

**CABINET FOR HEALTH AND FAMILY SERVICES  
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE**

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March 26, 2015  
10:00 A.M.  
Room 125 Capitol Annex  
Frankfort, Kentucky

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**MEETING**

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**APPEARANCES**

Elizabeth Partin  
CHAIR

Donald Neel  
Sharon Branham  
Susie Riley  
Susanne Watkins  
Peggy Roark  
Jonathan Van Lahr  
Barry Whaley  
Karen Angelucci  
Chris Carle  
Richard Foley  
COUNCIL MEMBERS PRESENT

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**CAPITAL CITY COURT REPORTING**

**TERRI H. PELOSI, COURT REPORTER  
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1 CHAIR PARTIN: We have a quorum  
2 this morning. So, the first item on the agenda is  
3 approval of the minutes from the November and January  
4 meetings.

5 MS. BRANHAM: Do you want  
6 separate motions?

7 CHAIR PARTIN: I think we can  
8 just make one motion and approve them both, if that's  
9 alright, unless there's some discussion.

10 MS. BRANHAM: That sounds good  
11 with me but I didn't know.

12 CHAIR PARTIN: If there's some  
13 discussion on any of them, then, no; but if everybody  
14 has no issues with either of those reports, then, we'll  
15 just approve them as one.

16 MR. VAN LAHR: I move they be  
17 approved.

18 DR. NEEL: I'll second.

19 CHAIR PARTIN: Any discussion?  
20 All in favor say aye. Opposed? So moved.

21 The second item here, we've got  
22 two things. I'd like to adopt a flexible agenda  
23 because one of our members must leave today by noon.  
24 So, I want to make sure that we get to everything that  
25 we need to do that has to be approved by the MAC before

1 she has to leave.

2 And, then, the second item is  
3 that we've been asked to move up the Home- and  
4 Community-Based Waiver presentation after the  
5 Commissioner's report. And so long as it looks like  
6 we're moving on time, we can do that. I'm told that  
7 report will take about thirty minutes. And, so, we'll  
8 just have to be mindful of the time.

9 If it looks like we can fit that  
10 in plus all the TAC reports plus any new information  
11 that we need to move on, then, we'll go ahead and do  
12 that. And if needs be, we will postpone the Coventry  
13 report until our next meeting if it looks like that  
14 we're going to run over time and we can't fit that in.  
15 So, I hope that works for everybody.

16 So, under Old Business, the  
17 first item is enhanced payments to primary care  
18 providers. And we know that Medicaid and Passport are  
19 continuing the enhanced payment program for providers,  
20 but we haven't had any word from the other MCO's, and,  
21 so, we would like to ask where we are with that from  
22 the other MCO's.

23 So, you representatives, can you  
24 come forward and let us know. You can sit there or you  
25 can sit there, just so long as you're at a microphone.

1 MS. HOWELL: I'm Kim Howell with  
2 Humana-CareSource and we have assessed the enhanced  
3 payment fee schedule and we are going to be working  
4 with individual applicable providers for a quality-  
5 based enhanced fee schedule. So, we will be offering  
6 that and it will be with the providers for quality.

7 CHAIR PARTIN: Will that include  
8 APRNs as well as physicians?

9 MS. HOWELL: Right. Those are  
10 primary care who are involved.

11 CHAIR PARTIN: And when you say  
12 it will include quality, is this going to be a pay-for-  
13 performance?

14 MS. HOWELL: Yes.

15 CHAIR PARTIN: And the criteria  
16 is yet to be determined?

17 MS. HOWELL: Yes.

18 CHAIR PARTIN: Okay. Thank you.

19 MR. ORRIS: This is Ben Orris,  
20 COO for WellCare of Kentucky. While we are not going  
21 to explicitly maintain the ACA PCRI rate increase in  
22 Kentucky, we likewise will be significantly expanding  
23 our pay-for-quality program in 2015 to the tune of 65%  
24 which is very material. We feel this targets  
25 providers, the same set of providers and places greater

1 emphasis on quality and member outcomes.

2 In addition to that, we will  
3 continue to have our ten field-based clinical HEDIS  
4 advisors visiting practices to assure that they can  
5 maximize their performance under this new program.

6 CHAIR PARTIN: Let me ask. In  
7 these pay-for-performance programs, providers can do  
8 everything that they're supposed to do. They can do  
9 the counseling, they can draw the lab work, they can  
10 prescribe the correct medication, but sometimes the  
11 patients just don't do what they're supposed to do.

12 So, are providers going to be  
13 penalized because patients have bad hemoglobin A1C's  
14 because they're noncompliant with their medication or  
15 their diet or their exercise?

16 MR. ORRIS: So, it does evaluate  
17 the HEDIS indicators. There's a set of eight to ten  
18 HEDIS indicators that are evaluated. Whether or not  
19 hemoglobin A1C is one of them or not, I can't comment  
20 on that, but I think it's more focused around the HEDIS  
21 indicators that are visit-based as opposed to outcome-  
22 based.

23 CHAIR PARTIN: Thank you. So,  
24 that's Humana-CareSource and WellCare. What about  
25 Anthem?

1 MS. ECKELBERRY: I'm Jennifer  
2 Eckelberry, Director of Provider Solutions with Anthem.  
3 We are not continuing the increased PCP enhanced  
4 payment as it was structured. We are evaluating  
5 additional quality programs where there will be  
6 incentive, that could be incentive payments; but at  
7 this point, I can't provide any detail about what those  
8 will look like. Our data is pretty limited based on  
9 the fact that we're just a year in, but that is what  
10 we're evaluating.

11 CHAIR PARTIN: Thank you.  
12 Coventry.

13 DR. TOLIN: Fred Tolin, Chief  
14 Medical Officer of CoventryCares. At this point, an  
15 evaluation of this, it looks like we're not going to  
16 continue with the enhanced payments but, in fact, take  
17 the approach of value-based programs which includes  
18 such things as HEDIS measures and other outcome-based  
19 measures to improve health.

20 And to answer the question I'm  
21 sure you're thinking in terms of holding physicians or  
22 providers accountable for actual outcomes, part of the  
23 way to look at this is not just the outcome but also  
24 the act. For instance, one of the HEDIS measures for  
25 hemoglobin A1C is actually whether one is taken or not

1 where the actual measurement is done.

2 So, that would be one component  
3 which doesn't necessarily hold the provider accountable  
4 for what the outcome is. First, it's to get the  
5 providers involved in actually doing the test.

6 CHAIR PARTIN: So, maybe. I  
7 guess the answer is maybe you're going to do enhanced  
8 payments.

9 DR. TOLIN: Yes. Well, but it  
10 would be in a different format in the terms of it's  
11 value-based.

12 CHAIR PARTIN: Thank you. Did I  
13 get everybody?

14 DR. NEEL: Can I make a comment?

15 CHAIR PARTIN: Sure, yes.

16 DR. NEEL: I'd like to drill down  
17 a little bit further into this if we could. Medicaid  
18 announced that as of the first of January, they would  
19 be increasing wellness payments and the immunization  
20 administration fee services, and that was just for fee-  
21 for-service.

22 Are you all now paying those?  
23 Are those being paid for a fee-for-service?

24 COMMISSIONER LEE: For fee-for-  
25 service, we are still waiting on our SPA to be approved

1 from CMS. We received additional questions this week.  
2 We have everything in place to begin paying those  
3 payments as soon as CMS approves our State Plan  
4 Amendment.

5 DR. NEEL: Okay. Now, there will  
6 be no increase in funds to the MCOs at this time. In  
7 other words, the contracts they've negotiated are  
8 staying the same. Is there any plan for renegotiating  
9 more money to them in the near future?

10 COMMISSIONER LEE: We will have  
11 contracts in place by July 1st. The current contracts  
12 expire July 1st and we will have contracts in place by  
13 July 1st.

14 DR. NEEL: Now, as far as the  
15 answers we're getting from the MCOs today, it appears  
16 that what they're saying is a little different from  
17 what we're really asking. They're saying they're not  
18 going to continue the enhanced payments, but that  
19 really is not the question.

20 The question is are they going to  
21 abide by the new rates that have been established by  
22 Medicaid? And it's been made abundantly clear by you  
23 and your predecessor that they are not obligated to  
24 increase the fees because you all increase the rates  
25 unless they are contracted to do so.



1 having to pay 100% of the Medicaid fee schedule.

2 DR. NEEL: Now, they wouldn't be  
3 the contracts with you. They would be the contracts  
4 with us as providers.

5 COMMISSIONER LEE: The Department  
6 is not privy to those contracts, so, that would be  
7 between the provider and the managed care organization.

8 DR. NEEL: Exactly. Okay. Go  
9 ahead.

10 COMMISSIONER LEE: And, then,  
11 what was the second part of your issues?

12 DR. NEEL: The second part of the  
13 question is if they're not obligated. We've got to do  
14 something. In the new contracts with them, is there a  
15 likelihood of increasing the amount of fees that  
16 they're going to get? During the first year, I believe  
17 they got two or three increases in fees with you all,  
18 did they not?

19 COMMISSIONER LEE: Well,  
20 currently I'm just not at liberty to discuss anything  
21 going forward with the new contracts.

22 DR. NEEL: That's fine. That was  
23 the second part of my question because it's a matter of  
24 access to quality care and that's what we've been  
25 talking about from the beginning, that if we don't

1 reimburse the providers at something that's reasonable  
2 to keep their doors open, they're not going to be able  
3 to. And for the last two years, we were getting the  
4 enhanced fees for primary care docs at least and that  
5 was what kept a lot of doors open.

6 And, so, I think it's important  
7 to know that this is a huge barrier to care and that  
8 the first of January we fought back. I think it's  
9 wonderful that the MCOs are developing pay-for-  
10 performance, and I know a couple of them have already  
11 started to pay some of those and that's great, but that  
12 can't be way out in the future. It's got to be  
13 something that makes docs able to keep their doors open  
14 now. So, I just want to make that point about it.

15 COMMISSIONER LEE: And we  
16 understand. My position with the Department is that  
17 this whole program exists to serve our Medicaid  
18 members. That's why we're all here, to improve their  
19 healthcare. Our main goal is to take care of our  
20 members.

21 We understand that we also have  
22 to take care of our providers in order to take care of  
23 our members. And I think going forward, as I've said,  
24 this Medicaid Program is fifty years old this year. It  
25 does not look like it looked fifteen years ago and it's

1 going to continue to evolve and change.

2 And I think that as long as we  
3 all keep the goal in mind that we're here to serve our  
4 members and make sure that they have access to care and  
5 that our providers are compensated in a manner that  
6 allows them to continue to provide those services.

7 I mean, we know that no Medicaid  
8 provider is going to get rich serving Medicaid members.  
9 We have 1.2 million members that we have to serve right  
10 now and we have a very limited pot of money and we have  
11 to stretch those resources as far as we can, and going  
12 forward, that's what the Department is going to do.  
13 We're going to continue to monitor access. We're going  
14 to continue to monitor what's going on with our members  
15 to make sure that they are receiving the healthcare  
16 services that they need.

17 DR. NEEL: Thanks. Appreciate  
18 it.

19 MR. VAN LAHR: Madam Chair, just  
20 a real quick question. As part of our role as an  
21 Advisory Council, if we have a strong feeling on  
22 something like this, should we maybe have a motion?  
23 Since they're in negotiations with the MCOs at this  
24 point in time, it would seem that would be a logical  
25 assumption to make, that we make a motion that this

1 issue be addressed in contracts and also at a  
2 consistent level among all contracts.

3 CHAIR PARTIN: If you'd like to  
4 make a motion.

5 DR. NEEL: I would certainly move  
6 that the Medicaid Advisory Council look into the  
7 contracts with the MCOs that are presently in effect  
8 and see if they are obligated for that. I do not have  
9 an answer to that at this point. And I think we ought  
10 to at least look into the obligation of the MCOs, and  
11 especially as it affects access to care for the  
12 citizens.

13 MR. VAN LAHR: I was thinking  
14 more along the lines of a recommendation that in future  
15 contracts, that DMS look into consistency among the  
16 MCOs as far as contracting issues, as well as the  
17 enhanced payments.

18 DR. NEEL: That's fine. I  
19 certainly accept that as an amendment to my motion.

20 CHAIR PARTIN: A second?

21 MR. CARLE: I'll second.

22 CHAIR PARTIN: Any discussion?

23 All in favor, say aye. Opposed. So moved.

24 MS. ANGELUCCI: I had a question.  
25 Do we have a lawyer that represents the MAC in

1 contracts and the verbiage that's inside and someone  
2 who knows what it actually says?

