

ORIGINAL

CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

REGULAR MEETING

March 22, 2012
10:00 A.M.
Room 125, Capitol Annex
Frankfort, Kentucky

APPEARANCES

Ron Poole, R.Ph.
CHAIRMAN

Donald R. Neel, M.D.
Elizabeth Partin, ANRP; NP
Barry A. Whaley
Susanne Watkins, O.D.
Sharon A. Branham
COUNCIL MEMBERS PRESENT

CAPITAL CITY COURT REPORTING

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APPEARANCES
(Continued)

Mr. Russell Harper
COVENTRYCARES

Mr. Marty White
KENTUCKY SPIRIT

Mr. Mike Minor
WELLCARE OF KENTUCKY

Mr. Nick DeAndre
PASSPORT HEALTH PLAN

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1 CHAIRMAN POOLE: Welcome, everyone,
2 to the Advisory Council for Medical Assistance. We will
3 call the meeting to order.

4 (INTRODUCTION OF COUNCIL MEMBERS)

5 CHAIRMAN POOLE: And if we could have
6 the MCO's introduce themselves.

7 MR. HARPER: Russell Harper of
8 CoventryCares.

9 MR. MINOR: Mike Minor with WellCare.

10 MR. DeANDRE: Nick DeAndre with
11 Passport.

12 MR. WHITE: And I'm Marty White with
13 Kentucky Spirit.

14 CHAIRMAN POOLE: Thank you. We're
15 going to have to skip the approval of the minutes until we
16 get a quorum here. So, let's go ahead and get into the
17 report. Acting Commissioner Wise.

18 REPORT OF CABINET FOR HEALTH AND FAMILY SERVICES,

19 DEPARTMENT FOR MEDICAID SERVICES:

20 COMMISSIONER WISE: Good morning,
21 members. Thank you, Mr. Chairman. I was asked to give a
22 status on managed care implementation and I thought about
23 that characterization, and I think the answer is steady
24 progress but still not progress at the pace we would have
25 hoped for.

1 By that, I mean we have our issue
2 logs that we have, specific logs for some programs, master
3 logs for other programs that have multiple programs on them
4 that shows the issues we have. And as we look down those
5 and go through those weekly, we see that many issues are
6 resolved but many issues aren't resolved, and we continue
7 to work on those daily.

8 We think we're around the corner and
9 better times are ahead. Based on all the evidence we have,
10 we're rapidly getting to where we need to be but still not
11 satisfied with where we are.

12 The bigger issues that remain are
13 there are still some provider who are having payment
14 issues. It's very concerning to us. When providers
15 contact us about those issues, we work with them. We
16 either try to get the MCO's to immediately address those
17 issues or in some cases the MCO's have done interim bridge
18 payments to tie that provider over until all the claims
19 issues can be worked out.

20 We've also noticed that each MCO has
21 their own strengths and weaknesses, and it tends to go
22 programmatically. Each MCO has at least two programs, like
23 pharmacy, physician, that they're better at than the other
24 two. Each of the MCO's has a program that they're not
25 doing as well as the other two. So, as you look at our

1 MCO's, we can't say that one is doing terrible and one is
2 doing great. They all have their challenges and things
3 that they excel at.

4 Our staff have been doing onsite
5 visits with the MCO's. When providers have requested,
6 Medicaid staff are traveling out in the state and being
7 with providers when they meet with the MCO's to work on
8 their issues. Over the last month, I know the MCO's have
9 done a lot of trips around the state meeting providers and
10 trying to resolve issues and we're encouraged by their
11 efforts there.

12 Another sign of progress is the
13 issues that we're dealing with are becoming the smaller,
14 more detailed issues. It's not that there's a whole
15 provider type that's not getting paid. It's that there's a
16 code that the MCO's aren't sure how to reimburse or they're
17 not sure if it's covered in a particular code.

18 And generally what we do there is we
19 go back to the history of Medicaid and show the MCO's that
20 in the data they're provided and our regulation that
21 governs the program, that that particular code or procedure
22 is described. You look at the documents you have to say
23 historically has Medicaid covered that particular procedure
24 code. So, we're getting to those kind of issues where
25 there might not be a rate for a code. So, it's smaller

1 type within a program issues that we're getting to and
2 we'll continue to work on those as we go forth.

3 Before I go a little farther, I
4 wanted to explain the implementation staff and introduce a
5 couple of people that are in Medicaid now. As you might
6 remember in our last meeting, Carrie Banahan with the
7 Cabinet was here with me discussing managed care
8 implementation because she was the managed care
9 implementation lead for the Department.

10 She is now in the process of phasing
11 out of that and we have two gentlemen who have probably
12 been with Medicaid I'm guessing five months who are
13 basically the overall Director and the Operations Director
14 of Medicaid's Managed Care Oversight and they will be
15 phasing into the duties that Carrie Banahan played.

16 And I'll introduce Tom McMann who is
17 the overall Director of Managed Care Oversight, and Ted
18 Lechner who is the Operations Director of Managed Care
19 Oversight, and they'll be our lead folks in the Department
20 for overseeing the MCO's as far as monitoring and
21 performance and dealing with the issues that the Department
22 has.

23 Not to minimize the role of the
24 existing staff, the whole Department really has had their
25 effort focused in resolving the issues and concerns we've

1 had with managed care implementation and they'll continue
2 to do that. When you have 90% of your program in managed
3 care, obviously making sure that's working becomes the job
4 of everybody in the Department and we'll continue that
5 focus.

6 As we look at the other sign of
7 progress as we look at the month, if we just isolate the
8 month of February, according to preliminary information
9 that we have, MCO's are actually paying above what would be
10 expected for a single month. Now, there's multiple reasons
11 for that. Obviously, they are catching up from the first
12 few months of managed care where there were some payment
13 issues that providers experienced, but that's another sign
14 that we think we're getting to where we need to be.

15 And as I mentioned earlier, it's kind
16 of program-specific. It might surprise the Chairman a
17 little bit, but as we look at the programs that are being
18 paid very close to where we expected them to be paid,
19 there's pharmacy, outpatient hospital and lab. Looking at
20 the month of February, they were paid very close to what we
21 would expect.

22 There are still some programs that
23 the MCO's are struggling with. Just a couple that stuck
24 out were DME, hospice and inpatient hospital is lacking
25 behind outpatient hospital. So, again, with the MCO's,

1 they're strong at some things. Others are strong at
2 others. And within the Medicaid Program themselves,
3 there's programs that are getting back to where the program
4 expected and those that aren't there yet. So, again, a
5 mixed bag which shows progress but still a lot of work to
6 do.

7 The main issues that we continue to
8 hear from providers and the concerns that they express are
9 mainly around the prior authorization issue - both the
10 timeliness of the prior authorizations, the response time
11 from the MCO's, the detail that's required in the PA's, in
12 other words, the amount of information that's required to
13 be submitted for the prior authorization, and general
14 issues with the number of total things that require a prior
15 authorization before the service can be provided with the
16 assurance that reimbursement will be there.

17 We continue to work with the MCO's on
18 that and providers and try to work out the best middle
19 ground we can get them to, but that will continue to be the
20 way that managed care operates is they do a lot of prior
21 authorizations and want to review a lot of services.
22 That's the increased managed care that we see.

23 I also want to talk a little bit
24 about on the member side and explain what's going on there.
25 The open enrollment period, the initial 90-day open

1 enrollment period ended at the end of January. Each member
2 will be able to make another choice of MCO's, in other
3 words, switch. Each member will have that chance sometime
4 before this coming December because initial enrollment in
5 managed care was in November of last year. Each member has
6 to have an annual choice within a year's time period. So,
7 they will have that. Actually, it will be before December.
8 It will be in November.

9 Brand new members who are new to
10 Medicaid will continue to have the initial 90 days after
11 their enrollment in Medicaid to switch MCO's. So, that's
12 not something that the initial enrollees had an option and
13 new members won't have that option, and then the members
14 will have 60 days in which to make that choice. So, 60
15 days before the year is up, they'll be notified they have
16 an opportunity to change. So, that will be ongoing.

17 We're starting to receive member
18 appeals which is where the member has been denied a
19 service. They've not been able to work that issue out with
20 the MCO and they've appealed through the State Fair Hearing
21 process. We have 81 of those cases so far that are under
22 review by the Administrative Hearings Branch in Medicaid
23 and an administrative law judge will be making that
24 decision.

25 There's not many final decisions yet,

1 and I can report on that later as to how that's going, but
2 that is still an avenue that members have when a service is
3 denied. And, of course, providers with the member's
4 permission may assist the member in that appeal.

5 As I said, we continue to have
6 multiple provider meetings with groups. We've offered to
7 some groups to have regularly scheduled meetings. Some
8 groups have said we want to work on those individuals
9 through our associations with the MCO's. Some have said we
10 would like a Medicaid organized, routinely occurring
11 meeting, and those are taking place also.

12 I've spent a lot of time in the last
13 few months hearing a lot of legislative testimony. And, of
14 course, that just reinforced what we already knew, that
15 there is a lot of interest and I guess the word concern
16 also in how managed care is going, and the legislators want
17 to give individuals ample opportunity to explain what
18 they're seeing in managed care and obviously make sure that
19 the issues stay out there and that the issues continue to
20 be addressed until everything can be resolved.

21 Just to give you a little update on
22 the membership distribution, WellCare and Spirit have
23 around 27, 28% of the members that were assigned beginning
24 in November. Coventry has around 45% of the membership.
25 And not to leave Passport out, Passport is obviously still

1 there, is still serving the recipients. They have about
2 170,000 members in Passport, and about 550,000 to 560,000
3 in the three new plans. So, when you do that math, about
4 90% of Medicaid recipients are now getting their services
5 through an MCO.

