

ORIGINAL

CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

REGULAR MEETING

July 24, 2012
10:00 A.M.
Room 125, Capitol Annex
Frankfort, Kentucky

APPEARANCES

Ron Poole, R.Ph.
CHAIRMAN

Mr. Chris G. Carle
Mr. Richard L. Foley
Ms. Oyo Fummilayo
Ms. Sheina C. Murphy
Dr. Donald R. Neel
Dr. Elizabeth Partin
Ms. Peggy S. Roark
Dr. Susie Riley
Mr. Barry Whaley
Ms. Sharon Branham
COUNCIL MEMBERS PRESENT

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APPEARANCES
(Continued)

Mr. Russell Harper
COVENTRYCARES

Mr. Daniel Willis
KENTUCKY SPIRIT

Ms. Dora Wilson
WELLCARE OF KENTUCKY

AGENDA

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1 CHAIRMAN POOLE: Let's get started.
2 A couple of things right off. Sheila Schuster's group for
3 Advocacy, they're doing an advocacy training video and
4 that's why we're being videoed today.

5 Also I'll make an announcement now
6 and then at the very end. If you want to be put on an
7 email list to let you know about up and coming meetings
8 with the MAC, see Sharley afterwards and give her your
9 business card with your email address. She doesn't mind to
10 do that at all. I've had a lot of people ask me about
11 that.

12 The first thing on the agenda is to
13 approve the minutes from our last official meeting which
14 was 12/15/2011 and 3/22/2012. We had those with us last
15 time. We didn't have a quorum, so, we could not approve
16 them. So, do I have an motion to approve?

17 MS. BRANHAM: I make a motion.

18 MR. WHALEY: I'll second.

19 CHAIRMAN POOLE: All those in favor,
20 say aye. Any like sign? Motion carries.

21 Now on behalf of the Medicaid
22 Advisory Council, I'd like to welcome our new Secretary,
23 Ms. Secretary Haynes for her comments, and we really thank
24 you for coming. We really appreciate it. And now Deputy
25 Commissioner Neville Wise also, welcome him as usual.

1 REPORT OF CABINET FOR HEALTH & FAMILY SERVICES,

2 DEPARTMENT FOR MEDICAID SERVICES:

3 SECRETARY HAYNES: How are you all
4 this morning? It's nice to be here and nice to see
5 everyone. I think it's probably been, what, three months.
6 You all met either just before or just after I started on
7 April 16th, but who's counting? Right?

8 I asked Neville yesterday what was
9 the expectations for comments here this morning. And, so,
10 I'll touch on a few things and then would certainly welcome
11 questions by any of you.

12 I would say that one of the newest
13 things that's happened is you referred to Neville as Deputy
14 Commissioner. We have just recently appointed a new
15 Commissioner for Medicaid Services who couldn't be here
16 today. He had a long awaited family reunion that only
17 happens every three years which, of course, he told us
18 about before his appointment. So, we could have waited
19 until next week to make the appointment, but we went ahead
20 and he's got a good two weeks under his belt before we knew
21 he would have to be gone this week.

22 Commissioner Kissner comes to us with
23 many, many, many years in the health insurance market and
24 also more recently in managed care. And because of the
25 complexities of dealing with the managed care system and

1 the organizations that are now in place, I would say that
2 having someone with his background and understanding about
3 how managed care companies work, how state governments can
4 best work with them to ensure improved quality outcomes for
5 our members is very important. And he comes to us knowing
6 quite well that getting to savings is one goal but
7 certainly quality health outcomes is equally as important
8 to the State of Kentucky for the longer-term savings that
9 we might be able to achieve.

10 And there is absolutely no doubt that
11 there have been bumps, people could say deep ravines, more
12 than a bump along the way in the implementation of managed
13 care. We still have improvements to make, but I must say
14 that the managed care companies have worked with us very
15 well.

16 As you see it play out in the press,
17 we don't always agree on how we're going to move forward,
18 but there is a real commitment among all of us to work
19 together. There's never a week that goes by and frankly
20 hardly a day that goes by that there are not meetings at
21 the Cabinet between provider groups, the managed care
22 companies and the Cabinet.

23 Most recently, we have engaged a
24 consulting firm that specializes in working with states
25 that have gone to Medicaid managed care to help us think

1 through the Department of Medicaid Services and how it is
2 that we best sort of reorganize our staff in the Department
3 of Medicaid Services, as well as how is it that we ensure
4 compliance to those contracts, the managed care contracts.

5 And, so, we just met with the firm
6 last Monday morning for the first time, and they'll be here
7 working with us for about the next six months. I have
8 really nothing more to report on that; but maybe the next
9 time you meet, we can give you a report about sort of what
10 they've done, how things are looking; but we're looking at
11 a little bit of everything, I will tell you.

12 We're looking at not just staffing
13 but we're looking at other aspects of providing Medicaid
14 services in the State of Kentucky that have been changed by
15 the managed care organizations now coming in. So, they're
16 kind of looking at a whole array of things and they'll
17 bring in some best practices from other states, and
18 certainly they're bringing a lot of lessons learned to us
19 from other states in which that they have worked and
20 currently are working.

21 So, we are looking forward to that,
22 and we've been very up front with all the staff in the
23 Department of Medicaid Services, and we know that new staff
24 training is on the horizon, and, so, people are pretty
25 excited about all that.

1 The second big thing that's going on
2 as far as from my office goes is every two weeks, the
3 Commissioners of Medicaid, Public Health, Behavioral
4 Health, Aging and Independent Living, and Department of
5 Community-Based Services meet for a two-hour block. And we
6 stay held up in my office to begin to have discussions
7 about how we can serve more people and how it is we can
8 better leverage our Waiver Programs. And I know that
9 advocates in the state are quite interested in our Waiver
10 Programs, as they should be.

11 And, so, we're beginning to take a
12 look across departments now as to really how is it that we
13 can work with CMS to re-frame, redo, update, refresh our
14 Waiver Programs so that they make the most sense. In some
15 cases, we're trying to fit square pegs in round holes and
16 vice versa. And the advocates and the consumers know quite
17 well that we're not always serving people the most
18 efficient way.

19 And, so, we're trying to get some
20 ideas that we can put on the table to the provider groups
21 at some point in the future about how we might look at sort
22 of updating some of our Waiver Programs in the future which
23 I think is probably going to be, from all the advocate
24 groups I've met with, I think they certainly don't want to
25 lose their services but dispensing with some of the hoops

1 and red tape and that sort of thing seems like to me could
2 be a welcome relief to folks.

3 So, I'm happy to take questions from
4 any of you at this time before Neville gives an additional
5 update.

6 CHAIRMAN POOLE: I'm glad to hear
7 your comments on the new Commissioner because obviously
8 knowing that he came from the MCO industry, there's some
9 concerns obviously among this whole panel up here as to,
10 you know, the main thing is unbiased representation to put
11 the patient in front of everything else.

12 Do you want to go ahead, Dr. Neel?

13 DR. NEEL: Madam Secretary, Dr. Neel,
14 pediatrician from Owensboro. I'm sure you're aware that we
15 gave up a managed care system, a management care system
16 called KenPAC that was doing a fairly good job of managing
17 care in Medicaid. We were not able to keep the
18 expenditures down to what we would have liked to but we did
19 manage care. So, pediatricians and primary care providers
20 were paid a fee for doing that.

21 Now we see that we've brought in what
22 is determined managed care. And I think that's the problem
23 that most of us in primary care are having right now is
24 that we want to know exactly who is managing the care
25 because after nine months, we're not seeing much coming

1 from the MCO's that's doing the very thing that we were
2 doing before.

3 And, so, we're struggling. We're
4 struggling to find our patients through auto assignment to
5 the companies but not to the physicians, and I could go on
6 and on. And I've laid awake nights before this meeting
7 trying to think how I could be positive about things at
8 this point.

9 But I'd kind of like for you to
10 define, if you would, who you expect to be managing the
11 care because we've lost a lot of the good things that we
12 thought we had in managing care and we don't see that we've
13 gained a whole lot of positive from them at this point.
14 And I can tell you that after nine months, they're still
15 struggling because we were premature in getting this
16 started and we've all been playing catch-up, and I'm not
17 sure we're all going to make it through this.

18 But I would like for you to kind of
19 define what you expect them to do in managing care other
20 than just managing the money.

21 SECRETARY HAYNES: Well, Dr. Neel, I
22 assure you we are going to manage our way through this for
23 the next two years. We have three-year contracts into
24 place, and Region 3 will be coming on board at the
25 Louisville area beginning in January, and we have an

1 eighteenth-month contract. So, all of the contracts will be
2 up at the same time in three months.

3 Regarding quality of care, the
4 managed care organizations have great incentive to do a
5 better job of managing care because the better care
6 management that they provide, the more preventative
7 services that they direct people to and the increased
8 wellness of our patients, of course, will be savings for
9 them in the end and it's good for Kentucky and our health
10 statistics.

11 So, I would just say at this point
12 that you're correct, that not everything has gone smoothly.
13 I suspect there will still be other problems. We know
14 right now that we're having problems especially in the area
15 of behavioral health because there are big gaps in the
16 service system out there, and we are having conversations
17 with providers as well as the managed care organizations
18 about how we are going to look at sort of narrowing those
19 gaps with other services that could be put in place out
20 there to assist.

21 I suspect that as we move forward,
22 each company in their contract, they have goals of how many
23 people will be truly managed by care. Out of the number of
24 people that they are receiving or that they have as
25 members, according to the acuity of that person, they have

1 a whole system in which that they prioritize the management
2 of care and assign them a nurse to begin to work with and
3 to help them.

4 We have a long way to go there, and
5 all I can say to you is that we're now at a point now that
6 providers are more often than not - I'm not saying every
7 time - but more often than not receiving payments on a
8 timely basis, on a more timely basis. It's not quite like
9 Medicaid did of paid within like seven days. It's usually
10 not quite that good, but certainly providers are now
11 beginning to get on a more timely basis.

12 So, I think that in the year going
13 forward, these are all areas that we hope to work with them
14 to improve upon. They provide to us about 140 reports in
15 the course of a quarter. Some of those are monthly, some
16 of those actually are even weekly and some are only
17 quarterly.

18 We have a thorough examination going
19 on right now of all of those reports and especially looking
20 at management of care, quality of care and those
21 indicators. So, we will have a much better idea going
22 forward at areas in which we will work with them to begin
23 to improve services. It's a lot to get one's arms around,
24 though. I would say that.

25 The other thing is I forgot to

1 mention in my opening comments - I'm sure all of you know
2 by now - that the Governor released the Executive Order to
3 create the Health Benefits Exchange last Tuesday. We named
4 Carrie Banahan, someone that this committee probably knows,
5 to be the first Executive Director of the Exchange, and it
6 will be located in the Cabinet for Health and Family
7 Services. We're on track to have that up and running
8 January of 2014 with no decision about Medicaid expansion
9 at this point.

10 CHAIRMAN POOLE: Thirty-four states
11 have either reduced benefits to Medicaid beneficiaries or
12 reduced the rolls by reducing qualifications. Obviously
13 our state isn't going down that road and that's fine. I
14 understand.

15 On a financial front, I understand
16 what those states are doing. If the funds aren't there to
17 take care of everybody, then, we need to reduce.

