations Presented at the January 22, 2015 MAC Meeting:

- 1) That the NCCI billing edits issues be resolved quickly, with a standardized implementation timeframe and a minimum of administrative burden on providers.

Response: This was resolved as of April 1st, 2015. The Community Mental Health Centers (CMHCs) may have systems issues, but DMS is working with the MCOs to have these issues resolved no later than July 1, 2015.

- 2) That data from the MCOs reported on the DMS dashboard be made available to the Behavioral Health TAC, specifically: Lengths of Stay in Psychiatric Hospitals and Crisis Stabilization Units; Percentage Denials for each behavioral health service; inpatient and outpatient; Readmissions to Psychiatric Hospitals and Crisis Stabilization Units; and HEDIS measure reported by each MCO of ambulatory follow-up post discharge from acute level of care. We request that the data in each instance be separated by children (up to age 18) and adults.

Response: We have a dashboard on the DMS website which can be found at <http://chfs.ky.gov/dms/pqomcoqbreports.htm>. We are working to create a standardized dashboard which will incorporate medical, behavioral and pharmacy data and will be made available when finalized. We will take these recommendations into consideration as we continue to build the database.

- 3) That the data being used by Dr. Langefeld for addressing the “Super-Utilizers” of the ER be shared with the Behavioral Health TAC.

Response: This is a broad request for data, some of which may include private health information. Dr. Langefeld or his designee will update the MAC on the ER “Super-Utilizer” project at a future MAC meeting.

- 4) 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.

Response: The Division for Program Quality & Outcomes will help facilitate meetings with the MCOs to discuss this issue with the Division for Community Alternatives and the Department for Behavioral Health, Developmental and Intellectual Disabilities.

- 5) That enrollment numbers of members across the MCOs be shared with the Behavioral Health TAC.

¹ 42 U.S.C. §1369

Response: This information can be accessed here: www.chfs.ky.gov/dms/stats.htm

- 6) That a date certain be established for making the ABI waiver slots actionable and communicated to the Behavioral Health TAC and IDD TAC.

Response: Based on the availability of funds, the need to amend the waivers to revise the reserved slot allocations for Money Follows the Person, the public comment requirement, and the timeframe allowed for CMS review of the waiver amendment, we anticipate that the first 150 slots can be released during the third quarter of 2015, while the remaining 153 additional ABI slots can be released during the first quarter of 2016.

- 7) That all of the MCOs communicate with DMS and with the Behavioral Health TAC their policy with regard to access to Abilify in its generic form (expected date: April 1st). Will prior authorization continue to be required for each member for whom it is prescribed?

Response: For TAC recommendations that are merely questions as opposed to recommendations, we ask that you work with your DMS TAC coordinator to funnel those questions to the appropriate DMS staff member. This will ensure that questions are answered more efficiently than if they were to go through the MAC recommendation process, and enables the MAC to focus on areas that have a greater impact. For responses to the March MAC recommendations and those that were outstanding due to lack of quorum from November and January, DMS will provide responses to recommendations that are questions. For all future MAC recommendations that are questions, the TAC should contact their DMS TAC coordinator. We have provided contact information to each of the TACs for their TAC coordinator, but if you need that information resent to you, please contact Barbara Epperson at Barbara.epperson@ky.gov.

When a new drug enters the marketplace, including a generic, there are several entry options available per FDA approval (authorized generic, exclusive, competitive or multisource). Currently, the entry condition of generic Abilify, aripiprazole, is only speculative and most likely will be dependent upon formulation. Pricing which may bear upon health plan PDL status cannot be established at this time. All of our MCO partners and the FFS program will independently address preference when the market pricing becomes known. Should aripiprazole enter under a period of exclusivity or with authorized generic entry significant pricing degradation would most likely be delayed. Also, preference status is directly impacted by price negotiations which are independently secured by each of our health plan partners. Although the MCOs are not bound to do so, KY FFS will continue to require a prior authorization on the entire therapeutic category including generic Abilify to maintain clinical appropriateness in the utilization of this class and consistency among our criteria. All current PDL information including PA requirements may be found at each MCO and FFS website.

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TO: Dr. Beth Partin, Chair, Medicaid Advisory Council (MAC) and MAC members

RE: Response to Behavioral Health Technical Advisory Committee (TAC)
Recommendations Presented at the March 26, 2015 MAC Meeting

Dear Dr. Partin and MAC members:

The following are responses from the Kentucky Department for Medicaid Services (DMS) to recommendations presented to the MAC on March 26, 2015 by the Behavioral Health TAC:

- 1) In order to expedite the work of the TAC, that the Behavioral Health TAC be provided a copy of the Commissioner's data binder at each MAC meeting, as it is presented to MAC members.

Response: The information in the MAC binders is posted on the DMS website in advance of the MAC meetings. Please visit www.chfs.ky.gov/dms/mac.htm to view.

- 2) That the rate of \$58.26/day for Intensive Outpatient (IOP) services be revisited, as it appears to be in err. This would appear to be the rate for one (1) hour of service, while IOP is, by definition, at least three (3) hours of services.

Response: DMS has resolved this issue and updated the rate to correspond with the time length of an IOP service. DMS has revisited the rate set for IOP and will change the rate to \$125 per three hour service for FFS members. This will require a SPA, rate change and systems update. We have communicated our change to the MCOs, who may or may not change their rate to correspond with our updated rate for IOP.

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BEHAVIORAL HEALTH TAC REPORT TO THE MAC – MAY 28, 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 May 7, 2015. All five (5) of the Medicaid MCOs and their Behavioral Health representatives were in attendance. In addition to the MCO representatives and four 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 staff from the KY Department for Medicaid Services, including the Medical Director Dr. John Langefeld, as well as representatives from the KY Department for Behavioral Health, Developmental & Intellectual Disabilities, including its Medical Director, Dr. Allen Brenzel.

A copy of the Behavioral Health TAC report presented to the MAC on March 26, 2015 referenced and the Behavioral Health TAC recommendations from the November 2014, January and March 2015 MAC meetings were disseminated and briefly reviewed.

In the invitation to the MCOs to attend the March TAC meeting, a request was made for them to provide the following information:

- We would like an update from each MCO on the progress to date in tracking and reducing the use of psychotropic medications for children, especially those in foster care. Each of the MCOs is required to have a Performance Improvement Plan (PIP) in the area of psychotropic medication with children and adolescents.

In response to a request from the Behavioral Health TAC, Dr. John Langefeld and Dr. Allen Brenzel made a presentation on their findings to date on the use of psychotropic medications for children covered by Medicaid or KCHIP in Kentucky. Also presenting were a team of four physician researchers from the University of Louisville who are following up with individual interviews with prescribers to add qualitative information to the research study. The goal is to interview prescribers to determine that factors contributing to the problem. Is it a lack of resources and access to other treatments or interventions? Is there adequate training of prescribers in this area? Is it influenced by parental expectations? By input from educational settings? To date, only a few interviews have been conducted, but more are being scheduled.

The data presented by Drs. Langefeld and Brenzel clearly indicate that Kentucky prescribers issues a significantly higher number of prescriptions for psychiatric medication to children across all age groups, including the age group of 0 to 5 years of age! **14%** of the Kentucky children had a prescription for at least one psychiatric medication as compared with the national rate of **7%** of children. The increased number of prescriptions is particularly evident in the data for Kentucky's foster children, where the Kentucky rate of **42%** of foster children on psychiatric medications vs. the national rate of **26%**.

There was a robust question-and-answer period with those present, with concern expressed by many of them about the high use of these medications without FDA approval, the extensive use of polypharmacy, and the disproportionate use of these medications with foster children. Also of concern is the high number of prescriptions being written without a psychiatric diagnosis. Dr. Brenzel's description of "Too young! Too Much! Too Soon! Too Often!" was echoed by those

present. The TAC thanked the presenters and asked for follow-up from Drs. Langefeld and Brenzel and the UofL research team as more data is gathered and more interviews are completed. Each of the MCOs briefly discussed their PIP with regard to psychiatric medications with their members. All are in the data-gathering phase for this first year and each will be implementing a somewhat different approach to prescribers and members, once the baseline data has been established. The TAC asked for regular updates from the MCOs on their studies in this area. Drs. Langefeld and Brenzel expressed the hope that these approaches would yield models that could be applied across the Medicaid/KCHIP population.

Two of the MCOs have provided the Behavioral Health TAC with denials, discharge and readmission data around psychiatric hospitals and PRTFs, based on individuals and not on claims data. Once we have the information from the other MCOs, the TAC will be presented to ask further questions and made some recommendations. The TAC is still 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?

MAY 28, 2015 RECOMMENDATIONS TO THE MAC::

RECOMMENDATION: 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.

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

RECOMMENDATION: 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 & Outcomes and are eager to meet with them to hear of progress in developing and reporting these measures.

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

Children's Health Technical Advisory Committee

Presented on May 28, 2015

Hello, my name is Tara Grieshop-Goodwin and I am the chair for the Technical Advisory Committee for Children's Health. Our TAC met on May 13 with DMS staff, MCO representatives, and most of the members in attendance.

At our May meeting, the TAC heard information from each of the MCOs about behavioral health data and questions raised about previous behavioral health reports. We had a great discussion about progress on their common PIP, specific medications prescribed to children that are only recommended for adults, and metrics each MCO uses to assess behavioral health outcomes.

We also discussed data on dental claims and engaged in good conversation about what may be contributing to denials of services. While we do not have a recommendation to the MAC at this time, one option raised was improving the information gathered on request forms so MCOs have more complete information from the provider before determining whether to approve or deny. We will be discussing oral health matters in more depth at our July meeting.

