

ORIGINAL

CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

December 13, 2012
10:00 A.M.
Room 129 Capitol Annex
Frankfort, Kentucky

APPEARANCES

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CHAIRMAN

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Elizabeth Partin, ANRP; NP
Susie Riley, D.M.D.
Chris G. Carle
Sharon A. Branham
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COUNCIL MEMBERS PRESENT

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1 CHAIRMAN POOLE: We'll go ahead
2 and get started. We will call the meeting to order.
3 We're going to wait on the approval of minutes until we
4 get one more member up here. So, let's go right into
5 Commissioner Kissner's updates, please..

6 REPORT OF CABINET FOR HEALTH AND FAMILY SERVICES,

7 DEPARTMENT FOR MEDICAID SERVICES:

8 COMMISSIONER KISSNER: I'd like to
9 walk you through a presentation I gave a couple of days
10 ago.

11 The first slide is, I think people
12 forget why we did what we did and what we were trying to
13 accomplish. So, the first slide is an historical
14 perspective of the cost on a per member, per month basis
15 for fiscal years '3 projected through '14. And you can
16 see that the blue is actual what we spent per member,
17 per month. This is all seven regions excluding Region
18 3.

19 You have the actuarial estimates
20 which was a moderate growth - you can work out the
21 percentages - moderate growth and what we anticipated
22 saving with the MCO's. This was actually presented to
23 Appropriations and Revenue back in July of 2011. So,
24 this is where we were.

25 So, the difference, if you want to

1 look at it - go to the next slide - this is what we
2 anticipated would happen with membership. And, again,
3 that's like a 1.3% membership growth which is very, very
4 moderate membership growth. We anticipated a growth.

5 So, if you go to the next slide,
6 Slide 4, when you take the members times the projected
7 rates and the members times the managed care rates, and
8 you do that out for the contract period which was
9 11/1/11 through 6/30/14, you come up with a savings of
10 \$1.3 billion. That's what the Governor put out in the
11 various press releases.

12 So, the State only funded the
13 Medicaid budget at the reduced amount. So, in essence,
14 they grabbed the savings right off the top, said we're
15 just not going to fund it. You're going to pay the
16 MCO's \$1.3 billion less than what Medicaid would pay and
17 we're going to accrue that immediately.

18 So, are we on track? That gets
19 you to the next slide. The answer is, yes, we are on
20 track. You can see the budgeted. We had thought it
21 would be three forty-five thirteen, and you can see what
22 we actually paid the MCO's on a monthly basis PMPM.

23 Then on the second part is the
24 July, August, September, October. That's where we are.
25 That's where we submitted our LRC reports through

1 October. We're about probably forty-five days after the
2 close of a month is when we submit the LRC reports. We
3 have not submitted November yet, but you can see there
4 that we are actually under budget from that perspective
5 on a per member, per month basis.

6 So, the other question is, well,
7 what do the M's look like? Is the membership coming in
8 projected? If membership increases, the fact that
9 you're paying a little bit less still blows your budget
10 because membership is higher. And membership - that's
11 this Slide 6 - membership is actually coming in less
12 than we projected, which is good.

13 It's good in one way and bad in
14 another. We want as many people who need the safety net
15 of Medicaid to have coverage as possible, but we haven't
16 exceeded the budget target of the 570,000 people in
17 those seven regions. You can see we've fluctuated as
18 high as 562,000 and October was 552,000 people.

19 So, those are the two key
20 indicators. One of them is what we're paying on a per
21 member, per month basis. The other one is how many
22 members are we covering, and those are the critical
23 components.

24 So, if you go to Slide 7, I think
25 people lose sight of the fact that this is only half of

1 our budget. We have a \$6 billion budget. Half of it is
2 managed care - 570,000 people under the seven regions.
3 It's about 700,000 people when you throw in Passport.
4 And you can see we spend \$2.9 billion is that portion of
5 our pie.

6 But the other side is the fee for
7 service, and we're still a \$2.8 billion business on the
8 fee-for-service side. So, if you go to Slide 8, you'll
9 see that it's a disproportionate membership. So, we
10 spend half of our budget on 85% of the people, and we
11 spend half of our budget on 15% of the people. And
12 those 15% are the very, very needy. They have high
13 claims' cost, high utilization, they have a lot of
14 medical conditions and they need the service that they
15 get which we pay on a fee-for-service basis.

16 And you can even slice that down a
17 little bit more in that there's about - I'm going to
18 ballpark - 50,000 of those people really get the bulk of
19 the \$2.8 billion. There's about 75,000 people where we
20 have actually a low expenditure because we pay some
21 Medicare premiums and some co-pay amounts which is sort
22 of de minimis in the big picture.

23 So, it's actually a very small
24 group of people - 50,000 people - where we spend the
25 bulk of that \$2.8 billion.

1 CHAIRMAN POOLE: And most of them
2 are long-term care?

3 COMMISSIONER KISSNER: Yes. About
4 a third of the budget, of that expenditure portion for
5 them is nursing facilities, yes, long-term care and
6 brain injury. It's all of our waivers. It's the
7 Michelle P. It's Money Follows the Person, a variety.
8 The Acquired Brain Injury short term, Acquired Brain
9 Injury long term, Michelle P., Money Follows the Person,
10 and there are several others, but, yeah, that's where it
11 is.

12 And then Slide 9 was just a piece
13 of budget versus enacted, and that's how we're coming
14 in.

15 And, then, Slide 10 is where you
16 can see some of those descriptors of the other half of
17 the pie, and you can see it's KCHIP, children's services
18 such as HANDS and First Steps, Impact Plus. Nursing
19 facilities is a pretty big chunk, waivers and other
20 state services. Any of those people that are covered
21 under the waiver, if they actually bounce to the
22 hospital or bounce to a physician, those are reimbursed
23 on a fee-for-service basis. So, that's in sort of the
24 other fee-for-service cost.

25 So, the bottom line on page 11 is

1 that we are on track through October in the seven
2 regions and we're also on track on the overall budget.
3 The difference, though, is about \$40 million year to
4 date is what we're under budget, which, when you think
5 of a \$6 billion budget, it's a 2.2 something percent.
6 We're under budget. We're 98% budget. So, it's very,
7 very close.

8 So, here are some of our
9 priorities that we're working on. We are hitting the
10 MCO's hard with contract compliance. We have created
11 the MCO Dashboard. I should be able to share that at
12 the next MAC meeting. We have everything - we talked
13 about this last time - everything that's a contractual
14 obligation, and we have lots of stuff that's not a
15 contractual obligation but that they report.

16 Prior authorizations, how many
17 prior authorizations are approved, how many of them are
18 denied and for what reasons. There's lots and lots of
19 information there. We do a monthly continuous network
20 adequacy review. So, every month, the MCO's give us, I
21 think once or twice a month, they give us their actual
22 network. Here is everybody who we have contracted in
23 our network. Every dentist, doctor, psychiatrist, you
24 name it, it's everybody that's contracted.

25 And, then, we run that against our

1 database and we compare it based on their membership in
2 a region and the number of providers that Medicaid had
3 prior to managed care. A simple example would be if we
4 had ten cardiologists in a region, we can't demand that
5 the MCO's have eleven because we only had ten. So,
6 network adequacy starts with what we had, and we had
7 100% of the population and ten cardiologists.

8 So, if everybody ended up with a
9 third, they would all be required to have at least three
10 cardiologists. And if they don't, we ask them to look
11 for another cardiologist in that region. If they only
12 had two, as an example, that we think they need to add
13 another cardiologist. So, we do that line by line on
14 every provider type.

15 We are encouraging the providers
16 and the MCO's to work out their issues. We have
17 facilitated over a hundred different meetings. We have
18 weekly MCO meetings. There's KHA and MCO meetings.
19 There's community mental health centers and the MCO
20 meetings. There's BH/DID which is our sister agency
21 with Behavioral Health, and they meet with the MCO's.
22 There's obviously TAC's and MAC's and P&T's and a
23 variety of other meetings.

24 Ultimately, there's a contract
25 between the provider and the managed care company, and

1 they have agreed in that contract to a variety of
2 different things that have been signed and agreed to.
3 And if they're not performing, they need to work through
4 those issues with the MCO's and we encourage that.

5 We've taken accounts receivable
6 lists from hospitals and we've brought it to the MCO's.
7 They bring it to the table and we've worked through them
8 line by line. Sometimes they identify that there's an
9 issue that something wasn't paying right and they fix it
10 and claims are readjusted. Sometimes there's a
11 disagreement on why something was denied or suspended,
12 but we work through those issues.

13 Go to page 13.

14 CHAIRMAN POOLE: Excuse me. Do
15 you all keep statistics on your call center calls like
16 how many you field a month?

17 COMMISSIONER KISSNER: Yes.

18 CHAIRMAN POOLE: What are the
19 complaints about.

20 COMMISSIONER KISSNER: Yes.

21 CHAIRMAN POOLE: I think that
22 would be a fair thing to put in the dashboard
23 performance, too, because you might field a lot of
24 provider complaint calls, not just MCO. I just would
25 like to know where - and I don't even know how many you

1 get a month. I have no idea.

2 COMMISSIONER KISSNER: Thousands.

3 CHAIRMAN POOLE: But just to give
4 us an indication of what complaints are out there from
5 the recipients.

6 COMMISSIONER KISSNER: Sure, we
7 could do that. Call stats. Okay. We do have the call
8 stats for the managed care companies I think in one of
9 the reports - if not, we can ask for it - what are their
10 top five reasons of calls and things like that, but we
11 have information on that. I can get that for you.

12 MR. CARLE: It also would be nice
13 if we could get that dashboard, as you mentioned
14 possibly at the next meeting, if we could get that in
15 advance so we could take a look at it.

16 COMMISSIONER KISSNER: Sure,
17 absolutely.

18 MR. CARLE: Thank you.

19 COMMISSIONER KISSNER: So, other
20 DMS priorities - one of them is a smooth transition for
21 Region 3. You may also hear it referred to as Region
22 31. That's sort of a technical thing because we have a
23 certain process for Region 3 and we've got a new process
24 for Region 31, and the system needed a way to say this
25 claim was Region 3, this claim was 31. And, so, you may

1 hear that.

2 We conducted readiness reviews
3 with each of the MCO's, of the four MCO's there. That
4 was all performed last week. We gave the write-ups to
5 CMS and they're reviewing our readiness reviews.

6 In those readiness reviews, we go
7 through a lot of stuff, everything they have ready.
8 Now, it was easier with Coventry and WellCare because
9 they're basically up and running in the state, as well
10 as Passport, and Humana, we did a lot of deep dive
11 there. We actually visited their claims shop. We
12 visited their customer service center. We asked them
13 for their network sample contracts. We make sure that
14 they have policies and procedures in place to handle
15 what happens if somebody complains, what happens if
16 somebody files an appeal, do you have the process, the
17 people, the system ready to accept those things?

18 We had a few follow-ups but there
19 was nothing identified that would hold up the actual go
20 live as of 1/1/13. So, we think that's ready to go.

21 Here's the open enrollment for the
22 seven regions. That was 8/19 to 10/20 of '12. You can
23 see that there was a significant shift. Coventry lost
24 33,000, Kentucky Spirit lost 7,600, and WellCare picked
25 up 4,100, and that was as of 11/1. And that was

1 isolated or the majority of it was in a couple of
2 regions on the eastern part of the state.