3 CHAIR PARTIN: No. The attorneys  
4 that would work with us would be the attorneys from  
5 DMS.

6 The next item. At the last  
7 meeting, we had asked for a report on psych hospital  
8 and IOP denials and we wanted admission and re-  
9 admission rates reported. Do we have that?

10 COMMISSIONER LEE: Yes, we do.  
11 That is in the miscellaneous tab in the binder. There  
12 is a hard copy in there. You can take that back and  
13 digest it, read it, and you can bring any questions  
14 back to the next MAC meeting or feel free to email  
15 Barbara Epperson with some questions that you may have  
16 for the next MAC meeting that you would like to have  
17 addressed.

18 CHAIR PARTIN: Thank you. Next  
19 on the agenda is a report on the work group developing  
20 a common preauthorization form for all of the MCOs.  
21 Where are we there?

22 COMMISSIONER LEE: As you know,  
23 we had some bad weather last month, quite a bit of it,  
24 and some of the work groups that were scheduled to meet  
25 had to be rescheduled. So, you will definitely have

1 information on this at the next MAC.

2 CHAIR PARTIN: Okay. The next  
3 item was reimbursement by Medicaid and the MCOs for a  
4 sports physical in addition to an annual physical. I  
5 know that's been brought up by the TACs and it's been  
6 brought up by the MAC, and Anthem has told us that they  
7 are going to reimburse - it's a Level II coding for a  
8 sports physical - but we haven't heard anything from  
9 any of the other MCOs or from Medicaid on that.

10 COMMISSIONER LEE: And I can  
11 speak for Medicaid fee-for-service. Medicaid fee-for-  
12 service, we reimburse for exams to children based on  
13 the American Academy of Pediatrics' periodicity  
14 schedule.

15 If children need an exam outside  
16 of that schedule, then, that can be covered under the  
17 EPSDT benefit. It would require prior authorization  
18 and the providers would have to make sure that what  
19 they're billing for is actually what was performed in  
20 that service.

21 And if the other MCOs would like  
22 to come up and address besides Anthem, if the other  
23 MCOs would come up and address what they're doing with  
24 sports physicals, we would appreciate it.

25 CHAIR PARTIN: Would the sports

1 physical come under the Early----

2 COMMISSIONER LEE: It would have  
3 to meet medical necessity. Any exam above the American  
4 Academy of Pediatrics' periodicity schedule, and the  
5 EPSDT is outlined in 907 KAR 11:034, but basically  
6 anything above those annual exams for EPSDT has to meet  
7 medical necessity.

8 CHAIR PARTIN: So, would a school  
9 requiring a physical exam before the child can play  
10 sports a medical necessity?

11 COMMISSIONER LEE: In order for  
12 the service to be covered, it's either going to have to  
13 be a diagnostic service. It's going to have to meet  
14 those guidelines in EPSDT. And as far as a sports  
15 physical is concerned, I'm not sure what's involved.  
16 I'm not sure if it's just an office visit, if you're  
17 just filling out a form.

18 CHAIR PARTIN: No. It's a  
19 comprehensive exam.

20 COMMISSIONER LEE: If it's a  
21 comprehensive exam, we only cover one per year. We  
22 could not cover two comprehensive exams. And I guess I  
23 need help understanding. If a child comes in before  
24 school and has a comprehensive exam, then, why would  
25 they need another complete comprehensive exam in the

1 same year?

2 CHAIR PARTIN: Because sometimes  
3 they come in in July for school exams and then they  
4 come in in January for a sports physical.

5 Everybody has heard in the news  
6 about kids dying playing basketball or football or  
7 whatever from heart problems and so forth, and those  
8 kinds of things can happen. Problems with the heart  
9 can happen within a six-month period of time. You  
10 can't say that the exam I did in July is going to be  
11 exactly the same as the one I do in January. It might  
12 be but it might not be. And, so, it's important.

13 And the exam that's done for the  
14 sports physical is different than the school physical  
15 exam. It's more comprehensive.

16 COMMISSIONER LEE: So, in order  
17 to be reimbursed for a comprehensive exam, all the  
18 components in the regulation would have to be performed  
19 and it would have to meet medical necessity.

20 CHAIR PARTIN: That's the Catch-  
21 22 because we're saying that it is a medical necessity  
22 to do the exam if there's been a period of time. Now,  
23 certainly--well, I don't know. The exam is different.

24 COMMISSIONER LEE: So, what I  
25 would recommend is if a child comes in and they've

1 already had one annual exam and the provider requests a  
2 prior authorization through EPSDT for a second exam and  
3 it's denied, then, that family, that parent needs to  
4 file an appeal with fee-for-service.

5 CHAIR PARTIN: Again, that's not  
6 going to be very feasible because the coach says you  
7 need your exam and we start practice in two days or we  
8 start practice today. So, kids aren't going to be able  
9 to play sports is what it's going to be.

10 COMMISSIONER LEE: Medical  
11 necessity has to be met. Medicaid's whole premise is  
12 medical necessity. I understand the situation. I  
13 understand the issue, but it has been Medicaid's  
14 position that we have really never covered sports  
15 physicals. We've never covered those.

16 And I know that there are certain  
17 providers, for example, in Frankfort. I know there's  
18 one particular provider who actually goes to the school  
19 and he does free exams for the children who are playing  
20 sports. It's just a very quick, simple sports  
21 physical. Medicaid's position is it has to meet  
22 medical necessity.

23 DR. NEEL: I think we've brought  
24 this up a number of times with them. And, so, the  
25 question is not to them at this point. I think we need

1 to get the answers from the MCOs and then I'll make a  
2 comment about that in general.

3 MS. DOHONEY: My name is Lisa  
4 Dohoney. I'm the Director of our Provider Network  
5 Management with Passport Health Plan.

6 I will tell you that we don't  
7 have an edit right now to stop more than one exam per  
8 year but we do accept the physician's opinion when an  
9 exam is needed.

10 MS. HOWELL: I'm Kim Howell,  
11 Provider Relations Manager with Humana-CareSource. We  
12 do not have a specific sports physical code set up to  
13 pay but it's very similar. If there's an exam that's  
14 billed that's medically necessary, then, it's not that  
15 we wouldn't pay for it. We do not have anything  
16 specifically set up for that, though, to cover a code,  
17 a CPT code to bill for it.

18 MR. ORRIS: Ben Orris from  
19 WellCare. Likewise, WellCare currently does cover the  
20 complete physical one per year. The benefits are in  
21 place for 2015. Anything beyond that would be  
22 considered an additional benefit that would need filed.

23 We hear the committee. We  
24 understand the importance of the additional sports  
25 physicals, and it is something that we will during

1 benefit planning phases toward the middle of this year,  
2 for the benefit planning year 2016, we will very likely  
3 be adding an additional sports physical; but, likewise  
4 to my colleagues here, any physical or code billed  
5 would be looked at by way of medical necessity.

6 So, to summarize, we offer the  
7 one complete physical, but next year we will strongly  
8 consider the additional sports physicals as an  
9 additional benefit filed.

10 CHAIR PARTIN: Thank you.

11 DR. NEEL: It has seemed to me  
12 for some time that we ought to look at this a different  
13 way and be meeting with the Kentucky High School  
14 Athletic Association because I think that's really  
15 where part of the problem is, and we need to know  
16 exactly what they're going to accept because what Dr.  
17 Partin and I are saying is that it's really a Catch-22  
18 for us.

19 And the days of the gymnasium  
20 physicals being done by optometrists, ophthalmologists,  
21 OB/GYN are long gone. And, so now we're actually doing  
22 a complete physical on most of these kids which is  
23 necessary for a sports examination, and Mr. Kissner had  
24 admonished us not to use the wrong code because that  
25 was fraud and I understand that, but so far we've not

1       been able to come up with anything.

2                       So, I don't know how we make it  
3 happen but we need to meet with these people because  
4 they're the ones requiring the sports physical. And  
5 now we don't just have one. We have two. The middle  
6 school one is separate from the high school one.

7                       There are two and it has to be  
8 the correct one, and there's a lot involved in it  
9 because now there's also a legal part because the  
10 parents have to on one of the forms actually say that  
11 they carry health insurance. So, there's a lot more  
12 that has to be done.

13                      COMMISSIONER LEE: I think that's  
14 a great recommendation, Dr. Neel, and I will take that  
15 back to the Department and find someone to reach out to  
16 the Kentucky Athletic Association to see what we can do  
17 moving forward.

18                      DR. NEEL: Okay, because we've  
19 been far too long discussing this and we're just not  
20 coming up with an answer. What we heard today was  
21 we're thinking about doing it next year, but next year  
22 just keeps happening and we've got to have an answer  
23 because the coaches are really doing that. They're  
24 handing out the form and they want the kid to have it  
25 the next day.

1                                    Now, in some places, the doctors  
2 are giving out the form with the physical examination  
3 and that should be good for a year; but that's a  
4 problem, as Beth says, because if it's been ten or  
5 eleven months, you wonder if that child still is  
6 healthy enough to participate.

7                                    COMMISSIONER LEE: The Department  
8 will reach out to the Athletic Association.

9                                    DR. NEEL: Thank you. I  
10 appreciate it.

11                                   MS. ANGELUCCI: Can we invite  
12 them to come here and talk to us here?

13                                   COMMISSIONER LEE: The  
14 Department will reach out and see what course of action  
15 we can take.

16                                   MS. ANGELUCCI: Ask if they'll  
17 come and talk to us. It's easier that way. Thanks.

18                                   MS. BRANHAM: I have a question.  
19 Is this a calendar year we're speaking of for prior  
20 auths for school physicals or is this like July to July  
21 or something such as that? Is it a calendar year  
22 January to December?

23                                   MR. ORRIS: The complete physical  
24 would be based on a calendar year, correct. So, if  
25 someone received a complete physical in January, if

1 they tried to go get another physical in July for the  
2 upcoming sports year, unless a plan filed an additional  
3 benefit with the State to say we're going to cover  
4 that, it's an additional benefit - the State doesn't  
5 fund it - we offer it out to our members - we would pay  
6 it. If they don't offer that as an additional benefit,  
7 they couldn't.

8 So, that clock would reset at  
9 1/1. And maybe other plans do it differently. Ours  
10 are calendar year-based as opposed to a rolling-based.

11 MS. BRANHAM: Well, we're here as  
12 providers and we're here to circumvent issues with MCOs  
13 and with Medicaid as well. And it would appear to me  
14 that this is something that has been, as Dr. Neel says,  
15 around for a long time, but we should be caring about  
16 the children that are involved in sports and the health  
17 issues and looking at them more than the one time a  
18 year for approval.

19 So, I think, Commissioner, your  
20 suggestion to reach out to the Kentucky Athletic  
21 Association and then I guess report back to us and then  
22 we need to have a discussion about what we can do.  
23 We're not talking about that much money, but we're  
24 talking about kids here that are active and we don't  
25 want things happening to them as we read in the paper

1 all the time. They're involved in sports. We want to  
2 talk about physical activity and we want to talk about  
3 doing this and that but, yet, we don't want to fund it.

4 So, we all really need to get on  
5 the same page about this and do something for the kids  
6 of the Commonwealth rather than saying we're just going  
7 to pay for one physical per year.

8 MR. VAN LAHR: I kind of agree  
9 with the Commissioner on this. I think involving KHSAA  
10 is integral to this and I think that they need to  
11 explain to Medicaid why an additional physical may be  
12 required and they need to justify that. And I think if  
13 they can justify that to Medicaid, then, I think it's  
14 an easier discussion. And it falls not on you guys but  
15 on the Athletic Association.

16 DR. NEEL: Let's make that happen  
17 pretty soon if we can.

18 It also brings up an additional  
19 thing that I bring up as a place for it is that primary  
20 care providers and nurse practitioners and the  
21 physicians are having patients assigned to them.

22 And, so, we're getting calls  
23 because of HEDIS and the other quality measures  
24 constantly that the kids on your list or the patients  
25 on your list are due for an annual physical

1 examination, and we're finding that the data used for  
2 that is very, very poor amongst all the companies.  
3 We're finding out that there are kids that we've seen  
4 within the last three to six months and oftentimes more  
5 recent than that that don't need physicals.

6 And, so, there are lots of phone  
7 calls and lots of time being consumed. So, we need to  
8 look at how that data is accumulated.

9 CHAIR PARTIN: That's a really  
10 good point. Just in the past month, I had a claim  
11 denied because of that. The parent got a note saying  
12 they had to bring their child in for an annual exam and  
13 they were told that they had to get this done. The  
14 child had been there for minor acute illnesses probably  
15 once a month for the past couple of months.

16 So, I had the letter saying they  
17 needed an annual exam. The parent had a letter saying  
18 they needed an annual exam. So, I did an annual exam  
19 and then I got denied.