6 And this is where I sound like the
7 broken record, but I don't want to lose sight of the big
8 picture is that we entered into MCO's because of a budget
9 situation. And I'm sure we've all heard the adage that the
10 definition of insanity is doing the same thing over and
11 over again and expect different results.

12 So, due to the budget situation, the
13 decision was made to go into managed care to try to provide
14 better care the best way we can within the budget
15 constraints we have. So, we're still going there and
16 that's the reason we did it, and we are dedicated in
17 Medicaid to making it work.

18 On that note, I wanted to go into a
19 little bit about the Secretary, the Cabinet situation. As
20 Tom McMann, our Managed Care Director, pointed out, he's
21 been here five or six months and he will soon be on his
22 third Secretary. So, we're blaming it on Tom. Secretary
23 Janie Miller did resign in February. I'm very fond and am
24 an admirer of Secretary Miller and how knowledgeable she
25 was in all the programs she had, and her dedication to the

1 job was above question. She was a very great Secretary to
2 work for personally.

3 Eric Friedlander, who had been
4 Secretary Miller's Deputy, has been Acting Secretary since
5 she left. He has been Deputy I think through the whole
6 Administration. So, he has been familiar with all the
7 issues that the Cabinet of Medicaid has.

8 On April 16th, our new Secretary,
9 Audrey Haynes, will start her work in the Cabinet. She is
10 very aware of the issues with managed care and the public
11 scrutiny that it's undergoing, and I'm sure that's her
12 number one focus when she gets here.

13 On that vain, I met with her briefly
14 for a couple of hours. She met with the executive staff
15 and she explained to us that even though she would love to
16 come and get involved right away since she had been
17 announced as Secretary, that she just needed two to three
18 weeks to close out her existing job as a National Director
19 of the YMCA or The Y as it's known now. She had a lot of
20 commitments she couldn't just abandon at that point and
21 come straight to start directing the Cabinet.

22 But what she said during the staff
23 meeting was, first, she wanted to know from each department
24 the top five issues that we felt she needed to be aware of
25 and begin to address when she got here and we're preparing

1 that list for her, but she also wanted to know the top five
2 groups or people that we think she needs to meet with upon
3 her arrival. Obviously, in my list, this Council will
4 probably be at the top of that list for her when she gets
5 here.

6 In her brief remarks to us and from
7 everything I can tell, she will be much more of a Secretary
8 who actively engages the public and wants to hear from
9 stakeholders and all the programs that she directs. That's
10 kind of the way she operates. She's a very outgoing, get
11 out and meet the people type of Secretary. And based on
12 everything I know about her in my two hours with her, I
13 believe that to be true.

14 So, I'm looking forward to her
15 arrival and her and her renewed energy. To be honest, the
16 Medicaid staff is pretty tired right now from managed care
17 implementation, and I think the new energy that she will
18 inject to the Cabinet when she comes will get us through
19 the next two to three years remaining in this
20 administration. So, I look forward to her arrival.

21 With that, I'm open to any questions
22 you have.

23 CHAIRMAN POOLE: Let me ask something
24 for the MAC here. I just want to verify. It does take
25 eight to have a quorum. Is that correct?

1 COMMISSIONER WISE: Yes. And did you
2 all meet Sharley? Did she introduce herself?

3 CHAIRMAN POOLE: I did not and I
4 should have. We have a new secretary for the MAC.
5 Introduce yourself.

6 MS. HUGHES: Sharley Hughes. I've
7 been with Medicaid now for two years. So, I'm still
8 learning.

9 CHAIRMAN POOLE: Welcome. Glad to
10 have you.

11 CHAIRMAN POOLE: And I wanted to
12 mention that Marla Smaltz, who organized the committee for
13 years, received a promotion. She went to be a Branch
14 Manager in our Money Follows the Person area.

15 CHAIRMAN POOLE: Well, it's certainly
16 no reflection on Sharley that we don't have a quorum
17 because I have been getting plenty of emails from her and
18 she's done a good job and communicated well, and certainly
19 Marla did a wonderful job when she was here.

20 At this time, does anybody else have
21 any comments for Commissioner Wise at this time?

22 MR. WHALEY: Commissioner, I had a
23 couple of questions. One, you had mentioned the next time
24 there's an open enrollment period, December. Is that a 60-
25 day period for people? You'll be notifying people 60 days

1 prior?

2 COMMISSIONER WISE: Prior to their
3 annual opportunity to re-enroll, to choose a different MCO
4 if they so choose.

5 MR. WHALEY: So, that's a 60-day
6 period, and how is that information being distributed to
7 people? How will they know?

8 COMMISSIONER WISE: We're still
9 working on the final details, but it will be multiple
10 letters to all those individuals advising them. In the
11 future, we will get it completely synced up with their
12 annual re-enrollment for Medicaid; but because of the
13 timing of getting all the initial folks enrolled, we
14 couldn't quite get that timing synced up.

15 But after this first year, we'll
16 probably do like three months worth of people in one month
17 and three months the next month to give them their annual
18 opportunity; but from there on after, it should be one-
19 twelfth of the people each month will have an opportunity
20 to re-enroll.

21 MR. WHALEY: And that's in a written
22 format that may include other formats for people who may
23 have difficulty?

24 COMMISSIONER WISE: Yes.

25 MR. WHALEY: And just one other

1 question. As far as the State Fair Hearing process, how
2 are people made aware of that as an option if they disagree
3 with their claim situation? How is that information being
4 distributed to them?

5 COMMISSIONER WISE: Any denial of
6 service generates a letter to the member telling them their
7 right to appeal. If they get denied five times, they'll
8 get five letters saying you have a right to appeal this
9 denial of service and it tells their rights. It quotes the
10 regulation and it tells where the appeal needs to be sent
11 to. And the folks who it's sent to are there. They can
12 answer questions if the member has questions. So, anytime
13 a service is denied, that letter is generated giving them
14 their appeal rights. Obviously, if someone hears of when
15 that doesn't happen, we want to know because that's what
16 should happen.

17 MR. WHALEY: Just 81 seemed like an
18 awful small number, considering the number of total
19 individuals enrolled and the potential for denied claims.

20 COMMISSIONER WISE: And some of those
21 are resolved. Generally the first step is the provider or
22 member will work with the MCO and a lot of those do get
23 resolved at that level. By the time it's taken to call and
24 fully discussed it, it gets resolved.

25 As I think I mentioned before,

1 members have the right as soon as they get the denial
2 letter to not work with the MCO. They have the right to go
3 straight to the State Fair Hearing at that point, but many
4 do work with the MCO because generally if they can't work
5 it out, that will get the result they need faster than the
6 regimented time that the State Fair Hearing process has.

7 MS. BRANHAM: Neville, is 81 the
8 number in totality that there's been information submitted
9 to the State Fair Hearing?

10 COMMISSIONER WISE: Yes. That was
11 information I got this morning.

12 MX. BRANHAM: So, that dates back to
13 November. So, there's 81. I agree with Barry. It's a
14 small number, but, yet, there are people there that are not
15 receiving services because they've not been able to
16 adjudicate any kind of claims or anything such as that.
17 So, I wonder what you all are doing to speed up this
18 process for these 81 folks?

19 COMMISSIONER WISE: Generally, like I
20 said, the member or provider has a chance to work with the
21 MCO to try to resolve it.

22 MS. BRANHAM: Yes, but that's a
23 cumbersome process in itself.

24 COMMISSIONER WISE: Under the State
25 Fair Hearing, once they get the letter, there are definite

1 time frames that kick in. For individuals who are
2 receiving ongoing services like nursing homes, outside MCO,
3 but that's the best example, if they're denied something,
4 if they appeal within ten days, that service continues
5 until the appeal is heard. So, if there's an ongoing
6 service, there's a way for that service to continue.

7 MS. BRANHAM: There is a way?

8 COMMISSIONER WISE: Yes, but if it's
9 an isolated, brand new service, it has----

10 MS. BRANHAM: But if it was a service
11 that was being provided prior to November 1 that didn't get
12 carried over, then, some of those folks, it's going to be a
13 new service under MCO's. So, some of those folks indeed
14 aren't getting continued service. Is that correct?

15 COMMISSIONER WISE: If it's a service
16 they already were getting like a good example - most of
17 them were outside managed care where it's ongoing services,
18 and it's an episode of care. It's not really isolated
19 individual events which nursing home being the best
20 example, but there are some examples within the MCO's where
21 they have appeal timely and the service has to continue,
22 maybe like if you're receiving maybe some ongoing home
23 health services, that type of thing.

24 MS. BRANHAM: As a provider, I've not
25 been successful in this attempt. If someone was receiving,

1 for example, home health aide services twice a week or
2 three times a week so they could be maintained in their
3 home and that's been denied by an MCO, then, they're not
4 getting that now. So, this is why I don't understand the
5 logistics of this.

6 COMMISSIONER WISE: That's where the
7 appeal ideally should have happened right after that.

8 MS. BRANHAM: It takes about two
9 weeks to generate a letter and then you start on it. So, I
10 just wonder, these 81, are ten of them from November and 24
11 are now? If it's outside of managed care, we're not
12 considering that, I guess, or how many of these are outside
13 managed care?

14 COMMISSIONER WISE: And these were
15 ones within managed care. It didn't include the ones
16 outside because they're attributed to a particular MCO.
17 So, the list says this many appeals -and I didn't bring it
18 with me - but this many appeals for Coventry, this many for
19 WellCare and Spirit. So, these are within MCO appeals.
20 It doesn't include the routine ones we used to get outside
21 of that.

22 DR. NEEL: Good morning, Neville. We
23 bring you greetings from all the provider world, the real
24 world and the trenches. I'm a little afraid that the fact
25 that the money looks about the same makes it look like

1 things are alright and they not. It's still a disaster out
2 there. I'm trying to be optimistic about the disaster, but
3 I want to make some points briefly, if I can.