3 The open enrollment for Region 3
4 is still going on, and you can see that this was as of
5 last Friday, 12/7. Passport has picked up another
6 27,920 members. So, they're at actually a 43.9% as of
7 that date. That will go up a little higher, I'm sure,
8 during this week.

9 We communicated a lot with the
10 members. We ran the letter by advocacy groups and said
11 here's what we're going to communicate, give us your
12 feedback. We sent them a letter and said heads up,
13 you're going to get another letter that assigns you to
14 an MCO. We sent them that second letter and said you've
15 been assigned to this MCO.

16 Passport filed an appeal or a
17 complaint or whatever, dispute, something, and they have
18 withdrawn that now. They were assigned initially 44,000
19 which was 19 or 20%, but now they've gotten a
20 significant influx of members and they have withdrawn
21 that appeal.

22 We're still working on the
23 organizational changes. We have some draft documents
24 back from Public Consulting Group, the basic concept
25 there that there is not any loss of Medicaid jobs. It's

1 just a restructuring. We're going to look at putting
2 like services together.

3 So, right now, to answer your
4 question about calls, we have an official call center
5 where we track the call stats, but we take other calls
6 in the organization. Like a provider may call somebody
7 in the provider organization and it may or may not be
8 tracked in a call center environment. So, the answers I
9 get you will be what we've tracked in a call center
10 environment; but, long term, it probably makes a lot of
11 sense to have all calls go to a call center.

12 When they come in, they get
13 tracked, they get logged, and you have call center
14 representatives that have skill sets. So, I can handle
15 bilingual, I can handle Medicaid, I can handle dual
16 questions about Medicaid and Medicare, I can handle
17 provider questions, and we get our staff trained up in
18 multiple skill sets and you handle the calls and you
19 route them around and you keep the average speed to
20 answer up and the talk time and everything. You manage
21 it like a call center. So, that's one idea of sort of
22 putting like services together.

23 We have the same thing with
24 financial stuff. Almost every branch that's in Medicaid
25 can deal with finances. So, we cut checks to doctors

1 and fee for service. We set reimbursement rates on a
2 fee-for-service basis. We project future expenditures
3 on a quarterly basis. Eight quarters out, for Medicaid
4 on a quarterly basis, we submit to CMS, here's what we
5 think we're going to spend going out long term.

6 And all of those things I just
7 mentioned are all done with different branches and that
8 might not be the most efficient way to do it either.
9 So, we've said maybe we want to bring the like services
10 of finance and the handling of that piece of it
11 together.

12 And, so, again, no loss in jobs
13 but structuring like services together so that we can be
14 more efficient and have more people talking to each
15 other because the projection of Medicaid expenditures,
16 that if you didn't talk to the people that just
17 increased the fee structure, maybe your projection might
18 be off a little bit. And getting all of those in the
19 same, you know, talking about costs is a very positive
20 thing. So, that's the basic principle there. We don't
21 know when that's going to actually be launched.

22 And, then, we do appropriate risk
23 adjustments. I don't know if we've talked about that in
24 this body, but you basically have a risk of a 1.0. So,
25 there's a pie. It says here's the risk of the Medicaid

1 population, and then people get a slice of that pie.
2 The MCO's get 100,000 members or 200,000 members. So,
3 you risk score every member based on their historical
4 claims data and diagnosis codes and you say, hey, I've
5 got a hemophiliac over here that may cost \$100,000 a
6 year and I have somebody that's never been to the doctor
7 that may cost \$100 a year.

8 So, you give a risk score to every
9 member in Medicaid, and then you say what slice of the
10 pie did your MCO end up with. And if your slice is
11 sicker with a higher risk score, we actually pull
12 premium and capitation payments from one MCO and channel
13 it to another. So, that's the risk form. We do that
14 every three months or sooner if it's deemed significant.

15 Some other priorities, page 14,
16 MMIS changes. That's a pretty big one. We need to
17 coordinate with the Health Benefit Exchange. In the
18 future, you guys know that the Health Benefit Exchange,
19 you call up or you go online and they make a
20 determination in realtime, are you eligible for
21 Medicaid, in which case that's where you belong, or are
22 you eligible for possibly an expansion product, or are
23 you in the 100 to 400% of the federal poverty level and
24 you're eligible to buy insurance through a subsidy from
25 the federal government, and they make all that

1 determination in realtime.

2 So, even if a state decides not to
3 expand or to build their own Health Benefit Exchange,
4 you still have to be the recipient, the catcher of that
5 data transfer because the federal government said, if
6 you don't do it, I'll do it, and I'm still going to say
7 this person is eligible for Medicaid and I'm going to
8 send them right back to you. So, you've got to catch it
9 and say, wow, we just found a person who was eligible
10 for Medicaid and now we know about them and we start the
11 process of getting them into the Medicaid Program.

12 So, building the acceptance ports
13 and the logic of saying here's how you do it, here's how
14 data is transferred between these various entities, you
15 need to do that. The Health Benefit Exchange is working
16 on that full bore, but it also impacts Medicaid because
17 we're part of that equation.

18 There's the Kentucky Health
19 Information Exchange. That's going and continues to go,
20 getting more and more electronic information available
21 online with providers accessing that information.
22 There's federal grants available for that so that the
23 providers are incented, financially incented to
24 participate in the Kentucky Health Information Exchange.

25 ICD-10 is coming down the road.

1 That's still scheduled for 10/1 of '14. ICD-9 is where
2 we are today. It's the International Classification of
3 Diseases, the 9th Edition. Most of the world uses the
4 10th Edition, and it explodes the number of possible--I
5 don't know if you guys have that discussion at all, but
6 it explodes the possible impact of--so, under the
7 current, if you sprained your ankle, it's right or left
8 foot, it's a high ankle sprain or a low ankle sprain,
9 interior, exterior. That's basically the parameters.

10 Under ICD-10, it's all of those
11 plus were you struck in a sporting event, were you
12 striking a ball, were you playing football, soccer,
13 baseball, hockey, basketball, and it just explodes the
14 possibilities of what a provider can code for.

15 So, organizations like ours who
16 are claims payors, we have to be able to accept both the
17 old code because, when it goes live, providers have like
18 a year to transform their offices to be able to bill
19 under the new codes. So, you have to be able to do
20 both. You've got to take an ICD-9 code and pay an ICD-9
21 code. You have to accept an ICD-10 code and pay an ICD-
22 10 code, and the reimbursement may not change at all.

23 An ankle sprain is an ankle
24 sprain, but the codes change, and literally you get
25 100,000 different new possibilities of codes, and that's

1 something that the federal government decided was
2 important for us to do as a healthcare system. So, it
3 is what it is. It's been put off a couple of times, but
4 there's been no indication that the 10/1 of '14 is going
5 to change. So, gearing up for that is no easy task.

6 And, then, the eligibility
7 updates, that's important. MAGI is the Monthly Adjusted
8 Gross Income. So, in the future, in the future, post
9 ACA expansion, or not expansion, just post ACA
10 implementation which is 1/1/14, the determination will
11 not be as complex as it is today.

12 There's certain areas of Medicaid
13 which are very, very complex. You look at incomes and
14 monthly incomes and house and bank accounts and cars and
15 assets - there's all sorts of stuff - expenditures, and
16 you come up with an eligibility. In the future, it's
17 going to be much, much simpler. They're just going to
18 go to line number "x" on your tax form and it's your
19 monthly adjusted gross income. It's going to be very
20 simple whether you're eligible for Medicaid or not
21 eligible for Medicaid.

22 So, anyway, that's a significant
23 change but that has lots of ramifications about training
24 and changing our systems and all sorts of stuff. So,
25 it's coming.

1 Island Peer Review is on board and
2 they've started their review of the MCO's. Their job is
3 to evaluate the performance of the MCO's and monitor
4 quality and performance. They deep dive a lot of
5 specific things and they're an outside third party. So,
6 they look at your systems, your database, your platform.
7 If we find something specific, they can conduct an ad
8 hoc analysis. If they review and find something doesn't
9 seem to be right in this area, they can deep dive that,
10 and they help in developing the quality improvement
11 action steps because we want the MCO's to drive a higher
12 quality outcome.

13 Rector & Associates, we've hired
14 them to analyze improved financial performance and
15 tracking of the MCO's. So, they submit to the
16 Department of Insurance a quarterly statutory filing.
17 They submit that to the DOI every quarter, and the DOI
18 looks at them to make sure that they're complying with
19 insurance regs, both in timeliness of claims payment and
20 in their risk-based capital and other things that you
21 have to have to be a licensed insurer.

22 So, we've hired these guys to do a
23 deeper dive and really focus. So, they're doing really
24 the financial data, a deeper dive on the financial data
25 and they're also looking at claims' practices, handling

1 of complaints, appeals and grievances, and they have
2 either had an onsite meeting or have scheduled an onsite
3 meeting with all of the MCO's. They did some last month
4 and the rest of them are happening this month. So,
5 they're actually coming onsite and visiting the various
6 MCO's and then following up with emails and electronic
7 access. So, that's what they're doing.

8 Here are some interesting results.
9 This is a prescription drug analysis. We looked at two
10 time periods - pre-managed care, post-managed care,
11 excluding Region 3 because Region 3 had Passport and
12 that kind of muddies the water a little bit.

13 So, we said here's 11/1/ of '10 to
14 4/30 of '11, a six-month period, and here's the
15 subsequent six-month period. So, what happened in
16 November? In November, the cost of prescription drugs
17 was down about 6%. The actual number of scripts was
18 almost equal to the prior year, a year earlier, and the
19 number of users was down a little bit.

20 Well, over time, you can see that
21 the cost of the drugs, as members become familiar with
22 the respective MCO's Preferred Drug List or their
23 formulary, as they become familiar with that, the cost
24 of the drugs is dropping, but the actual number of
25 scripts is going up which I think is very positive.

1 That's more services delivered at a lower cost, if you
2 assume drugs and service are equal, and I do because
3 that's the way we treat most conditions in the United
4 States. There's a medical and pharmacological treatment
5 for diabetes and congestive heart failure and asthma and
6 all that sort of stuff.

7 So, more being delivered at a
8 lower cost is a very positive outcome. And you can see
9 the members actually started to increase in December and
10 January, the number of users of prescription drugs, and
11 that's been relatively flat in comparison to the other
12 bars. So, costs are down. Scripts are up. Positive
13 outcome.

14 If you go to the next page, this
15 is emergency room visits, again, an interesting slide.
16 So, in November, the cost was down and we saw fewer
17 visits than the November before and we had fewer users.

18 Well, what's happened over time is
19 the visits and the users have dropped somewhere around
20 15%, but the actual cost per visit is going up. And I
21 think that's also positive because if it wasn't a
22 medically necessary emergency room visit, then, what is
23 medically necessary and a true emergency visit, what
24 services are rendered are higher severity services.

25 So, you would actually see the

1 cost per visit go up because they're the right visits
2 and we're doing a lot of services because they really
3 are emergencies and you're seeing that, which I think
4 is, again, a positive outcome.