20 MS. ROARK: I would like to add  
21 to that as a parent. My son has asthma and heart  
22 problems. I took him to the heart doctor. So, she  
23 okayed him to play sports and to the asthma doctor, and  
24 I guess I was lucky or blessed to have a doctor's son  
25 playing. So, he did an exam free for my son.



1 would help that much.

2 COMMISSIONER LEE: Since the  
3 binder was created, we have received approval for a  
4 couple of State Plan Amendments.

5 One of them relates to the  
6 community mental health centers. CMS had requested  
7 that the Department modify the reimbursement process  
8 for community mental health centers. We were supposed  
9 to change that process beginning January 1st of 2015.  
10 We were going to move towards a cost-based  
11 reimbursement methodology.

12 However, there have been some  
13 issues with determining exactly how to structure that  
14 cost report. CMS has been working with some particular  
15 community mental health centers.

16 So, the Department requested that  
17 we delay implementation of the reimbursement  
18 methodology for community mental health centers to  
19 October 1st of 2015 so that we can make sure we have a  
20 very smooth process in place and they have agreed to  
21 that.

22 The other State Plan Amendment  
23 that was approved was the after-hours coding or after-  
24 hours fee for services provided after normal business  
25 hours. That SPA was approved by CMS.



1 Medicaid - and give a legislative update.

2 CHAIR PARTIN: Tell us again,  
3 April 1st is the----

4 COMMISSIONER LEE: April 2nd at  
5 1:00 and it's at the Administrative Office of the  
6 Courts.

7 MS. BRANHAM: Commissioner, do we  
8 have to reply if we're going to attend or something  
9 such as that?

10 COMMISSIONER LEE: I think there  
11 were some emails sent out, but if you don't get  
12 anything, you're more than welcome to just show up, but  
13 we'll make sure we try to get something out to all of  
14 you about the SIM at the next meeting.

15 MS. CECIL: The Commissioner has  
16 given me the opportunity to provide some very good  
17 news. Senate Bill 107 which is legislation to remove  
18 the annual requirement from the Disclosure of Ownership  
19 passed and is awaiting the Governor's signature.

20 We are very thrilled about this.  
21 So, effective July 1st which is when the legislation  
22 will go into effect. We will be sending provider  
23 education letters out prior to, but this will allow us  
24 to remove the annual requirement for the filing of  
25 Disclosure of Ownerships.

1                   This will become a five-year  
2 requirement, and I think this is a really great thing  
3 for both Medicaid and providers. So, I'm happy to  
4 announce that.

5                   I think I've mentioned previously  
6 but I just want to remind you all that we are going to  
7 be going to an online provider portal system. That  
8 will be rolled out in a couple of months.

9                   Again, we'll send out provider  
10 letters and notify you all to let you know when it's  
11 active; but this, again, is our attempt to try to make  
12 the process as a participant in the Medicaid Program  
13 for providers, to make it a little bit of an easier  
14 process.

15                   Enrollment and maintenance  
16 documents will be able to be completed on that portal.  
17 It will give you notification by email or text if you  
18 prefer communication that way that you've got something  
19 due.

20                   And the great thing is we're  
21 setting up electronic feeds with all the licensing  
22 agencies. We're working on that. So, I don't know  
23 when they're all going to be into effect, but obviously  
24 we're going with some of the larger ones first. And,  
25 so, we'll have an electronic feed that will

1 automatically update licenses so we don't have to have  
2 the manual process that we suffer through upon every  
3 renewal. So, I wanted to share that.

4 The only other piece of  
5 legislation that passed that potentially affects us is  
6 Senate Bill 192 which is the heroin legislation. That  
7 piece of legislation requires Medicaid to process an  
8 application for a behavioral health substance use  
9 provider within 45 days. So, it puts on the Department  
10 a tighter time line to process those applications than  
11 all the other applications.

12 I just wanted to alert you all to  
13 that because that means we have to prioritize those,  
14 but my hope is going to the online enrollment is going  
15 to shorten the length for everybody on processing  
16 applications.

17 CHAIR PARTIN: Can I ask a  
18 question just to clarify? When you were talking about  
19 the licensure, were you talking about the notification  
20 of renewal for the provider's license that we now have  
21 to send in the paper?

22 MS. CECIL: Right. All those  
23 notices, when anything is required, you know, your  
24 license is expiring, your Disclosure of Ownership is  
25 due, your revalidation is due, all of those notices

1 will come in any format that you want it, either  
2 written, text or email; but for the licenses, we will  
3 be having an electronic feed. For instance, KBML, we  
4 would have an electronic feed from KBML on a regular  
5 basis that would continually update our system with the  
6 license.

7 And the great news is that then  
8 we can communicate that and you will be able to see  
9 realtime whether or not we've got your license.

10 That's the other great thing  
11 about the portal. You will have access to all that  
12 information. You will know if we've got your license  
13 updated, when your revalidation is. You will know  
14 where you are in the process, if you've submitted a  
15 form to change your address. All of that will now be  
16 very transparent and you will be able to track it in  
17 our system and see where it is.

18 CHAIR PARTIN: Will you link with  
19 KBN as well?

20 MS. CECIL: Oh, yes, ma'am. Yes.

21 MS. BRANHAM: So, anybody that's  
22 a provider will receive what their choice of  
23 information to receive from is, like all of those, and  
24 even the ability to update your license and board  
25 members of your association, address, counties served,

1 all of that kind of thing?

2 MS. CECIL: Yes, ma'am.

3 MS. BRANHAM: And then payment  
4 will be processed?

5 MS. CECIL: Payment will continue  
6 to be processed as it currently is. So, you would  
7 still go into Kentucky HealthNet if that's what you're  
8 talking about and submit----

9 MS. BRANHAM: No. Like your  
10 private duty license is due for renewal. So, you  
11 usually send that in hard copy with a check for renewal  
12 of your license.

13 MS. CECIL: Sorry. We are not  
14 taking the role of what the licensing agency has to do.  
15 So, you still have to apply to the licensing agency.

16 MS. BRANHAM: Okay, but all of  
17 this, then, will be updated online realtime.

18 MS. CECIL: Right. Once your  
19 license is updated with them, we get an electronic feed  
20 that updates our system that you've done it.

21 MS. BRANHAM: But we're still  
22 going to receive the hard copy to complete to mail in.

23 MS. CECIL: For any of our forms?

24 MS. BRANHAM: Like if your agency  
25 is due for a relicensure annually.



1 you no longer have to do that; but you will have the  
2 ability to upload that information, whereas, now you  
3 have to make a copy and mail it to us. It would be  
4 something that you could upload to us. All of that  
5 documentation will be able to be uploaded to us and  
6 sent to us electronically.

7 And, again, what we anticipate is  
8 the processing time for all of that is going to shorten  
9 enormously because then all of it is electronic and our  
10 staff will be going in and it gets put in a cue and we  
11 can process them so much more quicker.

12 MR. VAN LAHR: I assume the  
13 information is forwarded to the MCOs at the same time  
14 frame, then?

15 MS. CECIL: So, once our system  
16 is updated, every night a provider file goes to the  
17 MCOs. So, they would have it that evening.

18 CHAIR PARTIN: Thank you. Next  
19 on the agenda is a report on the Home- and Community-  
20 Based Waiver Program. We will need to make sure that  
21 we keep that limited to more than thirty minutes so  
22 that we'll have time to do the TAC recommendations and  
23 any New Business recommendations before noon.

24 MS. FLYNN: Thank you very much.  
25 I'm Lynne Flynn. I work in the Medicaid Commissioner's

1 Office and I really appreciate the opportunity to come  
2 and talk with you all about this today.

3 I will ask that when I get close  
4 to the thirty minutes, that someone make me stop  
5 talking if I'm still talking. I'll try to limit it and  
6 keep that time in mind, but I get very excited about  
7 this stuff.

8 So, again, thanks for making time  
9 on your agenda so that you can hear more about the new  
10 federal HCBS rules. They're going to be making a big  
11 difference to our Home- and Community-Based Waivers in  
12 Kentucky as well as nationwide.

13 My presentation is in the  
14 miscellaneous section of your binder and you probably  
15 want to look for that because there's a lot of content  
16 and I think it will probably be helpful if you can be  
17 taking a look at that.

18 I usually make this presentation  
19 to people who live, breathe and eat Waivers. And I  
20 realize that a lot of you, while you see those members  
21 in your hospital or your dental practice, you don't  
22 live, eat and breathe Waivers.

23 So, I just wanted to start with a  
24 very quick update on our Home- and Community-Based  
25 Waivers as kind of a way to lead into this.



1 Waiver for folks who are ventilator-dependent called  
2 Model Waiver II.

3 All of these Waivers provider an  
4 array of home- and community-based supports, not really  
5 medical care, that could not be provided through the  
6 State plan. So, it's services like personal care,  
7 respite so the primary care giver can get some relief,  
8 day programs which can either be within a location or  
9 out into the community, supported employment, and some  
10 of them provide residential services as well. Each  
11 Waiver has a slightly different array of those services  
12 based on the needs of that population.

13 So, now, moving into the  
14 presentation that you all have available to you, the  
15 first thing you've got is just a Table of Contents and  
16 basically I'm just going to talk about three things.  
17 So, really I'm going to talk about two and refer you to  
18 a third.

19 First, I'm going to talk about an  
20 overview of the new federal rules that apply to all  
21 states and what the states are required to do to comply  
22 with those rules. Then I'm going to talk about where  
23 we are in this process in Kentucky, and then I'm just  
24 going to refer you to the appendices that has the  
25 federal language because I know how much we all love to

1 read federal language.

2 Moving to Slide No. 3 now, this  
3 is just an overview of the rules. These regulations  
4 for the Home- and Community-Based Waiver Programs were  
5 actually effective in March of last year, March of 2014  
6 and there are four key elements of the rules.

7 On the left-hand side of your  
8 page, we have the person-centered service planning  
9 pieces. The first relates just to the plan itself.  
10 The box underneath that is the process, the person-  
11 centered process.

12 The third box is about conflict-  
13 free case management, and I'm going to read that  
14 because it's important to us here in Kentucky. The  
15 person who provides home- and community-based services  
16 for an individual must not also provide case management  
17 or develop the plan of care for that same individual  
18 unless there's a geographic exception. There aren't  
19 enough providers geographically located near that  
20 individual.

21 I bring this to your attention  
22 because it's not consistent with the way we currently  
23 do case management in most of our Waivers now, and it's  
24 very, very different for some of the Waivers and it's  
25 just a little bit different for others, but this will

1 have an impact on us in Kentucky.

2                   And then the fourth box on the  
3 bottom is provider settings, and a lot of the rules  
4 relate to provider settings. CMS gave us lots and lots  
5 of detail about this including not only regulations but  
6 sub-regulatory guidance, and we can all spend a lot of  
7 time--in fact, we have to, and our Waiver providers  
8 will really be focusing on this and we're really  
9 focusing on it and there's a great detail on what needs  
10 to happen in residential settings.

11                   Turning on to Slide 4, so, here's  
12 what CMS was about when they passed the rules. They're  
13 interested in an outcome-centered definition of home-  
14 and community-based services. So, they're trying to  
15 move from caring about, so, where is that provider and  
16 what does he look like to what kind of outcomes are we  
17 getting for our members.

18                   Secondly, they're focused on  
19 quality, same kind of concept as we see in all of our  
20 healthcare services at this point.

21                   And the last box is called access  
22 and I call it integration but the primary focus of  
23 these rules is assuring that folks who are receiving  
24 Home- and Community-Based Waiver services, in fact, are  
25 integrated into their community and, in fact, have

1 access to the same things that are out there in the  
2 community that all the rest of us who aren't receiving  
3 Waiver services have access to. So, that's the concept  
4 behind the federal rules.

5 So, things are never simple, and  
6 CMS has outlined for us in great detail in the  
7 regulations what the states have to do. Some parts of  
8 the rule were supposed to be effective in March of last  
9 year. However, the settings' requirements, that Box  
10 No. 4 on our first page, CMS allows states up to five  
11 years for implementation of all those settings'  
12 requirements.

13 So, here's what states have to do  
14 in the middle of your page. We have to send to CMS a  
15 Waiver-specific transition plan whenever we amend or  
16 renew any of our Waivers, and we did that back in  
17 August when we submitted a request to CMS to add slots  
18 to the Michelle P. Waiver. And, so, that slot request  
19 and that individual Waiver transition plan was  
20 approved.

21 Then, secondly, we have to submit  
22 a statewide transition plan for all of our Waivers and  
23 there's a time frame for that. So, Kentucky did that  
24 back in December, keeping right on that time frame, and  
25 there was loads and loads of public comment on that

1 transition plan. Lots of folks looked at that and we  
2 really appreciate it. We got a lot of comments from  
3 them and we made some changes based on those comments.