18 However, in this state, I practice
19 pharmacy now going on twenty-two years and we've received
20 six cuts in reimbursement counting this last one which was
21 contractual cuts. And at some point in time, there is no
22 more blood to get out of the turnip. The cuts cut to the
23 bone.

24 I've talked to many providers. We
25 talk back and forth through emails and stuff. We want to

1 take care of the patients. We've been doing it for a long
2 time. We have a lot of care and concern. Everybody has
3 the patient in the forefront of their mind and puts them
4 before a lot of other things. But I hope that in the
5 future, that when we look at budgetary shortfalls, that
6 it's just not another cut that puts everything back in a
7 budget.

8 I think all Kentuckians should share
9 in paying for the Medicaid Program. It shouldn't fall
10 unfairly on the providers to continue to take cuts and cuts
11 to the point where they're considering not taking Medicaid
12 anymore.

13 Now, I know as much trouble as home
14 health agencies have had, if they have an area that is not
15 saturated with Medicaid, they're just dropping Medicaid and
16 making it on cash, cutting back and just making it on cash
17 and other private third parties.

18 So, I hope that some day that we can
19 have other revenue sources or do other programs. I know in
20 pharmacy alone, there's a ton of pilot projects we can do
21 to save, whether it's asthma care, whether it's through
22 hyperlipidemia, through cardiac initiatives that we can do
23 to try to get our population healthier and that's the main
24 thing. So, I want you, if you don't mind, to comment on
25 that.

1 out, that many other states have done.

2 Some of the horror stories about how
3 some of the states have handled their Medicaid population
4 that I've heard just in the last three months are nothing
5 short of tragic for those consumers, and Kentucky has I
6 think done a very good job of managing that. It's not the
7 best job and it is going to hurt people across the board,
8 particularly our providers.

9 And I'm not sure what else to say
10 about that except at least our providers have been spared
11 the really deep cuts that we have seen in surrounding
12 states. I think if you talk to the managed care
13 organizations, they would tell you, which I hear from them
14 regularly, that our Medicaid rate is still quite lucrative
15 compared to surrounding states and their fees, their
16 reimbursement rates.

17 So, I can only sympathize with you
18 and empathize with you at this point and just tell you that
19 throughout the Cabinet for Health and Family Services, in
20 my Department for Community-Based Services with social
21 workers where we go out and work with kids and families in
22 crises day in and day out, I have social workers day in and
23 day out putting their lives in harms way for for \$35,000
24 and \$40,000 a year and I really worry about them, to be
25 perfectly honest, and they're working with many of the same

1 people that our Medicaid Program helps to support. So,
2 again, what we're trying to do is better leverage all of
3 our dollars across the board.

4 Regarding the Medicaid Advisory
5 Council, now that we have a new Commissioner, I'd like for
6 you all to think about a small group of you that would come
7 and meet with us in the coming weeks and let's have that
8 very discussion. I look forward to engaging with you now
9 that the landscape has changed on how that it is exactly
10 that you all could best be utilized, and then maybe we
11 could bring some good recommendations back to your group.

12 I'm not sure what the rules are for
13 conference calls and that sort of thing, but quite possibly
14 we could have some work between now and the next quarter
15 meeting that would really help to redefine or better define
16 your role moving forward in sort of the new normal, and we
17 would look forward to that. I certainly look forward to
18 that.

19 On that note, I'm not sure that I had
20 met any of you before today; however, the first two months
21 I was here, I had over sixty meetings in my office with
22 over 300 advocates with all aspects, of both Medicaid and
23 all other aspects of the Cabinet.

24 So, all these fine people sitting
25 behind me, most of them have probably been in my office at

1 least once, if not several times, and they know that my
2 goal and my number one goal was to open up the Cabinet and
3 to be a good listener, to try to find ways to better work
4 together, to better leverage each department in the Cabinet
5 so that we can provide better services to more people with
6 the same money that we have. The money is what it is.

7 And, so, I am listening and I look
8 forward to working with you in a more productive way.

9 CHAIRMAN POOLE: Okay, because that's
10 been the frustrating point with us. There's a lot of
11 meetings that go behind the scenes just like you. All
12 individual industries come to you. It certainly seems like
13 to me when you have everybody, unless you can tell me a
14 stakeholder that's not supposed to be in the room -
15 there's a few people that's not here - but a group that
16 couldn't address any situation with any industry that's
17 represented.

18 So, that's I guess the frustrating
19 point for me, and it could make your all's job a lot easier
20 if this was the forum that they could bring their problems.
21 That's what the TAC's should be about, the Technical
22 Advisory Committees.

23 So, I would like to get to that
24 point, and I think it would be a great tool for you guys.
25 I know Neville has tried to encourage that, and then right

1 afterwards, he has meeting after meeting after meeting
2 right after our MAC. So, that's where I come from on that,
3 plus what obviously the statute says, too, but I look
4 forward to working with you on that. And, yes, we'll be in
5 contact and we'll come up with some things that we want to
6 be beneficial obviously.

7 SECRETARY HAYNES: I hear your
8 frustration and look forward to trying to determine a
9 better way to move forward together.

10 MS. FUMMILAYO: Ron, may I ask a
11 question?

12 CHAIRMAN POOLE: Yes. Go right
13 ahead.

14 MS. FUMMILAYO: Oyo Fummilayo, and I
15 represent children, minority and women and low-income. You
16 said you had bimonthly Commissioner meetings. So, is that
17 anything that we could probably sit on or sit in on and
18 listen to and bring back, anyone from the Board, or is this
19 a closed-door meeting for the Commissioners and you only?

20 SECRETARY HAYNES: Yes, it is closed
21 door. It's just with my staff and me, just like I have a
22 Monday morning meeting from 9:30 to 10:30 with all my
23 direct reports, and it's kind of an update every Monday of
24 what's going on in all of the departments and offices, just
25 like any of you would have a staff meeting at your office.

1 And, so, it's a time without other
2 staff frankly or anyone else in the room for us to have
3 better conversations about ideas, leverage, better leverage
4 the Medicaid budget, better work. We have more guardians
5 of the state. They're at the highest level now than any
6 other time in our state's history both for those eighteen
7 and over as well as those eighteen and under. Many of
8 those end up being paid by General Fund dollars. That's
9 just like one item on the table. There are many.

10 How is it that we begin to get youth
11 into more community-based services and how do we keep them
12 out of these long-term stays in inpatient facilities.

13 MS. FUMMILAYO: So, it's your
14 Cabinet, right, your Cabinet?

15 SECRETARY HAYNES: It is only my
16 direct reports, my Commissioners, and there's five. But
17 then the job would be, after we leave those meetings and we
18 have ideas, everyone knows it's our job to begin to work
19 with the people, the stakeholders that care to sort of
20 surface ideas. This is something we've been talking about.
21 What do you think? And, so, I suspect that nothing will
22 happen without you know about it.

23 MS. FUMMILAYO: So, it's the meeting
24 after the meeting that we get.

25 SECRETARY HAYNES: Yes.

1 MS. FUMMILAYO: Okay. Thank you.

2 MS. BRANHAM: Madam Secretary, thank
3 you for coming today and it's nice to meet you. I think
4 the part that troubles me some being a participant on this
5 committee and really being dedicated and also legislatively
6 and with the Kentucky Home Care Association, on the Board
7 and things such as that, when meetings started in your
8 office, it would have been nice for some of your
9 Commissioners to advise you that this Council is in
10 existence.

11 Before the MCO's or other advocacy
12 groups were brought into your office for meetings, it would
13 have been nice for us to have been brought because I think
14 it was - when did we make our comments, Ron? What date did
15 we submit this, like May?

16 CHAIRMAN POOLE: Yes.

17 MS. BRANHAM: And, really, it's been
18 unaddressed since then. We're at the end of July.

19 So, this was out here. We had
20 comments. The Cabinet called for comments. We got
21 together. We put our comments together. We presented them
22 and they've been lying around with no attention given to
23 them at all. And we're all busy. We're all trying to deal
24 with the cuts that we're dealing with. We're trying to
25 deal with fighting for our patients and being advocates for

1 our patients, whether it's for their life-saving
2 medication, to allow them to remain alive and stay in their
3 home or whether it's for dressing supplies or whatever it
4 may be.

5 Now, I didn't get into the home care
6 business to make a lot of money. I'm a nurse by degree. I
7 got in the home care business because I care for people and
8 I advocate for people. And the population that we tend to
9 advocate for in the home care industry not only in the
10 nation but in Kentucky but in the nation as well are those
11 who are elderly or those who are disabled or sick.

12 And it's very frustrating when we
13 talk about cuts that we've had. You know, we've never had
14 any increases, for your information, on any reimbursement
15 on the home health side in fifteen years. So, I'm not just
16 doing it for the profit margin.

17 Actually, to get through this
18 transition of business as normal, and now we are through
19 July on this, this transition, by using, because I'm an
20 independent, small agency, and for twenty-five years I've
21 used my retirement money to get through this period.

22 We know there's a lot of dollars out
23 there that are not--you know, as we said, we had managed
24 care in Kentucky. It just wasn't called that, so to speak.
25 We didn't go out to the home or we didn't dispense

1 medications or someone didn't go to--well, they could go to
2 a hospital but they weren't admitted unless we had prior
3 authorization. So, there wasn't over-utilization.

4 And when we meet with the MCO's and
5 through this transitional period, comments have been made
6 to us that reflect, well, there's a lot of fraud in the
7 industry. Well, no, there isn't in Kentucky because we are
8 a certificate-of-need state. We have "x" number of home
9 health agencies, no more. That's it. And because of what
10 we're going through in Kentucky, we're getting less and
11 less which provides less and less choices for patients.

12 And if you are fortunate enough to be
13 in an urban area, you can have some private insurance. But
14 if you're unfortunate enough, or fortunate enough,
15 whichever - I call it fortunate - to be in Appalachia,
16 then, we've got Medicare and Medicaid. I mean, that's it.
17 And to have to battle for your \$85 for a nurse to travel
18 two hours to give one life-saving injection with an MCO
19 company, to me, is absolutely absurd.

20 And when we talk about the dollars
21 that are out there and reorganizing, then, we need to look
22 at we've got our advocacy groups, we've got people around
23 that know what's going on. Neville has worked with us but
24 Neville's hands have been tied. Carrie worked with us but
25 Carrie's hands have been tied. The MCO's have worked with

1 us and this is the end of July and the games continue to go
2 on and on and on.

3 We've shared with Ted. The Technical
4 Advisory Committee met last week. We shared with Ted
5 what's going on and what's continuing to pop up. Every
6 time we think we get something resolved, it just comes
7 right back. And then something else is attached to it, and
8 I don't know how many hoops that you're supposed to jump
9 through to provide direct patient care. (A) it's a
10 savings; (b) the patient gets to remain in the home because
11 nursing homes were left out of it.

12 But the whole point is there's money
13 out there. There's 6,000 slots right now under the Waiver
14 Program that are not filled and they're not filled because
15 of the low reimbursement rate. We can't afford to provide
16 free care. We have to cover our costs, and, actually, most
17 of us are not covering our costs.