5 And if we get people, members to
6 visit their primary care and visit their doctors, you
7 should see a reduction in the actual use of emergency
8 rooms because they're getting the appropriate delivery
9 system which is a doctor's office if it's not really an
10 emergency.

11 And, then, here's another view of
12 it. We looked at how many people, on page 19, how many
13 people had one visit or two visits or three visits or
14 four visits or five. We had somebody that had like over
15 eighty visits in a six-month period which is kind of
16 going every other day to the emergency room. I didn't
17 want to do a bell curve because you get weird on the
18 ends. There's people who never go to the emergency room
19 and there's people who went eighty times and those are
20 the extremes and those need to be handled specially.

21 This is the bulk of them, and you
22 can see the number of people who actually went five
23 times as an individual user dropped, and the number of
24 people who went four visits, the number of people who
25 went three visits. And, again, I think this is a

1 positive outcome. In six months, you're going to the
2 emergency room five times. It's almost every month.
3 You look around the room. How many people have been to
4 the emergency room - and don't raise your hand because
5 it's PHI - but that's a lot of use of the emergency
6 room. That's going to the emergency room an awful lot.

7 And, so, that's dropping which,
8 again, I think you can turn to use of primary care, use
9 of other forms of care might be one of the reasons for
10 that.

11 And, then, the last thing we have
12 here are some success stories. I'm not going to read
13 these to you - you can do that yourself - but increased
14 health screenings, improved health outcomes, some pretty
15 cool stories here. We get a couple of three of these
16 stories a month. So, we have thirty or forty of these
17 stories that we've received.

18 We ask the MCO's to provide these.
19 It's important that they provide them. They're real
20 examples with members. I've picked stories from each
21 MCO. So, this is reflective of all of them, and you can
22 see this is what managed care should do. A woman who is
23 eligible for a mammogram should be having a mammogram,
24 hasn't had a mammogram, call them up, remind them, even
25 set up the appointment, arrange for non-emergency

1 medical transportation if they need it, and then get an
2 actual mammogram. And lo and behold, there's early
3 stages of breast cancer and it gets treated and that's
4 exactly what we want to have happened. So, there's lots
5 of other examples here, but I think those are positive.

6 And with that, I guess I'll open
7 up for questions, and thank you for your time.

8 CHAIRMAN POOLE: Thank you for
9 that report. If we can, first of all, any of the
10 managed care organization representatives who are here,
11 you've sat over here to my left. We've got Kentucky
12 Spirit and Passport sitting up there. So, anybody else,
13 please join them.

14 I'll go into the topics that we've
15 submitted, Commissioner, and I'm not going to pretend to
16 know what's going on with litigation concerning Kentucky
17 Spirit, but could you just comment on what we can
18 anticipate with them pulling out June 13th.

19 And along with that, if you could
20 answer. I've got people from other states that have had
21 different MCO's pull out. And is it the CMS guideline
22 that in each district, there needs to be two providers
23 or is it three?

24 COMMISSIONER KISSNER: Two.

25 CHAIRMAN POOLE: Two. Okay. I

1 don't know what it is in Ohio. I don't know if it's a
2 state thing, but they've got to offer the fee for
3 service if they go below three.

4 COMMISSIONER KISSNER: If a region
5 is declared a rural region, which one of our regions is,
6 Region 8, you only need one, and the other seven
7 regions, you need two.

8 CHAIRMAN POOLE: Okay. Thanks for
9 clearing that up because I've had several questions from
10 a lot of provider groups and different ones knowing if
11 we're going to have to get somebody else to replace them
12 in those regions, and the answer is no there.

13 But if you could comment on what
14 you could on Kentucky Spirit pulling out and what effect
15 that is going to have and what can members expect that
16 are with them now, when is their transition period and
17 that kind of thing.

18 COMMISSIONER KISSNER: None of
19 that has been decided and it is in litigation, so, I'm
20 not going to comment. The date is July 5th, I believe,
21 2013. July 5th is when they signed their contract way
22 back when in 2011.

23 I will say that if there is a
24 transition, we will do everything we can to do
25 notifications and keep the members informed and give

1 being done to try to come up with a solution. I
2 understand when it was fee for service, Medicaid was
3 paying for certain things that the MCO's are not.

4 And I guess, in hindsight, it
5 would have been nice if Medicaid would have educated at
6 least the health departments on, hey, there's going to
7 be a change in what is going to be paid for. And the
8 main thing, it's the health departments that are
9 providing school nursing. So, like ours, we're in
10 arrears over \$600,000. We're into our reserve funds and
11 that's not uncommon across the state.

12 So, could you just tell me, is
13 there anything going on with negotiations there? Is
14 there anything that can be done?

15 COMMISSIONER KISSNER: There's a
16 lot of activity going on actually. So, we're following
17 the Model Procurement laws and sort of the dispute
18 resolution that's associated with that.

19 So, the first action is the
20 managed care company submits to the Cabinet and says I
21 don't want to do this. I'm not paying this or I don't
22 think this is in accordance with our contract. The
23 Cabinet responds officially, and we've done those first
24 two steps. Then the MCO has the right to appeal to the
25 Finance Cabinet which is the one that manages the

1 contract, and they've done that.

2 And, so, now we're in the response
3 of--and there's a certain number of days after each one
4 of these actions. You get fifteen days, thirty days,
5 whatever the case may be, and we're in that response
6 time frame from the Cabinet of Finance. So, that's
7 where they are is it's going through the official
8 process.

9 We believe, our position is they
10 should be paid and valid services should be paid. And,
11 then, after the Finance Cabinet makes a determination,
12 then, I think the MCO has probably another appeal which
13 would be to the court system if they wanted to take it
14 there.

15 It's an official, formal process,
16 and our position is a lot of these services should be
17 paid for, and the other position is this shouldn't be
18 paid for. That's about as much as I can say. We'll
19 just let the process work through the system according
20 to our Model Procurement laws.

21 CHAIRMAN POOLE: Okay. Do you
22 want to ask about the assignments of PCP's and disease
23 management?

24 DR. NEEL: We've had a chronic
25 problem with mis-assignment of patients and we have

1 asked about that before. It's been a problem. The
2 MCO's tell us that it may be data that they're getting,
3 but that doesn't seem to be getting very much better for
4 those of us who are in primary care. I don't know if
5 you can speak to that or not.

6 The problem is that patients are
7 being assigned to people who are not really primary care
8 providers. They're being assigned to nurses in Walmart
9 clinics, they're being assigned to nurse practitioners
10 that do geriatrics for pediatric patients. It's more
11 than we can handle at this point and it's not getting
12 any better.

13 COMMISSIONER KISSNER: I have
14 asked the call center to give me a list of their issues,
15 of why people are calling, and do we have this issue of
16 mis-assignment so I can give you a framework of is this
17 happening a thousand times a month or is it happening
18 twice a month. A member calls up and says I was mis-
19 assigned and this isn't the right kind of doctor and I
20 want to get reassigned.

21 They're allowed to make a change
22 and they can change their primary care. There's no
23 restrictions there. If they were mis-assigned, they can
24 change. All they have to do is call the MCO and say I'd
25 like to change from this doctor to this doctor. They're

1 allowed to do that.

2 So, let me get some more
3 information, but I would love to have some examples,
4 those examples where you have an actual person that was
5 assigned to the Walmart nurse where we can go in and see
6 how that nurse was actually coded in the system and it's
7 by MCO. I don't know, but they could be coded one way
8 with one MCO and coded another way. It could be our
9 issue where we coded them wrong.

10 I can't really get my hands around
11 this until I can dig into some specific examples. So,
12 that may be not discussable in a public forum, but I
13 will take the information, name and basically it's some
14 PHI stuff, but name and assignment and person and give
15 me some examples and we'll backtrack our system and say,
16 what's the issue and how did it work.

17 DR. NEEL: It's affecting access
18 to care and that's one of the major problems.

19 COMMISSIONER KISSNER: Right.

20 CHAIRMAN POOLE: Elizabeth wanted
21 to comment on it.

22 DR. PARTIN: I had a problem with
23 that recently. So, since you were asking, I thought I
24 would bring it up.

25 I have two patients - and Neville

1 helped me with this problem, so, I really appreciate
2 that - I want to say that publicly - but two patients
3 who were with Coventry. I live in a rural, under-served
4 area. And, so, access to care is a problem.

5 They needed to switch from
6 Coventry to another MCO because the hospital was no
7 longer going to participate with Coventry. And, so,
8 they received a letter except that they were not able to
9 read the letter. And, so, they saved it for their
10 monthly appointment when they brought it in to me. And
11 the letter said that they had until a certain amount of
12 time to change their MCO except that the deadline had
13 been two weeks ago, but they had held on to the letter
14 because they wanted me to tell them what it said.

15 I did contact Neville and he was
16 able to remedy that situation. However, when they got
17 their new card - and I have been their primary care
18 provider for over ten years - another provider was on
19 the new card. I was on their Coventry card; but on the
20 WellCare card that they received, they listed a
21 physician who had never seen these patients before.

22 I called WellCare and I was able
23 to get that changed, but it took quite a while on the
24 phone. And when you're in the middle of the day trying
25 to see patients, forty-five minutes is a long time, and

1 I did get that changed.

2 Also, one of the patients, she is
3 a diabetic and a hypertensive, she has high cholesterol,
4 and she was on a medication that Coventry was covering
5 but WellCare would not cover without preauthorization.
6 WellCare said that she had to be on Metformin before
7 they would cover this other medication and I had to get
8 it preauthorized. However, the lady has been on
9 Metformin, two grams, for years and that was on her
10 medication list, but they won't fill this medicine.
11 They told me it would take up to seven days to get the
12 medication.

13 And then I just learned yesterday
14 that they won't fill any of her medicine at the pharmacy
15 because they say that it looks like she has coverage
16 from two plans. And, so, I'm supposed to call and fix
17 this for her, and I have no idea who I'm supposed to
18 call and who is supposed to fix it, and I don't know
19 what two insurances they think that she has, but as far
20 as I know and as far as she knows, she only has
21 WellCare.

22 So, this is a whole array of
23 problems that has been going on for over a month. The
24 ladies, like I said, they don't read very well. So,
25 they didn't even realize that they had the wrong

1 provider on the new card because they just didn't. And
2 when they showed the card to me, I realized right away.
3 So, this just kind of feeds into what we've been talking
4 about.

5 DR. NEEL: If I might comment.
6 Commissioner, this is a WellCare problem. I have been
7 working with the president of WellCare for quite a while
8 and they realize the problem. I met with him and took
9 him about a hundred of these. I have a large Medicaid
10 practice and it's continuing.

11 It doesn't happen with Coventry
12 because actually they're not assigning patients as much
13 to PCP. And on many of the cards, it will say
14 unassigned or not needed, which I don't really
15 understand. I haven't talked with Coventry about it.

16 With Kentucky Spirit, they are
17 assigning PCP's and they're almost always accurate.
18 It's a WellCare problem and they don't seem to be able
19 to figure out exactly why it's happened, but it's been a
20 horrible problem.

21 The mis-assignments, for me as a
22 pediatrician, are not to other pediatricians. That's
23 not the problem. They're to PCP's that aren't PCP's.
24 They may be pain management doctors, and as I
25 reiterated, Walmart clinics that are not even accessible

1 at nights and weekends and holidays and things like
2 that.