At the July meeting, we will be hearing a presentation from Dr. Langfeld on the use of psychotropic medication in children. We appreciate his willingness to come speak to the children's health TAC on the work underway with that effort.

At the May meeting, we also coordinated with the Medicaid representative to identify key MCO reports that could impact children's health in the interest of receiving data that reflects only children in the population. We are grateful for Medicaid to work with us to identify child-specific data that allows the TAC to understand and accurately assess the impact of policy on the health of Kentucky's children.

Thank you for your time this morning.



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April 27, 2015

TO: Dr. Beth Partin, Chair, Medicaid Advisory Council (MAC) and MAC members

RE: Response to Dental Technical Advisory Committee (TAC) Recommendations
Presented at the January 22, 2015 MAC meeting

Dear Dr. Partin and MAC members:

The following are responses from the Kentucky Department for Medicaid Services (DMS) to recommendations presented to the MAC on January 22, 2015 by the Dental TAC:

- 1) It has been reported to the TAC that one of the MCO Dental subcontractors is reporting dentists to the National Practitioner Data Bank (NPDB) when the dentist decides to no longer participate in the plan, but fails to notify the plan in writing. **And providers have not been notified of this tactic.** Most are too busy trying to comply with the ever-increasing rules and regulations to write an additional letter. They just stop seeing the patients covered by the plan. This use of the NPDB is a bastardization of the intent of the Bank. Failure to file paperwork has nothing to do with the clinical practices and actions of the provider. The TAC recommends that DMS have the plan cease and desist from these reports to the NPDB. Terminating the provider from the plan and no longer processing his or her claims is sufficient sanction for failure to submit paperwork.

Response: Health plans are required by Section 1128E of the Social Security Act to report specific actions to the NPDB. Actions that health plans must report include adverse clinical privilege (including but not limited to network participation and panel membership). When an action is reported to the NPDB, NPDB notifies providers through an Initial Report.

- 2) It is the understanding of the TAC that the MCO Dental subcontractors are required by contract to have a Kentucky licensed Dental Director. This is not the case for each MCO plan. The TAC recommends that DMS review this contractual requirement and mandate any necessary changes. In addition, the TAC requests that these state-licensed dental directors participate in the quarterly TAC meetings as well as the monthly Medical Directors meetings.

Response: Response: WellCare, Coventry, and Passport subcontract with Avesis to administer their dental benefits. Dr. Jerry Caudill is the dental director at Avesis and is licensed in Kentucky. Anthem's dental director is Dr. Adam Rich, who is also licensed in Kentucky. Humana subcontracts with MCNA to administer their dental benefits. Dr. Rachel Davis is the dental contract at MCNA and is licensed in Kentucky. There is no requirement that the dental directors participate in the TAC meetings or the medical directors meetings. Dr. Ken Rich, the DMS Dental Director invites the dental directors to all MCO medical director meetings. It is the responsibility of the Dental TAC to invite the state-licensed Dental Directors for the MCO Dental subcontractors to attend the TAC meetings.

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TO: Dr. Beth Partin, Chair, Medicaid Advisory Council (MAC) and MAC members

RE: Response to Dental Technical Advisory Committee (TAC) Recommendations
Presented at the March 26, 2015 MAC meeting

Dear Dr. Partin and MAC members:

The following are responses from the Kentucky Department for Medicaid Services (DMS) to recommendations presented to the MAC on March 26, 2015 by the Dental TAC:

- 1) Some dental providers have provided services to Medicaid recipients in good faith after verifying on both the KYMMIS and MCO websites that the recipient is eligible and participating with said MCO. Copies of these eligibility verifications were saved by the provider. DMS then retro-terminates the recipient, so the MCO does not pay the provider despite several appeals, presenting his documentation that he has followed the rules. The MCO states that the provider cannot be paid due to the retro-termination. The TAC recommends that this be a matter between the MCO and DMS. The provider should be paid and not penalized when he provided services in good faith and followed all the guidelines for verifying patient eligibility. The only entity suffering in this scenario is the provider. He should be made whole.

Response: DMS understands this issue. We believe it is a systems error and when notified of specific, individual cases, we can research to find out where the system is failing. We do believe these instances of retro-switching MCOs will be alleviated with the streamlining of our eligibility and enrollment systems that are currently underway.

- 2) Oral pathologists at the University of Louisville and the University of Kentucky have not been paid for services provided to Medicaid recipients since the inception of MCOs in the state. UK representatives state that they are owed in excess of \$3 million. U of L's outstanding claims are less, but still significant. No MCO has paid them, claiming a "quirk" in the wording of the regulations that does not authorize payments. The TAC does not believe that the regulations were intended to have victims of oral cancer going undiagnosed. The TAC recommends that OMS and representatives from each MCO meet with the representatives from both UK and U of L to resolve this matter. In addition, regulations impacting the payment for oral pathology services should be clarified so that this will no longer be an issue going forward in the new contracts.

Response: Originally, codes for services provided by oral pathologists were not in the DMS dental regulation and as such were not reimbursable by DMS. We are in the process of updating our dental regulation, in which this change will be included to allow oral pathologists to bill for services.

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Tammy Branham, Director, Division of Fiscal Management
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Leslie Hoffmann, Behavioral Health Policy Advisor and Director, Division
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Jill Hunter, Director, Division of Provider and Member Services

Home Health Technical Advisory Committee Meeting Minutes- March 25, 2015

Technical Advisory Committee Members present:

Sharon Branham- KHCA
Billie Dyer- Nurse Administrator, MEPCO HH- KHCA
Susan Stewart- System Director, ARH- KHCA
Rebecca Cartright- Executive Director, Baptist- KHCA

Department for Medicaid Services staff present:

Gregg Stratton- Division of Community Alternatives, HCBS Branch Manager
Elizabeth Justus- Division of Program Quality and Outcomes- Branch Manager
Lynne Flynn- Medicaid Commissioner's Office- Advocacy Liaison
Sheila Davis- Division of Community Alternatives- MH/IDD Branch Manager
Erin Varble- Division of Community Alternatives- Director's Office

Department for Aging and Independent Living staff present:

Tonia Wells

Managed Care Organization representatives present:

Jack Bolos- Passport
Mary Hieatt- Humana Care Source
Laura Crowder- Coventry
Holly Garcia- Coventry
Pat Russell- Wellcare
Matt Fitzner- Anthem

Others present:

Annette Gervais- Operations Manager- KHCA
Arianna Afshari- Operations Manager- KHCA

The Home Health Technical Advisory Committee met on March 25, 2015 at 11:00 AM. Meeting was chaired by Sharon Branham, KHCA.

- I. Meeting was called to order.
- II. Introductions were made.
- III. Going to try and give the MCO's a heads up on issues for discussion at the meetings
- IV. Motion was made to approve the minutes from the January Meeting. Motion was seconded and approved.
- V. OLD BUSINESS
 - a. Medicaid Waiver Management Meetings were held in various places. The reports back to me were that they were confusing to the attendees due to the fact that Deloitte did not have specific answers for questions. This has created a tremendous

Home Health Technical Advisory Committee Meeting Minutes- March 25, 2015

amount of confusion for providers although I have been referring all providers to the Medicaid web site for information. I did email the presentation slides to assist the membership with information stressing that this is not the HCB Final Rule. Have all training seminars been provided (some may have been cancelled due to weather in Feb.)?

i. Gregg Stratton responded “There are ten remaining training classes scheduled, plus an additional 3 makeup sessions targeted for those agencies that have not sent anyone to training yet. Regarding a training contact, if individuals have questions about the schedule or training locations, they can contact ECU at MWMATRIS@EKU.edu. For all other questions they can contact the MWMA mailbox at wcm_implementation@ky.gov.

1. We are logging questions from classes and when possible, we are providing answers to participants before the end of each two-day session. For outstanding questions, we are working with the functional team to clarify answers and update our frequently asked questions (FAQs) which will be posted on the TRIS site and MWMA Information Page.

ii. Looking into the first full week of April for the makeup sessions.

iii. Are the trainings regional? Now the trainings are full, and can't get in.

1. May have to travel in order to attend.

2. Email the above address about these trainings.

3. Billie's group getting pushed out of trainings.

a. Billie has emailed the above address and gotten no response. Is there an individual she can contact?

b. Pamela Waller was originally working on those original correspondences.

c. Billie to get her info to Tonia and Tonia to follow up and see if she can get them into a training.

iv. Training materials will also be available online, especially for those who can't attend the actual trainings.

v. The system is not mandatory on April 17th. It is highly recommended that everyone start using it on the 17th.

vi. Will continue to deliver care in the same way they have always done it? Is that true? HH will be able to provide care and case management until when?

1. New services are needed, regardless of waiver. You will onboard the client. Email went out to whoever in the agency does billing.

2. Recommended to manually input current clientele into the system by July 1, 2015.

a. Each will take about 5 minutes to onboard.

b. This will also include permissions for employees.