18 With the great minds that are around,
19 we ought to be able to get our heads together and come up
20 with some ways to redistribute these dollars and to get
21 some other waivers that are out there for a state like
22 Kentucky. There's 6,000 slots that are unfilled merely
23 because of the reimbursement, and these people can use help
24 but they don't want to give up their home. When it comes
25 to signing the estate recovery, they don't want to sign

1 that. They don't want to give up what little bit they have
2 left.

3 And then the fact that they can't
4 remain in their home when we've got all these slots. I
5 know Kip, our Executive Director, has been meeting with
6 some of the advocacy groups because the services are there,
7 but we're going to have to try to work better with the
8 dollars that we have in order to better serve the people
9 that need the service.

10 We are "your police." It's costing
11 money to bring the MCO's in here; and I'm telling you, at
12 every turn that we think we've gotten issues worked out -
13 and believe you me, I've been meeting with them on an
14 ongoing basis - it was weekly and now we're down to about
15 monthly or whatever or at all and to emailing - but it's
16 really been poorly executed as far as MCO's coming in, and
17 every provider sitting at this table will tell you that.

18 The payments are better, but we've
19 asked for information now at least the last three quarterly
20 meetings we've had with the MAC, not just claims submitted
21 and paid but really how much of a whole claim has been
22 paid. And the providers reps that they put out there on
23 the streets to be our advocate to go back and forth,
24 they're ill-advised.

25 And the thing that I see coming down

1 the pike is your guys' dollars are part of CMS dollars and
2 CMS is going to start tying reimbursement to the job that
3 you do. Well, for the first time in I couldn't tell you
4 other than maybe a family that wasn't happy they didn't get
5 their bath at 8:00 a.m. on Monday, Wednesday, Friday, that
6 we're getting negative reviews.

7 And the negative reviews are coming
8 because the MCO's are not allowing the patients to have the
9 supplies that are needed to provide their service nor are
10 they allowing the agencies or the pharmacies or the
11 behavioral units or the physicians to do what needs to be
12 done in a timely manner. Waiting up to two weeks for prior
13 authorization causes us to have negative publicly-reported
14 outcomes. Our hands are tied, but we're going to be again
15 penalized because of that.

16 So, these are some of the issues that
17 I think you as the Secretary need to tune in on, and I
18 think you need to use us not only as is mandated but
19 because we are the experts in Kentucky of what we're
20 providing.

21 SECRETARY HAYNES: Thank you.

22 CHAIRMAN POOLE: Any other comments
23 or questions?

24 MS. MURPHY: My concern in all this
25 is the full focus of everything should be on the patient,

1 the consumer, mental health consumer for practical
2 purposes. And because of the nature of psych meds and
3 everything, a lot of people with mental health diagnoses
4 also have physical problems, too, and it can take you years
5 to work out that delicate balance between your psychiatrist
6 and your doctor.

7 What has happened in the western end
8 of the state, I talk to consumers all the time who tried to
9 do the responsible thing. They did due diligence. When
10 the MCO's first came, there was an open enrollment period
11 and you chose.

12 Consumers have that open enrollment
13 period once a year, but you can get all your ducks in a row
14 and get your providers--you know, make your decision based
15 on what works for you and what is covered; and then three
16 weeks after you choose, the contract abruptly stops with
17 your providers. You go to the doctor and there's a notice
18 on the door, as of August 1st, we will not be taking any of
19 the three MCO's.

20 And this is after you've gone through
21 an act of Congress to get your stuff worked out, and it
22 really concerns me. It would seem to me that the contracts
23 between the providers and the MCO's ought to be able to at
24 least last a year that the consumer is committed to.
25 That's all I have to say.

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CHAIRMAN POOLE: Thank you. Go ahead.

DR. PARTIN: Would this be a time for me to make the comments that I wanted to?

CHAIRMAN POOLE: Sure.

DR. PARTIN: My name is Beth Partin and I'm a nurse practitioner. I had a situation come up that Mr. Wise is aware of, and I really appreciate the help that you gave me on that situation. But I'd like to bring this information forward.

I had a patient who has Medicare and Medicaid. Her Medicaid is with Coventry and she had had home health services for quite a number of years. I received a letter from Coventry saying that the home health services were going to be denied.

So, I called Coventry to find out what I could do to appeal that. When I spoke with the representative, I was told that since the review for the appeal required a peer-to-peer review and I was a nurse practitioner, that I would not be able to do the appeal because it could only take place between a physician and another physician.

As a primary care provider for Medicaid patients, I was really pretty insulted about that, and I felt that my patients were being given short shrift

1 because I was a nurse practitioner.

2 Luckily for me, Mr. Wise intervened.
3 And the day that I emailed him, he responded to me within
4 about ten minutes of my email. That afternoon I received a
5 call from a nurse manager from Coventry, the manager of the
6 Appeals Department from Coventry and the Vice-President for
7 Operations from Coventry and I was pretty amazed. I was
8 really shocked that I generated that much attention.

9 I was told that the appeal process
10 would be put in place and that probably because the patient
11 had Medicaid and also Medicare, that it shouldn't have been
12 denied in the first place.

13 And, so, we went through all this. I
14 had to write a long letter to Coventry appealing it which
15 took a lot of time. I couldn't do it during my work hours
16 because I see patients during my work hours. So, I took a
17 weekend to do that. And eventually I got the letter saying
18 that, oh, yes, this was a mistake and she shouldn't have
19 been denied.

20 My problem with this is twofold; one,
21 that a nurse practitioner should be able to appeal a
22 denial. I have not heard anything from Coventry on that,
23 and I would like a letter stating that that problem has
24 been fixed because I don't think that patients who see
25 nurse practitioners should be second-class citizens and

1 they should not be denied the appeal process.

2 And, then, secondly, I think that it
3 was really pretty inefficient for Coventry to send me the
4 letter of denial in the first place when they said that it
5 shouldn't have been sent because it caused my patient to be
6 very upset for a number of days because she was very
7 frightened that she was going to lose her home health
8 services.

9 The home health agency did all they
10 could to be helpful. They switched her over so that
11 Medicare would cover her home health services in the
12 meantime while we were getting this problem fixed. But I
13 feel like we should look at the big picture and we need to
14 fix the overall problems. I shouldn't have received the
15 denial letter and I should be able to appeal denials for my
16 patients.

17 So, I wanted to bring this forward so
18 everybody could be aware of it.

19 CHAIRMAN POOLE: Thank you.

20 MS. ROARK: My name is Peggy Roark.
21 I'm a Medicaid recipient. I live in Jessamine County and
22 I've been hearing rumors that Coventry Care is trying to
23 get out of their contract. A lot of places, even the local
24 hospital, they're not accepting Kentucky Spirit.

25 And I guess I was curious, too, about

1 this new Obama Healthcare, that there's healthcare for
2 everyone because there's a lot of people that I know that
3 don't have any health coverage.

4 And to touch on the behavior side,
5 you're talking about saving money and filling in the gaps.
6 I don't know if you've heard of the Cope House. There's a
7 peer support specialist and this is on in other states and
8 it's been successful to cut down to keep these patients
9 from going into these long-term homes and I feel being
10 mistreated.

11 So, I think there's a lot of things.
12 I agree that we all need to get our heads together and come
13 up with some solutions and we need to have phone
14 conferences and be more up to date on all this because it
15 is getting left behind and fill in these gaps.

16 SECRETARY HAYNES: The first thing I
17 want to do is thank you for your involvement and your
18 honesty.

19 And, secondly, I would say I'll
20 answer one of your questions regarding the Affordable Care
21 Act, politically known as Obamacare, not officially known
22 as - it is the Affordable Care Act - that was recently
23 upheld by the Supreme Court, most of it, not completely all
24 of it. Kentucky is fully engaged in participating.

25 So, let me give you a couple of

1 examples of people that will benefit from the Affordable
2 Care Act whether we have Medicaid expansion or not. So,
3 one example is a friend of mine, a close friend of mine has
4 a sister who is a substitute teacher. She does not have
5 health insurance as a substitute teacher, full benefits.

6 It is estimated that at most, she
7 probably makes around \$15,000, \$17,000 a year. I think her
8 sister is probably in her forties. She is going to be able
9 to go, beginning January 1 of 2014, to the Health Benefits
10 Exchange and she is going to be able to purchase health
11 insurance. She may even without the expansion qualify for
12 Medicaid. I have no idea, but people would be able to go
13 on the Exchange, fill out their salary and their income
14 information and you would first be able to detect whether
15 or not you are eligible for Medicaid because we have people
16 right now out there eligible for Medicaid that don't know
17 it, right? So, she may be eligible for Medicaid.

18 If not, the federal government,
19 according to her income and according to the plan that she
20 will choose - and there will be a variety of plans, there
21 will be core components to each of these plans, so, core
22 services offered. Some will have higher co-pays. Some
23 will have lower co-pays and so forth, but she will choose a
24 plan. And according to her plan that she chooses and her
25 income level, the government will subsidize some of that.

1 So, the other great things about the
2 Affordable Care Act include no cap on lifetime benefits.
3 No preexisting conditions will be honored anymore. So, you
4 cannot be denied health insurance because of long-time
5 illness.

6 If our 24-year-old that just got out
7 of college, for example, has a job where the employer does
8 not offer health insurance, we could still cover up until
9 age 26 our child on our family's health insurance plan.
10 About 15% of Kentuckians currently are not covered by any
11 health insurance plan.

12 And, so, this is going to give a lot
13 more people a lot more access to health insurance which
14 hopefully will help Kentuckians pay more attention to
15 preventative care and do the kinds of things we need to do
16 on the front end so we can be healthier.

17 That is the goal of the Exchange, and
18 there will be some behavioral health services, of course.
19 Because of the Mental Health Parity Act, there will be
20 behavioral health services also that would be paid for.

21 People want to know what the services
22 will be. The Kentucky health insurance market is regulated
23 by the Department of Insurance in this state and we have a
24 lot of insurance laws about things that must be covered
25 already. So, all the health insurance laws for the state,

1 of course, we will first and foremost comply with those,
2 and then there were laws set forth by the Affordable Care
3 Act.

4 However, there's an advisory
5 committee of eleven people that will be appointed by
6 Governor Beshear in the very near future and they will have
7 a lot of say as to what these plans will look like and also
8 what they include. So, that's a little bit about the
9 Affordable Care Act.

10 Secondly, regarding Coventry or any
11 of the managed care companies, the Center for Medicare and
12 Medicaid Services, CMS, they have a standard by which the
13 managed care companies must prove adequate network and
14 there are rules that guide that standard.

15 So, regarding Jessamine County and
16 what's going on between Coventry, I can't answer that
17 specifically. However, I will tell you that all three
18 managed care companies, every month they send us their
19 current provider list in all categories of providers.
20 Those are run against a geo mapping system by member, not
21 MapQuest, not Google, not as a crow flies, but they are run
22 against a geo mapping system, and we hold them to the
23 federal standards about an adequate network, that they must
24 conform to adequate network.

25 Unfortunately, one of the things

1 that's going on at this point in time with Medicaid managed
2 care is that many of the managed care companies are
3 renegotiating their contracts with particularly you see in
4 the news our hospital providers where they were reimbursing
5 some people more than 100% of Medicaid and they are going
6 in and renegotiating.

7 They have to adhere to some pretty
8 stringent rules from us that were in their contract. They
9 cannot just stop a contract. They have to give advance
10 notice, 60 days or 90 days, to the hospital or the
11 providers.