4 So, sent that to CMS, our  
5 statewide plan in December and it has not been  
6 approved. We just received some questions from CMS.  
7 The last time I checked, no states' statewide  
8 transition plan have been approved. This is one of  
9 those things where CMS has this big deal going on, lots  
10 of stuff happening and they're working very hard to  
11 bring themselves along to where they can really do  
12 things like approve our transition plan. They have  
13 some processes that they're still working on.

14 So, then, the last box on this  
15 page is we have to be in full compliance with the final  
16 rules by the end of a five-year period which would be  
17 March 17th, 2019.

18 Moving on to Slide 6, this is a  
19 summary of the person-centered planning process  
20 requirements. I won't walk through it because of our  
21 time concerns, but I will just tell you the middle of  
22 your page summarizes the requirements pretty  
23 succinctly. In Kentucky, most of our Waivers are  
24 pretty consistent with these requirements, perhaps less  
25 so in our Home- and Community-Based Waiver that we

1 talked about earlier. Things have been done a little  
2 differently in that one. And, there again, the last  
3 bullet point under that blue box is that case  
4 management requirement that we talked about earlier  
5 that we're going to have to do some work on for all of  
6 our Waivers.

7 So, the person-centered planning  
8 requirements, the ones on this page, became effective  
9 in March, 2014. So, we're not in compliance at this  
10 point. Gee, somebody just wrote that down, didn't  
11 they? Okay. We're not in compliance at this point.  
12 Many states are not. CMS has notified the states that  
13 as long as we're making progress, they're not going to  
14 come out and take compliance actions against us. So,  
15 we are moving as rapidly as possible on those items.

16 Our planned time frame is to  
17 submit regulations in April or May to comply with these  
18 requirements which would then have an effective date  
19 about in November after going through the ordinary  
20 regulation process.

21 The next page, No. 7, talks about  
22 the person-centered service plan requirements. It has  
23 the same time frames that we just talked about on the  
24 previous page for the planning process, and there's a  
25 summary there that I'll let you read. And, again, most

1 of our Waivers are pretty consistent with these  
2 requirements already.

3                   Moving on to the next page which  
4 is page 8, and here is where we talk about settings.  
5 The federal rules define settings that cannot be home-  
6 and community-based settings, that can't provide Waiver  
7 services, and those are what you would expect - a  
8 nursing facility, and IMD, Institution for Mental  
9 Diseases, an intermediate care facility for folks with  
10 intellectual and developmental disabilities, and a  
11 hospital. I think we all knew those couldn't be Waiver  
12 service settings.

13                   Then they defined a whole new  
14 class of settings which are presumed not to be home-  
15 and community-based service settings, and there are  
16 some bullets there that describe what those settings  
17 are. We do have some settings in the State of Kentucky  
18 that are like a number of these bullets.

19                   So, the first one is just other  
20 locations that have the qualities of an institution.  
21 The second bullet is settings that are located in a  
22 building that's also a facility that provides inpatient  
23 care. So, a day program in the same building as a  
24 nursing facility or a hospital - and we do know that we  
25 have some of those in Kentucky - those are presumed not

1 to be, and I'll tell you what we're going to do about  
2 them in a minute, okay?

3 Any setting in a building on the  
4 grounds of or immediately adjacent to a public  
5 institution, CMS is saying, presumed not to be home-  
6 and community based.

7 The last one is the catch-all  
8 category that covers a whole lot of ground and that is  
9 any other setting that has the effect of isolating the  
10 folks who get Waiver services from the rest of their  
11 community.

12 And, then, CMS has given us lots  
13 of guidance about this. At the sub-regulatory level,  
14 they have a wonderful toolkit that I know we're all  
15 going to want to go find and read, but they give a  
16 number of examples. Some of their examples are, well,  
17 if it's an area where a lot of people who get home- and  
18 community-based services live like a neighborhood or a  
19 cul-de-sac or a street, then, we would presume that not  
20 to be home- and community-based.

21 If it's an isolated rural setting  
22 like a farmstead, they would presume it not to be.  
23 Settings on the ground of a private institution are  
24 presumed to fall into this category - schools. And,  
25 again, we in Kentucky have several Waiver settings that

1 fall into some of these groupings.

2                   So, the box circled in red is the  
3 important box. If a setting is presumed not to be  
4 home- and community-based, then, the State may present  
5 evidence that this setting, you know, yeah, we know  
6 it's located next to the institution, but, in fact, the  
7 people who receive services there are very well  
8 integrated into the community and really it is a home-  
9 and community-based setting.

10                   And the federal HHS Secretary  
11 through heightened scrutiny will tell us if we can go  
12 ahead and continue to provide Waiver services there.

13                   So, that's our approach in  
14 Kentucky. We're asking our providers that fall into  
15 this presumed not-to-be category to work on documenting  
16 their integration and the extent to which they really  
17 are a home- and community-based setting.

18                   So, there are specific settings'  
19 requirements and they're outlined on Slide 9. There  
20 are requirements for all Waiver settings and then there  
21 are more detailed requirements for residential  
22 settings.

23                   I need to tell you now - and I  
24 don't think I've said this before to this group - that  
25 Kentucky is planning on having two rounds of policy

1 changes. We're going to be doing this at two separate  
2 times related to the settings' rules. The first one we  
3 talked about will be the one that's effective in  
4 November of 2015 along with some of the person-centered  
5 planning stuff.

6 The second one, we're holding the  
7 very difficult and complex changes for the end of the  
8 five-year period. So, we and Waiver providers will be  
9 working on that but they won't be held accountable for  
10 those until 2019.

11 So, the all-settings'  
12 requirements under the first blue box on your sheet are  
13 kind of broad and general, things like the integration  
14 that we've talked about already. The individual shall  
15 select their setting as well as their provider; the  
16 rights of privacy, dignity and respect; individual  
17 autonomy for the Waiver member; and choice, choice,  
18 choice of the Waiver member regarding their services  
19 and supports and who provides them. Those apply to all  
20 Waiver settings.

21 The provider-owned residential  
22 setting requirements, as I said, are much more explicit  
23 and they include things like a legally enforceable  
24 agreement like a lease agreement. If an individual is  
25 receiving a Waiver residential service, they will have

1 the right to have a lease agreement. Some of our  
2 providers have that already. Many do not.

3 And it goes on. Privacy in the  
4 living unit; doors that are lockable and the individual  
5 has the key to; choice of roommates; freedom to control  
6 their own schedule and activities; food anytime they  
7 want it; visitors at anytime and so forth. So, those  
8 are summarized there.

9 Now we'll move to where we are in  
10 the process. That was all what the feds require. Now  
11 let's talk about where we are.

12 I mentioned earlier we developed  
13 a statewide transition plan. It is posted on the DMS  
14 website and we did get extensive public comment, much  
15 of which we incorporated, and it tells how we'll  
16 transition our policies as well as our providers to  
17 compliance with the final rules.

18 Your Slide No. 10 lists the  
19 components of the transition plan which were required  
20 by CMS. We tried to follow their outline. And as I  
21 indicated before, we've gotten some questions about  
22 that. They want a lot more information. They want a  
23 lot more detail and we will be working with them on  
24 that.

25 Turning to Slide No. 11, this

1 relates to what we did to figure out where we are, what  
2 our baseline is. And, so, we looked at all of our  
3 policy material for all of our Waivers and identified  
4 things that we would need to change to come into  
5 compliance.

6 We looked at our monitoring  
7 processes because obviously when we go out and do our  
8 regular monitoring, we're going to have to fold all  
9 this into that.

10 And we did a preliminary provider  
11 assessment which was based on surveys of individual  
12 providers. All Waiver providers got these surveys.  
13 And then when we got their responses, our Waiver staff  
14 reviewed and validated those responses based on the  
15 site visits and the monitoring that had been done  
16 previously.

17 And if you'll turn to page 12,  
18 this is what we had to submit to CMS. So, after we did  
19 all the surveys and our staff looked at the responses  
20 from the providers, we determined providers' initial  
21 level of compliance and put them into one of these four  
22 categories that CMS developed.

23 It is a federal requirement to do  
24 this. We were uncomfortable doing it because we were  
25 basing it on survey data and not on personal visits.

1 It was something we had to do to make this go.

2 I would ask you as you look at  
3 the percentages to keep in mind that this was for  
4 compliance with a new rule that nobody knew they had to  
5 comply with yet. So, if it had been 100% compliance,  
6 we would have had to wonder what was going on, and it  
7 wasn't. It wasn't 100% compliance.

8 We put providers into the  
9 preliminary categories based on their location - we  
10 talked about that - the ones presumed not to be home-  
11 and community-based. So, they ended up, then, in that  
12 Category 4, and then also there are survey answers  
13 about integration.

14 You will see that we didn't  
15 assign any providers to Category 3 which is can never  
16 meet these requirements and we don't want them in our  
17 state or we don't want them serving our Waiver members.  
18 And that's because our perspective is we want to work  
19 with providers over time to help them and for them to  
20 do the work necessary to come into compliance with  
21 these rules.

22 How am I doing time-wise?

23 MS. BRANHAM: You have twelve  
24 minutes.

25 MS. FLYNN: This is great. This

1 is going to work. Okay.

2 Your next page talks about  
3 remedial strategies which is another CMS piece of  
4 language, and these were also included in our  
5 transition plan. And I'm not going to talk much about  
6 this slide.

7 The remedial strategies are what  
8 we are going to do to our policies and our processes  
9 internally and we provided some examples of changes  
10 that providers might make. So, that's out there in the  
11 transition plan, and this is really just some general  
12 examples, but you will get a sense of the kind of thing  
13 we're talking about by looking at this slide.

14 Slide No. 14 tells where we are  
15 in our activities to implement the final rules and what  
16 our next steps are. We have had an inter-departmental  
17 work group within the Cabinet that's been working on  
18 this for so long that we're already tired of it, staff  
19 from the various Departments that are involved in the  
20 Waiver.

21 So, we've got folks from  
22 Medicaid, folks from the Department for Aging and  
23 Independent Living, folks from DH/DID, Behavioral  
24 Health/Developmental and Intellectual Disabilities  
25 Department as well, and some other folks within the

1 Cabinet as well, and we're the internal group that's  
2 trying to make this happen and kind of keep everything  
3 coordinated and put together.

4                   And what has happened so far is  
5 that we submitted the famous statewide transition plan  
6 to CMS which I've mentioned so many times. We've done  
7 some initial drafts of language that could be  
8 incorporated in regulation. So, those initial drafts  
9 have been worked on.

10                   A lot of the comments that we got  
11 on the transition plan related to stakeholder  
12 engagement. So, consumers, family members and  
13 providers all said, wait, we don't want to just read  
14 what you're going to do after you've already made up  
15 your mind. We want to be involved early on in the  
16 process.

17                   So, we developed a stakeholder  
18 engagement strategy to seek input at various stages in  
19 the process, and we're smack in the middle of that, and  
20 it was also delayed by those two terrible weeks in  
21 February. So, everything has kind of been collapsed.

22                   But we're holding consumer forums  
23 throughout the state to ask Waiver members and their  
24 families what would you like to see related to these  
25 key concepts in the new federal rules? What ideas do

1 you have that you want to share with us?

2 We held provider webinars in  
3 March to reach out to providers and get their comments,  
4 and what they wanted to comment on was called the  
5 compliance plan template which is a tool that they will  
6 be using to tell us where they are and help them plan  
7 how they're going to move toward compliance.

8 So, that's kind of what we've  
9 done and are in the middle of doing, and our upcoming  
10 is to continue doing these things. We will be  
11 submitting Waiver renewals or amendments to CMS as we  
12 work throughout this process because we're going to  
13 have to change our Waiver documents to reflect all  
14 these changes, too.

15 We'll be filing amended  
16 regulations, as I've mentioned, for each of the Waivers  
17 and then we'll continue to work intensively with the  
18 providers on their compliance plan templates. We'll  
19 also be working with CMS on their questions on our  
20 statewide transition plan.

21 The next slide is just kind of a  
22 piece out of our transition plan, our work plan. Some  
23 of the time lines I noticed when I was preparing for  
24 this presentation have actually slid a little bit  
25 partially because of the weather, partially for some



1 MS. BRANHAM: Yes, we did, and  
2 I'm sure this is Greek is the majority of people here,  
3 but I just want a clarification that I didn't ask  
4 yesterday.

5 Attendant care is one of the  
6 services that fall under HCB Waiver, and I know that  
7 hospice patients are eligible under the Medicaid  
8 benefit to receive not only their hospice benefit but  
9 also attendant care.