Home Health Technical Advisory Committee Meeting Minutes- March 25, 2015

3. For new clients, there will be a questionnaire, application process in order to ensure that they are placed in the proper waiver.
 4. For all intents and purposes the process for waiver application will still be the same as it is now, it will just take place electronically instead of on paper.
 - a. MAP 351 will still be in paper version. Will need to be scanned and then uploaded.
- b. Lynne- Three separate things are going on with HH at the same time.
- i. HCB Waiver is up for renewal. Changes will occur with the renewal. Summary of changes is posted on website. Open for comment until March 29th, so that the waiver can be submitted on April 1st.
 1. Some of the programmatic changes will go into effect on July 1st.
 - a. The Home delivered meals and the Personal Emergency Response Systems. (like Lifeline)
 - b. Going to schedule trainings for the programmatic changes as soon as they can.
 - ii. Thing # 3: The Federal HCB Rule, requiring changes in all waivers.
 1. Out doing Provider webinars, and forums. (All 5 in February had to be postponed)
 2. Forums are designed for clients to get information.
 3. Had a lot of HH and ADHC providers attend, and Lynne was unable to answer specific questions about the HCB Waiver.
 - a. Forum was to discuss the overall changes to all the waivers
 - b. Took the questions from the Providers back and will get the answers. Maybe put out on a FAQ sheet.
 - iii. Some items should have already been in place since March of 2014.
 1. Conflict Free Case mgmt. is one of those services.
 - iv. Implementation of all settings changes in place by Nov. 2015.
 1. Adopting ordinary regulations, addressing the changes.
 - v. Set of changes that were most difficult to implement that are to be in place by 2019.
 1. Will have a transition period between 4/1/15 and 11/8/15. Then a subsequent transition period after that.
 2. If someone is in a conflicting relationship, have time to remedy that.
 - a. Unless they are the only provider within a 30 mile radius of the clients home. (Geographic Exception)
 - vi. Rate for the new services.
 1. Not out yet.
 2. What was originally proposed, \$21, when currently getting \$26 an hour? To perform two services that has now been combined.

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Already losing money with the rate at \$26, how are we going to make it work when going to make even less money?

- a. That is not the rate. Commissioner Anderson in looking into an appropriate rate. Probably approximately between \$24-25. Final decision hasn't been made yet.
 3. Cap rate per day, for all services.
 4. Potentially loose case management services, which is where they make up some of the money they lose when providing in-home services.
 - a. Agencies debating on whether to continue in the waiver programs.
 5. Looking into all these concerns and working to alleviate these concerns.
 - vii. Going to open up In-Home services to ADHCs and ADD and other agencies.
 1. Everyone will want to be a case manager and no one will want to provide the services.
 - viii. Questions about forums send to ToniaA.Wells@ky.gov
 1. Forums are consumer forums, not providers, concerning all Final Rule changes, not just the HCB Waiver.
 - c. Billy didn't receive invite to webinar on Mar. 10-12.
 - i. Do we have the archive info for the Provider webinar on Mar. 10-12?
 1. Probably not posted yet. Will send to Sharon when it does.
 - ii. Please email CMSFinalHCBRule@ky.gov to add you email address to the list of people to receive webinar invites.
 - iii. May be that staff change caused the lack of email communication.
 - iv. Once approved, written answers to forum questions will be posted as well.
- VI. Earl gave list of Case Management Agencies.
- a. Some independent, some HH agencies.
 - b. How do you get on this list?
 - i. Missing a lot of HH agencies, that are providing waiver/case management services.
 - c. Lynne, Tonia and Gregg to follow up and see what is going on with the list.
 - i. List may not be what Sharon was actually looking for. Sounds like a list of providers for all services/waivers.
 - ii. Really looking for list of agencies that provide case management for the HCBS waiver.
- VII. Sharon requested info about the Pickle amendment.
- a. Sheila has a handout about the Pickle amendment. (see Pickle)
 - i. Identifying people who should never have been assessed a patient liability.

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1. As these people are identified, letters are being sent to the providers and the members stating the issue.
2. When these people receive these letters, the providers should scan a copy of the letter, with their provider number and the members MAID number on it, and send it to Sheila, requesting a mass adjustment.
3. Sheila will request a mass adjustment from HP.
4. Once reviewed and approved. HP will send a payment to provider.
 - a. Provider will then pay the client.
- ii. Concern about a large quantity of money suddenly appearing in a client's account, will kick them out of Medicaid eligibility.
 1. On letter, there are suggestions on how to pay client back, put in a trust.
- iii. Haven't heard of anyone losing their services from this so far.
- b. If agency never collected the patient liability from the client; the money stays with the agency.
- c. What about deceased clients? Does it go to next of kin?
 - i. Not sure, think it would be next of kin.

VIII. OLD BUSINESS

- a. Follow up with Public Home Health Agencies and contracts with MCOs.
 - i. Passport and Anthem- sort of dead in the water- no progress has been made that Billy knows of.
- b. Contracts with DME Providers.
 - i. Pat with Wellcare- Thought it was already resolved. Pat to check.
- c. Contracts with Therapy Providers (outside of home health) which if I need to direct to the provider relations of each MCO. Would each MCO please provide Sharon with updated list of whom to contact.
 - i. Looking for contacts on who to contact to expedite claims.
 - ii. All the MCO's are to send Sharon their contact information.
 - iii. Billy- IF it comes from Sharon, she is the last resort they use, many attempts have been made by home care to resolve issue already.
- d. Care Core (PT/OT) Training conducted with participants over the course of three days. Wellcare did provide the PowerPoint slides for the webinar.
 - i. 120 people attended.
 1. Currently reaching out to other groups, and will do these on a regional/individual basis as needed.
 2. Pat to help set up with Billy.
 - ii. Delay in getting Pas back within 48 hr. turnaround target time.
 1. Now have another group monitoring it on a weekly basis.
 2. Two fax numbers?

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- a. Shouldn't be two numbers, Sharon to get info to Pat.
- iii. Complaints that Wellcare doesn't make the best decisions.
 - 1. Wellcare reaching out, to try and establish a taskforce to address this issue.
- iv. Denials for Limits:
 - 1. NO LIMITS as long as medical necessity is met. Based on Interqual standards.
- v. Pediatric Form not on line (where to find?)
 - 1. Pat sent link to Sharon.
- vi. Will written PA numbers be given for Therapy and EPSDT?
 - 1. Yes, and be sure to put that number on any claims.
- vii. PA dates of requests not matching the dates of receipt.
 - 1. Please send examples.
- viii. What number to FAX authorizations to?
 - 1. Prefer to send through the Portal. Need to fill out the CareCore worksheet and any other substantiating evidence.
- ix. WellCare states no Pre-Auth is needed under \$500. But are denying due to individual supply amounts. For example 50 units of 4x4's and they wil only pay for 47. What is the limit and appropriate way to bill this?
 - 1. Send Pat examples.
- x. Limits on home health services and combination of in-patient services.
 - 1. No Combining.
- e. WellCare and CareCore have agreed to extend authorization recertification period from once a month to once a quarter.
 - i. Can make common knowledge.
- f. Saline limits- no way anyone can hit that limit. Send example.
 - i. Coventry Fax blast indicates changes for PA for services. Request has not been answered as to what form is to be used? Continue with the MAP 130.
 - 1. Can continue with the MAP 130.
 - ii. Follow up on EOB request for Medication Refill.
 - 1. Holly is working on this.
- g. Anthem is taking up to 4 weeks to authorize visits, the patients have wound care, and wound vacs and they can't miss their visits. Agencies are providing care in good faith.
 - i. Had a backlog.
 - ii. Thought it was just a backlog with therapy services.
 - iii. This has been within the past 30 days.
 - iv. Now addressing those issues internally at the moment.
 - v. Take back and research.
- h. Anthem is including supplies in a per diem rate, when did this change?

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- i. Took back from last meeting. Put in a new edit.
 - ii. Reprocessing and hopefully this is being resolved.
 - iii. No timeframe for completion yet. Currently testing system.
 - i. Agencies are having issues with Medicaid MCO recipients being switched from one MCO to another in the middle of the month. Agencies were told to check the site daily but that is not a practice that most agencies can accommodate. When a PA is given from one MCO agencies function under that additional PAs are needed or other services are requested. Why is this occurring and when did it start?
 - i. Have heard of this issue at other TACs as well.
 - ii. Currently no answer from the MCO side.
 - iii. Sharon to give to Elizabeth Justus to follow up.
 - 1. All within the last 45-60 days.
 - j. Matt Fitzner requested to be included when issues are not being answered.
- IX. Next meeting is May 27th at 11AM.

Home Health Recommendations

Presented at May 28, 2015 MAC

1. 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
2. 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)
3. 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.
4. 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.



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April 27, 2015

TO: Dr. Beth Partin, Chair, Medicaid Advisory Council (MAC) and MAC members

RE: Response to Nursing Technical Advisory Committee (TAC) Recommendations
Presented at the November 20, 2014 and January 22, 2015 MAC meetings

Dear Dr. Partin and MAC members:

The following are responses from the Kentucky Department for Medicaid Services (DMS) to recommendations presented to the MAC on November 20, 2014 by the Nursing TAC:

1) MCO Refund Requests

- a. On the repayment of refunds, the TAC request that the payback period match the look back period; that payments retained by payers from future remits be equal to the total percentage of claims paid during the look back; and that payments not be withheld at 100% until fully refunded. This would aid with practice cash flows and not jeopardize the providers' ability to continue services.

Response: Please refer to your individual provider contract with the MCO for guidance on this issue.

- b. The TAC requests that there be more transparency on rates paid to providers, with providers receiving a list of the reimbursement that the MCO is paying to that provider. MCOs should be required to honor the reimbursement rate noted on the EOBs sent to providers. The MCOs should not be permitted to decide two (2) years later that the fee paid and posted on the EOB was incorrect.

Response: MCOs negotiate rates with individual providers. The outcomes of these negotiations are proprietary. Please refer to your individual provider contract with the MCO for guidance on this issue.

2) Limitation on Level 4/5 visits.