3 So, we're trying to figure out why
4 are they PCP's in the first place, and they're still
5 trying to figure that out apparently in their software.
6 Maybe they want to comment today. I don't know.
7 They're trying to work on it but they haven't solve the
8 problem.

9 MR. RIDENOUR: Yes, I'll comment.
10 I'm Mike Ridenour with WellCare. I can tell you about
11 an example, and this has to be part of this issue.

12 It was brought to our attention
13 that we had assigned members to chiropractors early on
14 in the process. And we went back and looked at our
15 data, and, sure enough, we had. And it occurred because
16 apparently the forms that we use that go out to
17 providers, there's a box. There's a certification that
18 says are you qualified to be a primary care physician.
19 Well, these chiropractors had checked yes.

20 And, so, as that data was loaded
21 into our system, that's part of the issue. And, so,
22 part of peeling back the onion is going to be going back
23 and looking at the details of what was submitted on
24 behalf of the provider by the provider, making certain
25 that we cross reference that and ensure that we do have

1 people qualified to be primary care physicians linked up
2 as that and weed out any other additional specialties or
3 subspecialties that aren't appropriate for primary care.
4 So, we're committed to working through the problem.

5 CHAIRMAN POOLE: Okay. Disease
6 management, did you want to address that?

7 DR. NEEL: Yes. Under quality of
8 care and you've hired the outside organizations to look
9 at quality, if quality accidentally happens now, it will
10 be wonderful; but right now, it's just access to care.
11 I've said that at previous meetings.

12 I don't think we're to the point
13 now. We hope that we're providing quality care, but
14 with the access-to-care issues that are happening, I
15 think we're not ready to do that.

16 One thing is that primary care
17 providers so far are not getting any data. I know that
18 it's planned and I serve on two of them's Quality and
19 Disease Management Committees, and there are plans for
20 the future and I understand that; but I can tell you
21 that at this point, there's no data, for example, to cut
22 ER utilization, to do chronic disease management. We're
23 just not to that point yet and we're quite a ways from
24 it.

25 And while we're on that subject,

1 if you don't mind, you talk about meetings with the
2 MCO's. I feel as a primary care provider, and I can't
3 speak for all the other providers here, but have you
4 seen the commercial of the Aflac duck who is out in the
5 boat and the holes keep occurring, and I've got all my
6 fingers and all my toes and my nose and there's a new
7 hole.

8 Every morning I go into the office
9 and I wonder which new hole is in the boat, and that's
10 kind of what happens. And you say, well, we need to
11 talk with the MCO's about it; but part of the problems
12 that are occurring are things that occurred because of
13 the things that Medicaid is requiring of the MCO's.

14 And, so, basically, what's
15 happening is that if I had time to meet with MCO's or my
16 staff did, we probably could solve some of these
17 problems, but we don't really have time. We're all out
18 there struggling trying to survive, and I think I speak
19 for most of the other providers here. We're kind of
20 going broke getting paid, if you would.

21 The last thing that occurred was
22 the 1,300 babies. I'm sure you had no idea what kind of
23 a mess you were creating when you did that, and I hope
24 we talk about that a little bit later. But I think we
25 could solve some of the problems, but I wonder if this

1 Council is not the one statutorily required to work with
2 you all and we have all the provider groups.

3 Why could we not be used in a
4 better method to work between Medicaid, provider groups
5 and the MCO's because we feel - and I think I speak for
6 all of us - feel unloved and unused, if you would,
7 because we come and meet and you give us the
8 information, but the slide show that you gave us sounds
9 pretty good from your all's side. My slide show would
10 look very different from this. Okay? And instead of
11 success stories at the end, I'd have a lot of
12 unsuccessful stories at the end.

13 And I don't mean to be critical,
14 but I think this could work better if we worked through
15 us. Can I ask for a comment on that?

16 COMMISSIONER KISSNER: Sure. I'd
17 love to work through you. Bring the issues. You just
18 mentioned that things that Medicaid requires is causing
19 something to happen with the MCO's. So, I can't do
20 anything with that. I don't know what things are. So,
21 let's go line by line and let's talk about specific
22 issues because it may not be us. It may be CMS and
23 Medicaid.

24 The federal government is paying
25 70% of the bill and they require us to do a lot of stuff

1 that we have to do unless we want to put the 70% at
2 jeopardy. So, we, then, turn around and push those same
3 issues onto the backs of the managed care companies
4 because they need to help us respond to what we're
5 required to do from a Medicaid perspective.

6 So, I am more than willing to work
7 through issues, but we didn't pay the claim, didn't do
8 the prior authorization. Medicaid can't answer most of
9 the questions that a provider has about a patient and an
10 interaction with one of the managed care companies.

11 So, all we're doing is
12 facilitating. And during the Health and Welfare
13 session, the word facilitate, you know, you beat me up
14 over it, which I'm fine with. I did not deny the
15 authorization, don't know what reasons were used for
16 that. I do not have the claims payment system. I can't
17 go check what was billed, what was charged, what was
18 denied, what was medically necessary, what's not
19 medically necessary. All of the things that go on with
20 a transaction of a claim, they have the answers.

21 So, we facilitate meetings with
22 the answer people and the impacted providers. We're
23 trying to get them to talk. They bring lists together.

24 We're working with every major--if
25 we need to create a Primary Care Association meeting,

1 which I kind of think we have, that goes on on a monthly
2 basis. We do it with the Hospital Association, we do it
3 with the CMHC's. We're using their designees to say if
4 you've got issues, bring it to your association. The
5 association meets with the MCO's. They share the
6 information. They create logs. They say we're working
7 through the issues and they go literally line by line.

8 So, it's the same issue that just
9 came up. They found out chiropractors self-appointed
10 themselves as primary care and they accepted that as a
11 provider in Kentucky saying I can be a primary care.
12 You could have an OB/GYN say I can be a primary care.
13 You could have other people self-designate as primary
14 care. I'd have to investigate is there actual rules
15 that says to be a primary care, you must do the
16 following services. an a cardiologist be a primary care,
17 if that's your issue. I think the answer is yes, right?
18 Cardiologist could be a primary care if all of their
19 services are heart-related and that's who you see all
20 the time. I don't know. You guys are shaking your
21 head. I think that's the way it could work.

22 So, those are issues. We've got
23 to get them on the table, get them on the log sheet and
24 work through them. That's what we're trying to do.
25 That's what we're trying to facilitate, but the answers

1 have to come from the carriers who took the action
2 that's causing something on your end to not feel right.
3 And that's what we want to do. We want to work through.
4 We want to make this a success. And, so, yeah, I'm more
5 than willing to work through those issues.

6 MS. BRANHAM: Commissioner, I've
7 been sitting here for over a year listening to how the
8 different folks that have come and talked to this
9 committee want to try to help providers resolve issues,
10 but I've yet to see anything really happen.

11 As the doctor said, we are the
12 experts that are here for representing all the providers
13 in the state. Yesterday, at our TAC meeting, there was
14 one MCO provider that was there who does contracts, and
15 the other two were the liaisons from Medicaid to the MCO
16 providers.

17 Now, a year later, we're sitting
18 here and they're asking for the same information that we
19 have given to the MCO representatives over and over and
20 over and the same issues have been occurring.

21 For example, there were a couple
22 of agenda items on our TAC meeting yesterday that have
23 been sitting there on the agenda for over six months,
24 and we had no resolution yesterday again. We have
25 provided multiple specific PHI information to the MCO's

1 and their representatives and they're not being
2 resolved, whether it be system issues or whether it be
3 the issues that resolve around finally getting a prior
4 authorization from an MCO to provide a service and not
5 being paid for that service or being paid partially for
6 that service and then receiving a letter for the payment
7 to be repaid to them because they don't cover that
8 service.

9 If these folks operate in other
10 states, then, I'll tell you, I don't know why they're
11 still there because what they're doing here in this
12 state is not appropriate. Providers are not being paid.
13 Providers are dealing with the same issues that we've
14 been dealing with for over a year. Access to service is
15 being blocked.

16 And when you look at your
17 presentation that you presented, I thought of a couple
18 of questions that relate to that. When you talk about
19 your dashboard and prior authorizations, do you know how
20 many denials were in those prior authorizations, and of
21 those denials, how many were appealed and how many were
22 overturned which resulted in the actual patient
23 receiving services?

24 You said we have \$40 million in
25 savings. Does this number of savings include the

1 outstanding monies owed to providers to date?

2 As I said, the system issues have
3 been there for months upon months upon months upon
4 months, and the MCO's really no longer meet with us to
5 work through these issues. We're looking to the Cabinet
6 to enforce some of the contract areas that they can
7 enforce to make it easier to be a provider in the State
8 of Kentucky and take care of patients.

9 You talked about the usage of
10 scripts related to the fact that the number of scripts
11 are lesser. Well, I think Ron can testify to the fact
12 that that's because they're not being approved. If
13 somebody has to go without their diabetic medication for
14 seven to ten days, I don't think that is anything that
15 we should be happy about.

16 And is there any kind of stopgap
17 measure put in place if the litigation from the State
18 fails with Spirit and all of these outstanding monies
19 are owed to providers for providing the services to
20 ensure that we're going to be paid?

21 These are some of the issues that
22 I have. Again, I have been sitting here for over a
23 year. We are the group who should know exactly what's
24 going on between you guys and the MCO's and we're not.
25 We're kept in the dark.

1 paid by Medicaid. I don't know what the State expects
2 providers to do, I truly don't.

3 Do you want to address any of
4 that? Feel free to.

5 COMMISSIONER KISSNER: The MCO's
6 were not fined. That's a mischaracterization. They
7 provide----

8 MS. BRANHAM: I was quoting the
9 paper.

10 COMMISSIONER KISSNER: I know.
11 I'm telling you it is a mischaracterization of what
12 happened. They were not fined. They were asked to
13 provide a corrective action plan that said, hey, you
14 self-reported that you didn't pay your claims, 95% of
15 clean claims in thirty days. So, what is your plan to
16 fix it?

17 And that's what the Department of
18 Insurance has sent to the MCO's that were affected, and
19 the MCO's have responded and said here's what we're
20 going to do to fix all those things, and the Department
21 of Insurance handles that piece of it. So, that's the
22 process. There is no fine assessed.

23 As the Department of Medicaid, we
24 sped up claims payment and have slowed down claims
25 payment over many years a variety of times. During the

1 ARRA funding, which was enhanced funding, we paid claims
2 very, very quickly because we were getting an enhanced
3 match, and now that has ended. The prior program was a
4 21-day process. We're still paying the claims within
5 thirty days, clean claims within thirty days.

6 This one is a 19-day cash
7 management program. It's part of the State's budgetary
8 program that they have and it's built into our budget as
9 part of how we're going to come in and try to manage to
10 a budget. We've done it in the past. It's happening.
11 Yes, it's happening, and we're doing one day a week for
12 about twenty-two weeks because we're skipping the short
13 weeks between Christmas and New Year's. There's no
14 adjustment during those weeks; but during full weeks, we
15 are moving the needle of payment one day per week for
16 nineteen weeks over the course of about twenty-three or
17 twenty-four weeks.