12 MR. WISE: In thirty days.

13 SECRETARY WISE: In thirty days.
14 Thirty days' notice to providers. In some cases, they have
15 been given far more notice. I know of some hospitals that
16 have known for about ninety days, and a lot of that has to
17 do with what is in their contract.

18 So, in some cases, we have a
19 hospital, let's say Hospital A out there, they have in
20 their contract that one of the managed care organizations
21 must give them a ninety-day notice to make any change to
22 the contract.

23 And, so, being notified by a managed
24 care organization that the managed care company would like
25 to renegotiate the contract must be done in ninety days.

1 That doesn't mean the contract is going to end. That means
2 they're going to go to the table and try to renegotiate
3 rates.

4 So, the managed care companies are
5 motivated by having to adhere to adequate network
6 standards, and hopefully the provider is motivated by
7 trying to - unfortunately usually when a renegotiation
8 happens, it means the rate is going down - but hopefully
9 renegotiating the best rate possible with each of the
10 managed care organizations.

11 All three of them have the ability to
12 negotiate and they do negotiate separately with all
13 providers. And, so, you see in some cases, some of the
14 providers have the major hospital chains that they utilize
15 and some have the smaller, independent hospitals and some
16 have both. I know a lot of rural hospitals that have
17 contracts with all three.

18 So, I think it's a give and take and
19 it's on an individual basis, but every month we run the
20 program that looks at adequate network. And I don't know
21 if people realize this or not, but we have people from CMS
22 that sit in Medicaid each week. We have two people from
23 the federal government that are assigned to us and they
24 basically sit there. So, they're there. They oversee all
25 of this all the time. And, so, they know quite well what

1 is taking place. And because they here, they read the
2 papers as well. So, they have the ability to inquire.

3 I think some of the points that you
4 made are certainly valid. We are hoping that the managed
5 care organizations get to your point that when they sign up
6 a provider, that contract is good for one year.

7 And, again, that's between the
8 provider and the managed care organization - not the State
9 - the managed care organization and the provider. Those
10 contracts are between the providers and the managed care
11 companies, but we, too, hope that they can get to the point
12 to where there won't be changes in the middle of a year.

13 Another point that was made was
14 regarding open enrollment. Open enrollment will begin for
15 all regions but the Jefferson County region around August
16 20th, I believe, and it goes to around October 20th. And
17 at that point, we will increase the call line, help line.
18 There will be provider information for each of the
19 companies, new co-pay information.

20 So, basically their plans will be put
21 forth and people will be able to change a managed care
22 organization just because they want to, just like you and I
23 are given each year during our open enrollment an
24 opportunity to switch insurance plans for our own personal
25 use.

1 Also I would just say regarding that,
2 as provider contracts have been canceled, we have worked
3 with those Medicaid recipients or the members, the
4 consumers, we have worked with them to allow them to change
5 companies without cause. We have moved them to a company
6 in which their preferred provider is in.

7 The exception to that is between the
8 Appalachian Regional Hospital chain and Coventry, and we
9 have some folks that have requested to switch to WellCare.
10 The only reason we haven't done this so far is frankly
11 because there's nothing changed between Coventry's contract
12 and ARH's contract.

13 They're under court order, Coventry
14 is, to continue paying the contract amount to ARH. So,
15 there's no cause to switch at this point. So, people are
16 remaining. And the Judge has said to Coventry, you shall
17 maintain that contract with ARH until November 1, which
18 that gets us to the open enrollment period.

19 Hopefully, within that time, ARH and
20 Coventry will reach an agreement on a rate. They will
21 reach rate agreement and people may not change at all.
22 However, if they want to change between August 20th and
23 October 20th, they are sure welcome, and we will do
24 everything to answer their questions and to help them.

25 Maybe that was all too much, but I

1 tried to answer a lot of questions all at one time and
2 concerns that came up.

3 CHAIRMAN POOLE: If there are no
4 other comments, before Neville speaks, if we could have one
5 representative from each of the managed care organizations
6 to come up here to my left and sit on the end, please.

7 SECRETARY HAYNES: Am I finished?

8 CHAIRMAN POOLE: Yes. And we really
9 want to thank you. Thank you for coming.

10 SECRETARY HAYNES: I want to thank
11 you all for your service. You do have my commitment. Ron,
12 I'll get in touch with you next week when our new
13 Commissioner comes back and he and Neville and I can get
14 with you first and begin to map out a plan for how we move
15 forward together, and I do look forward to it very much.
16 And, again, thanks to all of you for your service. I look
17 forward to spending more time with you.

18 CHAIRMAN POOLE: Is your assistant,
19 Morgan, here?

20 SECRETARY HAYNES: My assistant is
21 Debbie Boone.

22 CHAIRMAN POOLE: Thank you very much.

23 DR. NEEL: Could we have them
24 identify themselves, the MCO people?

25 CHAIRMAN POOLE: Yes. If you all

1 wouldn't mind to introduce yourselves.

2 MR. WILLIS: My name is Daniel
3 Willis. I'm with Kentucky Spirit Health Plan.

4 MR. HARPER: Russell Harper with
5 Coventry.

6 MS. WILSON: Dora Wilson, WellCare of
7 Kentucky.

8 CHAIRMAN POOLE: Okay. Thank you all
9 for attending. We really appreciate it. The floor is
10 yours, Neville.

11 MR. WISE: I think she eventually
12 covered everything I was going to talk about. I did want
13 to re-emphasize open enrollment for members again. That
14 will be August 20th through October 19th, and that's the
15 annual period that members get to change plans, as the
16 Secretary said, without any cause, any reason, just because
17 they want to.

18 Information very similar to what
19 Medicaid recipients received last year, basically a letter
20 saying here's what this plan has, comparing the plans side
21 by side. It will be going out I think in early August,
22 right before open enrollment starts. And there may be some
23 benefit changes that you'll notice on there from the
24 various plans on those side-by-side. So, that process is
25 beginning.

1 Any change that's made between the
2 open enrollment period will be effective November 1st, the
3 start of the plan year as we have it, the contract year as
4 we have it. So, that's all going on.

5 We already have a letter I think in
6 the mail specifically to Regions 7 and 8, the Eastern
7 Kentucky regions, because we know the ARH issue has been
8 kind of controversial and confusing and really completely
9 what we would hope to avoid for our members to be confused
10 about where they can go get care and can't go.

11 So, we have a letter in the mail out
12 to them saying we understand it's been confusing. Open
13 enrollment is coming. Be looking for your information
14 coming in the mail, just a special letter for the members
15 in that area saying that here's your chance to fix if
16 you've been having problems. So, that's in the mail and it
17 should be this week.

18 MS. BRANHAM: Neville, I'm sorry to
19 interrupt you but I have a question. So, the plans are
20 changing. Each MCO is going to send a letter to the
21 recipient.

22 MR. WISE: No. We will be sending
23 it.

24 MS. BRANHAM: Oh, you're sending it.
25 The Cabinet is sending a letter.

1 MR. WISE: Right. It will compare
2 the plans to each other for the member.

3 MS. BRANHAM: But I thought you said
4 something about changes were going to be side by side.

5 MR. WISE: In our letter, the benefit
6 grid will be side by side, highlighting the various
7 coverages in each plan if they have differences. So, they
8 will be able to look and see.

9 MS. BRANHAM: But the MCO's are not
10 changing their basic benefits.

11 MR. WISE: Not their basic benefits,
12 just anything that's different. I think some are tinkering
13 with their co-pays, for example. Our requirement is that
14 they couldn't charge co-pays more than Medicaid was
15 charging prior to managed care. Two of the three chose not
16 to charge the full co-pays or the co-pays that we do. So,
17 I think a couple of them are tinkering with their co-pays
18 in that side by side. So, you'll see things like that as
19 to what has a co-pay and what doesn't. That's the major
20 thing I can think of.

21 MS. BRANHAM: Because I know we've
22 talked about some issues like on the global plan and
23 limiting therapy visits and we talked on the TAC last week
24 about we've always had soft limits, meaning not just ten
25 PT, ST or OT and those kinds of things.

1 We talked, Ted and I, and we did at
2 our meeting last week about trying to establish a meeting
3 even before those letters go out so that we can nail down
4 about the soft limits. And are there going to be hard
5 limits because it's just another way for them to deny
6 agencies the ability to give these services in the home, as
7 well as Medicare EOB's. So, you might want to give that
8 some consideration.

9 CHAIRMAN POOLE: And they are going
10 to be ready August 20th, because it's very similar to what
11 we see with Medicare every year, Medicare Part D. When
12 their plans open up, they're ready to go, because I want
13 the recipients to be able to compare and contrast and be
14 able to make the right decision.

15 MR. WISE: That's what we attempt to
16 do with that packet we send out.

17 I also wanted to mention as we
18 briefly touched on, in Region 3, we're in the process of
19 MCO procurement. Because it is a procurement, I can't say
20 too much about that. We'll be able to talk about that much
21 more at our next quarterly MAC meeting, but the bids are
22 due in this Friday to select managed care plans beginning
23 in January.

24 I wanted to mention again that it's
25 not that we were displeased with anything that Passport was

1 doing. It's just that the feds took a different direction
2 and said, since, Medicaid, now you have competition-based
3 managed care in the rest of the state, there's no reason
4 not for you to give managed care choice in the Passport
5 Region was CMS's ultimate decision.

6 So, we're going through that process
7 now and it's frankly taking up a lot of my time because we
8 have a question-and-answer period for potential bidders and
9 we have to respond to those questions. So, that was what I
10 had been engulfed in before my vacation last week.

11 I also wanted to address a comment I
12 heard or partially address that, is that a lot of the
13 Medicaid Program - and this is the one thing that I think
14 has struck Commissioner Kissner the most since he's been in
15 is how much the Medicaid Program is still outside managed
16 care.

17 This is very liberal rounding, but
18 approximately \$3 billion, half the Medicaid Program, is in
19 managed care and \$3 billion is not. The \$3 billion that
20 goes into managed care is serving over 700,000 individuals.
21 The bulk of the other \$3 billion that Medicaid spends is
22 for approximately 50,000 individuals who are our most
23 sickest individuals who are in facilities, in our MR
24 waivers, in our home waivers.

25 So, the program really is, even

1 though membership-wise, we've become a managed care
2 program, but when you look at the dollars spent, there's
3 still a lot of dollars that aren't managed through managed
4 care. They're still in the fee-for-service basis.

5 I just wanted to mention that because
6 someone made a comment that triggered that, and I think
7 that's the thing that really has struck our new
8 Commissioner the most as he started looking at things like
9 that as to how much is still outside.

10 And unless you have any questions,
11 that's the major updates that I had that the Secretary
12 didn't touch on. I did want to mention one more thing.

13 There is disenrollment for cause, so,
14 if a provider leaves a managed care network but he's still
15 in the other two. And we have a committee that reviews
16 these requests for disenrollment for cause.

17 So, if that provider who no longer is
18 available to that member because the plan that they chose
19 doesn't have that provider and that provider has been with
20 that member for a long time and providing their care and
21 has a history and the member has conditions that provider
22 is familiar with, that is the grounds we - that's the
23 primary grounds - there's other things in there - but that
24 we use to allow a member to disenroll for cause and switch
25 plans outside the open enrollment period. And we've

1 processed several thousand of those applications over the
2 last four to five months; and to be honest with you, we
3 approve some and don't approve others.