4 We had managed care. I've said that
5 a hundred times. Maybe we weren't managing the money as
6 well as we might but we had managed care. Now what I see
7 is we're managing the money and not managing the care.
8 That's what I fear as a physician provider.

9 The idea I understand from the
10 federal government was to give recipients choice of
11 Medicaid companies, MCO's, right? Okay. That was to give
12 them choice, but the problem with that was is it's gotten
13 turned around because now their choice is based upon who
14 their provider takes as working with as far as an MCO. And
15 I guess the assumption in the beginning was that all
16 providers would reasonably sign up with all three
17 companies, and, so, then, the recipient could take their
18 choice of company and go to that same provider.

19 That hasn't turned out to be true.
20 As you know with our own hospital in Owensboro, they just
21 now signed with one of the companies, but there are still a
22 lot who have not signed. And because of the way
23 contracting went, we have many, many providers who are only
24 dealing with one company for one reason or another.

25 I stopped in Hartford thirty miles

1 they're kind of babes in the woods about what's going on.

2 Assignment of patients has just been
3 absolutely a disaster, and I don't know where that's coming
4 from, whether that's data that you all are providing to the
5 three MCO's; but I have 3,000 Medicaid patients or did
6 have. I still have them because they don't look at their
7 medical card and see who they are assigned to, but I've got
8 children assigned to obstetricians, anesthesiologists, pain
9 care doctors. And the MCO's are telling me that that's
10 because of data they're getting from somewhere.

11 So, somehow we've got to get that
12 straightened out because no matter how much money you pay
13 me, we're all going crazy with that particular thing. And
14 it's not changing. It continues. So, I don't know if you
15 can answer that today or not, but somehow that's got to get
16 taken care of.

17 COMMISSIONER WISE: And the MCO's
18 have given latitude to most - I think they do - I have to
19 double check - to most members. They can change their PCP.
20 When we talk about the enrollment process, they can change
21 their PCP.

22 DR. NEEL: I understand, but they've
23 not tried. They have already been that PCP's patient for
24 years, 90% of them. People don't go on and off Medicaid
25 that much. Ninety percent of them are still there. As an

1 example, I had a mother in yesterday with a three- and a
2 five-year-old on one company. She's with the same company.
3 She had a new baby born. It's assigned to a different
4 company and that's the rule rather than the exception.

5 COMMISSIONER WISE: That's not
6 supposed to happen.

7 DR. NEEL: I know, it's not, but
8 those are things that are driving us crazy as PCP's out
9 there because even if the money is coming in, those are the
10 things that are killing us.

11 Now, the prior authorizations,
12 another huge, huge problem, what would happen - and I'd
13 like for them to comment on this this morning - what would
14 happen if we just did away with prior authorizations for a
15 year? What percent are they denying? Are we just denying
16 care or are we denying bad care? That's what I want to
17 know because it's kind of like second opinions. Second
18 opinions have disappeared because most second opinions were
19 the same as the first opinion. And, so, I'd like for
20 somebody to comment on that this morning.

21 So, I'll stop there and let you
22 answer some of those and others may have some questions.

23 COMMISSIONER WISE: That's something
24 that the Medicaid Program is in the process of looking at
25 is in programs where we see high denial rates, we're going

1 to do further investigation to see what's behind those
2 denials. That's something we have definitely on our radar
3 to be part of what we do ongoing.

4 CHAIRMAN POOLE: Do you all care to
5 comment on any of those, any of the managed care
6 representatives here today?

7 MR. MINOR: I'll be happy to comment
8 for WellCare. Contractually, we are required to return a
9 prior authorization request within two days. I'm sure each
10 company would talk about the decisions and the process that
11 they went into to create their specific prior authorization
12 rules, how they review that.

13 We've tried to take our experience in
14 other states to make sure that the things that we are prior
15 authorizing is what's needed. It's not what I think Dr.
16 Neel would refer to as just jumping through hoops. And I
17 do know that based on reports that I've recently received,
18 that 97% of the authorizations that we received are being
19 turned around in those two days.

20 So, if there are some specific issues
21 where providers are having issues and they don't think that
22 that metric is applying, I'd be happy to look at those. We
23 have made some changes in our prior authorization, one of
24 which was in pharmacy where just based on listening to
25 providers that said that they understood that every six

1 months, they would need to prior authorize specific drugs.
2 And after discussing that with them, we said, you know
3 what? That doesn't make as much sense as it did prior to
4 November; and as a result, we would make a change from six
5 months to a year. So, now that prior auth is a year.

6 And, so, I do think that what I've
7 seen in other markets is, as we mature in this managed care
8 implementation, that companies will make changes based on
9 the interactions that you have with providers and, again,
10 what you learn specific here in the Commonwealth.

11 MR. WHITE: I think the same would
12 hold true for Kentucky Spirit. I think that as we've gone
13 along, we've made several changes. I know a waiver that we
14 just sent through the pipeline on cystic fibrosis testing
15 for pregnant women, we're going to wave that. We're not
16 going to do it anymore because it doesn't make sense. They
17 need to get that testing.

18 So, I think it changes along the way,
19 but also remember that the prior authorization process,
20 it's a lot about managing the care, knowing what care is
21 being delivered, knowing what care the members are
22 receiving so that we can better manager that. Our Member
23 Connections' people can reach out to them when necessary to
24 help them get the care that they do deserve.

25 MR. HARPER: I don't want to berate

1 the point that they're both making, but we are looking at
2 issues as they arise. There are certain situations where
3 we have removed prior auths, for hospice, for example. In
4 our dental program, Avesis, we've removed prior auths for
5 certain treatments for kids that are under nine years old
6 and the EPSDT services.

7 Like you were saying, we are learning
8 as some of these issues come up that we may have to look at
9 those individually and determine whether or not the PA
10 process is legitimate.

11 COMMISSIONER WISE: And that's what
12 we would hope that the MCO's do as Medicaid used to do.
13 When we looked at stuff that required prior authorization,
14 we would periodically take a look and say, you know, we're
15 approving 99% of these. Why is there a need to have a PA?
16 And that's an ongoing process that we used to do and we're
17 certainly encouraging the MCO's to say they'll do that.

18 CHAIRMAN POOLE: Any other comments?

19 DR. PARTIN: I have a question for
20 the MCO's about the drug formularies. I understand the
21 need for a drug formulary because I know that it's a cost-
22 saving measure; but it gets really confusing for the
23 providers when you're trying to prescribe medicine for a
24 patient when the formularies are so different.

25 And I'm wondering if there's any way

1 for you all to get together to have some kind of
2 consistency with the formularies?

3 MR. MINOR: All companies will have
4 different formularies. I would ask is it beneficial if we
5 had a document that said here are all of the drugs by
6 classification where we all agree? And then at least we'll
7 know how--it narrows down the world of, okay, where are we
8 because I can't answer where we're all the same either.

9 If we could take that back and at
10 least be able - and maybe we come back and we give a report
11 that says here's the areas that we all agree. There are
12 some drug classifications where there's probably enough
13 volume in where we may not agree. And at that point, I
14 know that we all have our P&T committees and at least that
15 way we could help providers identify the world and the
16 differences as far as where we are in alignment.

17 DR. PARTIN: I think that would be
18 very helpful. At least it would give us some idea because
19 a lot of times when you're trying to see the patients, it's
20 like a game. You prescribe something and then you wait and
21 you kind of hold your breath and say, well, is this going
22 to be okay or not? It was okay last month, but maybe it's
23 not going to be okay this month. And it gets really
24 frustrating for the patients and it gets really confusing
25 for us.

1 CHAIRMAN POOLE: Mike, of course, I'm
2 the person who catches the tail end of that and has to call
3 them back; but I don't know what it would cost. Certainly
4 in this day and age with computerization, it shouldn't be
5 that bad because I know you've already got the database put
6 in place because we transmit to it.

7 So, I don't know. I would say as a
8 prescriber and certainly as a pharmacist, it would be nice
9 if that was just on a database provided through Medicaid or
10 whatever. And, of course, I know you're going to make
11 changes throughout the year for various reasons. That's
12 just typically what happens in this industry. When you
13 update, it updates the database, and I think it would be a
14 great resource and it probably would prevent a great deal
15 of prior authorizations which takes up a great deal of
16 everybody's time.

17 So, I think it would be a cost-saving
18 measure for everybody involved if we could develop that
19 somehow and make it easy enough that a prescriber can look
20 up real quick and know what MCO they're with and prescribe
21 what's on the formulary first.

22 MR. MINOR: I'm sure there's at least
23 several IT people who are not cringing somewhere waiting to
24 slap us, but if that's helpful, let us work together on
25 that.

1 DR. NEEL: Neville, this is just a
2 huge problem. Why can't we just say let's make that happen
3 if we have to come to a conference committee like they do
4 in the House and Senate to decide which ones we're going to
5 argue about, but it's a huge problem for us providers and
6 for them out there to do that. Every day in my office,
7 that's fifteen or twenty times. And, so, surely we could
8 agree on most of the drugs.

9 COMMISSIONER WISE: You're saying
10 like a reference or a cheat sheet based on the 50 most
11 frequently used meds?

12 DR. NEEL: Yes. Can't you all make
13 that happen? Can't we all agree to make something happen?

14 COMMISSIONER WISE: I made that note
15 as he was talking about it.

16 CHAIRMAN POOLE: I would have already
17 asked for that motion but we don't have enough people to
18 get that going today.

19 COMMISSIONER WISE: We'll make it
20 happen.

21 CHAIRMAN POOLE: Okay. I'm just
22 going to read through again since we can't pass this out as
23 a recommendation, but I'm going to for the sake of time
24 here pass these out to each of the MCO reps afterwards as
25 far as the reports that we're looking at just requesting

1 that it would be nice that we could get. It's not that
2 lengthy. But, again, it would be nice if you would work
3 with us and get that information; but until we can actually
4 pass out that recommendation, it's just for your
5 information right now. It would be nice if we could get
6 that.