- a. The TAC requests legal justification from DMS for limiting level four/five visits to two visits per patient per year, while at the same time requiring providers to meet nationally accepted standards in the provision of care.

Response: The legal authority for services offered by DMS is found in our State Plan. The limitation on the level four/five visits can be found in the Kentucky Medicaid State Plan, which was approved by the federal Centers for Medicare and Medicaid Services. However, DMS will continue to research other states' policies regarding this practice.

- b. If the limitation is to remain in place, the TAC requires real time notification from DMS or the MCOs that the patient has exceeded the two (2) visit limitation.

Response: Because providers have one year to submit claims to DMS or the MCOs for reimbursement, it is impossible to issue a real time notification that the patient has exceeded the two visit limitation.

- c. Does the two (2) level 4/5 visit restriction apply to any level 4/5 visits the patient may have had with any provider, or is it per patient, per provider, per year?

Response: For TAC recommendations that are merely questions as opposed to recommendations, we ask that you work with your DMS TAC coordinator to funnel those questions to the appropriate DMS staff member. This will ensure that questions are answered more efficiently than if they were to go through the MAC recommendation process, and enables the MAC to focus on areas that have a greater impact. For responses to the March MAC recommendations and those that were outstanding due to lack of quorum from November and January, DMS will provide responses to recommendations that are questions. For all future MAC recommendations that are questions, the TAC should contact their DMS TAC coordinator. We have provided contact information to each of the TACs for their TAC coordinator, but if you need that information resent to you, please contact Barbara Epperson at Barbara.epperson@ky.gov.

Pursuant to 907 KAR 3:010(4), the limitation is per patient per year. However, DMS will continue to research other states' policies regarding this practice.

3) Limitation to one (1) annual physical per year

- a. The TAC requests a report of claims denied for well child annual visits because an exam was already done.

Response: The Division for Policy and Operations has requested an ad hoc report for this information and will provide when it is completed.

- b. Is the limitation per calendar year, or is it a rolling date?

Response: For TAC recommendations that are merely questions as opposed to recommendations, we ask that you work with your DMS TAC coordinator to funnel those questions to the appropriate DMS staff member. This will ensure that questions are answered more efficiently than if they were to go through the MAC recommendation process, and enables the MAC to focus on areas that have a greater impact. For responses to the March MAC recommendations and those that were outstanding due to lack of quorum from November and January, DMS will provide responses to recommendations that are questions. For all future MAC recommendations that are questions, the TAC should contact their DMS TAC coordinator. We have provided contact information to each of the TACs for their TAC coordinator, but if you need that information resent to you, please contact Barbara Epperson at Barbara.epperson@ky.gov.

The limitation is per calendar year.

- c. The TAC requests a minimum of two (2) physical exams per year be permitted.

Response: DMS follows the American Academy of Pediatrics periodicity schedule for preventive exams. Any preventive exams that are requested outside of the periodicity schedule must meet medical necessity criteria and be covered by EPSDT. Please see <http://www.aafp.org/fpm/2006/1000/p39.html> for further clarification.

- d. The TAC requests that providers be notified in real time if a patient has met their limitation on physical exams for the year.

Response: Because providers have one year to submit claims to DMS or the MCOs for reimbursement, it is impossible to issue a real time notification that the patient has met their limitation on physical exams for the year.

4) APRN License Verification

- a. The TAC requests that DMS reduce paper waste and improve utilization of staff time by accepting a single electronic file from the Kentucky Board of Nursing, within 30 days of the deadline for licensure renewal, that lists all APRNs who have renewed their license each year. TAC requests that DMS not automatically drop APRNs from Medicaid on November 1, but extend the deadline to November 30.

Response: We are currently updating our system to be able to support electronic submissions of information. The TAC should take this request to the KBN. DMS will take a file as long as KBN will provide it.

5) Reimbursement

- a. The TAC requests that DMS and the MCOs provide improved reimbursement for APRNs at 90% of the physician rate and increase the physician rate to 90% of the Medicare rate.

Response: During the last budget session, DMS was not allocated additional funds to be able to increase provider rates. This issue should be taken up with state legislators to request that they allocate additional dollars to Medicaid during future budget sessions. In addition, APRNs may negotiate their rates with the MCOs during provider contract negotiations.

Recommendations presented to the MAC at the January 22, 2015 MAC meeting:

- 1) The TAC recommends that DMS require the MCOs to issue provider numbers within 120 days of receiving a completed provider application.

Response: MCOs do not issue Medicaid provider numbers. If the provider has chosen to enroll in Medicaid through one of the MCOs, once the MCO has credentialed the provider the MCO sends the enrollment application to DMS. DMS has 15 days from receipt to process the application. If corrections are needed, the clock starts over until a correct and complete application is received. MCOs are required to process a correct and complete credentialing application in 90 days. However, if corrections are needed, then the clock starts over because the application was not correct or complete. Providers will experience a quicker processing time by ensuring that applications are correct and complete.

Erin Hoben
Chief Policy Advisor

Office of the Commissioner
Department for Medicaid Services

cc: Lisa Lee, Commissioner, Department for Medicaid Services
Neville Wise, Deputy Commissioner, Department for Medicaid Services
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity,
Department for Medicaid Services
Dr. John Langefeld, Medical Director, Department for Medicaid Services
Dr. Samantha McKinley, Pharmacy Director, Department for Medicaid
Services
Barbara Epperson, Internal Policy Analyst IV, Department for Medicaid
Services
Patricia Biggs, Director, Division of Program Quality and Outcomes
Lee Guice, Director, Division of Policy and Operations
Leslie Hoffmann, Behavioral Health Policy Advisor and Director, Division
of Community Alternatives
Jill Hunter, Director, Division of Provider and Member Services



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April 27, 2015

TO: Dr. Beth Partin, Chair, Medicaid Advisory Council (MAC) and MAC members

RE: Response to Nursing Technical Advisory Committee (TAC) Recommendations
Presented at the March 26, 2015 MAC meeting

Dear Dr. Partin and MAC members:

The following are responses from the Kentucky Department for Medicaid Services (DMS) to recommendations presented to the MAC on March 26, 2015 by the Nursing TAC:

- 1) It has come to our attention that WellCare is requiring nurse practitioners who practice in urban areas, but not rural areas, to have a supervising physician. The physician is also required to participate with WellCare.

Nurse practitioners (NPs) are not dependent providers and are considered Licensed Independent Providers. This requirement by WellCare is contrary to Medicaid requirements; is not consistent with Kentucky law; and appears to be arbitrary. No APRNs are required to maintain a prescribing agreement for non-scheduled drugs after four (4) years. Therefore, many NPs who are establishing practices do not have a prescribing agreement with a physician. The decision by WellCare to apply their rule to NPs who are not practicing in a rural area has no foundation in law or in the WellCare manual. Finally, and perhaps most significantly, WellCare is limiting access to care.

Recommendation: WellCare not require APRNs to have a supervising or collaborating physician in order to credential with their company.

Response: DMS confirmed with WellCare that they are following the provisions of the Senate Bill 7.

- 2) Current Medicaid MCO reimbursement to all providers is very low and not sufficient to allow those providers to cover the overhead costs of providing care to participants. Well documented information is available that shows the Medicaid MCOs are making significant profits. Medicaid and Passport, the only non-profit organizations, have agreed to continue the enhanced payments.

Recommendation: All MCOs continue the enhanced payments for primary care services and that APRNs and physicians be included in those programs.

Response: This is a business decision of each MCO as to whether to continue these enhanced payments and which providers would be eligible.

- 3) We have been advised of a situation where a psychiatric “lock in” patient was assigned to a primary care provider who did not see patients in the outpatient setting and had not practiced in Kentucky since 2012. Therefore, the patient went without medication and eventually required hospitalization for suicidal ideation.

This situation is an example of the dire consequences that can occur when there is no process in place to verify that assigned providers are following locked in patients.

Recommendation: Medicaid, and all the Medicaid MCOs, should be required to verify that locked in patients are assigned to a provider who is practicing in Kentucky and that the patient is receiving care. Patients cannot be forced to receive care, but at least the MCO or Medicaid should be required to contact locked in patients who are not presenting for regular visits.

Response: DMS believes this is a serious issue and wants notification immediately when such issues are identified so that we can correct it. Medicaid MCOs are required to have a Lock-In Program to address and contain Member overutilization for services for pharmacy and non-emergent care provided in an emergency setting. Lock-in is for overutilization of those services in addition to and separate from other case management and member services provided through the MCOs. Lock-in providers are chosen by the MCOs based on the needs of the patient including geographical access. Understandably, no restrictions are made on out-of-state MCO providers, with Kentucky having seven contiguous states with many overlapping medical service market areas on state borders. If specific Lock-In Program issues are identified, those should be reported to the appropriate MCO Lock-In Coordinator and to DMS’s Division of Program Integrity.

Erin Hoben
Chief Policy Advisor
Office of the Commissioner
Department for Medicaid Services

cc: Lisa Lee, Commissioner, Department for Medicaid Services
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of Community Alternatives
Jill Hunter, Director, Division of Provider and Member Services

Optometric TAC Meeting
May 19, 2015 - Frankfort, KY
Minutes

Called to order at 2:00pm EST with a quorum present.

Present: Matt Burchett OD, Gary Upchurch OD, Steve Compton OD, James Sawyer OD, Brian Keplinger OD, Susanne Watkins OD, Mary Marcum, Kim Sizemore, Darlene Eakin, Sarah Unger, CJ Jones (Medicaid), and Charles Douglas (Medicaid)

Introductions of those in attendance.