18 MS. BRANHAM: Don't you think it
19 would have been better advised for providers in the
20 state to have received a letter when you all decided to
21 do this rather than just arbitrarily call and find out
22 why our claims are not being paid? I mean, honestly, I
23 don't understand why we weren't alerted.

24 COMMISSIONER KISSNER: Yes. The
25 communication could have been better on that.

1 service, we're just not going to pay anything because it
2 went towards the Medicare deductible, so, therefore,
3 they are telling us that it's in their contract they
4 don't pay on Medicare's deductible, and I don't know
5 where else recourse I can go to.

6 But basically every single member
7 that's dual eligible that we have that gets home medical
8 equipment - and that's a bunch - ostomy supplies,
9 diabetic supplies, C-PAP supplies, you name it - all
10 those people that get that every year, I'm paying \$140
11 of their first bills for free. I'm eating it.

12 DR. PARTIN: I think it's the same
13 way with the visits, too.

14 CHAIRMAN POOLE: And that's the
15 reason they're telling us is that's by contract that
16 they don't have to pay on Medicare deductible items.

17 COMMISSIONER KISSNER: I think we
18 will follow up. With this specific issue, it's our
19 understanding it is covered and we need to work out with
20 the MCO's. I've got to talk to my experts, but we think
21 this should be covered. We're in agreement with you.
22 It should be covered. It's part of the contract.

23 CHAIRMAN POOLE: One MCO even sent
24 us the penalty for if we tried to get it from the
25 patient, stated what we could be fined and everything

1 else if we tried to collect from a patient but they
2 weren't going to pay it. So, I appreciate that.

3 COMMISSIONER KISSNER: We will
4 follow up with this. We're in agreement that it should
5 be paid.

6 CHAIRMAN POOLE: Could you give us
7 an update on our Medical Director? Is it a part-time
8 Medical Director right now?

9 COMMISSIONER KISSNER: We have Dr.
10 Badgett. He works four hours a week. I don't believe
11 that's enough. So, we're looking to recruit a full-time
12 Medical Director.

13 DR. NEEL: We had asked that you
14 comment on the ACA requirements starting the first of
15 January about primary care reimbursement to 100% of
16 Medicare. When will that happen? Are you discussing
17 that with the MCO's now?

18 COMMISSIONER KISSNER: We are.
19 The timing of this is a little weird. CMS gave us a
20 sample SPA, State Plan Amendment, that says you need to
21 do this, so, here's a sample of a State Plan Amendment
22 that allows you to do it, but you can't submit it until
23 after January. It's effective January. You can't
24 submit the SPA to do it until after January 1st.

25 And we have to pull our data to

1 determine what exactly because it's not a very clean,
2 cut and dried every provider service under this provider
3 type gets an enhanced 100%. It's not that clean.

4 CMS and HHS has had a series of
5 explanation meetings and talked about as people ask
6 questions because every state, every state is impacted
7 by this. So, they keep having meetings and explaining
8 what they meant by this statement.

9 And, so, we attend those meetings
10 and we are looking to pull our data to determine what
11 codes - and they've provided recently some actual codes
12 to say these codes are what would be enhanced to 100% of
13 the Medicare fee schedule, which is the upper payment
14 limit for most intents and purposes. So, here it is.
15 This is the most you can pay is Medicare and we want you
16 to pay Medicare because we want to incent to primary
17 care - that's the concept - and we want them to accept
18 Medicaid members and setting up hopefully expansions of
19 Medicaid in every state. We want you doctors to be
20 willing to do that.

21 So, we're working through it.
22 We're listening to the meetings. We're designing the
23 report which we would pull the data. And once we get
24 the financial impact, we're pulling the MCO data of what
25 they've actually paid in those respective codes, we're

1 pulling our fee-for-service data.

2 And then we have to actually come
3 back and figure out what that is and come back with an
4 adjustment that we need to negotiate with the MCO's
5 because we're paying more. They knew this was coming.
6 And, so, they actually get an increase in their
7 capitation, and that's negotiation that needs to happen
8 because we're paying the docs more, so, we've got to pay
9 the MCO's more so they can turn around and pay the docs
10 more.

11 That's the process and it's just a
12 little--the sequence, it will happen in the first
13 quarter and it will be effective 1/1. It will
14 absolutely be effective 1/1, but it may not actually be
15 implemented until 2/1 or 3/1, but we'll go back and they
16 will re-adjudicate the claims to pay at 100%. It's a
17 little out of sequence but I can't help that.
18 Literally, we had meetings last week with the government
19 and conference calls where they invite lots and lots of
20 states together and talk about the issues.

21 DR. NEEL: When will the states
22 get the money? When will you all physically get the
23 money? You have to say what it is before you will get
24 it, I guess.

25 COMMISSIONER KISSNER: We have to

1 get the SPA approved and the SPA will be submitted with
2 an effective date of 1/1/13. And then once your State
3 Plan Amendment, the SPA, is approved - we're researching
4 the issue - there might actually have to be some reg
5 changes that go through the process of regs the way we
6 pay certain things.

7 And all that has to get lined up,
8 but it will all be effective 1/1, and we won't lose that
9 date. That date will be active. So, when do we
10 actually? We draw down federal funds on I think on a
11 quarterly or a monthly basis.

12 MR. WISE: Daily.

13 COMMISSIONER KISSNER: Daily.

14 Good. So, as soon as we start paying for it, we can
15 then pull the federal share of that down. And they're
16 paying a higher percentage of that because they're sort
17 of forcing it on the states to say we want you to do
18 this and you have to do this. So, we're going to pay
19 more for it, pay more as a bigger percentage of it.

20 DR. NEEL: So, basically what
21 you're telling me is that then the MCO's will be
22 required to reprocess, if you would, the claims that
23 will have been submitted by primary care providers from
24 January 1.

25 COMMISSIONER KISSNER: For a

1 specific code that was authorized to be paid at
2 Medicare, yeah, they would have to go back and say we
3 paid you \$50 and we should have paid you \$58. And, so,
4 they reprocess that and send you the additional \$8. I'm
5 just using those as made-up numbers.

6 DR. NEEL: Because I can tell you
7 that with a lot of us primary care providers, we're
8 still waiting on one of the MCO's to reprocess claims
9 that were to be re-adjudicated from last November and
10 it's not been done. So, I hope it will certainly happen
11 in a quicker period of time.

12 If you say we're going to do it
13 the first of March and they have to reprocess those
14 claims, that could be months and months down the line
15 before the primary care provider ever gets the money,
16 and that's very dangerous in the situation we're in.
17 So, I hope you all do something about that.

18 COMMISSIONER KISSNER: We've got
19 it on our radar. We know it's important. We're working
20 through the issues. To some degree, we wait on the feds
21 for clarification as to what exactly is included and
22 what's excluded and what should be enhanced and what
23 should not. So, we're working through that.

24 This is not an easy answer. It's
25 a good thought. It's just application of the law, we're

1 working through it. It's not a slam dunk but we've got
2 it on our radar. We know it's important. We want to
3 get it done as quickly as possible.

4 CHAIRMAN POOLE: And changing
5 subjects here, I've got to say this. There is no
6 solution to this problem. Neville was Interim
7 Commissioner longer than a lot of Commissioners served.

8 Again, the best thing that can
9 happen in my opinion for Medicaid is to have a
10 Commissioner for a long time because you build those
11 relationships with the MCO's, providers, the recipients
12 and you've got consistency there and you can really
13 build on something where if you've got to change all the
14 time, it hurts. And it's the same thing with the MCO's.

15 I hear this from every provider
16 group, every association out there. There's such a
17 turnover at higher positions with the MCO's, that it's
18 just so difficult. You think you're going to get some
19 change in policy or change in this and there's a
20 turnover.

21 So, I know there's no solution,
22 but I was asked by several people just to mention it. I
23 just wish we could get consistency within the MCO's to
24 where those relationships can be built, and it's just
25 like the same thing with contacting through them,

1 through the state, whatever. If you get people to get
2 together and you're working on a resolution to a problem
3 and then somebody is out of the picture, it just slows
4 things down.

5 Are there any other questions for
6 the Commissioner?

7 DR. NEEL: The 1,300 babies that
8 were assigned to different MCO's from their mothers,
9 that may have sounded like a good way to solve that
10 problem, and I understand it may have been a regulation
11 that was misread. Is that true, Commissioner? They
12 were assigned to different MCO's?

13 The problem is that's been a
14 nightmare for those of us who have cared for those
15 babies. And I can tell you that it seems to me if there
16 was one way that it could have been worked was for the
17 three MCO's to move the money around and not involve the
18 providers because what's happened is that we are all, as
19 pediatricians in particular, are getting letters for
20 recoupment from the first MCO because we correctly filed
21 those claims because babies were under that MCO when we
22 filed them.

23 Now we're having to have that
24 money recouped from us, and then the new MCO that
25 they're going to be assigned to will then pay us

1 with CMS is that if we identify that we did something
2 wrong, we are obligated to fix it. We have to fix it,
3 period. If we pay a claim at \$100 and we realize we
4 should have paid it at \$50, we have to recoup that
5 money, period.

6 In fact, we have to hire firms to
7 audit us to determine if our payments are accurate.
8 That is a requirement that the federal government puts
9 on us because I'm paying 70% of it, so, do it right.
10 And if you make a mistake, fix it. You have to fix it
11 if you identified that a mistake was made.

12 So, we discussed this issue with
13 the MCO's, and although that idea--you know, the idea
14 was definitely discussed of can you guys just shuffle
15 the cards and never let the cards come back to us, but
16 that was not really agreed upon by the MCO's.

17 And, so, the only way was to re-
18 boot the membership and then go through the adjudication
19 process. It's just the way that we had to work it. And
20 I apologize for the--I know it's a pain. I know it cost
21 administrative expense. There's par versus non-par
22 issues. The services were rendered. They get recouped.
23 I have to bill again to get paid. I may not have the
24 exact same contract with every provider, but my hands to
25 some degree were tied by regulatory responsibility to

1 fix it. That's all I can say on that.

2 DR. NEEL: Okay. Thank you.

3 CHAIRMAN POOLE: How are you
4 dealing with the ones that weren't contracted with the
5 one that they had got finally assigned to?

6 COMMISSIONER KISSNER: Well, I've
7 only had a couple of situations where that's popped up
8 and I have specifically sent a memo to the MCO and said
9 there's obviously no way--so, for the most part, and I
10 think you guys would all agree with this, that non-PAR
11 providers are prior-authed - are you correct in that
12 across the board? Yes. Okay. You're good. All right.

13 So, 100% prior authorization is
14 required for all non-par. So, we had a situation where
15 a person was moved from an MCO that had a contract with
16 the provider to an MCO that didn't have a contract with
17 the provider. And I said, guys, there's no way to prior
18 auth a year-ago services. So, I'm asking you to waive
19 your prior auth because that's the intent of this fix.

20 Now, par versus non-par may have
21 different reimbursement issues and that I can't help.
22 The provider made a decision to be par with one and non-
23 par with the others because we have any willing provider
24 laws. So, if any provider wanted to be contracted with
25 any MCO and they're willing to accept the contract and

1 the reimbursement structure, they have to accept them as
2 long as they're practicing within the scope of their
3 licensure.