4 If you've been to a provider one time
5 in the last two years and you say, well, you need to switch
6 because you can't--well, you have four other providers that
7 you see more frequently that are still in that network, but
8 that is the process that's there and open to members if
9 they think that most of their providers they usually see
10 are no longer available to them in the plan they chose..

11 CHAIRMAN POOLE: Does anybody have
12 questions? Go ahead, Dr. Neel.

13 DR. NEEL: Neville, I still wish you
14 could come and spend a day in my office and watch my
15 employees either going gray or pulling their hair out.
16 Maybe I should come and spend a day in your office and do
17 the same thing.

18 The problem is things after nine
19 months are not getting better. That's the problem we're
20 having in primary care. And I can only speak for Western
21 Kentucky. Most of us are primary care individual
22 practitioners or small groups who have always been involved
23 in Medicaid. We're not employees of somebody. We've
24 always provided a medical home, as you know, with KenPAC
25 and we've done that.

1 The other is that the data that the
2 MCO's seem to be getting from Medicaid does not seem to be
3 very valid. And I don't know how to say this, but the
4 problem is we're not capturing our patients. We had our
5 patients up to October and now when this has started, our
6 patients were assigned MCO's but not to us. And, so, then,
7 they secondarily were assigned then by the MCO's to us as
8 primary care providers, and that's where the system has
9 really broken down.

10 We get a lot of patients in all three
11 MCO's, particularly in Coventry and Kentucky Spirit, say
12 primary care not necessary. Well, how can they have a
13 medical home if they don't have a primary care provider.

14 Then the other thing particularly for
15 pediatricians in Western Kentucky is that we're getting
16 people assigned to Walmart clinics, we're getting them
17 assigned to anesthesiologists, dead physicians, people that
18 have moved out of the state. And this is not just an
19 uncommon thing. This is all day every day and trying to
20 wrestle with that.

21 The people all have two ID cards. They have
22 a Medicaid card they understand, but then they don't even
23 look at the ID card from the MCO which often has somebody's
24 name on it I can't even spell, but fortunately they don't
25 even look at that because they know they're my patient.

1 And I don't mean to belabor this, but
2 this is a huge problem in all our offices. And I think we
3 have a couple of folks here from some practices; and if
4 they would like to speak, I'd certainly like to have a
5 chance if they'd like to, but that's not getting any
6 better.

7 It's been particularly a problem with
8 WellCare and I feel like they're trying to do the best they
9 can, but it seems the data they're getting from the State
10 into their computers just really is very poor, and I'd like
11 you to comment on that. Are you talking to the MCO's about
12 that? We keep talking to them and it's not getting any
13 better.

14 MR. WISE: We don't think the data
15 we're sending them has problems other than timing, as you
16 mentioned. Frequently there's timing issues of, you're
17 right, either the recipient didn't come in or the case
18 didn't get worked that month, which I know happens.

19 And if the Secretary were here, she
20 would address it, so, I'll speak for her. In the last
21 General Assembly, they got additional funding, specific
22 funding for additional field workers, both on the
23 protective services' side and working the cases' side,
24 working the Medicaid and TANF cases.

25 So, there is a recognition that

1 there's staffing issues, and, again, as the Secretary was
2 referring to, overworked folks making \$20,000, \$30,000 a
3 year trying to do the eligibility for members. And there
4 is recognition that that's a hard job and that there's
5 under-staffing, but hopefully the staffing, I think it's
6 like 100 staff statewide just for the case-working part,
7 hopefully that will help that.

8 Again, in a system as big as ours,
9 you're going to have some I'll call them coding errors
10 where the case doesn't get coded exactly right in the
11 system. Those are minimal. There are some time delays we
12 have between getting our data from the eligibility system,
13 transmitting it to the MCO's; but once the data is in the
14 system, that's a fairly quick transfer process, twenty-four
15 hours.

16 So, I guess a question back to you.
17 So, when the member shows up in your office with the
18 managed care card showing a different assigned physician,
19 are you instructing the patient to call the MCO and say
20 they want to change their PCP?

21 DR. NEEL: Yes, and they get varied
22 responses. One of the MCO's actually agreed to put a kiosk
23 in my office so they could call from there, but many people
24 tell us they will call and then they don't, but it creates
25 a lot of secondary problems like referrals. Some offices

1 will not see a referral from us unless our name is on the
2 card, and I can understand that.

3 So, it's a big problem. It's not a
4 small problem and it's taking time. And even though the
5 computer may show when we query Medicaid that they're with
6 one MCO, they may actually be with another and have a card
7 that shows they are. So, it's just been a disaster from
8 that standpoint.

9 MR. WISE: And our system should be
10 the system of record.

11 DR. NEEL: I would love for the MCO's
12 to comment if they would on that. I know particularly
13 WellCare, I would appreciate a comment because I know
14 they've been trying to fix the problem, and so far it's not
15 been fixed.

16 MS. WILSON: Dr. Neel, I know that
17 we've been working together closely to try to recapture any
18 patients that may have been assigned out to other PCP's.
19 We, like you, have limitations on forcing that change
20 without the member's consent.

21 And, so, I think that now that we're
22 coming up on open enrollment, we have some increased
23 opportunities that that window is open and folks can choose
24 the PCP that they want to see. Certainly it's WellCare's
25 policy that any member can see any PCP without a referral

1 or without authorization because our main goal is to make
2 sure that people are afforded primary care and access.

3 So, while we work out the
4 technicalities of lists and member rosters, at the end of
5 the day, we hope and believe that our members can get care
6 where they choose to get care.

7 DR. NEEL: But the problem is that
8 the patients of all of ours - and every pediatrician has
9 shared this with me - it's not that they're assigned to
10 another pediatrician, another PCP - they're assigned to
11 people who aren't PCP's. That's the problem.

12 And, so, when they call those
13 offices, they say we don't see children. And I don't know
14 if that goes on out to the home health and the other
15 providers, dentists or not, but it's just horrible for us.
16 But it's not other PCP's, it's that they're assigned to
17 people who aren't.

18 CHAIRMAN POOLE: Any other questions
19 or comments for Neville?

20 MR. CARLE: Neville, in the contract
21 that the MCO's have with the State, what type of feedback
22 provision is there for the patients to actually provide
23 their satisfaction rating with the MCO's? And, again, I
24 know this is just new, but does that even exist?

25 MR. WISE: Yes.

1 MR. CARLE: Can you elaborate on that
2 or could you guys talk about that?

3 MR. WISE: There's a quality review
4 process that goes on that we're gearing up. It's to be
5 done at a year after start, and that will include gathering
6 member data as well as provider data as part of that
7 quality review process that will be kicking off this fall.
8 That's another RFP we have out on the street, and I'm not
9 even sure exactly where it is, but it may be the end is
10 near and we're about to decide. I've been out for a week.

11 But that is another step you have to
12 do to have a federal waiver. You have to have that
13 feedback process where you do the quality analysis and get
14 feedback from members and providers, and we should have a
15 vendor in here to do that very soon.

16 We have one of those with Passport.
17 They've had to do that every year and that vendor is still
18 finalizing that and may be bidding on the new one - I don't
19 know - but there is that process that goes on and it's time
20 to start that because we've been into it for eight to nine
21 months now.

22 MR. CARLE: Thank you.

23 CHAIRMAN POOLE: I do want to thank
24 Russell from Coventry for providing us the statistics that
25 we requested a couple of meetings ago; but for you other

1 two, we asked for how many recipients are enrolled in
2 network, how many providers are enrolled, areas of the
3 state that the MCO is lacking coverage, how many denied
4 prior authorizations are there to the following provider
5 groups per month, what percentages of claims are being paid
6 within the contracted time frame, and what percentages of
7 claims are being delayed for payment and for how long. So,
8 I really appreciate Russell for getting that to us. And
9 Elizabeth and Daniel, I've got copies of this for you guys.

10 MR. WISE: And, Ron, an update on
11 membership and where they are, and these are approximate
12 numbers, but there's 240,000 members approximately in
13 Coventry, 142,000 in Kentucky Spirit, 153,000 in WellCare,
14 170,000 in Passport. And as I mentioned, there's 114,000
15 that are still Medicaid fee-for-service; but of those,
16 approximately 70,000 are the individuals who have Medicare
17 where we just pay their premium and coinsurance and
18 deductible. They're not full Medicaid beneficiaries.
19 That's included in that 114,000 number.

20 CHAIRMAN POOLE: So, that's where you
21 roughly get that 50,000?

22 MR. WISE: When you take out the ones
23 that are just the partial beneficiaries, you get
24 approximately a little less than 50,000 who are just the
25 people we pay \$3 billion for approximately.

1 First some good news - we've had very
2 little of that today, so, I thought I'd start out with that
3 - we are extremely excited in the behavioral health world
4 about the initiative proposed by the Governor and funded in
5 the biannual budget to extend outpatient treatment to
6 Medicaid members who are dealing with a substance use
7 disorder. This program is scheduled to begin in January,
8 2013, and there's funding to extend services to 5,800
9 individuals over the next eighteen months.

10 We have advocated for this for so
11 many years that I've lost count, but we are delighted that
12 it is to be included now as a Medicaid service and that the
13 program will be launched. This is particularly important
14 because up to this time, substance use disorder treatments
15 were limited to postpartum moms and to youth.

16 So, if you were an adult in Medicaid,
17 particularly with a co-occurring disorder of mental illness
18 and substance use disorder, you could get treated in the
19 Medicaid Program for your mental illness but not for your
20 addictive disorder. And we're really pleased that the
21 Governor stepped forward and the legislators have put some
22 money into that program.

23 The urgent concerns that our TAC
24 members have continue to focus on problems that are
25 encountered with all three of the MCO's, and they're the

1 same ones that we have been here to talk to you about over
2 and over again. The very first concern and the one that
3 continues to be a problem is problems of access to
4 medications as prescribed for the member with behavioral
5 health issues.

6 The prior authorization processes are
7 still burdensome for the prescribers and are resulting in
8 members not getting their appropriate medications in a
9 timely manner. What happens then is that people go into
10 relapse. They end up needing hospitalization which takes
11 us to our second problem, and that is that the MCO's are
12 not authorizing a sufficient number of days in the
13 hospitals to really stabilize these patients.

14 We then have what we call the
15 revolving door and that is that people get put out of the
16 hospital. They're not truly stabilized. They end up
17 coming back and needing more services. This is not good
18 treatment management. I don't care what you want to call
19 it, but this is not good for people.

20 We are anxious for the dispute
21 involving ARH to be resolved since the psychiatric unit
22 there is the state's facility for seventeen counties in the
23 eastern part of Kentucky. While we understand the psych
24 beds at ARH are included in a contract with MHNet,
25 Coventry's subsidiary which manages behavioral health for

1 its members, we would like to emphasize the importance of
2 access to both acute care physical and behavioral health
3 beds provided by ARH. If access to those beds is not
4 maintained, patients and their families will be subjected
5 to difficult transportation problems to go to another state
6 psychiatric hospital either in Lexington or in Louisville.