Charles Douglas updated the TAC on the New MCO Contract Discussions for July 2015.

TAC discussed Medicaid EHR Incentive - Individual & Group NPI #'s Issues

TAC discussed CPT Compliance & Medicaid Vision Regulations/Fee Service Schedule of the MCO's

TAC reported concerns about individual MCO's:

- Wellcare/Avesis
- Coventry/ Avesis
- Anthem/Eyequest
- Humana CareSource
- Passport/Superior Vision

TAC discussed future meetings of Optometric TAC. Next meeting July 16th at 1pm at Transportation Dept. CJ Jones suggested a representative from each MCO & their Vision Provider to be in attendance.

TAC discussed what issues/questions to present at the next MAC meeting on May 28th, 2015

Meeting adjourned at 4:40pm

Optometric TAC Recommendations for MAC – May 2015

The Optometric TAC would request that Medicaid receive confirmation from all MCO's vision subcontractors that they are following CPT guidelines/definitions for coding?

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?

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?

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"?

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?

**Report of the
Pharmacy Technical Advisory Committee (PTAC)
in conjunction with the Kentucky Pharmacists Association
to the Advisory Council for Medical Assistance (MAC)
Department for Medicaid Services**

Appointees to the Pharmacy TAC by the Kentucky Pharmacists Association:

Jeff Arnold	Med Care Pharmacy Florence (LTC Pharmacist)
Cindy Gray	Diamond Pharmacy Services (340B Pharmacist)
Christopher Betz	Norton Audubon Hospital/Sullivan University College of Pharmacy (Health Systems Pharmacist)
Suzi Francis	Kroger Pharmacy (Community Pharmacist, Chain)
Robert Warford	EFill Rx Pharmacy (Community Pharmacist, Independent)

Following an earlier orientation session, the first PTAC Meeting was held Friday, May 15, 2015 at the Kentucky Pharmacists Association, 1228 U.S. 127 South, Frankfort, KY from 9:30 a.m. until 11:55 a.m. All PTAC Appointees were in attendance except for Cindy Gray due to a scheduling conflict. Additional attendees included KPhA President Bob Oakley; KPhA Executive Director Robert McFalls; Alan Daniels, WellCare; Tom Kaye, Coventry/Aetna; Own Neff, Care Source and Felicia Wheeler, Humana Care Source; Thea Rogers, Passport Health Plan; Andrew Rudd, Anthem; Samantha McKinley, Leeta Williams and Trista Chapman, DMS; Shannon Stiglitz, KRF; and, Angela Gibson and Scott Sisco, KPhA staff.

Members elected Jeff Arnold to serve as the PTAC Chair for 2015-2016.

All MCOs were represented at the meeting and gave a brief overview to the Committee of their Pharmacy benefits. A brief brainstorming session was held to discuss opportunities for Pharmacy/Pharmacist involvement. The PTAC is excited about its role and opportunities to serve the Medicaid population by exploring solutions to current healthcare challenges by seeking innovative solutions.

Bob McFalls provided an overview of Kentucky's Health Care Transformation Grant/SIM Model Design initiative. KPhA and pharmacist members have been participating in this planning initiative via the three stakeholder and five work group meetings. PTAC members had been previously informed about this initiative and updated workgroup meeting schedules were distributed at the meeting. Mr. McFalls encouraged pharmacists and other interested individuals to get involved, if they are not already participating.

Opportunities for Pharmacy/Pharmacists were reviewed and will be discussed in more detail at future PTAC meetings, including but not limited to:

- Medication Therapy Management
- Simple Public Service Announcements regarding the contributions of pharmacists
- Integrated Part of Home Health Teams
- Economics of what is happening with the generic drug industry

The Committee briefly discussed a communication issued earlier in the year from CVS Caremark regarding the Kentucky Medicaid Program and network and will asked for additional background information. The Committee also reviewed the MAC's recommendation to DMS regarding prior authorizations (PAs). There was a question from the pharmacist member regarding the process of sending the PA to the MCOs from the Patient's date of point or from the Pharmacist's date of point. The request dealt when and how can the pharmacist be contacted about the PA to miss any undue delay of service? The general practice is to respond to the person on the request form. The pharmacy should get a response back if they are in the return line. The pharmacist should work closely with the prescribing Physician so that the pharmacy will be on the return line for any of the PA communications. The PTAC will revisit this item at its next meeting.

The next PTAC Meeting has been scheduled for Friday, July 10, 2015 at the Kentucky Pharmacists Association, 1228 U.S. 127 South, Frankfort, KY from 9:30 a.m. until 11:30 a.m. Notification of the meeting will be posted by DMS staff on the CHFS web site. All interested parties are welcome to attend, and representatives from each MCO are strongly encouraged to participate.

Respectfully submitted,

Jeff Arnold, Chair, PTAC

Robert S. Oakley, President, Kentucky Pharmacists Association



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April 27, 2015

TO: Dr. Beth Partin, Chair, Medicaid Advisory Council (MAC) and MAC members

RE: Response to Physicians Technical Advisory Committee (TAC)
Recommendations Presented at the March 26, 2015 MAC meeting

Dear Dr. Partin and MAC members:

The following are responses from the Kentucky Department for Medicaid Services (DMS) to recommendations presented to the MAC on March 26, 2015 by the Physicians TAC:

- 1) A recommendation to form a coding and billing sub-committee for the MAC was made previously and is still on the table.

Response: All provider should adhere to correct coding guidelines pursuant to CPT and ICD-9. DMS does not advise on appropriate coding.

- 2) All the MCOs except Passport decided not to extend the primary care incentive payments. A recommendation from the TAC suggests the use of specific quality measures to provide incentives to physicians instead.

Response: It is an MCO business decision to use specific quality measures to provide incentives for physicians. They are currently reviewing their options.

Erin Hoben
Chief Policy Advisor
Office of the Commissioner
Department for Medicaid Services

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Lee Guice, Director, Division of Policy and Operations
Leslie Hoffmann, Behavioral Health Policy Advisor and Director, Division
of Community Alternatives
Jill Hunter, Director, Division of Provider and Member Services

Good Morning,

Lindy Lady, Medical Business Advocacy Manager for KMA.

The Physician Technical Advisory Committee met on April 23, 2015.

Provide Medicaid Reimbursement for kyhealthnow Priorities

As detailed by KMA President David Bensema, MD in a recent op-ed in both the Courier Journal and Herald Leader, KMA conducted a survey of its members to determine barriers to achieving the state's health priorities as set out in the Governor's kyhealthnow initiative. Based on the findings of this survey, along with additional comments from members of the Physician TAC, it appears that systemic barriers do exist to achieving these goals and we believe they should be addressed in order to help all Kentuckians achieve better health.

Since most MCO's chose not to continue with the primary care payment increases provided under the ACA in 2013 and 2014, something needs to be done to further incentivize treatment for Medicaid recipients, and addressing the barriers to the kyhealthnow goals could be a cost-effective way to do so.

What are these barriers? As we have discussed previously, one barrier concerns smoking cessation. Currently, if a physician bills for an E&M visit, and also bills for smoking cessation counseling, the MCO's will not pay for the E&M visit, but only pay for the smoking cessation counseling, which is substantially less. This sends a clear message to the provider that the payers do not care about what is actually done with the patient – they only want to pay the cheapest service performed. We also found numerous examples of smoking cessation drugs not being covered. Such a policy not only appears to run counter to the state's goals, but also sends the message to the patient that the insurer does not care about smoking cessation.

Other examples abound. Refusing to pay for cancer screening services – refusing to pay for prescriptions that are prescribed by physicians who may not choose to be a Medicaid provider – not covering medical nutritional therapy, which has proven beneficial for diabetics and people with pre-diabetes -- refusing to pay for sports physicals, despite the fact that children taking part in school sporting activities goes a long way to fighting obesity. That issue is made worse by the fact that various schools and various sports require different types of physicals and information. Help from the state to standardize these forms, physicals and timing of the requirements would also help promote good health and wipe away a significant barrier, especially to children who may not have the means to pay for such a physical.

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

Use of standardized quality measures

Payment based on so-called quality criteria are being implemented at all facets of the health care system, including discussions currently being held within the Cabinet through its SIM initiative. While we believe much work still needs to be done in creating appropriate quality measures, we also believe such measures should be as uniform as possible among third party payers, including the MCO's. Currently, commercial payers have implemented varying types of quality measurement programs, but all of them use different measurements and have differing criteria. This has put an undue burden on providers, to the point that many if not most simply ignore them and treat the patient as they normally would. This once again creates disincentives for providers. If one plan uses one set of criteria and another plan uses a second set, which criteria truly measures quality? Providers don't know, the public does not know and it simply provides meaningless burdens on the providers, at least that's certainly how they see it.

But if there are differing measurements for quality, how can the state adequately measure which plans and which providers are actually providing quality care? It seems important to have consistency across the payers so that their work can be monitored to ensure quality of care.

Currently, most of the MCOS have clinical staff review the patient's medical record to see if a specific HEDIS (Healthcare Effectiveness Data and Information Set) goal has been met. Manual review of the record whether paper or electronic takes considerable time and cost for both the physician and MCOs, often necessitating on-site visits where physician offices have to provide a working space for the reviewer and access to patient records.

The primary component of quality measures is data collection. For example the use of existing CPT tracking codes to report quality measures would decrease the need for record abstraction and chart review, minimize the burden on physicians and other healthcare professionals, and improve data collection by accurately describing clinical components associated with a quality measure. It would be a cost-efficient way for the state and MCOs to track specific quality measures and identify where patients have made improvements in their health.