7 So, for right now, skipping over that
8 item, I'm going to give time for each managed care
9 representative to just give their comments on how
10 implementation has been going, the problems, the successes
11 you've had and to just let us know. And I know Passport
12 has been around a while and just give us an update there,
13 too, but just give you an opportunity right now.

14 MR. WHITE: Again, Marty White,
15 Kentucky Spirit. The Commissioner said it well, that there
16 are some things that are going very well and other things
17 that need work.

18 And we continue to work on those, and
19 I know ultimately that's what we want to do is fix any
20 issues that are out there. But I will say that we are
21 processing claims in the neighborhood of \$10 to \$13 million
22 a week. Nine million of that is medical claims, \$1.7
23 million in pharmacy, \$1.6 million in behavioral health.
24 So, claims are being processed. We've processed as of
25 February 17th about \$119 million in claims.

1 Our member interaction is very high.
2 We received in February about 17,000 phone calls from
3 members. Those are all being received and handled in a
4 timely fashion. That compares to November when we received
5 34,000 calls. So, we can see the call volume going down a
6 little bit, but, again, we do want to hear from those
7 members.

8 The average answer time for those
9 calls is about eleven seconds. We spend about on average
10 five minutes with each member. And I will say our Member
11 Connections Department is going out in the communities. In
12 the past month and a half, we've made more than 150 visits
13 to community support and Medicaid support organizations and
14 it's all about reaching out to those folks and educating
15 them as well.

16 Prior authorizations, as Mr. Minor
17 said before, we are meeting our contractual obligation, the
18 two-day turnaround. We are doing about eleven to thirteen
19 thousand prior authorizations monthly.

20 Our provider network continues to
21 grow - over 12,000 physicians, specialities, nurse
22 practitioners and others that are in our primary care and
23 specialist network, about 95 hospitals and 90 FQHC's at
24 this point in time. And, again, that continues to grow. I
25 believe the most recent hospital to come on board is Dr.

1 Neel's. Owensboro just came on board. So, we're happy
2 about that.

3 We are continuing to have a lot of
4 provider interaction. Orientations are going on statewide.
5 We've had about 338 this year. We continue to conduct
6 those. We're doing workshops across the state now that are
7 being very well-attended.

8 We've registered about 9,500
9 providers on our web portal which hopefully makes access to
10 the plan much easier. And we received in February about
11 8,700 calls from providers fielding those and answering
12 those questions.

13 We continue to be very proud of our
14 pharmacy benefit and Kentucky Spirit is very proud. The
15 independent pharmacists have told us we're doing a good job
16 and our dispensing fee is adequate along with our MAC
17 pricing and we're very proud to continue to do that.

18 We do have issues with hospice, I
19 will say that, and we continue to work with hospice to work
20 those out. Another area of concern is the Departments of
21 Health, and I think Mr. Wise briefly spoke about those, but
22 those are things that we continue to work on.

23 We meet with the State weekly to work
24 on all those issues. Tom and Ted, we appreciate their
25 input and we know they're working hard and we're doing the

1 same to continue improving the plan.

2 CHAIRMAN POOLE: Thank you.

3 MR. DeANDRE: Once again, I'm Nick
4 DeAndre with Passport Health Plan; and as you've already
5 noted, we have a rich 14-year history with the State of
6 Kentucky, and I look forward to continuing to serve the
7 members in Region 3 for the years to come.

8 I did want to make one comment about
9 our dental provider. We did terminate our relationship
10 with MCNA yesterday afternoon. During the next 180 days,
11 we will be transitioning to a new provider. We'll issue an
12 RFP for that, but we do have a 180-day out-clause.

13 But, once again, we continue to
14 provide the high quality healthcare to the members in our
15 region and look forward to continuing to do that in the
16 future. Each of you next week will receive our annual
17 report, early next week, which will be helpful for you all
18 with the metrics and that's stuff that we do with Passport
19 Health Plan. So, I look forward to your questions in
20 regard to that when you get that next week.

21 CHAIRMAN POOLE: Thank you.

22 MR. MINOR: Mike Minor, WellCare.
23 Let me start with just member and community activities.
24 During the last quarter, since the last time we were able
25 to give this committee an update, we've sponsored or hosted

1 more than 100 events throughout the state. These include
2 some of our Health Connections Councils. We've also had
3 our QMAC for Quality and we've done our open houses as well
4 as four town hall meetings.

5 We've had over 10,000 individual
6 community touches. These are WellCare members that we've
7 been able to touch in the last quarter. Some of these were
8 sponsored through hearing screenings, community health
9 affairs, events with preschools and other community
10 organizations, again, trying to connect with WellCare
11 members.

12 From a health program side, we've
13 utilized Community Health Ranking data along with the
14 health data that we receive from the State, as well as the
15 claims that we've paid. And what we've been able to do is
16 identify what we believe are top community issues. And
17 these, of course, as we've talked before, they're different
18 across the Commonwealth.

19 And, so, now we find ourselves where
20 we're talking with providers about pilots and where those
21 pilots make sense, who would like to participate, help us
22 lead and integrate those into those communities.

23 We've referred more than 700 members
24 and families into local community services. I will tell
25 you almost all of those come from the members that we have

1 in case management. We've also identified and filled more
2 than 45 gaps in the social services.

3 We've developed a relationship with
4 the Center for Independent Living and the National
5 Association of Social Workers. And without going into a
6 whole lot of context, this is an area where we see that
7 what we'd like to do is, whether it is through internships
8 or other methods to help, but to identify social workers
9 that would also want to help and work in the Medicaid
10 environment here in the Commonwealth. And, so, that is
11 something that we're very much trying to get lifted off.

12 From, again, the quality, we have had
13 our initial QIC and UMAC Committee meetings during the
14 first quarter. Again, this was reviewing our program
15 documents and plans that we plan on doing over the next
16 year. Some of those are simply those were contractual
17 requirements. Some of those were things that we put in our
18 RFP that we said we felt this is what we wanted to do in
19 the Commonwealth. And, again, there's a lot of provider
20 interaction to make sure that those take off.

21 Case management. We currently have
22 20,000 members currently in our case management review.
23 There are over 5,500 active care plans that have been
24 created that we are tracking. And one of the things as we
25 talk about what we do, those case plans may have five or

1 six services that we think are important that we would like
2 to help facilitate for that particular patient. And as the
3 claim information comes in, you're able to literally just
4 check those off.

5 Let's say that there were five
6 activities, five services that we thought were needed from
7 that case management and only four come through. Then you
8 have our nurses who are following up to say let's make sure
9 we get this service done, too. So, it's an active flow of
10 not just establishing a case management program but then
11 following up that the service has happened to help the
12 patient.

13 We've hit a little bit about our PA
14 turnaround time. Provider Relations, we have established
15 work in operational meetings. Many of these are on a
16 monthly basis. We do this in other states. It's with big
17 health system, big providers where we have the opportunity
18 to address issues that are identified by the provider,
19 identified by us and it's one setting again in big
20 organizations, hundreds of providers and, of course,
21 multiple hospitals to make sure that if, especially during
22 implementation, that if there are issues, those are being
23 worked.

24 We still make approximately 400
25 individual and group contacts a month. Again, we have

1 roughly now, it's 25 Provider Relations' reps spread across
2 the state. They continue to work with providers. I think
3 from Neville's comments, I would agree that there are areas
4 that from a WellCare perspective that we still are
5 addressing. I'm happy to say that I feel very confident
6 that I know where those spots are.

7 Providers, as well as Tom, Ted,
8 Neville, have been extremely helpful when we've had
9 questions as far as we're not sure - there's a gap here in
10 the fee schedule - what did Medicaid pay so we can resolve
11 that. Providers have been more than willing to come forth
12 and say, hey, I was being reimbursed for this. This fee
13 needs to be updated. And, again, there are particular
14 service areas that we're aware of that we're working very
15 diligently to make sure that we get those resolved. But,
16 again, I'm happy and I agree with Neville, we have
17 identified what those areas are.

18 Within the implementation phase,
19 there are providers that are still, as we talk about
20 working towards the future, and these are things that we
21 talked about during the RFP and the lead-up to November 1
22 about things that we wanted to do collaboratively to
23 address whether it was a service gap, something that they
24 thought that that particular community needed. I won't
25 call them innovations because we've talked about that.

1 of the statements that he made was poor people don't
2 deserve poor care. And I can tell you on a Coventry
3 perspective that we take that as a motto from the top of
4 our corporate ladder from our CEO all the way down to our
5 folks that do the case management and the outreach.

6 And I know Dr. Neel talked about how
7 the provider network has been managing the care for
8 Medicaid recipients since the inception of the program; but
9 I would say and I would argue that this is the first time
10 in forty years that we've had a coordination of care for
11 those members.

12 And I can give you an example--I can
13 give you plenty of examples but one I'll just pull out that
14 I just remember off the top of my head was an individual
15 who used to have to take a public bus to get his dialysis
16 and it would take him almost an hour to get a round trip to
17 get to a provider that was across town.

18 Well, now that he is a Coventry
19 member, we have reduced his time. We've coordinated his
20 transportation and we've gotten him a provider that's
21 closer to his home. So, basically he's ten minutes in the
22 van and he's back home spending more time with his family.
23 So, that's one story of many that I could share with you,
24 and I know the other plans could do the same thing.

25 But I think there's also been a lot

1 of chatter that we sort of have this free run at doing
2 whatever we do; but I can tell you that Commissioner Wise
3 and Mr. McMann and Mr. Lechner earn their money because
4 they spend a lot of time with us and hold our feet to the
5 fire to make sure that we are providing the care and the
6 access to care that their members need.