4 So, we had those situations. I
5 asked the MCO in that specific instance to waive the
6 prior authorization because that's impossible. You
7 can't do a prior auth on a service that was rendered a
8 year ago. And, so, I'll work through that issue with
9 them.

10 CHAIRMAN POOLE: Okay. Thank you,
11 Commissioner, and appreciate your time.

12 COMMISSIONER KISSNER: Thank you.

13 CHAIRMAN POOLE: Let's go ahead
14 with our Technical Advisory Committees. First up is
15 Behavioral Health.

16 REPORT OF BEHAVIORAL HEALTH TAC:

17 MS. SCHUSTER: Good morning.
18 Happy holidays to you all. It's so nice that red is our
19 advocacy color on behavioral health, so, it fits with
20 the season. Good morning. I'm Sheila Schuster serving
21 today as the spokesperson for the Behavioral Health TAC.

22 Our TAC had its third meeting on
23 December 3rd with four of our six members present as
24 well as nine individuals from the behavioral health
25 community.

1 The number one concern - and this
2 is the broken record part of this - from the behavioral
3 health community continues to be the difficulty in
4 obtaining appropriate medications without experiencing
5 barriers to access. As Ron and others of you know,
6 access to medication is the foundation of recovery,
7 particularly for people with severe mental illness.

8 Consumers and family members see
9 the problem when they go to the pharmacy and cannot get
10 their medication. Providers describe it as burdensome
11 prior authorization processes with all three of the
12 MCO's.

13 Perhaps the biggest concern
14 expressed was from consumers and family members who
15 describe increasing frustration and a growing sense of
16 hopelessness as consumers with persistent mental illness
17 try to navigate the MCO phone system. They have been
18 told to communicate directly with the MCO's to resolve
19 these problems, and it's almost impossible for them to
20 make that contact.

21 They are literally beaten down by
22 the managed care system that is supposed to be serving
23 them. Their recovery, I think, is in jeopardy.

24 Our question is this. How do
25 these devastating problems with prior authorizations,

1 delays and denials of care get addressed in a systemic
2 way? Even if each and every individual consumer is
3 dealt with by that particular MCO, and there are
4 hundreds and thousands of them out there, how do we get
5 their needs met across the system? What about those who
6 have no support system to help them navigate that
7 horrendous call system?

8 Why are the MCO formularies not
9 the same? Why are the MCO P&T Committees hidden from
10 view? What are the criteria for requiring a PA on
11 medications? Why can't there at least be a consistent
12 PA form across the MCO's and across the state? What
13 happens to the PA's that have been submitted?

14 The lack of information and the
15 lack of transparency blankets the managed care system in
16 a cloak of impenetrable secrecy, and with secrecy comes
17 lack of responsiveness and avoidance of accountability.

18 Consumers and family members are
19 beaten down and they're scared, quite frankly.
20 Providers of behavioral health services are beaten down
21 and they are going broke. They are dealing with again
22 an incredibly burdensome PA process countless times a
23 day for medications, for therapy visits, for sufficient
24 days in the hospital to achieve stabilization and
25 treatment, particularly for children, in short, for

1 every level of service and treatment that is needed.

2 They are carrying unpaid claims,
3 which I know many of you all as providers - probably all
4 providers are carrying - while incurring increased
5 administrative costs.

6 I cannot state strongly enough how
7 frustrating and how anxiety-producing it is to
8 consumers, family members, advocates and providers that
9 these same barriers to care continue to exist.

10 We are hopeful and appreciative of
11 the efforts that the MAC is making to continue to push
12 for data and for answers to these questions. We in the
13 behavioral health community will continue to push for a
14 forum where these issues can be addressed at a systems'
15 level. All of us, I know, will urge transparency and
16 accountability.

17 On behalf of the Behavioral Health
18 TAC, I will repeat the request that we made in September
19 for the Cabinet to enforce the MCO contracts and for
20 Medicaid Commissioner Kissner to bring transparency to
21 the process by sharing with us and with the MAC these
22 data points: numbers of request for services that are
23 denied are reduced, PA denials and their outcomes,
24 numbers of appeals and their outcomes, numbers of fair
25 hearings and their outcomes, numbers of non-formulary

1 medication requests and their outcomes, numbers of
2 admissions and re-admissions to hospitals for behavioral
3 health issues, particularly for children, numbers of
4 days of therapeutic rehabilitation programming that are
5 actually approved for members.

6 Finally, we bring again to the
7 attention of the MAC and the Commissioner ongoing
8 issues: the long waiting list for services for
9 individuals who have a traumatic brain injury or TBI,
10 the lack of movement from the MCO's in addressing the
11 integration of physical health and behavioral health
12 services, and the lack of response from the MCO's in
13 reimbursing for services that could be provided by a
14 cadre of trained and certified mental health peer
15 support specialists.

16 On behalf of our TAC, and I'm sure
17 for others who are here in the audience, I would request
18 that Commissioner Kissner's written report to you all be
19 shared electronically with all of us. Lynne Flynn from
20 the Department does a great job of communicating with us
21 about MAC meetings and so forth, and I would request
22 that that report be disseminated electronically.

23 Finally, I'm delighted that there
24 are success stories, but where are the reports of the
25 failures? I would invite any of you, the MCO's,

1 Commissioner Kissner, to come to Participation Station,
2 a completely consumer-run, consumer drop-in center where
3 recovery is happening in Lexington and sit with these
4 folks as they try to navigate the communication system
5 to get to the MCO to get their issue resolved. We have
6 some representatives here from Participation Station and
7 I'm sure they would be happy to talk to any of you about
8 arranging such a visit.

9 I think we need to keep track of -
10 and I hate to call them failures - but the problems that
11 are out there as well as the successes. And I
12 appreciate very much the work that you all are doing,
13 Ron, and all of you on the MAC. This is the forum where
14 all of this should be happening. And the TAC's, at
15 least our TAC feels like, again, we're kind of whistling
16 in the dark and trying to send messages over to you all.
17 And I know you're trying to send them to the Medicaid
18 Department and to the Secretary because I think the
19 voice of consumers and family members are not being
20 heard and they need to be.

21 I appreciate it very much. Thank
22 you.

23 CHAIRMAN POOLE: Have you
24 submitted those suggested statistical requirements that
25 you all would like to see? Have you submitted those to

1 Medicaid?

2 MS. SCHUSTER: I haven't submitted
3 them in writing but I will do that and I will get you
4 all a copy of it as well.

5 CHAIRMAN POOLE: Sharley, if you
6 can help me to get this out to the email list of this
7 report here.

8 MS. HUGHES: I will. And just for
9 everybody to know, we have set up a MAC website where
10 we're putting all the documents and the minutes and
11 everything out there also.

12 MR. CARLE: And, Ron, what could
13 be done, since they all have subcontractors that provide
14 the mental health aspect of it, they could supply that
15 to them in the form of the balanced scorecard just like
16 ours. They could be two separate reports.

17 CHAIRMAN POOLE: Right.

18 MS. SCHUSTER: I would be happy to
19 submit my remarks if it's appropriate for that to be
20 posted on the website. We'd be happy to do that.

21 CHAIRMAN POOLE: I've talked to
22 Sheina, who is not here today, unfortunately, about that
23 group of statistics that would be extremely helpful in
24 measuring outcomes, period, and that's what we're all
25 about.

1 MS. SCHUSTER: The overwhelming
2 fear, I think, for all of us is that we have an almost
3 50-year-old public community mental health system that
4 is under such siege between the Medicaid managed care
5 and the pension system, that we really wonder if we're
6 going to continue to have that system. And I know that
7 many of you as providers have interacted with that
8 system.

9 And, so, part of it is, maybe in a
10 year or two, we get the MCO's to actually approve the
11 services, but we don't have a provider system left out
12 there. One of the CMHC's said that for every MCO they
13 have to deal with, it probably costs them \$10,000 a
14 month in administrative costs.

15 So, if you multiply by three or by
16 whatever the number if they're there in the Passport
17 region or the Region 3 and it's going to be four, you
18 know, nobody can sustain that. And our Medicaid rates
19 in the community mental health centers have been frozen
20 at the 1999 rate. So, we're trying to see more people
21 and do more services, but the question really is whether
22 we're going to have a system to deliver those services.
23 That's really the fear.

24 Thank you.

25 CHAIRMAN POOLE: Do you have that

1 address of the website?

2 MS. HUGHES: I don't have it
3 handy, but I can send it out to everybody.

4 CHAIRMAN POOLE: Please do. Thank
5 you.

6 Next up is Children's Health.

7 AUDIENCE: No report.

8 CHAIRMAN POOLE: No report.
9 Consumer Rights and Client Needs. Next up is Dental.

10 REPORT OF THE DENTAL TAC:

11 DR. RILEY: The Dental TAC met
12 this morning and that's why I was late. We addressed a
13 number of issues. Many of them are continuing issues,
14 but there were a couple of new things on the plate
15 today.

16 The biggest one is that
17 CoventryCares has decided that the dentists are overpaid
18 and, therefore, will be getting a fee reduction of the
19 published Medicaid schedule that we have been using for
20 a number of years. The oral surgery will receive a 5%
21 reduction in fees, general practice and orthodontics a
22 10% reduction.

23 Where they have a shortage of
24 dentists and are concerned about keeping the network
25 viable, those will receive no reduction.

1 It kind of came as a surprise
2 because under previous MCO contracting, the MCO
3 contractor was allowed to add either fees or procedures
4 to the published Medicaid regs but not lower fees or
5 detract from the system.

6 So, dentists were kind of caught
7 unaware as to the legality of this new contracting.
8 And, of course, it does create a potential for denial of
9 access when we were already on a tight budget from not
10 having any fee increases for many years now. And then
11 to have them cut, it's going to definitely create an
12 access issue.

13 One of the other issues that was
14 discussed at length was that some of the MCO's are using
15 gift cards as enticements to have patients participate
16 in their exams, various types of exams, whether it be
17 dental, vision or what-have-you.

18 Especially when fees are being
19 cut, if gift cards are being used as an enticement, it
20 kind of makes the provider feel that they're not very
21 important in that equation. And one of the suggestions
22 that the Dental TAC wanted to send to the MAC is the
23 development of a no-show code. This would be a non-
24 reimbursed code, however, it would be a code that could
25 be used to track whether the efficacy of the enticement,

1 whether the carrot that's being dangled to increase
2 patient participation in services that are already free,
3 whether that carrot is actually working or not because
4 if you had a procedure code that would document no
5 shows, either medical or dental or any other type of
6 service, then, you could see whether that gift card
7 policy is actually being effective.

8 Other than that, the dentists are
9 pretty much feeling like Ms. Schuster just said, kind of
10 beaten down, banging our heads against the door and not
11 much is happening. And that's it.

12 CHAIRMAN POOLE: Thank you. Up
13 next is Nursing Home Care. Kip. It looks like you're
14 up with Home Health Care.

15 REPORT OF HOME HEALTH CARE TAC:

16 MR. BOMAR: Good morning and
17 thanks for the opportunity to be here. Probably
18 something similar to the happy tales from Behavioral
19 Health and Dental TAC, we had our TAC meeting yesterday,
20 and, similarly, we have a combination of continuing
21 issues such as the difficulty in getting claims paid.