10 So, when this is transitioning, I  
11 think we need to probably keep in mind the conflict-  
12 free case management comes into play, yet, how is that  
13 going to occur with an entity that they're under a  
14 benefit for, yet, are receiving additional services  
15 through the Waiver because that's two different----

16 MS. FLYNN: So, how would the  
17 conflict-free case management play out in the situation  
18 of a hospice patient who is also receiving Waiver  
19 services?

20 MS. BRANHAM: For attendant care.

21 MS. FLYNN: Okay. So, I  
22 appreciate that and I'll make note of the question.  
23 Thank you.

24 Other comments or questions? Was  
25 this what you needed to know? Was this what you

1 wanted? I'm getting a few nods and a couple of stares.  
2 I'm done unless you all have additional questions.  
3 And, again, thanks for the opportunity.

4 I came into Waiver world about  
5 seven years ago. It's something that's very different  
6 from the rest of the Medicaid benefits and I think it's  
7 really important that we all are kind of aware of what  
8 everyone is doing on both sides. So, thanks for the  
9 time.

10 CHAIR PARTIN: Thank you very  
11 much. Next up are our reports from the TACs. And,  
12 again, I think we do have most of the reports. So, in  
13 the interest of time, just hit the high points and then  
14 state what your recommendations are so that we can get  
15 through and get everybody's recommendation approved,  
16 and we'll make sure that DMS has all of the summary  
17 information that they need in order to respond.

18 So, Behavioral Health.

19 DR. SCHUSTER: Good morning, and  
20 you have my report. I also submitted recommendations  
21 from our March meeting and resubmitted the  
22 recommendations from January and November since you all  
23 did not have a quorum there.

24 I would point out that at our  
25 last TAC meeting, Dr. Allen Brenzel, who is the

1       psychiatrist who is the Medical Director at the  
2       Department for Behavioral Health, came and provided  
3       some very helpful information.  And, Dr. Neel, this is  
4       a topic that is near and dear to your heart and that is  
5       the extensive use of psychiatric medications in  
6       children, including some very young children.

7                       As you may know, Dr. Langefeld  
8       who is sitting behind me, the Medical Director at  
9       Medicaid, has pulled together a group to look at this.

10                      I do want to tell you that Dr.  
11       Langefeld and Dr. Brenzel have agreed to present their  
12       findings to date at the next Behavioral Health TAC  
13       meeting which is May 7th at 1:00 p.m., and we always  
14       meet here in the Capitol Annex.

15                      And any of you who are  
16       interested, and I'm thinking, Dr. Neel, if you're  
17       available, certainly plan to come.  The Children's  
18       Health TAC may be particularly interested in coming to  
19       that presentation as well.  So, I wanted to highlight  
20       that.

21                      We have asked and asked and asked  
22       for the data that Commissioner Lee says is in your  
23       miscellaneous tab - the miscellaneous tab must be  
24       pretty big because there seemed to be a lot of things  
25       in miscellaneous - and that is the data on discharges

1 and re-admissions to the psych hospitals, to the PRTF's  
2 and so forth.

3 But it does lead me into our  
4 first recommendation which is that - and I'm going to  
5 make this request on behalf of the Behavioral TAC but I  
6 think probably other TACs might want to do the same.

7 I would like to make a formal  
8 recommendation that each TAC be provided with a copy of  
9 the binder. When I have asked for information separate  
10 from that, 11 x 14 pages have been condensed to  
11 8½ x 11, scanned and then faxed and you can imagine how  
12 readable they are. It has taken months to go back and  
13 get the information.

14 I know that I've dealt with the  
15 Children's Health TAC and trying to get this  
16 information and there are gaps in the data and the  
17 information that we get. The very answer that we've  
18 asked for has apparently been given to you all.

19 How do we get that information to  
20 the TAC that's asking for the information as well? I  
21 know the Hospital TAC has also asked for that  
22 information.

23 So, I just want to recommend that  
24 to you. Yes, there's probably some cost to Medicaid,  
25 but some of us are donating our time and it's extensive

1 time to meet bi-monthly and pull together a lot of  
2 people to come to these TAC meetings and we really do  
3 need that data. And, so, I'm going to make that  
4 recommendation again to you all.

5 The other was about the IOP or  
6 intensive outpatient services' rate. We think there's  
7 a mistake because the rate that's in there is for one  
8 hour of service. And by definition, IOP services -  
9 those are kind of a stepdown, for those of you not  
10 familiar with that, from an inpatient setting to a pure  
11 outpatient setting - are three hours.

12 So, we think the rate is in error  
13 and it should be three times that \$58.26 or \$174.78 and  
14 we're asking for that to be reviewed.

15 MR. VAN LAHR: Dr. Schuster, a  
16 real quick question. The three hours, is that a  
17 requirement of who?

18 DR. SCHUSTER: That's in the  
19 regulations as the definition of what an intensive  
20 outpatient program consists of - three hours a day,  
21 four days a week.

22 MR. VAN LAHR: Is that a state  
23 requirement or a----

24 DR. SCHUSTER: It's in the state  
25 regs and I don't know whether it's a federal. It's at

1 least at the state level.

2 MR. VAN LAHR: Thank you.

3 DR. SCHUSTER: And I'm happy to  
4 answer any questions. We do appreciate the opportunity  
5 to come to the MAC and we're so glad you have a quorum.

6 CHAIR PARTIN: Yes, we are, too.

7 DR. SCHUSTER: And we have some  
8 people that are going to apply for some of the slots  
9 that are open for Medicaid recipients and advocacy  
10 folks. Thank you.

11 CHAIR PARTIN: Thank you.

12 Children's Health.

13 MR. VAN LAHR: Madam Chair, real  
14 quickly. When do we approve the recommendations; after  
15 everybody finishes?

16 CHAIR PARTIN: After everybody  
17 finishes.

18 MS. GRIESHOP-GOODWIN: Good  
19 morning. My name is Tara Grieshop-Goodwin and I work  
20 at Kentucky Youth Advocates. I'm the new Chair of the  
21 Children's Health TAC. And thank you, Dr. Partin, for  
22 your guidance yesterday on bringing the recommendations  
23 forward.

24 At our Children's Health TAC, we  
25 have been looking at a number of issues that Dr.

1 Schuster just raised on behavioral health and  
2 psychotropic medications for children as well.

3 Another issue has been looking at  
4 Medicaid eligibility for children who have aged out of  
5 foster care. We don't have recommendations at this  
6 point on any of those issues. As we heard the  
7 discussion about data, we have been trying to get good  
8 data on behavioral health for children.

9 We thought we were working with  
10 some numbers that we could look at over the course of  
11 several months; but we learned at the last meeting that  
12 the data is not of sufficient quality to make any  
13 recommendations based on those numbers.

14 And, so, we understand now that  
15 it will be several months longer until we have good  
16 reports so that we can look at those issues.

17 We are interested also in some of  
18 those issues raised by the Behavioral Health TAC on  
19 hospitalizations, re-admissions and things of that  
20 nature.

21 Another piece that we're looking  
22 at with the Children's Health TAC is just staying up to  
23 date on the progress on the PIPs from the MCOs that are  
24 related to children.

25 Another piece that we're looking

1 at and trying to find a solution for related to data is  
2 on grievances and appeals. We had understood back in  
3 the fall that we would be able to get that information  
4 broken out for children specifically. Currently, the  
5 grievances and appeals' information is just for the  
6 entire population.

7 But, again, we learned at the  
8 March meeting that that is not possible to currently  
9 break out and, so, we are interested in trying to find  
10 some ways to get that information for children. We  
11 know some of the issues are unique for that population  
12 and that age group.

13 So, as I said, at this time, we  
14 do not have recommendations but we will I'm sure have  
15 some based on the work that we have planned for the  
16 next upcoming meeting. Thank you.

17 CHAIR PARTIN: Thank you.  
18 Consumer Rights and Client Needs. Dental.

19 DR. RILEY: The Dental TAC met  
20 yesterday. It was a fairly lengthy meeting, from eight  
21 to noon, and we covered quite a lot of issues.

22 Two of the main things that we  
23 covered were the dental regulations and the Kentucky  
24 Dental Association also has a Medicaid Roundtable  
25 that's been working with the recommended revisions of

1 the regulations and funneling those suggestions to  
2 Stuart Owens in DMS.

3 The other biggie for us was the  
4 mobile and portable vans. There are guidelines that  
5 have been suggested, and Commissioner Lee had asked  
6 that the TAC have recommendations.

7 Those were presented at the  
8 meeting yesterday and there was a good bit of push-back  
9 regarding some of the suggestions from the University  
10 of Kentucky and its mobile services because they have  
11 had a nationally-recognized program for about twenty  
12 years that would conflict with some of the guidelines.

13 So, the guidelines were referred  
14 to a committee composed of TAC members, UK  
15 representatives, a representative of the MCOs and I  
16 think someone from DMS as well. So, it's been referred  
17 to a committee.

18 The Dental TAC has two  
19 recommendations to bring forward to the MAC. The first  
20 one is - background - is some dental providers have  
21 provided services to Medicaid recipients in good faith  
22 after verifying on both the Kentucky web portal and the  
23 MCO web portals that the recipient is eligible and  
24 participating with the said MCO. Copies of these  
25 eligibility verifications were saved by the provider.

1 DMS then retro-terminated the  
2 recipient. So, the MCO does not pay the provider  
3 despite several appeals including presenting his  
4 documentation that he had followed the rules. The MCO  
5 states that the provider cannot be paid due to retro  
6 termination.

7 The recommendation is that the  
8 TAC recommends that this be a matter between the MCO  
9 and DMS. The provider should be paid and not penalized  
10 when he provided services in good faith and followed  
11 all the guidelines for verifying patient eligibility.  
12 The only entity suffering in this scenario is the  
13 provider and it should be a policy that he be made  
14 whole.

15 The second recommendation is  
16 regarding oral pathologists. And the background is  
17 that oral pathologists at the University of Louisville  
18 and the University of Kentucky have not been paid for  
19 services provided to Medicaid recipients since the  
20 inception of MCOs in the state.

21 The UK representatives state that  
22 they are owed in excess of \$3 million. U of L's  
23 outstanding claims are less but still significant. No  
24 MCO has paid them claiming that a quirk in the wording  
25 of the regulations does not authorize payments.

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The TAC does not believe that the regulations were intended to have victims of oral cancer going undiagnosed.

The recommendation is that DMS and representatives from each MCO meet with the representatives from both the University of Kentucky and the University of Louisville 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 new contracts.

Any questions?

CHAIR PARTIN: Thank you.  
Nursing Home Care. No report. Home Health Care.

MS. BRANHAM: Yes. Just to back up to our January 22nd that was included in the packet that was emailed to you, I'm happy to report that all of the recommendations have been addressed.

And just for consideration of the House Bill 144 related to presumptive eligibility that are going to enter home health for services from a hospital to decrease the wait times, that did come out of the Senate this week. So, that's going to be on the books soon. So, that's all taken care of there.

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Our TAC meeting was yesterday and I will submit that electronically to Barbara for our records and everything really was resolved.

A couple of shout-outs to WellCare when they transitioned to CareCore doing the prior authorizations and some issues related around that. They conducted training for providers over three days, a webinar, and I think we cleared up a lot of questions related to that. So, thanks, WellCare, for reaching out and resolving some of those issues that we were having.

I think everything else was handled yesterday in the TAC to their satisfaction.

The one thing I would like to point out is I don't know if it relates to what the doctor was saying, but when a patient is referred to home health and they're with an MCO, we receive a prior authorization for the services. We have a signed plan of care by the physician.

So, we are functioning under the prior authorization for services even if it's a two-week or three-week period for the services that have been requested under the plan of treatment.

I don't know if it's a glitch and we're checking on that as of yesterday or brought it to

1 their attention, but mid-month, patients are being  
2 switched to other MCOs. So, we think we're functioning  
3 under a prior auth of MCO A, only to find out when  
4 claims are submitted that they were switched  
5 arbitrarily on the 18th of the month to another MCO and  
6 MCOs aren't necessarily honoring those authorizations  
7 we've had from our initial contact with them to ask for  
8 services under our auth.

9                   So, I would make a recommendation  
10 that--I don't know if they're late enters or what's  
11 going on there, but this is something--normally it  
12 occurs at the beginning of the month. So, it is  
13 creating some issues for agencies throughout the state  
14 because we can't check the site every day to look to  
15 see if they're still valid under the MCO that we're  
16 functioning under.

17                   And, again, it's not like that we  
18 have a long prior authorization. The prior  
19 authorizations could be as short as for four visits or  
20 for six visits but we've got some kind of a quirk or  
21 glitch going on there.

22                   So, that's something that I would  
23 recommend that the Cabinet look at in submitting  
24 because I guess you all do that as far as bouncing them  
25 out to the MCOs. So, we're providing these services

1 and thinking we're functioning under one MCO, and then  
2 as it turns out on billing for those services, they're  
3 under another MCO, and 99.9% of the time, the clients  
4 don't even know it as well. So, that would be my only  
5 recommendation. Thanks.