7 And that goes in line, too, with a
8 lot of the federal quality assurances. There's state
9 regulations, federal regulations. I mean, there's tons of
10 things that we have to abide by and there are certain
11 designations that Mr. Minor was speaking of with the
12 National Quality Assurance that we all want to get to at
13 some point during our time here in Kentucky.

14 But just to get into some of the
15 statistics, we did have a rocky start - I'm not going to
16 deny that - but we are proud to say that 99% of our claims
17 now are paid within 30 days and 97 of them are within 15.
18 So, hopefully, the providers are getting the funds and the
19 resources that they need. And if they are not, then, I'm
20 happy to take their information today and take that back to
21 our office to get on top of it.

22 We're averaging about 200,000 claims
23 per week, processing about 200,000 claims per week. And,
24 so, you can see the volume that we're dealing with and what
25 we're doing and the expeditious cycles. We've increased our

1 pay cycles to three times a week. We are within the two-
2 day turnaround for the PA process currently.

3 That's just some of the basic
4 statistics, and I won't bore you with a lot of the detail;
5 but I can tell you that we have a very extensive provider
6 and community outreach network that has reached thousands
7 of organizations. We've participated in conferences like
8 the Kentucky School Nurses Association, the upcoming Public
9 Health Association conference next week in Louisville, and
10 some of the FRYSC's and the YMCA's and I can go on and on.

11 We also participate to help keep our
12 providers in a good stature as the Cabinet has set up
13 weekly meetings with the Hospital Association, and those
14 cross over to the behavioral health side a little bit; but
15 the community mental health centers is usually on about a
16 two-week cycle now or as needed.

17 So, we work with those providers hand
18 in hand and we have an issues log that we go through that
19 have action dates and resolve dates, and we don't get to
20 decide if they're resolved. It's a decision that's made
21 between both the provider and the managed care organization
22 and the Cabinet. So, there's a three-prong process of
23 making sure that that issue doesn't just arbitrarily get
24 taken off the list.

25 If you're read the Auditor's report,

1 we are taking his recommendations in stride and we are
2 following those and still reviewing those and provided a
3 response back to the Cabinet on how we are addressing those
4 with an action plan.

5 And we are also - I'm just reading
6 through some notes here - I don't want to repeat a lot of
7 the things that they said - but we are also identifying
8 certain fraud areas through members and providers and we're
9 hoping to, as we get more into this process, of being able
10 to identify those areas where we can bring efficiencies to
11 the system.

12 Like I said, we are not a perfect
13 organization and we still have a ways to go to get to the
14 point of the Coventry standard, but I know that if we all
15 work together and can continue to keep these communication
16 lines open, that we will all get there.

17 I've been on this job since January
18 17th. So, I can kind of go with Mr. McMann. This will be
19 my third Secretary and I can tell you that we look forward
20 to working with Secretary Haynes and we really enjoyed the
21 relationship with Secretary Miller and with the current
22 Secretary Friedlander. So, it's a great group of
23 leadership and I can tell you that they are very active and
24 they want this to work just like everybody else does.

25 Than you, sir, and the committee.

1 CHAIRMAN POOLE: Do you all discuss
2 the different formularies amongst the MCO's?

3 MS. HAWKINS: We are very aware that
4 there are different formularies, but it's not something
5 that Magellan can obviously control as far as what the
6 MCO's put on their formularies.

7 CHAIRMAN POOLE: No, but the Pharmacy
8 and Therapeutics TAC is not Magellan. It's always been
9 represented by physicians, other pharmacists. So, it's not
10 a Magellan directive. It's that PTAC directive. So, would
11 they not have suggestions especially like on behavioral
12 health on things that are left off formularies?

13 MS. HAWKINS: I think that P&T
14 Committee would love to give suggestions to the MCO's if
15 asked. If that's something that you all would like, they
16 would love to have say.

17 CHAIRMAN POOLE: Well, again, I
18 thought that was part of the directive anyway. I mean,
19 that's what therapeutics is all about is if you find that a
20 great deal of people are being removed from their medicine
21 they've been on for five or ten years, that would be, to
22 me, an immediate concern, especially in the behavioral
23 health world and anti-seizure also.

24 MS. HAWKINS: Correct.

25 CHAIRMAN POOLE: So, if it's okay

1 with you guys to examine that, I'm sure the rest of the MAC
2 would really appreciate that.

3 MS. HAWKINS: I will take that back
4 to the Department for Medicaid Services and see how we can
5 work that in.

6 CHAIRMAN POOLE: And it's really
7 those two groups. The anti-seizure medications have been a
8 hot button for probably the last five years, both federal
9 and state, but certainly behavioral health is huge now with
10 the changing to the MCO model and a lot of things are not
11 covered automatically.

12 MS. HAWKINS: And the fee-for-service
13 PDL has always been fairly open as far as those two classes
14 of drugs go.

15 CHAIRMAN POOLE: Okay. Anybody have
16 any questions? Thank you, Tina.

17 COMMISSIONER WISE: I think you're
18 correct. That is an area that we want the P&T Committee to
19 move into is helping us review what the MCO's are doing.
20 it's also on my list to discuss with the incoming Secretary
21 and make sure that's in line with her thinking, but I
22 understand your request.

23 REPORT OF PHARMACY TAC:

24 CHAIRMAN POOLE: I appreciate it.
25 Russell, I don't know if you'll be able to address this or

1 not. Since we're just on pharmacy, I'll finish up with a
2 couple of things here. Do you have a pretty broad--well, a
3 decent amount of drugs still on that 100-unit dosing limit
4 or are you trying to phase that out?

5 MR. HARPER: I can find that out for
6 you, sir, and get back to you, if that's okay. I know
7 enough about pharmacies to be dangerous.

8 CHAIRMAN POOLE: That's why I
9 qualified by saying I don't know if you can answer or not.
10 Obviously I'm putting you on the spot but you can answer
11 what you're qualified to do, but there's medications like
12 Gabapentin which 95% of the prescribing out there is for
13 pain management, but it is an anti-seizure medication and
14 there's a 100 limit on that. There's muscle relaxers and
15 certainly all the C-II's.

16 So, typically, what's happening,
17 especially when you're dealing with C-II's, the doctor
18 writes for 120 Percocet, whatever strength - and I've seen
19 this in our pharmacy and I've talked to many other
20 pharmacists that this is happening, too - so, they can only
21 get 100 of those paid for.

22 So, you have a decision there to say,
23 okay, are you going to pay for the other 20. some doctors
24 are refusing to say, well, I'm not going to write a
25 prescription for every 25 days. And, of course, if the

1 person cannot pay for the other 20 - and these are routine
2 C-II prescriptions every month. This isn't like somebody
3 just had surgery and gets whatever. But what happens there
4 is that if somebody can't afford it, then, they're just
5 getting 100 and then they're going five days without and
6 then getting another prescription for the next month.

7 So, you can see where that poses
8 quite a bit of issues with access to care. Those who can
9 afford to do it are doing it which puts a great deal of
10 responsibility on us to make a legal claim because it can
11 only be one prescription for a C-II.

12 So, there's just a lot of issues with
13 that 100-unit limit. It would be nice if we could have an
14 update on that, if you could shoot me an email. I'll pass
15 along to Bob McFalls of the Kentucky Pharmacists
16 Association and we can let people know what's going on
17 there.

18 MR. HARPER: Yes, sir.

19 CHAIRMAN POOLE: And then as far as
20 Kentucky Spirit, you still have your four Rx limit and then
21 everything from there is a PA.

22 I've got just as an example, August
23 15th of 2006, this was when it first came out the four
24 prescription limit for the prior Medicaid, and it even goes
25 back past Magellan, past First Health on back to the people

1 managing at that time, but here's an exclusion list. And
2 I'll just give you this for information afterwards. It
3 goes into different disease states and even specific
4 products like prenatal vitamins and folic acid,
5 contraceptives, on and on, antibiotics - an exclusion list.
6 that would, again, if you all could develop that, would cut
7 way down on your prior authorizations.

8 If you're looking at your prior
9 authorizations and pretty much 100% of the time you're
10 paying for this, then, it may as well be an exclusion list.
11 So, it's something that you all can look at statistically
12 and see. So, hopefully this will be an aid to you.

13 MR. WHITE: Thank you, Mr. Chairman.
14 I appreciate that and know that we continue to make
15 adjustments to those exceptions, if you will, and we'll
16 happily take that back and have our pharmacy people to take
17 a look at it. Thank you.

18 CHAIRMAN POOLE: Thank you. Next up
19 is Behavioral Health, Ms. Sheila Schuster.

20 REPORT OF BEHAVIORAL HEALTH TAC:

21 DR. SHEILA SCHUSTER: Thank you, sir.
22 This is not my boxing glove; but at this stage of the
23 session, one sometimes feels like one might want to use it.

24 I'm Dr. Sheila Schuster. I'm the
25 Executive Director of the Mental Health Coalition, one of

1 the members of the Behavioral Health TAC. The TAC has not
2 formally met yet, but I want to share with you as we have
3 with legislators the continued and ongoing problems, and
4 you just addressed some of those, Mr. Poole, with the
5 medication issues that continue to be a problem.

6 There are two bills that many of us
7 have worked on, not just the behavioral health but across
8 disciplines and across provider groups to try to bring some
9 increased oversight and regulation to the MCO's. One is
10 House Bill 540 which was heard for discussion only in the
11 House Health and Welfare Committee meeting and it had to do
12 with the formulary, the lack of transparency of the P&T
13 process.

14 We understand that one of the MCO's
15 held a conference call as their P&T Committee meeting. I
16 think those meetings need to be open meetings, open
17 records. It gives no opportunity for input.