22 According to our survey, we found
23 that on average, that the home health providers have
24 been paid 57% of the dollar value of claims submitted to
25 Coventry, 41% from Kentucky Spirit, and 69% from

1 WellCare, certainly far different than the 97% that is
2 touted.

3 And I think part of the reason
4 that that occurs, if you submit a claim for \$1,000 and
5 they pay you eighty-seven fifteen of it - and by that, I
6 mean \$87.15 - they count that as a clean paid claim even
7 though that that is not a paid claim.

8 So, one of the things that we are
9 in the process of developing an open records' request
10 because we haven't been able to get this information
11 from either the MCO's or from Medicaid voluntarily to
12 date is the dollar value of claims submitted versus the
13 dollar value of claims paid because home health agencies
14 have been successfully billing Medicaid for forty years
15 without a problem.

16 And by comparison, when we have
17 done surveys, the Medicaid reimbursement rate of claims
18 paid versus claims submitted has ranged anywhere from 85
19 to 95%. So, clearly it's an issue that rests with the
20 MCO's.

21 We've also had real problems with
22 the dual eligibles. There are certain services that
23 Medicaid covers that we've never been required to bill
24 Medicare for. We just have a place on the application
25 to mark; but yet with Kentucky Spirit, they're requiring

1 agencies to bill Medicare first and get the denial, and
2 they know that this has been an issue for at this point
3 at least seven months now and we've been unable to get
4 that issue resolved.

5 And I really like the idea of an
6 increased use of the MAC to help be able to resolve
7 these issues because we have been bringing a lot of
8 these issues up with our TAC, and sometimes we had been
9 able to get certain issues solved but other issues we
10 have not.

11 I do want to say that our agencies
12 that have been working with Passport, though, we've had
13 no problems. That has worked well and hopefully that
14 will be able to continue. And we'd like to be able to
15 see improvement on other issues that we're working with
16 in regards to that.

17 One of the new issues that we've
18 had arise with Kentucky Spirit is requiring an hour of
19 discharge from a hospital before being able to put this
20 to bill for a home health agency, even though that's
21 something that they wouldn't necessarily have access to.
22 And, once again, it's just delaying access to the start
23 of care and increased difficulty in getting paid. We've
24 got a lot of providers that are really struggling with
25 cash flow; and with the Cabinet's decision to kind of

1 slow down the timely reimbursement, it really hits the
2 agencies at a difficult time because the reimbursement
3 from the MCO's have been so poor.

4 But that would be, I think,
5 probably the conclusion of our report, unless Sharon has
6 anything else that she would like to add to that.

7 CHAIRMAN POOLE: Thanks for your
8 report, Kip.

9 Up next is Hospital Care.

10 REPORT OF HOSPITAL CARE TAC:

11 MR. CARLE: The Hospital
12 Association appreciates our weekly meetings with the
13 MCO's, and I think Steve Miller is here from the KHA to
14 give a very brief report.

15 MR. MILLER: Good morning. My
16 name is Steve Miller with the Kentucky Hospital
17 Association, and I have basically three points to make
18 today. Two of them are very consistent with what you
19 have already heard.

20 As it relates to the meetings, as
21 Mr. Carle pointed out, we are now meeting with the MCO's
22 on a monthly basis. It started on a weekly basis back
23 in February. After about four or five months, it went
24 on a bi-weekly standpoint and now on a monthly time
25 frame.

1 period of about nine months, things are not being paid
2 as timely or as well as they had been before.

3 The third item which has not been
4 mentioned here today as it relates to cancellation
5 notices and some of the negotiations taking place with
6 hospitals, since September 30th, approximately twenty-
7 five hospitals have received termination notices from
8 WellCare as it relates to the need to renegotiate
9 contracts or contracts will be terminated basically in
10 the first quarter of 2013.

11 We believe that will create a
12 major access problem. At this point, it hasn't been
13 addressed, the reason being is the cancellation has not
14 yet happened. We know that the cancellation is
15 scheduled to take place, again, if terms are not agreed
16 to, at terms that are less than the Medicaid rate.

17 Much like Dr. Riley pointed out
18 earlier, we, too, feel those same sort of pressures and
19 those same sort of aggravations. That's the environment
20 that hospitals are dealing with today and it's similar
21 to what you've already heard. Thank you.

22 CHAIRMAN POOLE: Thank you, sir.

23 REPORT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

24 TAC:

25 MS. ROBB: Good morning. My name

1 is Darcie Robb, and I am staff for the state
2 Developmental Disabilities Council. In the interest of
3 transparency, I want to be clear with you. I am not a
4 member of the IDD TAC, but the members asked me to
5 present today because I attend meetings with staff and
6 they were unable to make it.

7 Our TAC held our second meeting on
8 December 5th. We also held an initial organizational
9 meeting on September 19th. There are six members
10 currently serving and we're seeking the remaining three
11 that will bring our TAC up to its full complement of
12 nine.

13 There were two major topics
14 discussed at the IDD TAC meeting in December, and those
15 are the upcoming changes to the Michelle P. Waiver, as
16 well as the EPSDT Program. EPSDT stands for the Early
17 and Periodic Screening, Diagnosis and Treatment.

18 Regarding the Michelle P. Waiver,
19 the BH/DID staff presented the meeting attendees with a
20 crosswalk of the proposed Michelle P. Waiver services
21 and rates. And now except for the fact that Michelle P.
22 does not provide residential services, the services and
23 rates do mirror the current proposed SCL Waiver.

24 The DMS staff at that meeting also
25 clarified that the plan is, once the proposed SCL

1 changes have been approved - that's kind of the big
2 topic going on in the IDD world these days - then the
3 plan is that the Michelle P. Waiver changes will be
4 formally proposed. So, that was just sort of an
5 informational item.

6 Regarding EPSDT, on October 1st,
7 letters were sent to the SCL providers who provide
8 services under the Michelle P. Waiver, and that letter
9 said that as per CMS, occupational therapy, physical
10 therapy and speech therapy for children under 21 would
11 now be provided through the EPSDT Program, no longer
12 through the waivers. DMS is offering SCL providers a
13 fast-track option to become EPSDT providers.

14 DMS staff at this meeting gave
15 committee members the one-page application sheet and the
16 matter was discussed in a bit more depth. The rates
17 under the EPSDT Program are extremely close to the OT,
18 PT and speech therapy rates in Michelle P. The intent
19 is for the providers to continue providing services as
20 they currently are provided.

21 And unlike Michelle P., EPSDT does
22 allow for "prevention of regression". Now, also the
23 EPSDT Program does not have a fixed allotment of service
24 units which is key. The determination is based on
25 medical necessity, prior authorization and inclusion and

1 plan of treatment.

2 And, so, although I think it's
3 fair to say that initially there have been some
4 nervousness on the part of some of the committee members
5 of this change, the committee members were very
6 appreciative of the information. And members expressed
7 thoughts that under these conditions, receiving the
8 occupational therapy, physical therapy and speech
9 therapy under EPSDT will actually be a good thing for
10 Kentucky and for those children served.

11 Some of the issues that are going
12 to be looked into and discussed at the next meeting on
13 behalf of the TAC member requests were will children on
14 the Michelle P. Waiver get their behavioral services
15 through EPSDT or will they continue to be served through
16 the waiver?

17 The second question is how will
18 children without private insurance receive ABA services
19 or services for autism and that is per House Bill 159
20 which is the autism bill that was passed regarding
21 insurance coverage that went into effect the start of
22 2011.

23 The third question about the
24 credentialing program in the proposed SCL regulations,
25 whether or not this can be used for new hires once the

1 regulation goes into effect or whether it's just for
2 current staff. That's a question that's being looked
3 into on behalf of member questions.

4 The latest updates on the new HCB
5 Residential Waiver, and that's a waiver that's not yet
6 in existence, but it's intended for individuals who are
7 transitioning out of institutions under the Money
8 Follows the Person Program. And as of our meeting last
9 week, that waiver was pending approval from federal CMS.

10 And the final item was the members
11 wanted to have information on the latest updates of
12 available SCL slots.

13 So, that is a summary of the
14 discussion of our IDD TAC meeting, and I thank you for
15 your attention. I'd be happy to answer any questions.

16 MR. WHALEY: Darcie, do you have a
17 time frame right now in regard to the rate changes with
18 Michelle P.? We've heard several dates thrown around
19 and I don't know what the current situation is.

20 MS. ROBB: That's a good question.
21 From what I understood, there are not any set dates. As
22 I'm sure you are aware, the SCL Program is currently
23 entering the legislative process.

24 So, what DMS staff had told our
25 committee was that they want to wait until the SCL

1 changes are finalized and then they plan to introduce
2 Michelle P. rates. And I think it's because the process
3 works,-----

4 MR. WHALEY: It's pretty
5 convoluted.

6 MS. ROBB: -----I don't have a
7 sense of when that is going to be.

8 MR. WHALEY: Thank you.

9 CHAIRMAN POOLE: Another possible
10 suggestion for you, the new guidelines for autism
11 diagnosis are due out next year.

12 MS. ROBB: The DSM-5?

13 CHAIRMAN POOLE: Yes. And I am
14 really interested in how they're going to break that
15 down and how it's going to impact coverage of services
16 for those. So, I don't know if that's something that
17 you can put on your agenda just to look into. I don't
18 know what kind of preliminary information is out there.

19 MS. ROBB: We did discuss that
20 briefly, although not in the context of the TAC. My own
21 group, the Commonwealth Council, did look into that. I
22 don't know if you would be interested in any information
23 from that.

24 CHAIRMAN POOLE: Yes.

25 MS. ROBB: We had looked into that

1 because, frankly, my Council members were not sure
2 whether to be concerned about the upcoming changes
3 proposed or not. And essentially the changes are that
4 Asperger's Syndrome, which is currently recognized as
5 its own thing, is going to be kind of melded into the
6 autism spectrum diagnosis.

7 I can tell you my Council members
8 had some discussion about it and ultimately at this time
9 did not feel a need to necessarily be concerned. And,
10 again, this is coming from my Council and not from the
11 TAC, but because a lot of folks with Asperger's don't
12 necessarily receive services, they receive them in the
13 perspective brought up of, well, if you are considered
14 to be on the autism spectrum, but some folks might
15 actually be eligible for services where they hadn't been
16 before.

17 So, I agree. You're right. I
18 think that's something we need to keep an eye on, but at
19 least initially - and, again, this is coming from my
20 group, the Council, not from our TAC - that wasn't
21 something we were initially concerned about, but I do
22 agree, we do need to keep an eye on that.

23 CHAIRMAN POOLE: Thank you.

24 DR. NEEL: Ron, I just might
25 comment as a pediatrician. As autism spectrum has

1 widened except for Asperger's, if you would, it's
2 becoming more and more difficult for us to get those
3 children evaluated. The Weisskopf Center, the only
4 place in Kentucky that we're aware of that actually does
5 those evaluations, will not take Medicaid, will not
6 accept any of the three MCO's unless somebody can direct
7 me there. So, we have to get them in in some other way.

8 And the length of time, even when
9 they were seeing them, was as much as a year before we
10 could get children evaluated, not even to talk about any
11 treatment services, medications or that sort of thing.
12 So, it's becoming an impossible situation for us all
13 over the state.