Simplify Provider Enrollment

Building on the legislative changes made this year, the TAC also discussed the need to further reduce the time it takes to enroll into the Medicaid program. This would also assist with any potential gaps in workforce shortages if it took no more than 30 days to be enrolled and have MCOs use the same standard enrollment platform to make the enrollment process simpler. The current system of long waits and various enrollment platforms has not been shown to increase quality or access to care, at least that we are aware of.

Thank you for the opportunity to speak here today and I am happy to answer any questions now.

Physicians TAC Recommendations

Presented to MAC on May 28, 2015

1. Provide Medicaid reimbursement for all KYHealthNow priorities
2. Use standardized quality measures for all MCOs



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

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Governor

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April 27, 2015

TO: Dr. Beth Partin, Chair, Medicaid Advisory Council (MAC) and MAC members

RE: Response to Primary Care Technical Advisory Committee (TAC)
Recommendations Presented at the November 20, 2014 and January 22, 2015
MAC meetings

Dear Dr. Partin and MAC members:

The following are responses from the Kentucky Department for Medicaid Services (DMS) to recommendations presented to the MAC on November 20, 2014 by the Primary Care TAC:

1. The Primary Care TAC requests that DMS recognize and approach these issues in partnership with the providers and MCOs and work together on a common shared problem affecting over clinics across the State.

DMS has been and continues to be working together with the MCOs, the TAC, and numerous providers to address all issues pertaining to the WRAP. MCO representatives have been present at the Primary Care TAC meetings. DMS has always identified the issues of this process as being a global issue and intend to continue to work together toward rectifying the issues.

2. The Primary Care TAC requests there be joint meetings between DMS, MCOs and the affected parties to work on the resolution of the wrap and outstanding issues related to payment for Medicare/Medicaid dual eligible claims.

This is being addressed with the attendance of the MCOs at the TAC meetings. DMS has been in discussions with each MCO pertaining to the submitting

of the dual eligible (AKA crossover) claims as a denied claim when they should be sent as a \$0.00 paid claim. The automated system does not look at denied claims, it only considers paid claims. While the MCOs will mostly not pay anything on these, they still must allow due to processed to occur as there is a small possibility they would pay. If the MCO deems that the Medicare paid amount is above its customary charges, then they should pass that on to DMS as a \$0.00 paid claim, not a denied claim. DMS has brought this to the attention of the Primary Care Association and various providers that have inquired about this matter so that they too can relate the same message to the MCOs. - See #8 and #9 of the attached Wrap history document.

3. The Primary Care TAC requests that DMS deal with the resolution of the issue with Kentucky Spirit since there is a formal court ruling involving the contract DMS held with Kentucky Spirit and the State and it does not appear the providers can intervene, even on their own behalf.

We are currently in litigation with Kentucky Spirit and cannot discuss this matter with the TAC at this time due to legality issues. However, DMS has addressed it by allowing providers an extended review period of the reconciliation data and to identify any claims that they identify as missing from the data (including Kentucky Spirit). -See #12 and #13 of the attached Wrap history document..

4. The Primary Care TAC recommends that a working group including the TAC, DMS and the MCOs be established to sample, test and resolve the reconciliation process (all claims prior to June 30, 2014) to assure all data is being captured, to avoid misunderstandings by any party and to avoid confusion, as well as duplication of effort which will only result in extending the length of time needed to resolve the matter.

This will be difficult to achieve in a timely manner. In a sense, we are doing this as a working group. We send the facility the reconciliations and the encounter data we have, they identify anything we do not have, and then we (DMS and the facility) work with the MCOs to get the data cleaned up. We will accept the information sent back by the Facilities after doing a random sample of the submitted encounters.

5. The Primary Care TAC recommends that for the dual eligible claims, DMS instruct the MCOs to transmit a \$0 paid amount instead of a denial when the claim is processed to DMS.

Please see response to Recommendation #2.

6. The Primary Care TAC recommends that DMS include additional identifiers on EOBs – such as: MCO Member ID, claim number, subscriber number and patient name – in order to allow clinics to reconcile payments more efficiently.

Response: DMS has submitted a change order to an HP Business Analyst for design and impact analysis.

7. The Primary Care TAC recommends that DMS add a legend to the reconciliation spreadsheet to provide clear definitions for the column headers to ensure accuracy when completing the spreadsheet.

Response: DMS worked with Myers & Stauffer and provided a data dictionary with the spreadsheet to address this request.

8. The Primary Care TAC recommends DMS extend the current timeline for providers to complete the wrap payment reconciliation process from 30 days to 60 days to allow clinics more time to review their data.

Response: DMS granted the requested extended timeline to 60 days and then further extended the due date to April 30th.

Recommendations presented at the January 22, 2015 MAC meeting.

1. In light of the fact that the reconciliation process for 11/1/11 – 6/30/14 includes a tremendous amount of paid claims data and requires a very manual process to complete the spread sheet developed by DMS, we recommend that DMS work with KPCA and a select group of clinics to determine the most effective way to collect needed information electronically from the clinics' EMRs.

Response: DMS has conducted several meetings with the Kentucky Primary Care Association and facilities to discuss the data fields of the spreadsheet and to address issues several facilities were experiencing while trying to collect the data. During these meetings, it was determined and agreed that some fields previously requested on the original spreadsheet could be eliminated to ease some of the burden of gathering the data. The decision of what fields to eliminate was a group effort by DMS, KPCA, and some facilities. A letter discussing this matter in detail was sent to the facilities at the beginning of this year. It was also agreed to grant all facilities until April 30, 2015 to provide this data.

2. In light of the magnitude of this process, including the lack of adequate claims data provided by DMS and given that we are dealing with both the wrap payment and the Medicare dual eligible issue, the Primary Care TAC recommends that DMS provide additional extensions beyond the initial 30 days to allow providers sufficient time to complete the process. While we would like to have it completed quickly, we feel it is

much more important to accomplish the reconciliation in the correct and equitable manner for all parties, DMS, the clinics and the MCOs. It is after all a partnership.

Response: DMS addressed this issue by extending the deadline to April 30, 2015 for all facilities.

3. Our final recommendation concerns the process for responding to recommendations made by the TAC through the MAC. We realize responses must be publicly posted, but there is no notification that responses have been provided to the group who made the recommendations. The Primary Care TAC recommends that TAC members and the KPCA be sent a copy of the responses to the recommendations directly and within the required 30-day timeframe.

Response: When a quorum is present at the MAC, DMS will issue responses to recommendations made the MAC. Recommendations must be submitted in writing to Barbara Epperson at Barbara.Epperson@ky.gov. The responses will be issued to the MAC and the TAC within 30 days from receipt of responses in writing to DMS.

Erin Hoben
Chief Policy Advisor
Office of the Commissioner
Department for Medicaid Services

cc: Lisa Lee, Commissioner, Department for Medicaid Services
Neville Wise, Deputy Commissioner, Department for Medicaid Services
Veronica Cecil, Chief of Staff and Director, Division of Program Integrity,
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Dr. John Langefeld, Medical Director, Department for Medicaid Services
Dr. Samantha McKinley, Pharmacy Director, Department for Medicaid
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1. In November 2011, Managed Care was implemented and the Managed Care Organizations (MCOs) were allowed to set their own rates. However, that placed the responsibility on the Department for Medicaid Services (DMS) to pay the difference in what was paid to the RHC/FQHC facility and their PPS rate.
2. DMS first addressed this issue in November 2011 by beginning to issue monthly supplemental payments based upon each facility's historical average payment. In addition, the Department started looking into ways to modify the Medicaid Management Information System (MMIS) to automate this process to make this a seamless process for the facilities.
3. The planning and development stages of the automated payment process took time to design as there were many facets to the process that needed to be considered and addressed. In June 2013, the automated process was turned on to test the process but had to be terminated in September 2013 after the payment amounts were processing far less than anticipated. However, DMS continued to process the supplemental payments during this entire testing phase of the automated process and the months that followed.
4. DMS received several complaints from facilities stating that the monthly supplemental payments were not enough so DMS completed "Interim Reconciliations" for all facilities for the November 2011 through September 2013 period using the facility's self-reported information in an attempt to make them whole. The intention was to process "Final Reconciliations" for this period using the MCO encounter data sometime around August 2014. DMS did not intend to process an Interim reconciliation for facilities for the 10/1/13 through 6/30/14 time period but planned to process a Final reconciliation for that time period beginning in March 2015. The reason for this delay was to ensure all claims were incorporated to constitute a "Final" for that time period. DMS needed to allow for the timely filing of claims. The timely filing period with the MCO's is 6 months, therefore in order to ensure DMS incorporate all claims for the time period, DMS needed to wait until after December 2014. The MCO's then have up to 30 days to forward the corrected encounter to the Department which is why March 2015 was stated as the anticipated date.
5. This anticipated process sparked multiple complaints from many facilities and the TAC. After the Primary Care TAC meeting on 7/21/2014, DMS decided to change this process. A new "Preliminary Reconciliation" will be processed using the MCO encounter data that the Department has received from each MCO's and will now incorporate the claims with dates of service 11/1/2011 through 6/30/2014. Then, DMS will pull the data again (approximately March 2015) for the exact same time period for a "Final Reconciliation" as planned to bring in any timely filing claims we have received since the preliminary reconciliation was processed.