7 In addition, we know as mental health
8 providers that the lack of proximity to home and family can
9 be detrimental to the recovery process for the patient.

10 Although we are established to look
11 at behavioral health issues, we're also concerned about the
12 physical health of Medicaid members who have a behavioral
13 health disorder, and this is essentially the issue that
14 Sheina brought up earlier. We do know that there are
15 difficulties with people doing their due diligence,
16 researching it, signing up with an MCO because their
17 primary physical health specialist is with that MCO, and
18 then they come to the office to find out that that provider
19 is no longer honoring that contract and is no longer a part
20 of the MCO.

21 We realize that the providers
22 certainly have that choice, but there needs to be some
23 accommodation made for those members. And hopefully what
24 Deputy Commissioner Wise talked about in terms of being
25 able to move to a different MCO to follow that provider

1 would be helpful.

2 We appreciate Ms. Roark bringing up
3 an issue that we have brought up before and that is the
4 lack of reimbursement to provide peer support services. We
5 have over 100 mental health consumers who have been well-
6 trained and certified and could save money while giving
7 direction, help and support particularly to those newly
8 diagnosed with a severe mental illness. It makes so much
9 sense and I think that's why nobody is doing it. It just
10 absolutely makes so much sense.

11 A final issue of concern to the TAC
12 members is the continuing lack of coordination or
13 integration of physical health and behavioral health
14 services. This was given as the primary reason for
15 behavioral health services to be incorporated in the MCO
16 responsibilities, but we see little evidence that
17 integration and collaboration are occurring.

18 We do know that persons with severe
19 mental illnesses die on average twenty-five years earlier
20 than their peers - twenty-five years - and it's because of
21 lack of access to physical health providers.

22 We would like to know, and perhaps,
23 Mr. Poole, when you all meet with the Secretary and the
24 Commissioner, we keep hearing about 1,140 reports that are
25 being given. What's in those reports and what's the access

1 to those reports from the public from those of us on the
2 TAC's that would really like to dig deep into those numbers
3 and see what is being said about access to medications,
4 about the number of prior authorizations and how long it's
5 taking to get those approved or denied, and what's really
6 happening to the individual members out there.

7 We also want to be sure that when
8 we're talking about Waiver Programs like the Brain Injury
9 Waiver that we are continuing to look at integrated care so
10 that those folks are getting the full range of both
11 physical health and behavioral health needs that need to be
12 met.

13 I'd like to pick up on Oyo's question
14 to the Secretary. If the Commissioners are meeting every
15 two weeks, I'd like to see some communication from those
16 Commissioners back to providers and advocates. I have no
17 idea what's being talked about in terms of those waivers.

18 And I understand the need for staff
19 meetings; but if the people like you all and like those of
20 us that are serving on the TAC's never hear that
21 communication back from those Commissioners or have the
22 opportunity to give them input, then, it seems like there's
23 a real disconnect between the staff level meetings and
24 what's happening out in the real world that we all live in.

25 We will schedule our next TAC meeting

1 with sufficient notice to the behavioral health community
2 so that others can join us and can contribute to the
3 discussion.

4 And let me thank you all and give you
5 my praise for the steadfast way in which you all have
6 addressed this issue. You were left out of the decision to
7 go to managed care. You've hung in there. You have
8 doggedly come back time and time and time again, and I for
9 one really appreciate the efforts that you're putting
10 forward. Please think of our Behavioral Health TAC and I'm
11 sure the other TAC's as your partners in moving this
12 forward.

13 CHAIRMAN POOLE: The Children's Health
14 TAC met on June 13th, and I'm just going to give their
15 quick report here.

16 REPORT OF CHILDREN'S HEALTH TAC:

17 Items relevant to improving
18 children's health including the Children's Health Insurance
19 Program Reauthorization Act and what Kentucky can do to
20 improve coverage through the reducing barriers to enroll
21 and maintain children in the program.

22 The group discussed the CHIPRA issues
23 and goals, the options for improvement, the successes in
24 Kentucky as well as surrounding states and other options
25 for improvement.

1 The group is working on a
2 recommendation to decrease waiting periods for enrollment
3 for children. The group will talk more about this at their
4 next TAC meeting.

5 The TAC also discussed key issues
6 concerning children's behavioral health, specifically in
7 reducing children's length of stays in hospitalizations
8 which can lead to re-admissions, inappropriate denials,
9 substance abuse treatment for postpartum women being
10 extended from sixty days to six months, extended lengths of
11 stay for residential substance abuse treatments for youth,
12 and private psychologists being able to see children with
13 Medicaid. Again, this topic will be further discussed, and
14 they set their time for the next meeting.

15 I know Ms. Fummilayo attended that
16 meeting. So, I didn't know if you had anything to add to
17 it.

18 MS. FUMMILAYO: No. Basically, that
19 was it, and I did ask them--well, they invited me to the
20 meeting so that I could bring information back to the
21 Board, and I did suggest that they put us on their regular
22 minute review, that they would be sending them to you.

23 CHAIRMAN POOLE: Great. Thank you.
24 Consumer Rights and Client Needs. No report.

25 Now, Dr. Riley with the Dental TAC.

1 REPORT OF DENTAL TAC:

2 DR. RILEY: Good morning. The Dental
3 TAC met this morning. We had representatives from the
4 three MCO subcontractors there.

5 One of the big issues with the dental
6 community at this point is that we have received no reports
7 over what's happened as far as services provided, providers
8 participating, no reports and no numbers on what's happened
9 for the last nine months.

10 So, we had developed a scrub report
11 to distribute to the MCO subcontractors to ask if they
12 would follow the format and present us with some reports
13 that we can actually use for decision-making and
14 management.

15 Dr. Julie McKee from the Department
16 of Public Health was there also, and she stated that they
17 also needed that type of information to help them make
18 their decisions. So, we have the format out. We got a
19 commitment from one of the subcontractors. The other two
20 are looking at it, and we're being told that it has to pass
21 legal muster.

22 So, the sooner we get a decision
23 about what is legal for public information versus
24 proprietary information, then, perhaps we can move forward;
25 but one would think that after nine months, that would have

1 been decided.

2 One of the other large concerns is
3 that the providers in Eastern Kentucky are saying that they
4 have no referral doctors or they have very few for oral
5 surgery and orthodontics. So, their patients are having to
6 be referred to the University of Kentucky, which we are
7 concerned whether geo access is being met.

8 So, the companies are also supposed
9 to provide the State folks with geo access reports in a
10 short fashion as to whether there are sufficient providers
11 actually participating as opposed to just being
12 credentialed and having a closed panel.

13 And, then, probably the last thing is
14 that whereas with four MCO's, we have four subcontractors,
15 by the middle of September, they will be down to two. One
16 company will be representing three of the MCO's or
17 subcontracting for three of the MCO's. So, that kind of
18 changes the playing field a little bit. That's it.

19 CHAIRMAN POOLE: Thank you, ma'am.
20 Home Health Care. Kip.

21 REPORT OF HOME HEALTH CARE TAC:

22 MR. BOWMAR: Good morning. I'm Kip
23 Bowmar from the Kentucky Home Care Association. Our TAC
24 met on July 10th and discussed a number of issues in regard
25 to both Medicaid MCO's and traditional Medicaid.

1 With Coventry among some of the
2 issues that we're seeing is that they've been utilizing a
3 more stringent definition of requiring a patient to be
4 homebound to qualify for home health services, even though
5 CMS has specifically said that's not allowed in Medicaid.
6 So, we've kind of had some issues with that.

7 On certain individual denials, we've
8 been able to get that overturned, but it's just the fact
9 that they're leading off with a policy that really is in
10 conflict with the federal regs in regards to Medicaid and
11 the access to home health services is a bit of a
12 frustration.

13 One of the other issues that Beth
14 talked about was requiring the Medicare eligibility of
15 benefits for the dual eligible population. One of the
16 things that Medicaid has not required is that in the past,
17 for services for which a home health agency would never
18 bill Medicare in the first place, it didn't have to get
19 that EOB before it could qualify for services because on
20 certain services that you would never bill Medicare for in
21 the first place, you wouldn't even get an EOB back.

22 And we had had that issue worked out
23 with all three of the MCO's a couple of months ago, but for
24 whatever reason, in the last month or two, that issue has
25 come back with all three of the MCO's leading to an

1 increase in denials, and they really haven't been able to
2 give us a clear explanation as to why.

3 Visit limits on physical therapy,
4 speech therapy and occupational therapy, while Medicaid has
5 had that in the global choices plan previously, as Sharon
6 indicated, those were soft limits. When it was medically
7 necessary to get more visits, patients were able to qualify
8 for those visits; whereas, the MCO's have currently been
9 treating this as a hard limit. Boom, you've hit the visit
10 limit. There's nothing that can be done. So, that's also
11 causing some loss of access to services.

12 And, then, of course, payment
13 continues to be a real issue. One of the things that I
14 asked our agencies to share with us on a time-to-time basis
15 is the percentage of dollar values of claims submitted and
16 the percentage of dollar values of claims paid for both
17 traditional Medicaid as well as the four MCO's.

18 There were a couple that I got back
19 in the last week that traditional Medicaid was about 99%.
20 Passport was about 96%. WellCare and Kentucky Spirit were
21 around 20%, and Coventry was down around 15.

22 Now, they're paying a lot better now,
23 but a lot of these claims are the things that go back to
24 the beginning of the program in early November and they're
25 still for some vendors as much as several hundred thousand

1 dollars in unpaid claims and it's really causing a
2 continued problem.

3 And, then, since the TAC meeting,
4 we've had one issue emerge and that is the lock-in program.
5 And Medicaid had had that previously, but it had not been
6 applied particularly in regards to home health. I think I
7 very rarely ever talked to a home health agency that had
8 ever had a patient that had been denied services because
9 they were in the lock-in program.

10 I've had six agencies in the last
11 week tell me that with Coventry, they've gotten a denial
12 just because the referral didn't come from the PCP. But a
13 lot of times when a patient is leaving the hospital, the
14 PCP is not there. So, with home health, a lot of times the
15 referrals for those services in addition to being made,
16 because all home health services have to be--you know,
17 there has to be a physician referral in the first place.
18 So, it's not like somebody is going to the emergency room
19 ten times.

20 To access home health services, you
21 do need a doctor's order. And, so, what we've asked is
22 that at least in regards to home health services, that
23 Coventry allow for any doctor's order to be able to stand,
24 particularly in those situations where a patient is leaving
25 the hospital. If you can't get those services authorized,

1 they may end up staying in the hospital two or three days
2 more and costing far more money.

3 The Medicare EOB issue is also an
4 issue with WellCare and Kentucky Spirit but maybe not quite
5 to the extent that it has been with Coventry.

6 And I think that's kind of a recap of
7 where we are, although our members do want to say that
8 working with traditional Medicaid and Passport has been
9 very good. And while I know Neville can't comment on that,
10 we're certainly hopeful that Passport continues because
11 they have really been in the last fifteen months very good
12 to work with, both from patients' access to care as well as
13 timely authorization of services and payments to providers.

14 CHAIRMAN POOLE: Thank you.

15 MS. BRANHAM: We still have the issue
16 with the problem with getting prior authorizations in a
17 timely manner. Prior authorizations continue to take way
18 too much time.