6 CHAIR PARTIN: Thank you.  
7 Hospital Care.

8 MS. GALVAGNI: Good morning. I'm  
9 Nancy Galvagni with the Kentucky Hospital Association.  
10 I just wanted to bring you all up to date.

11 The Hospital TAC met informally  
12 in February. And as you will recall, Carl Herde, who  
13 is our TAC Chairman, had been here prior meetings  
14 testifying about some concerns we had where the Cabinet  
15 had proposed to redo our DRG payment methodology going  
16 to an entirely new system because the grouper that is  
17 in that current system is not ICD-10 compliant.

18 And we had a number of concerns  
19 with that and I think the MAC had adopted some of our  
20 recommendations.

21 At the informal meeting in  
22 February, we were told by the Cabinet that they are  
23 backing off that proposed new methodology and going in  
24 an entirely different direction.

25 So, basically they have withdrawn

1 that regulation and filed a new proposed rule to pay a  
2 percent of Medicare. We have not been provided any  
3 information in terms of the impact of that on  
4 individual hospitals. The individual hospitals have  
5 been told to individually contact Medicaid to find out  
6 what the impact is going to be.

7 We've requested that file, and,  
8 so, we hope that we can get that so that we can see  
9 what the impact will mean for our members. We've only  
10 been told that about half of our members will have a  
11 gain and half will have a loss but we don't know the  
12 magnitude of that.

13 And, so, that sort of gets back  
14 to one of the concerns that Carl talked about I think  
15 when we were here before is having a transition period  
16 so that we don't have an entirely new rate system  
17 dropped on people that they haven't been able to budget  
18 for and they don't know about.

19 So, we're going to continue to  
20 ask for that, as well as maintaining a process for  
21 appeals; and in the proposed rule that's been released,  
22 there is no real appeals process.

23 So, those are things that I think  
24 we've brought to the MAC before and you guys have  
25 endorsed and we would continue to ask for your

1 endorsement around those issues.

2 The other thing that this has an  
3 effect on is that all of the hospital contracts with  
4 the MCOs are tied to pay at the fee-for-service rate.  
5 So, it will implicate every contract that every  
6 hospital has with all the MCOs.

7 And, so, we have begun  
8 discussions with the MCOs and our members around what  
9 should we do because the Medicare system may not be a  
10 good fit for the MCO population which is mothers and  
11 babies. So, those discussions are ongoing.

12 The good news is that the reg  
13 wasn't filed as an emergency, and, so, the goal is to  
14 have it take effect in October. So, we have a few  
15 months to work on it.

16 And just the last thing I would  
17 say is that we also would endorse the recommendations  
18 which Sheila Schuster made. The IOP rate, that's  
19 something that's been brought up at the Hospital TAC  
20 meetings as a concern, that we think that's in error,  
21 and also having more data around the MCO denials.

22 I'll be happy to answer any  
23 questions.

24 CHAIR PARTIN: Intellectual and  
25 Developmental Disabilities.

1 MS. DEMPSEY: Hello. I'm Patty  
2 Dempsey and I'm from the IDD TAC. I'm with the ARC of  
3 Kentucky. Thank you for the opportunity to be here  
4 today.

5 We do not have recommendations to  
6 submit today. We had submitted recommendations  
7 previously and they have been responded to, but I did  
8 just want to touch on a few things that our group had  
9 talked about.

10 Our TAC met on March 13th; and as  
11 I said, some of the recommendations we had have been  
12 responded to. And of those recommendations, they were  
13 recommendations that must be approved by CMS or it was  
14 going to take additional funding through the  
15 legislative system.

16 So, we did talk about--I just  
17 wanted to bring you up to date on what we did talk  
18 about that day. And one of our concerns was in our  
19 recommendation that the Michelle P. Waiver slots, we're  
20 still concerned about that.

21 There are 3,800 members on the  
22 waiting list; and of that waiting list, 70% are under  
23 the age of 21 and we are still without a pediatric  
24 assessment tool which was one of our recommendations  
25 that does have to be approved by CMS.

1                   So, one of the suggestions we had  
2                   and that we would meet with the Commissioner for  
3                   Medicaid about is our TAC group, we understand that the  
4                   Department for Medicaid Services are looking at several  
5                   tools but has not decided on a tool yet and we've asked  
6                   that we be included, that someone from our TAC group be  
7                   included on those discussions when the assessment tool  
8                   was being looked at.

9                   The other thing I just wanted to  
10                  kind of touch on is that we have been really, really  
11                  following closely, because it affects those of us and  
12                  our family members and self-advocates that live and  
13                  breathe the Waiver services every day, and that's the  
14                  final rule that Lynne Flynn talked about.

15                  So, we are real concerned about  
16                  following that and actually following that statewide  
17                  transition plan. And one of our concerns was that we  
18                  make sure that there is some stakeholder involvement  
19                  included as that plan goes forward, and the Department  
20                  for Medicaid Services has been very receptive.

21                  We've asked that they come and  
22                  talk to various groups, various family members and  
23                  self-advocates in the different parts of the state  
24                  about what's being looked at for that final rule and  
25                  how those are done and to make sure that there is some

1 stakeholder involvement.

2 As Lynne had pointed out, some of  
3 those trainings or forums are actually going on across  
4 the state right now. And actually we hosted one in  
5 February that went extremely well and we had several  
6 family members and self-advocates that were able to  
7 provide input about how they want to live their life,  
8 how they live their daily life and how they're affected  
9 by services and supports. So, we are really pleased to  
10 get that input provided.

11 Another thing we were kind of  
12 concerned about is the rewriting of the Home- and  
13 Community-Based Waiver, and that's the Waiver that's  
14 for people that are elderly or people that have  
15 physical disabilities and some other disabilities  
16 because it was our understanding as that's being  
17 written, some of the therapies were being discontinued,  
18 but it's our understanding that those therapy services  
19 are going into the State Plan for the Home- and  
20 Community-Based Waiver.

21 The other thing I just wanted to  
22 touch on and not take up a lot of your time is you've  
23 probably all heard of the federal legislation that was  
24 also passed recently back in the winter which is called  
25 the Able Act. That's federal legislation that states

1 can decide to implement in their state where  
2 individuals can save up to \$14,000 per year without it  
3 affecting their Medicaid eligibility. This was  
4 discussed at our TAC.

5 This legislative session, we were  
6 able to get some legislation filed both in the Senate  
7 and in the House. It did not pass, of course, but,  
8 anyway, it's a start, but it's very new and it's  
9 something we'll continue working on and that our IDD  
10 TAC will still address.

11 And what these are are 529  
12 accounts, that there's also some similar accounts  
13 already set up in the state. So, anyway, I did want to  
14 touch on that which was part of our discussion, and I  
15 think that's about it.

16 CHAIR PARTIN: Thank you very  
17 much. I will give the Nursing TAC report.

18 The Nursing TAC met on March  
19 20th. The first issue is that WellCare is requiring  
20 nurse practitioners who practice in urban areas to have  
21 a supervising physician but not nurse practitioners who  
22 practice in rural areas.

23 It's not really well-defined  
24 what's an urban area or what is a rural area in the  
25 manual, but nurse practitioners are not dependent

1 providers and are considered licensed independent  
2 providers. The requirement by WellCare is contrary to  
3 Medicaid requirements and is not consistent with  
4 Kentucky law and appears to be arbitrary.

5 No APRNs are required to maintain  
6 a prescribing agreement for non-scheduled drugs after  
7 four years. Therefore, establishing practices and  
8 requiring a physician to be supervising will be very  
9 difficult or impossible for APRNs who wish to establish  
10 practices to provide care for Medicaid patients.

11 So, the recommendation is that  
12 WellCare not require APRNs to have a supervising or  
13 collaborating physician in order to be credentialed  
14 with their company regardless of geographic location.

15 The next issue was the enhanced  
16 payments for primary care. And I won't belabor the  
17 point, but the recommendation was that all the MCOs  
18 continue to provide enhanced payments for primary care  
19 services.

20 And then the third issue was  
21 about the lock-in patients, and there was an incident  
22 that was reported to us but this issue is not just  
23 isolated; but in this particular instance, the primary  
24 care provider that the patient was locked into did not  
25 see patients in the outpatient setting and had not

1 practiced in Kentucky since 2012, and, therefore, the  
2 patient went without medication and eventually required  
3 hospitalization for suicidal ideation.

4 This situation is an example of  
5 dire consequences that can occur when there's no  
6 process in place to verify that assigned providers are  
7 following locked-in patients.

8 So, the recommendation is that  
9 Medicaid and all the Medicaid MCOs should be required  
10 to verify that locked-in patients are assigned to a  
11 provider who is practicing in Kentucky and that the  
12 patient is receiving care.

13 Patients cannot be forced to  
14 receive care, but at least the MCO or Medicaid should  
15 be required to contact locked-in patients who are not  
16 presenting for regular visits.

17 Those were all the  
18 recommendations for March, but, of course, we have the  
19 recommendations for the previous two meetings. Any  
20 questions?

21 Okay. Moving along, we've got  
22 like fifteen minutes and we've got another issue under  
23 New Business. So, we need to go quickly. Optometric  
24 Care.

25 DR. WATKINS: We have nothing to

1 report other than we are planning on having a TAC  
2 meeting before the next MAC meeting. All TAC members  
3 have been reaffirmed and put into place.

4 CHAIR PARTIN: Thank you.  
5 Pharmacy.

6 MR. VAN LAHR: We finally got a  
7 committee, but due to bad weather, they weren't able to  
8 meet yet.

9 CHAIR PARTIN: Thank you.  
10 Physician Services.

11 DR. NEEL: The Physicians TAC met  
12 on February 27th and had a continuing discussion of  
13 reimbursement issues.

14 We had a recommendation that's  
15 been on the table for some time of establishing a  
16 coding/billing subcommittee which had partly to do with  
17 this issue of sports physicals and other things and we  
18 might add to that some other things at this point.

19 The other recommendation had to  
20 do with the continuation of the incentive payments and  
21 we've already discussed that today. Thank you.

22 CHAIR PARTIN: Thank you.  
23 Podiatry Care. Primary Care.

24 MS. BEAUREGARD: Good morning.  
25 Emily Beauregard with the Kentucky Primary Care

1 Association. We continue to still primarily be dealing  
2 with issues of wrap payments, both the reconciliation  
3 process and the automated wrap payment process. And I  
4 won't go into the details, but if you have any  
5 questions, let me know.

6 I'll go straight to the  
7 recommendations. Our first is in light of the manual  
8 nature of the wrap reconciliation process and continued  
9 issues with missing claims data, the Primary Care TAC  
10 recommends that DMS continue to approve requests for  
11 extension past the April 13th deadline. And DMS does  
12 seem to be agreeable to this but we just want to make  
13 it a formal recommendation.

14 The second is to improve the  
15 automated wrap payment process and decrease  
16 administrative burden on providers. The TAC recommends  
17 that DMS provide EOBs or electronic Explanation of  
18 Benefits electronically with the necessary identifiers  
19 to allow clinics to reconcile payments more  
20 efficiently.

21 Right now these are being  
22 provided on paper and have to be posted manually.  
23 These identifiers should include the MCO member ID,  
24 claim number, subscriber number and patient name.

25 The third recommendation to avoid

1 unnecessary recoupments based on eligibility status,  
2 the TAC recommends that DMS provide more timely and  
3 accurate eligibility information to providers and MCOs.

4 Additionally, we recommend that  
5 DMS have a clear process in place for communicating  
6 recertification delays to the assigned PCP so that the  
7 PCP can engage a Connector to assist members in  
8 completing the recertification process.

9 The fourth is to assist providers  
10 and health plans in making lock-in programs more  
11 effective. The TAC recommends that DMS work with the  
12 MCOs in a coordinated effort to provide lock-in alerts  
13 to providers in a more clear and consistent manner.  
14 We've also seen issues around that a little different  
15 than what you just mentioned.

16 And, finally, in order to improve  
17 the MCOs' and providers' ability to more effectively  
18 outreach to members, the TAC recommends that DMS work  
19 with the MCOs and providers to develop an alternative  
20 process for updating member information that does not  
21 require the member to use KyNect exclusively. We think  
22 that this can include a form that requires the member's  
23 signature but could be filled out to assist them with  
24 the process.

25 That's it.

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CHAIR PARTIN: Thank you very much. Those are all really significant issues. Therapy Services.

MS. ENNIS: Good morning. I'm Beth Ennis. I'm the Chair of the Therapy TAC. You have the minutes from our March 3rd meeting. I just want to bring you up to date on some things that have happened since then.