6. DMS advised the MCO's that the encounter data needed to be addressed and that DMS would be implementing various penalties and withholds on the MCO capitations to further address the encounter issues. The automated process was turned back on in July 2014 for services since July 1, 2014. The facilities were given multiple versions of notifications from DMS and the Primary Care Association advising them the supplemental payments were stopping and the automated process was scheduled to be implemented on July 1, 2014. Upon implementing the process, it was discovered that some providers were not properly enrolled with DMS' Provider Enrollment. DMS worked with these providers to get the, enrolled correctly and had the payments issued.
7. Several facilities also asked for a face to face discussion with DMS pertaining to the data used for the reconciliations. DMS met with approximately eight providers to discuss their situations and to provide them a complete listing of the encounter data. After they had ample time to review the data, they were to follow up with DMS on any issues they noticed with the data.
8. Based upon research of sample claims submitted to DMS by various providers, it was determined that some encounters were being submitted to DMS with only the rendering provider information and that Dual Eligible claims were being sent in as denied claims when they should have been sent in as \$0.00 paid claims. The exclusion of the Billing Provider information makes it impossible for DMS to tie the paid claim to the FQHC/RHC facility. This is the main contributing factor to the absence of claims on the reconciliations as well as providers not receiving any wrap payments for paid claims via the auto payment process that was implemented in July 2014.
9. Commissioner Kissner and Deputy Commissioner Wise met with all of the active MCO's individually to escalate attention to the FQHC/RHC wrap situation as well as to address the submission of correct data to DMS. As a result of this meeting, a spreadsheet was sent to the MCO's to populate with data for claims paid to any PCC, FQHC, and RHC for dates of service between November 1, 2011 and June 30, 2014. It took the MCO's a couple of weeks but the data was received from all MCO's, with the last one submitted on Thursday, 10/2/2014.
10. A review of the data was completed to ensure that DMS can correctly identify the facility that received reimbursement by comparing the submitted NPI, Taxonomy, and/or Tax ID to the data DMS has within the MMIS. Due to the size of the data, this review did take some time but DMS staff worked around the clock as this was considered a high priority.
11. The results of DMS' review of the MCO submitted data dump of claims determined that the data was too flawed to use and maintain the integrity of the data. DMS determined to use the encounter data again.

12. DMS pulled the encounter data again and worked up the database to be delivered to Myers & Stauffer to restart processing the Preliminary Reconciliations. DMS will use the Kentucky Spirit encounters currently in the MMIS during the reconciliation process.
13. The reconciliation database was delivered to Myers & Stauffer on Friday, November 14, 2014. The Preliminary Reconciliations will be processed for the PCC's first due to satisfy date constraints within current litigation. Then Myers & Stauffer will process the Preliminary Reconciliations for all FQHC/RHC facilities. As part of the reconciliation process, a disk of the claims and a spreadsheet layout will accompany each summary sheet sent to the facilities. If there are still any claims that the facilities have identified as missing from the data (including Kentucky Spirit), the facility will have 30 days from the date of the letter to forward the information to DMS for consideration. If additional time is needed, DMS will consider an extension on a case by case basis. Facilities need to understand that this information is subject to future State and/or Federal auditing. A final reconciliation will still be processed in 2015 to consider any timely filings.
14. DMS is also working with the MCO's to clean up their data for dates of service July 1, 2014 and after to address certain issues (such as the rendering versus billing provider information) that are preventing the processing of the wrap during the auto payment process. There are also issues that may require interaction between the facility and DMS provider enrollment to update the provider profiles. As part of this process, DMS has requested all FQHC and RHC facilities to complete a spreadsheet with all claims they have received payment from the MCO. DMS is using this data to identify and issue any payments due to facilities from DMS and to identify any further issues with the encounter data received and/or not received from each MCO.



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May 12, 2015

TO: Dr. Beth Partin, Chair, Medicaid Advisory Council (MAC) and MAC members

RE: Response to Primary Care Technical Advisory Committee (TAC)
Recommendations Presented at the March 26, 2015 MAC meeting

Dear Dr. Partin and MAC members:

The following are responses from the Kentucky Department for Medicaid Services (DMS) to recommendations presented to the MAC on March 26, 2015 MAC meeting:

1. In light of the manual nature of the wrap reconciliation process and continued issues with missing claims data, the Primary Care TAC recommends that DMS continue to approve requests for extensions past the April 13th deadline.

Please see DMS response submitted to the MAC on April 27, 2015.

2. To improve the automated wrap payment process and decrease administrative burden on providers, the Primary Care TAC recommends that DMS provide EOBs electronically with the necessary identifiers to allow clinics to reconcile payments more efficiently. These identifiers should include: MCO Member ID, claim number, subscriber number and patient name.

Please see DMS response submitted to the MAC on April 27, 2015.

3. To avoid unnecessary recoupments based on eligibility status, the Primary Care TAC recommends that DMS provide more timely and accurate eligibility information

to providers and MCOs. Additionally, we recommend that DMS have a clear process in place for communicating re-certification delays to the assigned PCP so that the PCP can engage a kynector to assist members in completing the re-certification process.

Currently, the MMIS system receives member MCO assignment changes through a variety of systems. These changes are consumed by MMIS on a nightly basis. The next day a member file is sent to each MCO containing only their members. That list is then consumed by each system and sent out to each subcontractor for each of their systems. These are daily processes but as you can see there can be time gaps if changes are made. To date, DMS does not possess the technical capability to make each change in real time across all possible systems.

Assuming your recommendation on recertification delays concerns when a member completes or fails to complete their annual Medicaid eligibility recertification process DMS cannot share that kind of information with anyone besides the member or the member's authorized representative. If the individual had a connector apply for them, I believe there is a task generated to show the recertification steps and when they are due. DMS is also working to develop recertification processes that require less intervention by the member. The ACA authorizes passive renewal in certain circumstances. When these processes are implemented DMS expects fewer gaps in eligibility.

4. To assist providers and Health Plans in making lock-in programs more effective, the Primary Care TAC recommends that DMS work with the MCOs in a coordinated effort to provide lock-in alerts to providers in a more clear and consistent manner.

DMS supports efforts to assist providers and Health Plans in making lock-in programs effective and will consider options through the MCO contracting process to improve the ability to identify those managed care members placed in Lock-in.

5. Finally, in order to improve the MCOs' and providers' ability to more effectively outreach to members, the Primary Care TAC recommends that DMS work with the MCOs and providers to develop an alternative process for updating member information that does not require the member to use kynect exclusively. This could be a form that requires the member's signature.

Members can work through kynect, their local DCBS office, or use the DCBS call center at 1-855-306-8959.

Erin Hoben
Chief Policy Advisor
Office of the Commissioner
Department for Medicaid Services

cc: Lisa Lee, Commissioner, Department for Medicaid Services
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Recommendations to the MAC

Prepared by the Primary Care Technical Advisory Committee

Presented on May 28, 2015

The Primary Care Technical Advisory Committee met at 10:00 AM on Thursday, May 14, 2015. A majority of TAC members were present along with DMS staff and representatives from the MCOs. Agenda items included:

- The automated wrap payment process from 7/1/14 onward.
- Status of the wrap payment reconciliation from 11/1/11 – 6/30/14.
- The need for an electronic remittance process for automated posting.
- Issues related to the lock-in program.
- Issues related to eligibility status, re-certification delays and retroactive enrollment.
- Options for correcting/updating member addresses and demographic information

Since our last report to the MAC, we have continued to work on issues related to completing the wrap reconciliation process and improving the automated wrap payment process. The most significant update is that DMS no longer plans to do an additional “final” reconciliation. Instead, we’ve been told that they plan to start processing the reconciliation spreadsheets in June, which should be a sufficient timeframe for capturing the vast majorities of claims with dates of service prior to 7/1/14. Any claims that are processed after the reconciliation process is complete will be dealt with on a case-by-case basis. We were also told that the process would include a “mini-audit” of claims to ensure no duplicate payments are being made. Once the audit is complete, the practice will receive a letter with DMS’s findings and the total payment or recoupment amount. Finally, there will be a 30-day appeal process before the payment or recoupment takes place. While it’s good news for providers that this is the final reconciliation they will be asked to complete, we do have some concerns that the timeframe for this process will be drawn out, which will be a burden for many practices that have been struggling financially due to incomplete wrap payments since 2011. Some of these practices are owed in excess of \$1,000,000 and have been taking out lines of credit to meet payroll. For these practices, we would like to see an expedited process.

In addition to the wrap reconciliation timeframe, we have received clarification from DMS on how Licensed Primary Care Centers are supposed to proceed with the reconciliation. Because of the ongoing lawsuit, all LPCCs must request their claims disk through the law practice. We have found that many LPCCs do not know this, so we are working to get that information out.

In regard to the automated wrap payment process, we’ve been working with DMS and the MCOs to identify and resolve issues with the system. Over the past few months, DMS has made a number of corrections to system edits that were incorrectly kicking out paid claims and therefore not generating a wrap payment. While the majority of these issues seem to be

improving, there is still an issue with crossover payments for dual eligible patients and appealed claims that are not receiving consistent wrap payments. We are continuing to collect examples of these issues to facilitate their resolution. There also seems to be disagreement with how some claims that did not initially make it into DMS's system are to be reprocessed for the period post 7/1/14. We have suggested that DMS meet with the MCOs to determine the most efficient process without creating an additional burden to providers.

Another ongoing problem that continues to be an issue with the automated wrap process, is that DMS's system currently only provides electronic EOBs for FFS patients, not those enrolled with an MCO. This has created a tremendous amount of work for practices, as they must manually enter this information into their systems. We have been told that DMS is actively seeking a solution that would allow for auto-posting, so we hope to have an update for you at the next MAC meeting.