19 And I think some of these issues that
20 we thought we had resolved with the MCO's as we were
21 working hand in hand together that have crept back up has
22 probably some relation to the fact that the three Medical
23 Directors that we had been working with are now gone.

24 So, we've not had that reach out and
25 that dialogue to try to understand why these same kinds of

1 things that we thought that we had worked through because
2 agencies are getting demand letters for overpayments merely
3 because the claim was not processed correctly.

4 And, Russell, I know that you issued
5 this information to us which we had requested, and it's
6 percentages of claims that are being paid in a contracted
7 time frame - 93% - and then delayed payment for how long -
8 only 1%.

9 We've long been shouting that there's
10 no way can that be possible, and I can give you a first-
11 hand example. If I submit a claim for \$3,000 and
12 everything on the claim was prior-authorized and I am
13 reimbursed \$30, I think you're calling that a clean claim,
14 paid claim. But I have to resubmit that claim with all the
15 prior authorization information that's already been
16 submitted with that claim, and it can take up to three and
17 four times to get that one claim paid.

18 So, when you say you're paying 99% or
19 93% less than thirty days, that cannot be in all actuality.
20 It may be a portion of a claim being paid but it's not a
21 full claim. And to track the remittance advices are a
22 nightmare. So, just something to take back with and maybe
23 work with your folks about.

24 Again, Ted is going to work with us.
25 And as I mentioned to Neville, I hope it's done before

1 those letters go out so we can get this homebound status
2 taken off of the website which the MCO's are utilizing hard
3 and fast, the Medicare EOB must be submitted with your
4 bills, and then the hard limits.

5 I think those are three things that
6 the Home Care Association would like to see polished up a
7 bit before the letters go out so patients are choosing what
8 provider they would like to continue with in open
9 enrollment.

10 And I don't know how it can come
11 about, but an example is, you know, business as usual.
12 November and December I think we all were told, and I guess
13 long about March, supplies were not being paid. And then
14 long about May, I guess it came out with Coventry - I'm
15 sorry to pick on you, Russell, but that's just the way it
16 is - that the supplies being utilized on a wound when you
17 have a physician's order to go care for that wound would
18 not be reimbursed. It would be part of your per visit
19 rate.

20 Well, we've never had that before in
21 Kentucky, and I frankly cannot provide tape, costly
22 dressing supplies and it be combined in my \$87 skilled
23 nursing visit. Passport gives about \$135, by the way.
24 And, so, we've got this \$87 and I'm supposed to provide
25 some of the most expensive home health dressing supplies to

1 are just kind of reoccurring like in home health.

2 MR. CARLE: The one thing, Ron, I
3 might want to add, we talked about this in the past. This
4 information that you provided is very good. It might be
5 nice if we could have a standard set of questions, what I
6 would call a scorecard from each one of those that we could
7 look at every quarter or at every meeting that they could
8 provide in advance.

9 And, so, maybe what we need to do is
10 to come up with that list of questions, very similar to
11 this in the same format where we can actually look at a
12 crosswalk with all three side by side and see who is doing
13 what and when.

14 CHAIRMAN POOLE: Okay. Can we work
15 on that together, Neville?

16 MR. WISE: Yes.

17 MS. BRANHAM: And on that note, maybe
18 we should meet more often.

19 MS. FUMMILAYO: Thank you, even if by
20 telephone. And I don't mean to just interrupt, but I was
21 thinking about that on the way in that maybe that's why
22 we're kept out of things sometimes is because we don't meet
23 often enough to address the things. And by the time we get
24 back here for another quarter, we not only have the things
25 that we talked about before, we have all new issues again

1 in addition and things just begin to pile up. So, maybe if
2 we could meet more. I don't know if it's mandatory that we
3 just meet four times or if we are to meet at least four
4 times, I don't know, but that's something that we might be
5 able to think about, even if it's, like I said, by
6 teleconference.

7 CHAIRMAN POOLE: Well, obviously
8 there's expense involved in doing that. So, I've got to
9 talk to Neville, got to talk to the panel here, too, but
10 certainly by teleconference would be a great option and we
11 need to utilize that. So, I will be emailing and talking
12 to Neville and getting some input from Commissioner Kissner
13 and everything on that.

14 MS. FUMMILAYO: And I have to admit,
15 I'm not a very good teleconferencer, but I do think that we
16 need to just hear each other a little bit more so that we
17 can get more things done. We don't seem to be getting a
18 lot done. Am I wrong? Do you think we're getting a lot
19 done? I don't either.

20 But I think if we met just a little
21 bit more often, we could get some things finalized at
22 least or pushed forward and we don't have to pile it all on
23 the MCO's all at one time because it seems like when we do
24 that, they respond with nothing anyway so far.

25 MS. SHARLEY HUGHES: I'll just let

1 you know the statute does say that you must meet at least
2 quarterly but you can have other meetings or special
3 meetings or regular meetings as desired. And the Cabinet
4 does have the ability to set up conference calls.

5 CHAIRMAN POOLE: Thank you, Sharley.
6 Next up is Intellectual and Developmental Disabilities.
7 Nothing to report. Nursing Home Care.

8 MR. FOLEY: The Nursing Home TAC has
9 no report.

10 CHAIRMAN POOLE: Nursing Services.

11 DR. PARTIN: No report.

12 CHAIRMAN POOLE: Physical Therapy.

13 REPORT OF PHYSICAL THERAPY AND THERAPY SERVICES TAC:

14 MS. BETH ENNIS: Just as we met last
15 quarter, this is kind of a combined TAC. It's not just
16 Physical Therapy but we are also representing OT and
17 Speech. So, it's combined with the Therapy TAC that's at
18 the end of your list.

19 I'm Beth Ennis. I'm the Chair of the
20 TAC. We have conference called. We've utilized the
21 conference calls that the Cabinet has available on a
22 monthly basis. Since the last meeting, we have added two
23 speech members. So, we're now fully represented which is
24 really nice.

25 Most of our focus has been on a lot

1 of the issues that we're hearing about today - difficulty
2 getting authorizations, difficulty getting paid.

3 What we have found out from a survey
4 that we sent to providers was we're also having difficulty
5 just serving the people that are already enrolled in
6 Medicaid because there's a lack of providers. Difficulty
7 getting enrolled as providers has been an issue.

8 OT and speech cannot become Medicaid
9 providers outside of waivers, and PT can't do it outside of
10 home health, hospital or if it's a dual-covered patient.
11 So, what we found on our survey was either wait lists or
12 turning people away because they were not able to serve the
13 clients.

14 We did try to survey physicians. I
15 sent a link for a survey to the Kentucky Medical
16 Association. We didn't get any physician responses. So, I
17 don't know that it ever got sent out to the primary care
18 physicians to get their perspective on need.

19 We are still seeing issues with
20 reimbursement. I know each of the disciplines has a
21 reimbursement committee within their organizations that
22 have tried to meet and in several cases have met with the
23 MCO's, but I'm still hearing from constituents that they
24 haven't been paid since November. So, we're still trying
25 to investigate that.

1 we could be beneficial in preventative care, in wellness,
2 as well as in return to work. And, so, we're going to pull
3 some efficacy studies together that we can present with
4 hopefully some recommendations on how to help within the
5 whole Medicaid process as far as cost savings and services
6 to our constituents.

7 CHAIRMAN POOLE: Thank you.

8 Physician Services.

9 REPORT OF PHYSICIAN SERVICES TAC:

10 DR. NEEL: Our Physicians TAC met by
11 phone last week, and I think some of you all are more
12 optimistic that this is working than physicians are at this
13 point.

14 After nine months, we don't see that
15 things are getting better. Older physicians are opting
16 out. Younger physicians are not getting in. Older
17 physicians are borrowing from their retirement. Younger
18 physicians are borrowing from the bank.

19 A physician emailed me who is a
20 physician in a Western Kentucky city who has a large
21 Medicaid practice and said, I'm very seriously looking at
22 other alternatives. I have an interview tomorrow. I don't
23 see how this is ever going to work. I'm way too far in
24 debt and don't want to keep digging a deeper hole. I still
25 want to see this corrected and I'll do what I can to help.

1 Essentially we're going broke getting
2 paid - I don't know how else to say that - because the
3 MCO's are paying and they're paying fairly quickly; but the
4 hassles that have arisen in this are just almost more than
5 the physician offices can stand.

6 The prior authorization process by
7 itself has been a nightmare. It reminds us a little of the
8 second opinion thing that we used to go through. If most
9 of them are going to be approved, then, why do we do it,
10 and that seems to be the case and that's been a very
11 difficult thing.

12 There are less and less specialists
13 who are willing to see patients sent to them by the primary
14 care providers. And I had a pediatrician tell me this week
15 during that meeting that he thought it probably would be
16 easier to get a child an appointment with the Governor than
17 it would with a child psychiatrist, and I think that's
18 somewhat symptomatic of what we have.

19 But we're all in this together,
20 folks, and we've got to somehow make this work, otherwise,
21 some of us are not going to be on this committee next year
22 because we may not be in business. And, so, we've all got
23 to see it improve somehow.

24 So, I would like to be optimistic.
25 I've actually had a very good relationship with the three

1 MCO's, but it seems it's very difficult for them to make
2 change, and that's why I mentioned some of the data that
3 we're getting.

4 Our goal is to provide a medical home
5 more than it is to manage care, in my opinion. And if
6 people have a medical home, then, I think care will be
7 managed and Kentuckians will be healthier, and that's the
8 important thing that we've got to face here.

9 And I don't mean to lecture, but I've
10 been at this for forty-two years, and I'm having people who
11 have managed offices for thirty years tell me that they've
12 dealt with every kind of managed care, insurance company,
13 whatever, and this is the worst situation they've ever had.
14 And I think I'm seeing some nodding out there from it.
15 And, so, this has got to be improved. So, I just call on
16 us.

17 And the Secretary committed to have
18 us meet with her and to talk about what we need to do, and
19 I'm not willing to come here and be involved unless
20 somebody is going to listen to what we say. And if we
21 listen but nothing ever changes, then, how do we expect a
22 different outcome? So, I plead if we meet with her, that
23 maybe we can make something happen. Thank you.

24 DR. PARTIN: Dr. Neel, Matt wanted to
25 talk for a moment about lock-in.

1 CHAIRMAN POOLE: Go ahead, Matt. Go
2 ahead and introduce yourself so she can have it on record.

3 MR. MATTHEW ADAMS: My name is
4 Matthew Adams. I manage an internal medicine practice in
5 Danville, Kentucky. I'm also with the Bluegrass Chapter of
6 the MGMA.

7 We just recently had to start dealing
8 with lock-in through Coventry. The first member that we
9 dealt with was a blind diabetic in renal failure with
10 cardiology problems. So far, I've spent seven hours on the
11 phone with Coventry just trying to get referrals done.

12 What's the plan on lock-in? I'm
13 being told that it's supposed to be identical to the way
14 the State did it. Hate to break it to you. It's not. So,
15 can we get some feedback on that?

16 DR. PARTIN: Ron, I had a question
17 that related to lock-in. Could I ask that and then they
18 could answer it all together?

19 CHAIRMAN POOLE: Sure.

20 DR. PARTIN: We had some patients
21 locked in to our practice and they were patients who
22 regularly have seen us as providers. When I asked why they
23 were locked in, I was told it was because of their complex
24 medical problems.