18 We asked in that legislation which is
19 not going to be held for a vote that we get a list from
20 each of the MCO's about the prior authorizations that
21 they've requested and what their outcome was. And I was
22 pleased that a representative of the Cabinet said that she
23 thought that was possible as data to get. I think we all
24 need that because what's happening, as you all know,
25 particularly those of you who are providers, is every PA

1 that you have to go through starts altering your
2 prescribing practices and takes up so much time, and we it
3 essentially amounts to denial of care.

4 The other thing that I would like to
5 bring to your attention - and, I'm sorry, I was late - you
6 may have already discussed it - but it was the report that
7 Auditor Adam Edelen released and his ten recommendations.

8 And on behalf of the behavioral
9 health community, we would like to bring your attention to
10 Recommendation No. 9 in that report which was that the
11 Cabinet should study whether behavioral health patients and
12 others who receive specialized medical services would be
13 better under the Medicaid fee-for-service structure
14 administered by the Cabinet than to be managed by the
15 managed care organizations.

16 And we have pledged our support to
17 the Cabinet. We really urge the Cabinet to look at those
18 recommendations, particularly Recommendation 9 and to
19 really look. Behavioral health makes up at most 3% of the
20 budget, but our 178,000 folks that are treated by the
21 community mental health centers are being hurt.

22 We know that there are people that
23 have a severe and persistent mental illness and they go to
24 the pharmacy; and because of the MCO, whatever, their
25 medication is not available, and those people turn around

1 and walk away and most often don't go back. So, we are
2 paying the price and those consumers and family members are
3 paying the price in increased incarcerations, homelessness,
4 increased hospitalizations and deterioration, and we've got
5 to put a stop to that.

6 I'm happy to answer any questions.

7 CHAIRMAN POOLE: Just to let you know
8 on the one, that is one of the suggested reports. And I
9 saw you come in. We don't have a quorum, unfortunately.
10 We actually just have six because she hasn't been appointed
11 yet by the Governor, but I'm going to be handing them the
12 suggested list for reports, but the prior authorization is
13 on there, the statistics on it.

14 DR. SCHUSTER: I just think we need
15 to shine a light on that. Thank you, sir.

16 DR. NEEL: If you recommend removing
17 mental health from the MCO's and going back to where we
18 were, will we be able to administrate that within our
19 Medicaid Department now or has it been reduced in size to
20 the point could we? I have a little concern about that.
21 Could we do what we need to do with it back in Medicaid?

22 DR. SCHUSTER: I'm not sure I'm the
23 best one to answer that, Dr. Neel, but I will tell you that
24 for forty-five years, the community mental health centers,
25 as you know, have been billing Medicaid and working very

1 well with Medicaid. And, so, we have been out of the loop
2 for now six months, seven months, eight months, and we are
3 begging to get back into that loop.

4 What's happened, as you know, and all
5 of the twelve community health centers that are affected,
6 all but the Passport Region, have signed up with all three
7 of the MCO's because they don't know who their patients are
8 going to be assigned to. So, they are dealing every day
9 with three different formularies, three different prior
10 authorization processes - you understand that because you
11 probably have done the same thing - three different
12 mechanisms. Everything is multiplied by three.

13 So, I would hope that the staff that
14 was handling that - remember, we're really a very small
15 portion of the claims and the claims paid. So, I would
16 hope that they would be able to do that.

17 DR. NEEL: I see an affirmative from
18 Neville.

19 DR. SCHUSTER: Great. Thank you.
20 Good question. Thank you.

21 DR. WATKINS: One thing I wanted to
22 bring up along this line, a patient I had in yesterday was
23 a young man. He's 19 years old, still a senior in high
24 school, and he has been taken off of his nerve medication
25 while they are trying him on different regimens of

1 medicines because of the type of MCO he's been placed in.
2 And I had done an eye exam on him a year ago, and we had
3 good results. He fell 50 feet from a building, had head
4 trauma, was in a coma for three and a half months. You can
5 imagine the situation this young man is in.

6 But we did a fine comprehensive exam
7 a year ago; and now without this medication, I mean, try to
8 hold his head still behind a four-opteron to get a
9 refraction on this young gentleman. His vision had dropped
10 two lines in each eye just because he couldn't hold still
11 long enough to see the letters for me. When your world is
12 moving, you cannot see it clearly.

13 And for him to be trying to graduate
14 from high school in this situation was just very sad, and I
15 hate to see patients being placed in this situation.

16 DR. SCHUSTER: I appreciate that.
17 And, unfortunately, with our population and the acquired
18 brain injury population, if they're not in the waiver
19 program, we have hundreds of those kinds of stories. And
20 the MCO's and the Cabinet have been very good on a one-to-
21 one basis, but we don't have any of the systemic changes
22 that we need to take care that those holes are not in the
23 safety net. I appreciate your concern. Thank you.

24 CHAIRMAN POOLE: Thank you. Next,
25 Consumer Rights and Client Needs. The Dental TAC report.

1 DR. SUSIE RILEY: Good morning. I'm
2 Susie Riley and I'm the newly appointed Chair of the Dental
3 TAC. I'm also on the Passport Partnership Council in
4 Louisville. I'm a dentist practicing in Louisville.

5 For us, the transition outside of the
6 Passport area has been a work in progress as well. We've
7 had several issues, and I think our representative, Dr.
8 Bill Collins, did an excellent testimony before the Program
9 Review Committee earlier this week with photos and
10 documentation of many of the issues.

11 So, I won't try to belabor them here,
12 but certainly some things are a priority concern. One is
13 that the special needs children are falling through the
14 cracks with the way the program is currently structured.
15 When you have children with cleft palates, then, you have
16 need for a multidisciplinary treatment. And that's going
17 from nurses, physicians, plastic surgeons, dentists, the
18 whole nine yards.

19 And they are currently short in the
20 orthodontic area because no one wants to commit to take
21 them. That's for several reasons, not the most of which is
22 money, but having the MCO's commit to the treatment needs
23 of these children, say, in orthodontics, if they're going
24 to need two stages after they've had the surgery for
25 corrections, then, if you can find an orthodontist, the

1 subcontractor companies are only committing to Stage 1.
2 Well, who wants to leave a cleft palate child in the middle
3 of treatment? That's an issue.

4 We also have issues with the dentists
5 versus hospital mismatch because not all dentists are
6 taking all three and not all hospitals are taking all
7 three. So, if you've got a child or an adult patient who
8 needs to go to surgery requiring general anesthesia in a
9 hospital setting and the dentist takes one, the hospital
10 takes another, in Louisville, that might not be as
11 critical, but out in the state in a rural area, that's a
12 real hoop to jump over and to try to work through. So,
13 that's a problem.

14 Prior authorizations as they have
15 been administered up to this point have been seemingly to
16 delay access to care; and access to care is a big issue,
17 even outside the State of Kentucky.

18 So, it doesn't seem that it's just
19 trying to justify the quality of care or the medical
20 necessity. It's just an access hindrance. Especially if
21 you get a denial originally and then, on appeal, about 90%
22 of the denials are overturned, that's a delaying tactic.

23 And another issue is if you have
24 evidence-based guidelines for care and the gatekeeper at
25 the MCO or the MCO subcontractor is telling you, no, it

1 doesn't meet our standard, you need to treat this patient
2 in your office under local anesthesia. I think the most
3 egregious one that we have as an example is a practitioner
4 and oral surgeon who needed to take the patient who was a
5 special needs adult to an OR and was trying to get the
6 authorization from the MCO. The MCO was saying no,
7 however, the patient had had three strokes in the past
8 year, and the neurologist was saying the patient needs to
9 be treated under general anesthesia.

10 All day and into the night, they
11 tried to get the authorization. Finally, the patient had
12 to be removed from the OR schedule because they couldn't
13 get it. That's excessive. So, those type of challenges
14 need to stop.

15 Someone previously had quoted Dr.
16 Bill Collins in saying that poor people don't deserve poor
17 care. Another one of his quotes is any healthcare reform
18 that obstructs access to basic healthcare is deeply flawed
19 and is failing its citizens.

20 Thank you. Any questions?

21 CHAIRMAN POOLE: Thank you, Susie.
22 Cindy, have they had a DMRAB meeting?

23 AUDIENCE: No, sir.

24 CHAIRMAN POOLE: So, no report there.
25 Home Health Care.

1 REPORT OF HOME HEALTH CARE TAC:

2 MR. KIP BOWMAR: I'm Kip Bowmar with the
3 Kentucky Home Care Association. We've continued to work on
4 a number of implementation challenges with Medicaid MCO's,
5 particularly around issues of reimbursements and prior
6 authorizations.

7 There have been some improvements but
8 there's still a long way to go. I think one of the
9 challenges that a lot of our agencies are struggling with
10 is consistency. The reasons for which a particular service
11 is denied one time and then approved another I think is
12 something that the agencies are struggling with.

13 We have had training sessions with
14 two of the three MCO's and we're going to have additional
15 trainings going forward, but there's still a lot of
16 challenges and a lot of agencies are really strapped with
17 difficulties from cash flow problems from the slow payment
18 of claims, but basically that's probably the primary update
19 from the home health side. Those are the main two issues.

20 CHAIRMAN POOLE: Do you have anything
21 to add, Sharon?

22 MS. BRANHAM: I guess, Kip, something
23 else we ought to mention is that we've been meeting with
24 them frequently and discussing issues. And at sometimes we
25 feel like we're peddling forward, only the next week we

1 find out that we've fallen off the bicycle. So, there are
2 some issues that relate to that.

3 And for the life of me, I can't
4 understand why we come to an agreement and then that
5 agreement seems to not be moving forward except at like the
6 snail's pace and it's very frustrating for providers.

7 You know, managed care, managed
8 money, whatever you want to call it, it's here. We don't
9 mind it, but it's the cumbersome issues that we have to
10 deal with that take manpower that we don't have because of
11 the low reimbursement rates that we have.