We have been very fortunate in having good participation from Cabinet and MCOs at all of our TAC meetings which has been very helpful in resolving some issues that keep coming up.

We did get responses on the first two questions that are still in our minutes but there have been other things that have come up related to those since then.

They did respond to the 30-day recert in fee-for-service, but we're having one part of the Cabinet tell us that, no, you don't need to do a 30-day recert. It's a 20-visit benefit. CareWise is saying we're using InterQual criteria. You still have to do it every 30 days and there's some stumbling blocks with that. So, we're trying to still clarify that issue.

There was a response on the

1 therapist assistant differential, however, that didn't  
2 get sent out to members. And, so, what they came up  
3 with was a use of a modifier to denote when a PTA  
4 provided the treatment versus a therapist but that was  
5 not communicated apparently to providers. So, we've  
6 asked for a letter to be sent out to providers so that  
7 they know.

8                   The big issue that has been  
9 continuing to be concerning to therapists out there is  
10 the shift in EPSDT from the 45 provider type and per  
11 visit billing to therapy billing directly to make it a  
12 more seamless system and it makes sense, but there's a  
13 lot of folks that are very concerned about (a) how will  
14 that happen and (b) what will the cut in rates do to  
15 their ability to continue to see children across the  
16 state.

17                   Two letters have gone out, but  
18 basically the letters have said either you have an  
19 EPSDT number and a Medicaid number, so, you're just  
20 going to continue to provide under Medicaid, or you're  
21 an EPSDT provider but you don't have a Medicaid number,  
22 so, you need to get one.

23                   Other clarifications on the  
24 process haven't come forth, and, so, we don't know  
25 where the Cabinet is in that process as far as how that

1 shift is going to change, how they're still going to  
2 denote what are EPSDT funds versus the initial benefit  
3 funds and how providers need to be dealing with that  
4 when they're billing and when they're prior-authing.

5 So, we would love some further  
6 clarification, and that's the last item on our  
7 recommendations.

8 CHAIR PARTIN: So, is that a  
9 recommendation that you're asking?

10 MS. ENNIS: Yes, and it is in the  
11 recommendations that were submitted.

12 CHAIR PARTIN: Thank you very  
13 much.

14 So, we have recommendations from  
15 November 2014, January 2015 and today from the TACs.  
16 And, so, would somebody like to make a motion to  
17 accept?

18 MR. VAN LAHR: I do have a  
19 comment real quickly on Ms. Schuster's comment about  
20 the binders being available to everybody. In order to  
21 save some trees, can this information be available  
22 electronically?

23 COMMISSIONER LEE: It is.

24 MR. VAN LAHR: I do like the much  
25 thinner binders. I do appreciate that.

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CHAIR PARTIN: So, can we have a motion to accept the recommendations?

DR. RILEY: So moved.

DR. NEEL: Second.

CHAIR PARTIN: Any discussion? All in favor, say aye. Any opposed? So moved. Thank you. And I would like to request that not only do members of the MAC receive the letters in response from DMS on these recommendations but also that each of the TACs receive a copy of the letter so that they can also know what the response was from DMS.

MR. FOLEY: I don't want to add to what Medicaid would have to do, but is it possible to have for us like a grid that has each of the TACs, each of the recommendations and where we are in that point and process for each meeting? It might be too much to ask. I don't know.

Wouldn't it just be easier instead of all these different responses just to have them all laid out in front of us and we can say, okay, we can check this one off, we add this one here, this one is resolved? At least it has an answer one way or the other so that you see there's progress.

COMMISSIONER LEE: I've been told that we do that.

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MS. CECIL: We haven't provided it to you all.

COMMISSIONER LEE: So, we do have one that we can possibly put in the binder or post online or something.

MR. FOLEY: Because some of the recommendations seem to be over and over and over and at least you would see what's going on with it.

CHAIR PARTIN: So, we'll have that plus the letter response to each of the recommendations. Thank you.

DR. NEEL: Part of that is because we haven't had a quorum, so, we really haven't gotten all the answers, but what you suggest is very helpful.

CHAIR PARTIN: We have one other item under New Business that we would need to possibly have a recommendation, and that is on pharmacy preauthorization notification.

Apparently the pharmacies are not notified when preauthorizations are approved, and, so, therefore, they don't know that it's okay to fill the prescriptions. And, Jonathan, do you want to speak to that?

MR. VAN LAHR: Yes, just real

1 briefly. We now have five different providers  
2 basically, five different PBMs that we're dealing with.  
3 Each one of them is different as far as the criteria  
4 for preauthorization which is bad enough, but the issue  
5 we have is that the prescriber might be notified. The  
6 patient may or may not be notified. We don't know.  
7 So, the patient calls us and says has it been  
8 preauthorized yet.

9 So, we have to submit a request,  
10 and, again, that's time and effort on our part to deal  
11 with this, to actually go online and bill for it  
12 basically and say, well, no, not yet, but we don't know  
13 in that process where we are. Has the provider  
14 submitted it? Was it approved? Was it denied?

15 And, so, what we would ask is  
16 that DMS ask the MCOs to ask the PBMs to notify the  
17 pharmacies as to the status or approval or denial of  
18 any preauthorization requests for pharmacy services.

19 CHAIR PARTIN: Do you want to  
20 make that as a motion?

21 MR. VAN LAHR: Yes.

22 CHAIR PARTIN: Does somebody want  
23 to second that?

24 MS. ROARK: I'll second it.

25 CHAIR PARTIN: Any further

1 discussion? Everybody in favor, say aye. Anybody  
2 opposed? So moved. Thank you.

3 It's five till twelve and the  
4 last thing we have is the presentation from Coventry.

5 DR. TOLIN: Dr. Partin, Thank you  
6 for the opportunity to speak before the MAC today and  
7 to share a little bit of information about  
8 CoventryCares of Kentucky.

9 With me is Mr. Richard Schultz.  
10 Rick Schultz is the Vice-President of Health Services.  
11 My name is Fred Tolin. I'm the Chief Medical Officer.  
12 I joined CoventryCares a little less than two years  
13 ago. What you don't know is I grew up in Owensboro and  
14 attended the University of Kentucky. So, I'm happy to  
15 be back in the state and participating in the Medicaid  
16 Program.

17 I don't know where this is in the  
18 binder, Dr. Partin.

19 CHAIR PARTIN: It's under  
20 miscellaneous.

21 DR. TOLIN: That's a good place  
22 for it. I realized this morning that when this came  
23 over to you, the page numbers disappeared. So, please  
24 excuse us for that and we should be able to follow  
25 along. Hopefully everything is in order.

1 CoventryCares opened the doors  
2 back in November of 2011 when managed Medicaid occurred  
3 again in the State of Kentucky. We were purchased by  
4 Aetna in 2013, although we still carry the  
5 CoventryCares' name which will continue until later  
6 this year.

7 We did participate in Expansion  
8 last year and earlier this year expanded our own  
9 office. We added our prior authorization team here  
10 locally. We added fifty new employees to our  
11 Louisville office. So, we now have 281 employees  
12 throughout the state, most of them in our main office  
13 in Louisville.

14 We now have over 300,000 members.  
15 At the end of February, it was slightly over 306,000  
16 and I have a pie chart that shows the distribution of  
17 that membership. You can see that the majority of our  
18 membership is in the TANF population. Our Expansion  
19 population now represents about 23% of our membership.

20 On page 4, although our main  
21 office is in Louisville, we do have employees  
22 throughout the state. Specifically we have Provider  
23 Relations' representatives, at least one or two in each  
24 of the eight Medicaid regions, as well as having a  
25 Member Outreach Coordinator in each of the regions.



1                   On the following page, just a few  
2 notes about our Provider Relations. Again, we do have  
3 Provider Relations' representatives in each of our  
4 regions. The Member Outreach, of course, are focused  
5 on members, where these representatives are really  
6 focused on our relationship with our providers.

7                   They're involved in not just  
8 credentialing and recredentialing but also any issues  
9 that may come up with the providers. They are a point  
10 of contact for our provider community and a path to  
11 resolve any issues that come up with the plan - as an  
12 example, claims' issues and things like that.

13                   On the following page which is  
14 page 7, a few notes about our Quality Program. Last  
15 year, we went through NCQA - National Committee for  
16 Quality Assurance - we went through NCQA accreditation  
17 for the first time. We actually scored quite well as  
18 you can see - 49.6 out of 50 points.

19                   This accreditation was achieved  
20 in August. It's a three-year accreditation. And, so,  
21 we will be recredentialed in 2017 and we're already on  
22 the path to do that.

23                   One of the things we are  
24 interested in and I think I mentioned earlier briefly  
25 is value-based purchasing, often called pay-for-

1 performance programs or other such names. We do have  
2 programs in place. These include several standards  
3 such as HEDIS measures and other incentives for  
4 provider groups and in achieving those, and I know I  
5 mentioned a few of those earlier today.

6 One of the things we focus on  
7 other than HEDIS measures are the Healthy Kentucky  
8 measures. If you're not familiar with those, it's a  
9 series of measures really focused on health that may or  
10 may not be HEDIS measures. Such things include things  
11 like the BMI measurement in adults, screening for  
12 tobacco use in adults and adolescents, cholesterol  
13 screening, etcetera, things like that. It's more along  
14 the screening and prevention side of things.

15 On the following page, some of  
16 our initiatives. Like the other managed care  
17 organizations, we do have several Performance  
18 Improvement Projects. These are the six listed  
19 currently in place.

20 The antipsychotic medication  
21 utilization in children, that program is one that's  
22 shared among the other MCOs. So, we all have a similar  
23 program. This is a request coordinated with DMS so  
24 that we're all focusing on a single issue that's  
25 pertinent for Kentucky.

1                   Several of our other programs are  
2 either behavioral health or focused on medical issues.  
3 In particular, our Attention Deficit/Hyperactivity  
4 Disorder is a program that focuses on children who are  
5 on ADHD medications who may not be in therapy.

6                   So, identifying these children  
7 and coordinating or assisting with them being in their  
8 therapy. It's well known that children with medication  
9 and therapy in combination do better than just  
10 medication or therapy alone.

11                   Our emergency department program  
12 is focused on high utilizers. I think everybody is  
13 well aware that there is an ongoing issue with over-  
14 utilization or perhaps inappropriate utilization of the  
15 emergency department.

16                   And for this reason, we have a  
17 program focused on this to identify those high  
18 utilizers, reaching out to them and identifying  
19 whatever gaps in care may exist to steer them to  
20 appropriate levels or alternative sites of care.

21                   One of the newer programs I'm  
22 excited about which is not implemented yet is our  
23 dental initiative. I'm sorry, Don, we don't have page  
24 numbers on there, so, I can't tell you what page.

25                   DR. NEEL: That's all right. I'm

1 reviewing as you're going.

2 DR. TOLIN: Our dental initiative  
3 which is not yet implemented, I think in the last six  
4 months or so, maybe more than that, it's been really  
5 identified that we have an opportunity with dental care  
6 in this state. We're doing worse than most of the  
7 other states are. I know Dr. Riley is over there  
8 smiling. You know what I'm talking about.

9 So, the way that we've decided to  
10 approach this is focus on children who are eligible for  
11 but have not received any preventive or screening care.  
12 It's really two groups, those zero to age five for  
13 fluoride and then the older children for sealants on  
14 their permanent teeth. So, it's not just a screening  
15 but also preventive in terms of their fluoride or  
16 sealants.

17 So, that's a program that we've  
18 developed but at this point we've not yet implemented  
19 that, Dr. Riley.

20 On the following page, I talk a  
21 little bit about case management. All the managed care  
22 organizations have case management in some form or  
23 another. The program is designed to outreach to our  
24 members who have ongoing concerns.

25 We identify members for case

1 management through a number of different methods. We  
2 do have a predictive modeling program. We also look at  
3 index hospital admissions, as well as direct referrals  
4 either by physicians or identification by members of  
5 their own health plan. We have several different  
6 programs that are listed there.

7                   And I'd like to share just a  
8 brief story with you, if I can, about how well we're  
9 able to do with this. We recently identified a 17-  
10 year-old female who was a Type I diabetic that was  
11 poorly controlled, and, in addition to that, she had  
12 some behavioral health issues and specifically some  
13 suicidal and homicidal ideations.

14                   At the time we were able to  
15 identify her for case management, her hemoglobin A1c  
16 was 11. You know that's not good. By coordinating  
17 with her primary care physician, we were able to  
18 confirm that she did keep her appointments and attended  
19 a diabetes workshop to have some ownership of her  
20 diabetes, control of her diabetes as well as with her  
21 family.