14 MS. ROBB: Thank you for that
15 information. I think that's definitely something that
16 our committee members would want to talk about. I
17 couldn't predict a plan of action, but thank you for
18 sharing that with me. I'll be sure and pass that on.

19 CHAIRMAN POOLE: Thank you.

20 Nursing Services.

21 DR. PARTIN: There was no meeting.

22 CHAIRMAN POOLE: Optometric Care.

23 Therapy Services.

24 REPORT OF THERAPY SERVICES TAC:

25 MS. TERRY: I'm Kathy Terry. I

1 work with EPSDT in DMS, and I am presenting a report
2 prepared by Beth Ennis, the Chair of the Therapy
3 Services TAC.

4 The TAC has had face-to-face
5 meetings once a month in addition to--well, had one
6 face-to-face meeting and had monthly phone meetings
7 since the last Medical Advisory Committee.

8 We continue to progress with
9 regulation recommendations which the committee hopes to
10 provide to the Cabinet early next year. One recent
11 issue brought to the attention of the committee is the
12 shift of therapy coverage from the Michelle P. Waiver to
13 EPSDT special services.

14 Children with Down's Syndrome,
15 autism and cerebral palsy, as well as many other
16 diagnoses currently receive the services through their
17 Michelle P. Waiver Programs, and these services will
18 need to shift to EPSDT providers according to a letter
19 that was sent to the providers by April 1st.

20 While the committee understands
21 the federal regulations that mandate this shift, the TAC
22 is concerned about the lack of EPSDT providers available
23 to handle the shift by April 1st. Several regions in
24 Kentucky have reported a lack of EPSDT providers
25 available to cover these children. And those who are

1 currently providers have waiting lists prior to the
2 shift occurring.

3 The committee strongly encourages
4 the Cabinet to address the complicated process of
5 becoming a provider prior to this change occurring. And
6 we have contacted several other TAC's regarding this
7 issue and they have reported that they haven't gotten
8 any responses.

9 CHAIRMAN POOLE: Thank you for
10 your report. Physician Services.

11 REPORT OF PHYSICIAN SERVICES TAC:

12 DR. NEEL: Physicians have asked
13 me to bring this to the committee, and that is this, is
14 that the bottom line of all of this is reimbursement for
15 all of us to survive, for recipients to be seen, for
16 Medicaid to make budget, and for the MCO's to obviously
17 be profitable.

18 One would assume that the three
19 companies that were picked to provide services in the
20 state had track records in other states and, therefore,
21 it was thought that they would be the best three
22 companies to provide Medicaid managed care for Kentucky.

23 So, the larger issue is, is did
24 they base their bids upon data that may have been flawed
25 in some way because although the companies have all said

1 that they expected to lose money possibly in the first
2 year or so of the contract, it would appear that they're
3 losing more money than they had anticipated.

4 Is that based upon the fact that
5 they bid a too-low a bid based upon data they were
6 given? Does it have to do with changes in utilization?
7 I don't know the answers to that.

8 But physicians are particularly
9 concerned because the contracts for the first year were
10 basically for 100% of Medicaid and that is already
11 starting to change. The primary care physicians,
12 because of ACA, as we've talked about earlier, will be
13 paid 100% of Medicare. And unless that changes in the
14 Congress, it looks like that that will protect somewhat
15 the primary care physicians in Kentucky.

16 However, there is already evidence
17 in new contracting to specialists that there will be
18 drops below 100% of Medicare, and we're hearing figures
19 anywhere from 85 to 95% of Medicaid.

20 Now, that creates a particular
21 problem for access for all of us and affects all the
22 providers because I live in the fourth largest city in
23 the state, and already two groups have come to me this
24 week and said - and they're important groups that I
25 refer to as specialists - that they will no longer see

1 Medicaid patients, that they can't afford to see them
2 under the amounts that they will be paid.

3 Therefore, access to care starts
4 to become much more difficult. And I don't know whether
5 the MCO's will be willing to comment, but I fear that
6 if, as we are being told anecdotally that they are
7 losing money and will continue to lose money, how can
8 that problem be solved unless somehow Medicaid provides
9 more money to each of the MCO's because that's going to
10 filter down to all of us.

11 And I wanted to make that very
12 clear to this Council meeting because I think it sort of
13 makes all the other problems pale if it starts at the
14 top and is a problem. And I don't know if any of the
15 MCO's would like to comment, but I certainly wanted to
16 bring that to everybody.

17 CHAIRMAN POOLE: Does anybody care
18 to comment at this time?

19 MR. COPLEY: On that issue
20 specifically? My name is Jon Copley with Kentucky
21 Spirit, and I will say our statutory filings are out
22 there now for the first three quarters of this calendar
23 year, and we are definitely losing a lot of money. So,
24 that's out there with the Department of Insurance, with
25 the SEC for everyone to look at and it's indeed true.

1 Under our circumstances with the
2 legalities and everything, that's about as far as I can
3 go, but I can definitely comment on that and I can
4 appreciate the perspective that maybe more money needs
5 to be put in the system for the MCO's and providers.
6 Thank you.

7 CHAIRMAN POOLE: Thank you. Up
8 next is Podiatric Care. Primary Care. Pharmacy and
9 Therapeutics Advisory Committee.

10 REPORT OF PHARMACY AND THERAPEUTICS ADVISORY COMMITTEE

11 TAC:

12 MS. PURVIS: My name is Casey
13 Purvis, and I am with Magellan Medicaid, and I am their
14 Provider Relations Manager.

15 As far as our updates go, the Drug
16 Review Management Board has not met since the last time
17 you all convened.

18 Pharmacy and Therapeutics recently
19 met on November 15th and we covered anti-convulsants,
20 anti-psychotics, stimulants and medications related for
21 depression.

22 The meeting went very well. We
23 are currently waiting on the final decisions for the
24 Preferred Drug List, and we expect those to be produced
25 in the next two weeks, and we're only anticipating some

1 minor changes. So, that's about it for us.

2 CHAIRMAN POOLE: Have your
3 providers in your long-term care facilities gone to the
4 weekly dispensing yet or is it still a monthly
5 dispensing on the long-term care?

6 MS. PURVIS: It depends. Like
7 their controls, it is still four a month.

8 CHAIRMAN POOLE: Okay. I didn't
9 know. I was wanting to ask you about the impact that's
10 had on costs, being it has gone to a weekly dispensing.

11 MS. PURVIS: No, it has not, but,
12 yes, it has been with that, that it's still discussed,
13 yes.

14 CHAIRMAN POOLE: Thank you, ma'am.
15 Can I hear a motion or anything on working with the
16 MCO's and get the MCO's to have a no-show code put in
17 place to keep up with the statistical data for dental
18 visits so we can look at the impact that the gift cards
19 are having?

20 DR. RILEY: So moved.

21 MS. BRANHAM: Second.

22 CHAIRMAN POOLE: Second by Sharon.
23 All those in favor, say aye. Any opposed? Motion
24 passes.

25 Anything else under Old Business?

1 Approval of our last meeting minutes on 9/25.

2 DR. NEEL: Move they be approved.

3 DR. RILEY: Second.

4 CHAIRMAN POOLE: All those in
5 favor, say aye. Any opposed? Minutes are approved.

6 Anything under Old Business? New
7 Business. On the 2013 meeting schedule, Sharley, if I
8 can put a deadline on you and I getting together and by
9 the first week of January, having dates put out there.
10 You and I will work together and I will be polling our
11 group here, too.

12 Obviously, the sooner the better
13 because of appointment schedules for providers that have
14 the appointments. So, I will put that responsibility on
15 myself to get those out soon.

16 Anything else under New Business?

17 DR. NEEL: Ron, should this
18 Council consider meeting more frequently with the MCO's
19 and/or the Department of Medicaid Services because, for
20 this system to be sustainable and for us to be able to
21 provide quality healthcare to the Medicaid recipients in
22 Kentucky, we've got so many problems that we need to
23 solve, we all have to survive through this. The MCO's
24 have to. The Department of Medicaid has to live with
25 its budget, and I understand the problem that the

1 Legislature has.

2 But, on the other hand, we can't
3 have the most needy in Kentucky which is a fifth or more
4 of our population not receiving medical care. We were
5 announced this week that we're 44th in the nation,
6 almost the sickest state. Thank God for Mississippi,
7 Louisiana and whoever else is down there. But we've got
8 to improve. We're just going to be in this morass of
9 sickness that we're in if we don't improve, and we can't
10 do it with what's happening now. We've got to improve
11 it.

12 And, so, it looks like we need to
13 meet with the MCO's. We can't do it once a quarter, I
14 don't think. I don't want to give up time to do it,
15 but, on the other hand, we all have to do it. We're
16 committed to it. I just would like to propose in some
17 way that we consider meeting more frequently with the
18 MCO's. The hospitals are meeting, did you say weekly?

19 CHAIRMAN POOLE: Monthly.

20 DR. NEEL: Monthly. Well, we
21 certainly can't meet any more often than that but we
22 certainly need to meet more often than we are.

23 CHAIRMAN POOLE: I know Sharon has
24 said the same thing before. Would we like to at least
25 start--obviously with the new Affordable Care Act coming

1 out the first of this next year, different things being
2 implemented with it, it's going to have an impact.
3 Whether our Governor decides to get on full board with
4 that is going to have an impact.

5 So, I think there's a lot of
6 things that we're going to need to meet. So, would you
7 all like me to propose at least every other month; and
8 then if we see the need to set it up sooner, depending
9 on our needs, would that be okay?

10 MS. BRANHAM: I'm in agreement
11 with that because the success has to come from us
12 working with the MCO's and the Cabinet in order to
13 provide the care to the population that we have been
14 charged to do.

15 We have been sitting here for a
16 period of time since we have had managed care in the
17 state and I don't feel like we've accomplished a whole
18 lot. I feel like we're dealing with the same issues we
19 were dealing with when we said let's don't implement it
20 until we get more prepared.

21 So, I'm willing, but I also would
22 like to say that I think it is the Secretary's and the
23 Commissioner's responsibility to use this group of
24 experts to assist them in making managed care successful
25 in Kentucky. And whatever we need to do, I'm willing to

1 do it.

2 CHAIRMAN POOLE: So, would that be
3 a good enough, to try to do it six times a year instead
4 of four times a year, at least for now and see how it
5 works?

6 DR. NEEL: I would certainly like
7 to see us meet within a couple of months from now, if
8 necessary, and then we can gauge it, depending on what
9 kind of success or problems we see because the MCO's
10 have problems, too, and we don't get a lot back from the
11 MCO's in these meetings. And I'm not exactly sure.
12 Grant it, it's a public forum, but I guess any meetings
13 we have will be a public forum, but we're all going to
14 have to be honest with each other about where the
15 problems are.

16 And if they don't have the money
17 to provide the providers with the kind of remuneration
18 they're going to have to have, then, we've got to go
19 back to the State and ask for more money, but we can't
20 allow healthcare to slip any further than it is now.

21 MS. BRANHAM: I would concur.

22 CHAIRMAN POOLE: Any other New
23 Business? A motion to adjourn.

24 MR. CARLE: So moved.

25 DR. NEEL: Second.

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CHAIRMAN POOLE: Thank everyone
for coming.

MEETING ADJOURNED