25 The question I have about the lock-in

1 is that I was told that the patient, even though we have
2 two nurse practitioners in our practice, the patient would
3 just be locked in with me and could not see the other
4 practitioner in the office if I happened to be sick or on
5 vacation or something.

6 And then they said, well, okay, they
7 can see the other provider, but you have to submit an
8 authorization within fourteen days and we'll decide if
9 we're going to pay you for that visit after that. And then
10 on top of that, I was told that even if there was another
11 person covering for me, that if that person wrote a
12 prescription for that patient, that the pharmacy couldn't
13 fill it because I was the only one who could prescribe
14 medicine for that patient.

15 And, so, if I'm off or I'm sick or
16 I'm out of the country, even if I have somebody covering
17 for me, I may or may not get paid for that visit and the
18 patient cannot receive a medication. Even if they have a
19 strep throat, they can't get an antibiotic because I'm not
20 there to write the prescription.

21 CHAIRMAN POOLE: Would you address
22 that, Russell? What is your all's future plans for the
23 lock-in program?

24 MR. HARPER: I can tell you the lock-
25 in program is identified in the Kentucky Administrative

1 Regulations of 907 677 and those are the criteria we use to
2 identify members that are eligible for this program.

3 I will tell you that the initial list
4 that we put together is now being scrubbed to kind of go
5 back and find some of the individuals that could possibly
6 have been not qualified for the program that received a
7 letter. So, that sets the criteria there.

8 And when we did this initially, we
9 identified a little over 4,000 members that qualified for
10 this. And if you look at the criteria, it's number of
11 pharmacy visits, provider visits, to hospitals, things like
12 that. It really doesn't have anything to do as far as the
13 amount or the types of care that an individual receives.
14 It's more or less on the utilization rates.

15 I'll just take them one by one if
16 that's okay. To address Mr. Adams' concern, I'm not real
17 familiar with the patient. So, I can't really comment on
18 their particular condition or why they were selected for
19 the lock-in program.

20 I would assume that the normal appeal
21 process, if this person was not eligible for the program
22 because they're blind or in a nursing home or whatever,
23 then, that would catch that, if we haven't already. And
24 then if not, then, I would have to--I mean, I guess we
25 could get the information from you or whatever we need to

1 do to take that back.

2 And, then, to address Ms. Partin's
3 issue is that I guess the question I would have is if you
4 have a singular contract with Coventry or does your
5 practice have a contract in itself would probably make the
6 difference between whether or not that other individuals in
7 your partnership can work with a lock-in member.

8 DR. PARTIN: I think we have both.
9 We get checks both ways. We get checks individually to us
10 and we get checks to our practice.

11 MR. HARPER: And I think there's
12 requirements in the regulation that allow for the
13 continuation of care regardless if the provider is not
14 available for those services or whatever services there
15 are.

16 I'm not entirely familiar with that
17 section of it, but what I'll do is I'll take these concerns
18 back. We do have a lock-in committee that's required by
19 the regulations that goes through all these particular
20 issues and things like that. So, I'll be happy to take
21 this back. I apologize I can't give you more detail. I
22 just don't know a lot of the specifics.

23 DR. PARTIN: Could you respond to us
24 in writing?

25 MR. HARPER: Yes, ma'am. Respond to

1 the committee or to you specifically?

2 DR. PARTIN: Both would be fine.

3 CHAIRMAN POOLE: Thank you. Any Old
4 Business?

5 MR. CARLE: Ron, before we leave
6 Physician Services, I wanted to ask Dr. Neel a question.
7 With the ACA, with the private medical home, with the
8 development of then Exchanges, does the physician community
9 feel like we have enough primary care providers in the
10 State of Kentucky to actually provide the care that our
11 patients deserve?

12 DR. NEEL: No, I don't think we have
13 enough primary care providers now to provide for the ones
14 that we have now, much less for the future. Now, it
15 depends on who delivers primary care. As we have more mid-
16 level practitioners supplying care, then, that will take
17 care of part of it, I suppose.

18 For example, in Owensboro, we have a
19 critical shortage of primary care at this point and we're
20 having a terrible time having providers available,
21 particularly for Medicaid patients. We take care of them
22 pretty well with children; but for adult Medicaids, we only
23 have one practice, one practitioner actually in Owensboro
24 who will even accept adult Medicaid who are a totally
25 different situation. So, that's a good question and I

1 don't have an answer for the future.

2 DR. PARTIN: I've got one more
3 question on the subject of referrals, and I just wanted to
4 touch on that subject since it had already been brought up.
5 We've been having a terrible time referring to specialists.
6 With dermatology, for instance, I'm in Adair County, and we
7 don't have any dermatology in that area.

8 And all of the dermatologists that
9 are within a reasonable driving distance have told us that
10 they will not accept referrals because--they will only
11 accept Medicaid referrals if the county that you're in
12 touches the county that they're in. For instance, I can't
13 refer to Somerset or Glasgow or Bowling Green or
14 Elizabethtown because those counties don't touch Adair
15 County, and those were the places that we referred to in
16 the past.

17 So, I had a patient that I had to
18 refer to a dermatologist and the only place that I could
19 get her an appointment was in Frankfort. And that's kind
20 of crazy to make somebody drive all the way to Frankfort,
21 particularly a Medicaid patient who already is financially
22 in a difficult situation and transportation problems.

23 So, referrals are a big problem, and
24 then just getting the authorization sometimes for the
25 referrals is very difficult. Thank you.

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CHAIRMAN POOLE: Anything under Old Business?

Under New Business, I want to try to get through these really quick. It's going to be taken on as a whole. These are directives and recommendations by this body up here to the Cabinet for Health and Family Services to evaluate and to get answers, solutions, feedback on these. So, I will read through these.

The Medicaid Advisory Council asks the Cabinet for Health and Family Services to evaluate how the managed care organizations are working with our home health agencies and hospice providers.

If Medicaid deems the behavior of the MCO's to be substandard when working with these agencies, then, Medicaid needs to take appropriate action to get the MCO's abiding by the contracts and to send out a timeline for these improvements to all contracted home health agency and hospice providers.

We have suggestions down there for reviewing the authorization process for services and supplies, to evaluate the lower reimbursement rates for these services and supplies, the amount of time it takes for reimbursement and the response time in dealing with the MCO's on these issues.

The second recommendation from the

1 MAC to the Cabinet is to persuade Coventry to change its
2 policy concerning certain drugs being limited to 100 dosing
3 units, to allow for a 30-day supply on all medications as
4 authorized by the prescriber. For example, when a
5 physician writes for 120 Percocet four times a day,
6 Coventry pays for the 100. This inconveniences the
7 patients and physicians due to the remainder of the
8 prescription being null and void.

9 Sometimes the physician refuses to
10 write a new prescription every twenty-five days. So, if
11 the patient needs enough medicine for the month, they have
12 to pay for it out of pocket or just get the 100 and go
13 without for five days.

14 The third initiative is what we just
15 talked about. The Medicaid Advisory Council asks the
16 Cabinet to persuade Coventry to not implement the lock-in
17 program which again is another mechanism for barriers to
18 care. It takes away patient choice and can prevent
19 patients from gaining any kind of healthcare services such
20 as getting medicine filled on Sundays for a pharmacy that's
21 not open on a Sunday.

22 The fourth recommendation is the MAC
23 asks the Cabinet to persuade Kentucky Spirit to eliminate
24 its four-prescription limit for thirty days. Every
25 prescription thereafter requires prior authorization. It's

1 true that Medicaid had this limit before the MCO
2 implementation; however, there was a drug class exclusion
3 list that allowed for prescriptions per month based off of
4 the chronic medical condition exclusions. This process
5 delays Medicaid recipients access to care.

6 The fifth recommendation, the MAC
7 asks the Cabinet to convince the MCO's to allow drug
8 therapy management for behavioral health patients to be
9 wholly determined by the prescribers and pharmacists
10 working together to obtain the best health outcomes.

11 Behavioral health medications will be
12 exempt from prior authorization processes. A request
13 and/or a justification inquisition may be made by the MCO's
14 to verify the validity of the drug therapy, but the request
15 cannot interrupt drug therapy management in any manner.

16 Just in the topics of mental health
17 issues that need to be addressed - lack of coverage with
18 local private hospitals with psychiatric wards, arbitrary
19 shortening of hospital days, the medication prior
20 authorization processes that we've talked about. And the
21 rest just summarizes the points about the prior
22 authorization which I will leave that part out and that
23 will save some time here.

24 The proposed titration, out-of-day
25 programs or TRP's, refusal to pay for crisis stabilization

1 unit services, and payment for peer support services. That
2 was number five.

3 Number six recommendation, the
4 Medicaid Advisory Council asks the Cabinet for Health and
5 Family Services to examine why the states of Connecticut
6 and Oklahoma ceased to allow their Medicaid Programs to be
7 operated by contracted managed care organizations and
8 placed the administration of the program back in the state.
9 That was number six.

10 Seventh and last is what we asked of
11 Secretary Haynes earlier. KRS 205.2550 states the subjects
12 on which the Council advises. I've read those before in two
13 other meetings, but the MAC would like clarification from
14 the Governor's Office and the Cabinet for Health and Family
15 Services in defining the function and charge of the MAC.

16 And we've got some questions down
17 there we need answers. Why was the Medicaid Managed Care
18 Oversight Branch Department within Medicaid formed? What
19 purpose do they serve that is different from ours? And are
20 the members of the Medicaid Managed Care Oversight Branch
21 paid positions? When, if ever, will the actions and
22 recommendations enacted by the MAC be given true
23 consideration by the Cabinet to improve policies of
24 Medicaid and truly increase the quality of care provided to
25 our Medicaid recipients?

1 Do I hear a motion to accept these
2 recommendations be brought before the Cabinet?

3 MS. FUMMILAYO: So moved.

4 CHAIRMAN POOLE: Second?

5 MS. BRANHAM: Second.

6 CHAIRMAN POOLE: All those in favor,
7 say aye. Any opposed? Motion is unanimous.

8 And, Neville, with you being the only
9 one back in here, I will get these to Commissioner Kissner
10 and yourself and the Secretary. You've got variations of
11 these. Some of the items have been taken care of. So, I
12 revised them again.

13 Is there any other New Business to go
14 before the MAC today?

15 MS. HUGHES: Just for clarification,
16 you all did get the June 7th response that I sent out in
17 response to your recommendations, correct?

18 CHAIRMAN POOLE: Yes, the original
19 comments, but there were still some that we were going to
20 address further. So, now that we are actually presenting
21 it in a meeting that has a quorum and with the new
22 Commissioner, we want to address these issues.

23 You can see the suggested meeting
24 dates. Obviously we've talked about meeting more. I
25 already have a conflict with that first date, but, again,

1 I'll communicate with everybody on the MAC here to come up
2 with a good date and, of course, coordinate that with
3 Sharley and the Commissioner's Office to get that done.

4 Do we have any other information?

5 Take a motion to adjourn.

6 MS. BRANHAM: So moved.

7 MS. ROARK: Second.

8 CHAIRMAN POOLE: All those in favor,
9 say aye.

10 MEETING ADJOURNED

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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 1st of August, 2012.



Notary Public
State of Kentucky at Large

My commission expires February 10, 2013.