12 It's not a luxury to have staff
13 sitting there to deal with ongoing issues that relate to
14 the PA is not timely. I mean, you all make it sound good,
15 and I'll give you credit. I'll give the MCO's credit for
16 moving things along better than they were when we went into
17 implementation; but to be the size companies that you are
18 and to have the benefit of working with providers that are
19 giving you direct information on a one-on-one basis on a
20 weekly basis, it seems like there are just multiple
21 roadblocks that have been thrown up in our faces that allow
22 us to not care for the most vulnerable population that
23 we're caring for.

24 We're not making money. That's just
25 here and now. Providers that have been accepting Medicaid

1 in the State of Kentucky under home health has not been
2 making money for a number of years. It's been eleven years
3 since we've had a reimbursement increase. So, we're way
4 behind the times.

5 We've addressed I know to Mike and to
6 some of the physicians with the MCO's and even back to
7 Neville about trying to do some type of an episodic
8 payment. Give us approval for this patient. Give us a
9 dollar amount and let's manage it.

10 We're here to take care of the
11 patient. We all have publicly-reported data and we're not
12 looking to have our scores put in a predicament that
13 doesn't hold us in the highest standard of care. So, I
14 really think ti's something that you all need to look about
15 as well.

16 The slow pace that you move forward
17 at, it's very, very exhausting. And it sounds good and 98%
18 of the PA's are returned within two days. Well, not
19 really. And as far as denial letters, sometimes they're
20 two weeks being put out to the physicians prescribing the
21 services because they don't come to the provider. They go
22 to the physician because we're not seen as the prescribing
23 entity.

24 So, I really think you all as being
25 the Chief Operating Officers of the MCO's need to tell the

1 people that are working with the providers on these weekly
2 phone calls that have been suggested that we do to bring to
3 light issues that we're having to take action on them, not
4 just talk about them - take action on them.

5 CHAIRMAN POOLE: Any other questions?
6 Anything else, Kip?

7 MR. BOWMAR: No. Thank you.

8 CHAIRMAN POOLE: A report from
9 Intellectual and Developmental Disabilities? A report from
10 Nursing Home Care? Any report from Nursing Services? That
11 brings us to Optometric Care.

12 DR. SUSANNE WATKINS: I'm Susanne
13 Watkins, an optometrist practicing in Russell Springs,
14 Kentucky. And I wanted to bring to you some of the
15 problems that we've dealt with since the MCO's have taken
16 over.

17 I wanted to verify and ask of each of
18 the MCO's if there is a licensed Kentucky optometrist on
19 the review committee that takes care of any denials that
20 are being processed. This is a requirement by state law
21 and it is necessary that any denial that is given to an
22 optometrist is handled by a licensed Kentucky optometrist
23 on that review committee before it is sent back as a
24 denial.

25 Are you aware of a licensed

1 optometrist that is there on your board?

2 MR. MINOR: I'll confirm.

3 DR. WATKINS: Please check on that
4 for me and get back to me on that.

5 One of the things that I did want to
6 address that we have had a significant problem with,
7 especially it seems to be listed in the Kentucky Spirit
8 handbook, that there is some misunderstanding that adults
9 are covered for eyeglasses or contact lenses also.

10 It's been traditional with Medicaid
11 that the coverage for eyeglasses is terminated in the month
12 that a person turns 21, and that has been carried on
13 through the MCO's. And at anytime that we have tried to
14 get approval for anyone above that age, it has been denied.
15 But we have dealt with many very adamant patients that have
16 spoken with the MCO's are assured that they're going to get
17 eyeglasses paid for when they are over the age of 21.

18 And I've had many patients leave my
19 office mad saying that we don't know what we're talking
20 about, that their MCO has promised them otherwise and
21 they're going to go somewhere else that is going to be able
22 to abide by that. But when I get a denial over the
23 computer and I know what's going to happen, I'm not going
24 to make eyeglasses for that patient, knowing that they're
25 not going to be paid for.

1 So, if that is something that is in
2 your handbook, the wording is very poor because there is a
3 lot of misunderstanding going on there and I'd like to see
4 that addressed.

5 Also, we have experienced a very poor
6 turnaround with Select Optical which is their provider for
7 Kentucky Spirit's vision product. Usually it's taking two
8 to three weeks for us to get a pair of eyeglasses back.
9 They do have an outlet if it is a provider such as myself
10 that has an in-house laboratory. If we have a frame on our
11 board that we are willing to provide for the patient for
12 \$25 or less and give them a year's warranty on that, then,
13 we can make them in-house.

14 And I'll tell you, if I was to make
15 glasses for that patient, it would usually take me to two
16 to three days turnaround, and that's even ordering lenses
17 out and having them delivered to my office.

18 So, for my patients who have had
19 Medicaid for years and have been used to that turnaround,
20 and now it's taking them two to three weeks to get their
21 eyeglasses, especially when they're a student in school who
22 cannot see the board because they do not have their glasses
23 - they've been broken, situations like this. We have had
24 numerous phone calls with patients that are not happy with
25 the turnaround that we are seeing there and that needs to

1 be improved upon.

2 Any further questions or things to be
3 brought up? Thank you.

4 CHAIRMAN POOLE: Thank you. Any
5 report for Physical Therapy?

6 REPORT OF PHYSICAL THERAPY AND THERAPY TAC:

7 MS. BETH ENNIS: Good morning. I'm
8 Beth Ennis. I'm a physical therapist. I'm the newly
9 appointed Chair of the Therapy Advisory Committee. So, I'm
10 actually reporting for PT, OT and Speech.

11 We have met twice in the last sixty
12 days. So, we are still relatively new, doing a lot of
13 information-gathering and trying to do some problem-
14 solving, but a lot of the issues that we're getting from
15 our constituents sound very similar to the kinds of things
16 that other providers are seeing. Prior authorization
17 turnaround time, especially with children, is taking a
18 long, long time. So, kids are waiting three weeks to a
19 month to get back into therapy once an evaluation is done.

20 Clarity on what those evaluations
21 should contain to give them the most clear information that
22 they apparently want for the referral process and the
23 authorization to go through.

24 There's also question about - and
25 some of these may be Medicaid in general, not necessarily

1 for the MCO's - OT's, occupational therapists' ability to
2 provide services outside of EPSDT. It doesn't seem to be
3 that they're eligible to be Medicaid providers outside of
4 EPSDT. So, we're looking for clarification on that.

5 Differences in reimbursement rates
6 for outpatient clinics that may be off-site versus
7 hospital-based clinics is an issue that we're looking into.

8 Some of the things that we've heard
9 from constituents is concern about high no show and
10 cancellation rates that are kind of inherent, whether it's
11 frustration from the patient's point of view or whatever.
12 They have no recourse as to what to do to try and remedy
13 that. We've all talked about reimbursement rates not being
14 the greatest, so, trying to fill that time and figure out
15 how they can do it.

16 And, then, along the same lines,
17 there's been questions about are there specific guidelines
18 for patient management that are similar to those under
19 Medicare because that may limit what they can do as well.

20 I think one of the biggest things
21 that came up, though, was provider eligibility because
22 right now it seems to be limited to clinics that are
23 affiliated with hospitals. And we have heard some pilot
24 information coming out I think in one region where there's
25 a private practice that is being trialed, and I heard one

1 of the MCO's talking about some pilot projects and I think
2 that may fall under one of those. But is there the
3 possibility of that happening; and if so, what do they need
4 to do to do that?

5 The only other thing that we wanted
6 to bring up - and I'm going to ask them to refresh my
7 memory, too, if I've forgotten anything - is right now we
8 have no appointees from speech therapy on the TAC. So,
9 we're trying to reach out to them as best we can; but if we
10 had a speech member, too, as well, we might be able to be
11 more representative.

12 CHAIRMAN POOLE: And you all have
13 been actively engaged with the MCO's on all these issues?

14 MS. _____: Correct. There
15 have been several meetings I know from the PT side and the
16 OT side both with them to resolve issues, and some have
17 been resolved and some are still in progress. And, so,
18 we're still doing a lot of information gathering and trying
19 to resolve issues as best we can.

20 CHAIRMAN POOLE: And the speech
21 people haven't been represented. They need to get on here
22 so they can be.

23 MS. _____: We reach out to them
24 and try to send things out to the organizations while we're
25 waiting for somebody to get appointed, but we haven't heard

1 from them.

2 CHAIRMAN POOLE: Okay. Any
3 questions? Thank you. For Physician Services?

4 REPORT OF PHYSICIAN SERVICES TAC:

5 DR. NEEL: The Physician TAC met last
6 week and we mainly reiterated among many things that we've
7 already talked about today and I'll just take a brief time.

8 Problems with prior authorizations,
9 of course, and not so much the time it takes to turn them
10 around but the problem that you just have to do them for
11 things that are best practices that we've been doing for
12 some time. Particularly for pediatricians, ADHD drugs,
13 things that we've been using for some time all of a sudden
14 are cut out. That's just not a good idea. And, so,
15 physicians are complaining about that.

16 Again, the fact that there are three
17 different formularies and we've talked about that today.

18 The other is a lot of people are
19 still having problems with assignment of patients that
20 we've talked about. So, I won't go into that more but
21 those are the things we talked about.

22 CHAIRMAN POOLE: Thank you.
23 Podiatric Care? Primary Care? And you also reported for
24 Therapy Services.

25 I did not have anything under Old

1 Business. Yes.

2 MS. McNARY: Children's Health TAC.

3 CHAIRMAN POOLE: I'm sorry. For
4 Children's Health. Sorry.

5 REPORT OF CHILDREN'S HEALTH TAC:

6 MS. LACEY McNARY: We don't want to
7 leave out the children. Anyway, my name is Lacey McNary,
8 and I'm the newly appointed Chair of the Children's Health
9 Technical Advisory Committee, and I work with Kentucky
10 Youth Advocates.