22                   In addition to that, identifying  
23 her behavioral health issues, we were able to  
24 coordinate with her behavioral health professionals  
25 therapy sessions not only as an individual but also

1 family therapy sessions.

2 Doing so, we've had a positive  
3 response for this young lady. She is more active in  
4 school and I understand she recently joined the  
5 softball team. I don't know if she got a sports  
6 physical, though, Dr. Neel. Sorry. A little off track  
7 there.

8 Her last hemoglobin Alc was 8.2.  
9 So, she's not quite there but she's certainly a lot  
10 better than the 11 she was when we found her several  
11 months ago.

12 Also as part of case management  
13 on the next page, we do have some specific programs for  
14 those at risk. As you're probably aware, we do have a  
15 number of patients who have Hepatitis C in the Medicaid  
16 Program. There are a number of medications available  
17 for Hepatitis C, although they can be complex regimens  
18 with combination prescription therapy.

19 For this reason, we made a  
20 decision to reach out to any individual who has a  
21 diagnosis of Hepatitis C to enroll them in case  
22 management. Our goal here was really to identify the  
23 individuals who are at risk of being noncompliant with  
24 medication because of the complex regimens that might  
25 occur. I see you shaking your head. You know how

1 complex and challenging some of the hepatitis  
2 medications can be. This is a program to help  
3 encourage and improve their compliance with that and we  
4 have actually seen some positive results with that.

5 One of the other programs I'd  
6 like to touch on is our Neonatal Abstinence Syndrome  
7 Program or NAS. I think everybody is well aware of the  
8 challenges and issues we have with Neonatal Abstinence  
9 Syndrome in this state.

10 Our goal really was not just to  
11 identify the neonates once they've been born but really  
12 to reach back further in the time line to identify  
13 those women who are pregnant who have a drug addiction  
14 and, in doing so, provide some options for the  
15 management of their opiate dependency during their  
16 pregnancy, and, then, after delivery, continue to  
17 follow up with the mother and child for at least one  
18 year, depending on their needs.

19 On the following page, I list our  
20 six disease management programs which are designed for  
21 the chronic conditions. These programs work with  
22 varying levels, depending on the needs of the member.

23 As an example, individuals who  
24 are familiar or comfortable and have adequate knowledge  
25 of their disease, we would have what we would call a

1 Light Touch with reminders for follow-up appointments  
2 or screening exams as appropriate, and for those  
3 individuals who require more intensive care or  
4 management, of course, educational programs and other  
5 outreach as appropriate. So, these programs really  
6 have very different levels, depending on the actual  
7 member's needs.

8 On the following page, I'd like  
9 to talk a little bit about one of our goals at  
10 CoventryCares and that is really to look at our members  
11 as a whole and not treat our members as a list of  
12 diagnoses.

13 So, instead of looking at them as  
14 a dental patient or a medical patient or psych patient,  
15 really try to evaluate them as a whole individual,  
16 looking at not just their medical issues, surgical  
17 issues, behavioral health issues but also for the  
18 social issues that may go along with that. As you're  
19 well aware, a lot of Medicaid members do have  
20 challenging and complex social environments.

21 So, in treating the member as a  
22 whole, we try to take a very holistic approach and we  
23 actually have integrated our case management team to be  
24 able to do this so that there's a single point of  
25 contact for individuals instead of having to reach

1 different departments for either medical or behavioral  
2 health concerns.

3 I can tell you that this works  
4 and we have seen some success with that. In the  
5 interest of time, I won't belabor the point with  
6 another success story, if that's okay with you, Doctor.

7 I've mentioned a couple of  
8 programs and some outreach that we do, and I think that  
9 all that sounds great, but what are we doing to help  
10 the health of Kentuckians because that's really what  
11 we're all about, isn't it?

12 And I've included on the next two  
13 pages just a couple of items to show some places that  
14 we've been able to actually make a difference by  
15 working with our provider community and working  
16 directly with the facilities.

17 And just as a couple of examples,  
18 we've increased well-child visits, increased the  
19 adolescent immunization rates which I know had been  
20 dropping in the state, as well as my particular--the  
21 diabetes is a particular interest of mine, as you've  
22 probably heard throughout this presentation. We've  
23 actually been able to increase the hemoglobin Alc  
24 testing in our diabetics to over 80%.

25 So, Dr. Partin, that's just

1 making sure the test is done. The next step will be  
2 making sure that they're getting close to 7.

3 And, then, the following page, a  
4 couple of programs related really from the  
5 hospitalization side. On the med/surg side, we're  
6 really looking at unplanned 30-day readmissions. I  
7 know this is a big issue and we do have a Performance  
8 Improvement Project or PIP involved in this.

9 At this time, what we've done  
10 separate from that is to focus on several chronic  
11 illnesses that are at high risk for readmission such as  
12 the diabetics. By focusing on these individuals as a  
13 subset of our membership, we've been able to reduce  
14 their particular readmission rate to less than 5%,  
15 unplanned readmission over 30 days.

16 We've taken a different approach  
17 on the behavioral health side, really looking to  
18 enhance their follow-up after hospitalization in a  
19 behavioral health facility. Our challenge here has  
20 really been follow-up on an outpatient basis.

21 For this reason, we have a Day of  
22 Discharge planning encounter, and in that encounter,  
23 one of the components is confirming that there will be  
24 a follow-up appointment made and then we confirm that  
25 that's kept, and we've actually been able to improve

1 our appointment rate within 30 days to 75%.

2 The final slide, the future for  
3 us, the remainder of this year, later this year, we're  
4 going to be expanding our Louisville office. Once  
5 again, we're adding our Member Services and Member  
6 Outreach team and this includes hiring 40 new  
7 employees. So, we'll be up over 300 employees before  
8 the end of the year.

9 We are adding another component  
10 to our case management program. We'll actually have  
11 face-to-face, in-person encounters instead of primarily  
12 telephonic which is the way that we handle case  
13 management at this point.

14 And, then, last on the list but  
15 not necessarily final, as you know, Coventry was  
16 purchased by Aetna in 2013, and the CoventryCares' name  
17 will be sunset later this year. We will be re-branded  
18 as Aetna Better Health of Kentucky, and I'm officially  
19 now allowed to give you that information. That's  
20 planned for the fall.

21 Thank you again for the  
22 opportunity to speak before you, and I'll be happy to  
23 answer any questions that any of you may have.

24 CHAIR PARTIN: Any questions?

25 DR. NEEL: A couple of quick

1 ones. Fred, thank you for the presentation. On  
2 credentialing, you were in our TAC meeting. You know  
3 that continues to be a bugaboo. It's just taking too  
4 long to get providers credentialed.

5 Are you all working to try to  
6 shorten that period? It's got to happen because we're  
7 having so many providers that are not getting paid out  
8 there partly because of credentialing.

9 DR. TOLIN: In the Dental TAC  
10 yesterday, we spent some time talking about this. I've  
11 heard numbers or length of time as high as nine months  
12 to a year.

13 We actually use a centralized  
14 credentialing service through Aetna and we look at  
15 these things on a monthly basis. So, certainly, Dr.  
16 Neel, I'll take that away and see what our time frame  
17 is. I don't know off the cuff what our average time  
18 frame is, but I do know this is an ongoing concern for  
19 the physicians as well as dentists and other healthcare  
20 providers.

21 DR. NEEL: Okay. And just one  
22 final. I think the percentage of well visits is higher  
23 than is documented here. Part of that problem is poor  
24 data. We brought it up earlier. We've got to have  
25 data to know if they're really getting their exams or

1 not.

2 DR. TOLIN: Doctor Neel, I'm not  
3 able to share at this time, but I can tell you that so  
4 far, the data collection that we're doing this year for  
5 HEDIS shows that that number has improved  
6 significantly. So, we have made strides by working  
7 with you and your colleagues.

8 CHAIR PARTIN: Thank you very  
9 much.

10 I have a comment or something  
11 that I would like to bring up related to ordering of  
12 durable goods, and I'd like to thank WellCare for  
13 contacting me about this issue.

14 Let me go back a little bit on  
15 the history. About a year ago, I contacted the  
16 Attorney General's Office and the OIG Office because  
17 I'm receiving requests for durable equipment for  
18 patients when I didn't order the equipment, but the  
19 request is sent to me as though I had ordered it and  
20 asking for my signature, and it's for things that I  
21 wouldn't have ordered for the patient.

22 And this is not isolated. I know  
23 a lot of other providers have the same issue. So, I  
24 called to report that and I was told since I hadn't  
25 signed the forms for the orders, that no fraud had been

1 committed and, so, therefore, nothing could be done  
2 about the issue.

3 So, a few weeks ago, I received a  
4 call from a representative from WellCare who had  
5 somehow received information about this and was  
6 following up with me and wants to do something about  
7 it. And, so, I was really pleased to hear that and she  
8 wants me to send her all of these requests that I have.

9 So, I have taken on this mission  
10 saving all of these requests from the various companies  
11 that I receive and I'll send them to her but they're  
12 not all WellCare patients. So, I don't know how far  
13 that would go.

14 So, I'd like to ask that maybe  
15 some of the other MCOs and Medicaid look into this  
16 because I think it's really easy to sign----

17 MS. BRANHAM: Maybe you want to  
18 tell them what.

19 CHAIR PARTIN: Wheelchairs, beds,  
20 back braces, knee braces, heating pads, diabetic  
21 testing supplies. Everything you could imagine that's  
22 a durable medical equipment I get requests for when I  
23 haven't ordered them, and a lot of these people are  
24 diabetics but some of them aren't, but the patients are  
25 already receiving their diabetic supplies locally, and,

1 so, these requests are coming from out-of-state  
2 companies.

3 So, it would be very easy to sign  
4 that form thinking, oh, the patient requested it  
5 because that's what the form says -the patient has  
6 requested this, and, so, it would be very easy.

7 And maybe I have signed them in  
8 the past and didn't even know it, but now we've started  
9 calling which is extra work but you have to call the  
10 patient and say are you getting your supplies locally  
11 or are you getting them from this company and that  
12 takes a lot of time to do that.

13 So, I would like to ask that  
14 maybe some of the other MCOs and Medicaid look into  
15 this issue and see what can be done. I'll be glad to  
16 share what I have.

17 And, then, on a slightly related  
18 topic, I have been receiving requests - mostly this is  
19 from WellCare - for durable medical equipment after  
20 their representative had talked with the patient and  
21 they're for durable medical equipment supplies that I  
22 didn't order but that the representative talked with  
23 the patient and determined that the patient needed.

24 And, so, I can't tell these  
25 requests from the other bogus things that I get. So, I

1 think it would be really helpful if the representatives  
2 from the MCOs are going to talk with the patients and  
3 determine that they need a heating pad or they need  
4 whatever, that they contact the provider first and let  
5 the provider know that they're recommending it so that  
6 when the order comes to the provider, that they know,  
7 because, again, we have to stop and call the patient  
8 and say did you want this or did somebody talk to you  
9 about this and it's very confusing.

10 MR. VAN LAHR: Dr. Partin, as a  
11 DME provider, one of the issues we have in dealing with  
12 this a lot of times is the patient is discharged from  
13 the hospital or an emergency room and they're told to  
14 get this item but the ER doc is nowhere to be found.

15 And, so, what they will tell the  
16 patient is have your primary care provider do this.  
17 So, that is problematic for us as far as on our side  
18 sometimes in that they're told by the ER doc, they're  
19 told by the discharger at the hospital or the resident  
20 at the hospital and there will be a prescription for  
21 this item, but they're nowhere to be found. They're  
22 not going to fill the paperwork out. They're not going  
23 to do anything with it.

24 So, the question sometimes for us  
25 is what do you do. That should be a communication

1 issue with the DME provider with you directly if  
2 there's an issue with that, too.

3 CHAIR PARTIN: So, there's  
4 another facet to the problem. So, anyway, I just  
5 wanted to bring that up so that everybody could be  
6 aware of that that problem and maybe together we can  
7 work on this and fix it.

8 Any other issues? Comments?

9 MR. CARLE: Just one other one  
10 with regards to the binder. I'd like to echo  
11 Jonathan's comments.

12 As I was going through it,  
13 though, on Section 7 of the audits, somebody provides  
14 an executive summary of what the audit was about; but  
15 it would be nice also to have an executive summary of  
16 what the findings were so that we don't necessarily--  
17 right here at this time, we don't have the ability to  
18 go into the website and find the findings.

19 So, what I would ask is that we  
20 have just one paragraph, an executive summary of what  
21 the audit was for and what the audit outcomes were.

22 CHAIR PARTIN: Thank you. If  
23 there's no further business, then, I'll take a motion  
24 to adjourn.

25 MR. VAN LAHR: So moved.

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DR. NEEL: Second.

CHAIR PARTIN: Thank you very  
much.

MEETING ADJOURNED