In addition to wrap payments, another important issue that has been affecting PCPs is patient eligibility and retroactive enrollment that has led to a significant amount of recoupments, many of them going as far back as two years. We have been told that some of these problems were due to issues with kynect and have already been resolved or are in the process of being corrected. However, as long as DMS retroactively dis-enrolls a member after a date of service has been provided, the provider will be left with the bill. This is true even when the provider's office verifies eligibility using the DMS and MCO portals on the date of service. We believe that DMS should be ultimately responsible for the timeliness of the eligibility information they publish.

Another item we touched on briefly was improved notification regarding the lock-in program. DMS has agreed to consider improving this process through MCO contracting and we will continue the conversation with them on what would be most effective.

Finally, we discussed options for correcting or updating member information to ensure providers and MCOs have the right information with which to contact patients most effectively and, even more importantly, to provide appropriate treatment to patients. Currently, only patients have the ability to correct this information, but they don't always have the time, motivation or understand the significance of a wrong number or incorrect date of birth. Therefore, we have requested that DMS create a form that can be completed by the provider or MCO and authorized by the patient or guardian.

The Primary Care TAC submits the following recommendations for the MAC's consideration:

1. 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.

2. 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.
3. 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.
4. 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.
5. 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.
6. 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.



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April 27, 2015

TO: Dr. Beth Partin, Chair, Medicaid Advisory Council (MAC) and MAC members

RE: Response to Therapy Technical Advisory Committee (TAC) Recommendations
Presented at the January 22, 2015 MAC meeting

Dear Dr. Partin and MAC members:

The following are responses from the Kentucky Department for Medicaid Services (DMS) to recommendations presented to the MAC on January 22, 2015 by the Therapy TAC:

1. Shift in EPSDT billing which is to occur in June – do you use provider type 45 and switch to CPT code billing or use specific therapy provider types? Providers would like the cabinet to recognize the significant impact of the rate shift on facilities.

Response: For TAC recommendations that are merely questions as opposed to recommendations, we ask that you work with your DMS TAC coordinator to funnel those questions to the appropriate DMS staff member. This will ensure that questions are answered more efficiently than if they were to go through the MAC recommendation process, and enables the MAC to focus on areas that have a greater impact. For responses to the March MAC recommendations and those that were outstanding due to lack of quorum from November and January, DMS will provide responses to recommendations that are questions. For all future MAC recommendations that are questions, the TAC should contact their DMS TAC coordinator. We have provided contact information to each of the TACs for their TAC coordinator, but if you need that information resent to you, please contact Barbara Epperson at Barbara.epperson@ky.gov.

DMS has issued clarification on this issue. Please see additional attached clarification.

Erin Hoben
Chief Policy Advisor
Office of the Commissioner
Department for Medicaid Services

cc: Lisa Lee, Commissioner, Department for Medicaid Services
Neville Wise, Deputy Commissioner, Department for Medicaid Services
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Audrey Tayse Haynes
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Commissioner

March 20, 2015

TO: Medicaid Providers
Community Mental Health Centers (30) – Provider Letter #A-102
Supports for Community Living (33) – Provider Letter #A-40
Home Health Agency (34) – Provider Letter #A-115
Home and Community Based Waiver (42) – Provider Letter #A-3
Adult Day Health Care (43) – Provider Letter #A43
Early and Periodic Screening, Diagnostic and Treatment (EPSDT 45) –
Provider Letter #A-9

RE: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefits
Physical, Occupational and Speech Ancillary Therapies

Dear Providers:

The EPSDT benefit is designed to provide comprehensive and preventative health care services for Medicaid enrolled children under the age of 21. EPSDT services have always been an essential benefit designed to ensure children and adolescents receive the appropriate preventive, dental, mental health, developmental, and specialty services. In the past, the Department for Medicaid Services (DMS) required all providers to obtain a Provider Type (PT) 45 number in order to bill traditional Medicaid for services provided to members through the EPSDT benefit.

The ancillary therapy services, physical therapy, occupational therapy, and speech therapy for children were previously provided through the EPSDT benefit are now covered under other State Plan services and are not billable through the EPSDT 45 provider number. Effective July 1, 2015 if your agency plans to continue to provide these services, you will need to bill with the appropriate provider type according to the therapy being provided.

For example, if you are a waiver provider and your agency utilizes an EPSDT provider number to bill for these ancillary therapy services, your claims will not process after close of business on June 30, 2015. If your agency would like to continue to provide these ancillary therapy services, you must qualify for the appropriate provider type and complete a provider enrollment packet to obtain a provider number (PT 87 for physical therapy, PT 88 for

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occupational therapy, and PT 79 for Speech Language Pathology). The Provider Licensing and Certification Branch is expediting these applications upon receipt. Please include a letter requesting expedited service.

Beginning July 1, 2015 your agency should bill these ancillary services through the appropriate PT number. If your agency is providing speech therapy services to a client who is enrolled in the Michelle P. Waiver program, the billing would be submitted utilizing the PT 79 Medicaid enrolled provider number. As of July 1, 2015, if your agency bills this service with the EPSDT (PT 45) provider number, the claim will be denied. Your agency's EPSDT provider number will end-date effective July 1, 2015 regardless of whether or not you have enrolled in another provider type.

If you currently contract with another agency that is not an enrolled Medicaid provider and bill for the services of that agency, DMS encourages you to request that the agency become a direct Medicaid provider. Otherwise, the agency will not be permitted to provide services to the member after July 1, 2015.

If your agency is currently enrolled as a Medicaid provider who is eligible to provide these ancillary therapies (i.e., Home Health agencies), your agency does not need to obtain a separate provider number. Your agency should continue to bill therapies as you have previously done.

DMS also recommends that you contact the Office of Inspector General Division of Health Care to ensure that you understand any Kentucky non-Medicaid laws and regulations that must be followed by practitioners when providing services in the areas of speech, occupational and physical therapy. The Division may be reached by calling 502-564-7963.

All other requirements related to the EPSDT benefit have not changed. All prior authorization and medical necessity requirements are still active. Should you have any questions about EPSDT, please contact the EPSDT Manager at (502) 564-9444. Any questions regarding enrollment in the Kentucky Medicaid Program may be directed to the Provider Licensing Branch at 1-877-838-5085. Additional information regarding provider enrollment may be found at the following web address: <http://www.chfs.ky.gov/dms/provEnr/>. DMS will continue to work with providers to ensure a smooth transition throughout this process.

Sincerely,



Lisa D. Lee, Commissioner

LDL/KEH

**Kentucky Therapy Technical Advisory Committee
March 3, 2015 Meeting Minutes**

Advisory Committee Meeting 8:30 am-9:30 am

Members in Attendance: Dr. Beth Ennis, Charlie Workman

Members Attending via Conference Call: Linda Gregory and Leslie Sizemore

Others in Attendance: Mary Hieatt, Humana caresource; Dell Frazee, Passport; Scott Sagaser, Associates in Pediatric Therapy

Other Conference Call Attendees:

Pam Marshall, Marshall Therapy

Previous Minutes: No corrections; accepted as written.

Issues from Previous Meeting:

Medicaid Forum: Held in Louisville on April 17th. Attendance from all MCOs and the Cabinet; presentations well received. PTs main request was to allow recert prior to expiration of recert so there is no gap in service and do away with the Therapist/Assistant differential. Also discussed 30-day recert issue (see below) and episodes of care vs ongoing therapy. Some discussion of categorizing by intensity, such as high intensity (short term), periodic, and consultative.

30-day recert issue with Fee-for-service Medicaid: Caresource and the Cabinet spoke with Interqual, and a 90-day period is doable. Just waiting on Cabinet to tell Caresource to make the change. Unclear if this is targeted as July 1 as well.

EPSDT Transition: All services beginning July 1 will use therapy provider types and CPT codes for billing. Letters did go out to providers who do not have a Medicaid number to expedite this process. Rates continue to be discussed as a concern, and next year is a budget year, so changes may be considered at that time.

OT member for TAC: Linda DeRossett is the newest member and joins Leslie Sizemore representing OT on the TAC.

Certificate of Need Issues: Email received stating that something would be published in the next newsletter regarding changes to the state health plan, as well as possible changes to CON.

Duplicate Coding Issue: This has been corrected, so PT and OT billing the same code on the same day will no longer get denied for duplication of services as of May 1.

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Therapy Benefit under fee-for-service: the 20 visit benefit is considered a soft benefit, and visits can continue to requested based on medical necessity.

New Issues

Dr. Beth Ennis discussed need to look at several codes on the PT fee schedule that are listed as visit codes but are actually timed codes. No one from the cabinet present, so will forward to Carrie to see where it needs to go from here.

Also, word from the cabinet that the commissioner would like to change the process so that questions can be directed to the cabinet directly from the TACs but any recommendations, changes, etc would still go through the MAC. This would greatly speed up the process of having questions answered.

ST meeting with the Commissioner on Friday at 3 pm to discuss rates.

Online provider enrolment is supposed to be up by July 1 for fee-for-service medicaid.

Received word via email that Department of Insurance was going to use the broad federal definition of habilitation to make sure services are being covered. If folks are getting denials due to services being habilitative in nature, contact DOI so they can investigate.

Discussion of creating a repository for therapy best practice documents, that can be accessed by members, MCOs etc. Dr. Ennis will start to develop. Please send any documents to her.

Discussion regarding Speech CFY -- they have a license (it is provisional) so they should be able to bill.

Questions for MAC to ask Cabinet:

None at this time.

Next Meeting

Members agreed to meet on Monday, 7/6/2015 at 8:30 am. Dr. Ennis asked members to email her with issues.