11 We had our second meeting last week
12 and we're still trying to get a few of our ducks in a row,
13 making sure we have all the members who need to be at the
14 meetings there, approving bylaws and that sort of thing.

15 I do have a co-chair and her name is
16 Mary Burch, and she represents the Kentucky Association of
17 School Nurses. We also have representation from the
18 Kentucky Academy of Pediatrics, the Kentucky Psychological
19 Association, Kentucky Association for Early Childhood
20 Education, Family Resource and Youth Services Coalition,
21 and the Kentucky Dental Association. And we're still
22 waiting to hear back from the PTA, the Association of
23 Hospice and Palliative Care and a parent which is always
24 challenging but very important. We'd love to have that
25 representation.

1 We have also had active involvement
2 from others who have been attending our meeting including
3 the MCO's. They have been great coming to our meetings and
4 answering questions and participating with us in our
5 conversations.

6 And just to remind you all, the
7 mission of this TAC is to make recommendations to the
8 Cabinet on issues relating to children's health. And since
9 we've only had two meetings, we're kind of still getting
10 organized, but we will be a very active committee and
11 submitting recommendations to the Cabinet and sharing those
12 with you all.

13 We'd love to have a member from the
14 MAC to attend our meetings as well so you can fully stay in
15 the loop and be active with us.

16 At our last meeting last week, we
17 talked about we really want to look at some data because
18 we're hearing tons of stories, lots of anecdotes and
19 stories and we'd love to really look at some of the data
20 and specifically some of the information that's included in
21 the required MCO reports. It's an 11-page document or
22 something listing all these data points. And, so, we're
23 going to be looking at that to see which ones we'd like to
24 see on a regular basis.

25 We're also really interested in

1 looking at enrollment and retention of children in Medicaid
2 and KCHIP. So, we will be looking at that as well.

3 Our focus for the upcoming year
4 includes three things, and we're kind of still flushing
5 this out, but these are the three things that kind of arose
6 to the top of the agenda - looking at behavioral health,
7 and I keep hearing that today. And, so, we're going to
8 hopefully work with Sheila's committee and anyone else who
9 would like to work with us and getting a sense of what's
10 going on and what we can do to improve that; and like I
11 said, ensuring that children have the access to KCHIP and
12 they can stay enrolled and be retained in that.

13 And, then, we'll be doing, as every
14 other TAC I'm sure is doing, kind of monitoring managed
15 care in relation to children.

16 So, our next meeting is June 13th at
17 2:00. We welcome others. This is kind of a different TAC.
18 It's not all providers. So, we have a different
19 perspective on things a little bit.

20 So, at our next meeting, we're going
21 to be hearing about this federal CHIPRA bonus that other
22 states are getting for simplifying enrollment and retaining
23 children. So, we're going to hearing a presentation on
24 that and maybe how Kentucky can be eligible for that. And
25 we're also going to be hearing an overview of children's

1 behavioral health at the next meeting.

2 So, thank you very much. We're
3 taking lots of notes on what we're hearing today and being
4 very active in attending committee meetings and things like
5 that.

6 CHAIRMAN POOLE: I want to get your
7 contact information because a huge need in children's
8 health is nutritional treatment and therapy for autism
9 spectrum disorder patients. We don't have anything paid
10 for a great deal for nutrition for these children, and I
11 find that the children that I work with in this realm, that
12 a lot of times, it happens to be a Medicaid patient and
13 they just don't have the funds to--you know, you can get a
14 test that will show the deficiencies and what they need and
15 they just cannot afford it.

16 And, of course, I use different means
17 to assist them in that; but I just know it's a huge need.
18 It's certainly a multi-faceted nutritional deficiency
19 condition and it needs a great deal of help. So, I would
20 really like to work with you guys on that and hopefully
21 Medicaid will do a pilot project or something we can work
22 with on that.

23 Anything else? Thank you very much,
24 and sorry about skipping over you there.

25 Anything under Old Business? I had

1 two items here under New Business, one of them on the
2 actions. Since we don't have a quorum, what I'm going to
3 do, Neville, is update them because we've talked about some
4 of these things today and send you an email with the
5 updated list.

6 And, then, secondly, we have a guest
7 here today to talk to us about the Public Health
8 Departments.

9 DR. SWANNIE JETT: Thank you for
10 having me. I'm Dr. Swannie Jett, Executive Director for
11 the Bullitt County Health Department, a Doctor in
12 Epidemiology, Public Health, and Preventive Medicine.

13 I've been in local health departments
14 now for about sixteen years, and with the change to MCO's,
15 even though I'm in a Passport region, it has become a
16 critical impasse. Twenty out of 58 health departments are
17 currently in the red.

18 Now, let's put that in proper
19 perspective. According to the KRS statute, they are the
20 safety net not only for the poor but for anybody that needs
21 service in those local areas. There's limited
22 transportation in some of the rural communities. There's
23 limited health access. There's a lower amount of
24 physicians in some of these areas. There are no hospitals
25 in some of these areas.

1 So, when reimbursement is late from
2 the MCO and local health departments need to take a loan
3 out or they have to borrow money from the State in order to
4 pay their staff, that's a critical problem.

5 Right now a lot of health departments
6 are going through that situation. They're trying to deal
7 with it as best as they can; but I have to be very candid.
8 We need the MCO's to be on board and provide the assistance
9 that's needed.

10 Also, the local health departments,
11 we've had a 20% match, and I'm sure that Neville knows
12 about that. With us having to pay a 20% match for Medicaid
13 services of reimbursement, that also puts us in a further
14 deficit. Other providers do not have to pay this 20%
15 match. So, somehow we need to have that layer removed as
16 well.

17 I do appreciate what has been done to
18 this point because a lot of health departments are just now
19 starting to receive funds. We usually keep probably three
20 to six months' worth of a budget to cover when we don't get
21 paid up front or when reimbursement is late; or because the
22 State budget is late in its approval process, we are
23 allowed by the statute to have a three- to six-month
24 reserve.

25 Well, well are beyond the reserves.

1 Some health department have begun to dip into reserves for
2 the last few years and it's become critical. Even the
3 health departments that might have \$2 million in reserve,
4 they are on the brink of two years not having that. So,
5 we're at a critical impasse and I reach out to the MCO's.

6 The KPHA meeting is next week, the
7 Kentucky Public Health Association. I reach out to you to
8 attend that meeting, to find solutions fast. Thank you.

9 CHAIRMAN POOLE: Isn't the matching
10 funds closer to 30%?

11 MR. JETT: It's closer to 30%. It
12 started at 20% a couple of years ago but it's closer to 30%
13 now.

14 CHAIRMAN POOLE: I'm on the Board of
15 Health in Muhlenberg County. Every Board of Health is
16 looking at their taxing district, looking at increases,
17 trying to gain revenue somewhere, and we're dipping into
18 our savings that we've had for those rainy days. Well, now
19 is a rainy day and some health departments don't have that.

20 DR. JETT: That is correct.

21 CHAIRMAN POOLE: Thank you for
22 coming.

23 MR. MINOR: Just a quick comment. I
24 know that in the public health methodology, the way that we
25 are contracted to follow this, originally this was the

1 public health department claims would go to DPH. They
2 would submit the claims to us. We would pay them back to
3 DPH and then they would, in turn, push the money down to
4 the individual public health departments.

5 I know from everyone's perspective,
6 Dr. Davis as well as our CFO have been working with us to
7 try to facilitate a methodology that shortens that cycle.
8 And I do know that they were able to supply claims to
9 WellCare at the end of February, and we, in turn, were able
10 to process those claims and send those payments directly to
11 the individual health departments.

12 And I know that each of us are
13 working still with DPH to make sure that those payments can
14 be reconciled and there's an avenue for individual health
15 departments to be able to look those up online. I had
16 heard that's something that we wanted to do previously, but
17 that would allow perhaps quicker reconciliation.

18 We look forward to your feedback to
19 see if that does help as we go forward. If not, we
20 understand and we'd like to make sure that that's as easy
21 as possible to reconcile those payments.

22 DR. JETT: The meeting next week is a
23 good meeting to attend and I know some of you already have
24 that on the agenda. Also, KHDA meets, Kentucky Health
25 Department Association, meets once a month in Frankfort at

1 Franklin County Health Department. That's also a good
2 meeting to always attend and you can hear directly from
3 health departments themselves.

4 Part of the issue is the Kentucky
5 Department of Public Health is a quasi agency for local
6 health departments. So, we do not directly report to them.
7 We have our own Boards of Health. So, our issues are
8 sometimes a little different.

9 Unlike me, I'm in a Passport region.
10 So, my funding comes directly from them. My agreement does
11 not go through DPH. That's the luxury that we do have. And
12 maybe somehow in contract talks in the future for
13 reimbursement, that's something that should be looked at.

14 MR. MINOR: And I think also one of
15 the messages that we need to push is make sure that the
16 health departments have access to electronic payments and
17 that will also increase that. And I think at that point,
18 the funds will be flowing very quickly.

19 CHAIRMAN POOLE: Thank you. Since we
20 don't need a motion to adjourn since we don't have a
21 quorum, I guess let's adjourn.

22 MEETING ADJOURNED

23

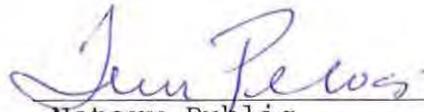
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STATE OF KENTUCKY
COUNTY OF FRANKLIN

I, Terri H. Pelosi, a notary public in and for the state and county aforesaid, do hereby certify that the foregoing pages are a true, correct and complete transcript of the proceeding taken down by me in the above-styled matter taken at the time and place set out in the caption hereof; that said proceedings were taken down by me in shorthand and afterwards transcribed by me; and that the appearances were as set out in the caption hereof.

Given under my hand as notary public aforesaid, this the 27th day of March, 2012.



Notary Public
State of Kentucky at Large

My commission expires February 10, 2013.