

## BEHAVIORAL HEALTH TAC REPORT TO THE MAC – MAY 28, 2015

Good morning. I am Sheila Schuster, serving as Chair for the Technical Advisory Committee on Behavioral Health (BH). Our TAC had its most recent meeting at the Capitol Annex on May 7, 2015. All five (5) of the Medicaid MCOs and their Behavioral Health representatives were in attendance. In addition to the MCO representatives and four of our six TAC members who were present, we had other members of the behavioral health community in Kentucky, including members of the KY Mental Health Coalition and others interested in the topic being presented. We also had staff from the KY Department for Medicaid Services, including the Medical Director Dr. John Langefeld, as well as representatives from the KY Department for Behavioral Health, Developmental & Intellectual Disabilities, including its Medical Director, Dr. Allen Brenzel.

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

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

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

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

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

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

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

Two of the MCOs have provided the Behavioral Health TAC with denials, discharge and readmission data around psychiatric hospitals and PRTFs, based on individuals and not on claims data. Once we have the information from the other MCOs, the TAC will be presented to ask further questions and made some recommendations. The TAC is still interested in obtaining the “industry standard” for readmissions to an inpatient acute hospital setting for a Medicaid population and for a non-Medicaid population. We wonder if this information is available to Medicaid and could be shared with the TAC?

### **MAY 28, 2015 RECOMMENDATIONS TO THE MAC::**

**RECOMMENDATION:** That the DMS dashboard of data from the MCOs regarding: Lengths of Stay in Psychiatric Hospitals and Crisis Stabilization Units; Percentage of Denials for each behavioral health service: inpatient and outpatient; Readmissions to Psychiatric Hospitals and Crisis Stabilization Units be reported by numbers of persons in addition to the claims data now being reported. We request that the data in each instance be separated by children (up to age 18) and adults and be reported on a quarterly basis.

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

**RECOMMENDATION:** That DMS work with the Behavioral Health TAC and with the MCOs to further discuss appropriate reporting and measures for documenting integrated care and its outcome. We have had no response to date from the Division for Program Quality & Outcomes and are eager to meet with them to hear of progress in developing and reporting these measures.

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

**Children's Health Technical Advisory Committee Meeting**  
**Public Health Building**  
**275 East Main Street**  
**Frankfort, Kentucky**  
**July 8, 2015 – 10:00 a.m. EST**

TAC members in attendance: Chair Tara Grieshop-Goodwin, Mary Burch, Dr. Kelli Whitt, Janice Jackson, Michael Flynn, Dr. Charlotte Haney and Cecelia White.

Managed Care Organization (MCO) representatives in attendance: David Hanna, Jessica Beal, Liz McKune and Micah Cain, Passport Health Plan; Lee Ann Magre and Stephanie Jamison, WellCare; David Crowley, Mary Maupin, Gwen Embry and Andrew Mudd, Anthem Blue Cross-Blue Shield; Kimberlee Richardson, Dr. Jeb Teichman, Mendy Pridemore and Kelly Fellonneau, CoventryCares; Dr. Vaughn Payne, Kristen Mowder and Paula Cissell, Humana-CareSource .

Medicaid staff in attendance: Dr. John Langefeld, Cindy Arflack, Deborah Simpson, Catherann Terry and Candace Crawford. Others in attendance: Dr. Deborah Winders Davis, Dr. Gilbert Liu, Dr. William D. Lohr and Dr. Charles Woods, University of Louisville; Dr. Jerry Caudill, Avesis; Dennis Yastes and Mahak Kalra with Kentucky Youth Advocates; Jason Baird, DentaQuest; Dr. Julia Richerson with AAP-KY; Karen Mercer, Commission for Children.

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The meeting was called to order by Ms. Grieshop-Goodwin, Chair. Introductions were made by the TAC members.

Behavioral Health Presentation:

Dr. John Langefeld, Chief Medical Officer for Department for Medicaid Services (DMS), made a presentation on psychotropic medication use with children. The summary of concerns he reported are as follows:

- Kentucky has one of the highest rates in the U.S. of psychotropic medications prescribed to children
- Psychotropic medications are being prescribed to very young children at high rates and often in combination with other medications
- The rate of use for foster children is disproportionately higher (nearly six times that of TANF children in Medicaid)

Dr. Langefeld discussed the steps taken to date to address this:

- (1) Preliminary analysis is completed on Medicaid claims data (medical and pharmacy)
- (2) DMS is engaged in active discussion with all Medicaid MCOs, with the implementation by MCOs of a Performance Improvement Project (PIP) focused on the effectiveness of treatment that includes the use of psychotropic medications in children. The 2015 HEDIS measures to be looked are the use of higher-than-recommended doses and use of multiple antipsychotics, the use of first-line psychosocial care and follow-up visits and metabolic screening and monitoring.
- (3) DMS is engaged with faculty at U of L Department of Pediatrics. A multidisciplinary research team called Child and Adolescent Health Research Design and Support (CAHRDS) has been engaged to:
  - Validate and further refine initial data analysis
  - Research clinical evidence-based best practices in prescribing and treatment
  - Make recommendations regarding potential programmatic actions
  - Be actively involved in continued research, education and interactions with treating physicians
  - Make recommendations on appropriate and effective quality outcome metrics

Dr. Deborah Davis with the University of Louisville introduced the CAHRDS research team who were in attendance at the meeting to address the group. Dr. Davis discussed a PowerPoint presentation entitled "Patterns of Psychotropic Medication Use Among Kentucky Medicaid Children in 2013."

The highlights of this analysis are:

- Approximately 45% of children aged 6-11 with a diagnostic code of mood disorder are prescribed an antipsychotic medication. This subgroup should be prioritized for intervention.
- Rates of prescribing psychotropic and antipsychotropic medications vary slightly by region. Region-specific interventions do not seem to be warranted.

- The rate of prescribing to children five years and under is 15-20% lower for non-APM psychotropics when those with seizure diagnoses are removed.

Dr. Davis discussed the next steps to take:

- Look at behavioral health claims in each diagnostic category and by age and region
- Look at whether laboratory monitoring was done versus the HEDIS appropriate lab monitoring
- Look at concurrent antipsychotic medication use
- Look at appropriate versus inappropriate use in foster care population

Dr. William D. Lohr with U of L discussed the provider interviews performed, the provider survey methodology and the provider survey preliminary results.

Dr. Langefeld stated that the TAC's feedback on these reports and any input concerning what steps to take in the future are welcomed.

Approval of Minutes:

A motion was made by Mr. Flynn and seconded by Ms. Burch to approve the May 13, 2015 meeting minutes. Motion passed.

Cabinet Updates on Medicaid & KCHIP:

Ms. Arflack reported that as of June 1, there were 44,226 children enrolled in KCHIP. She noted that the dental regulation should be final by the end of the year, and that the federal KCHIP match for federal years 2016 and 2017 will be 100%. Ms. Arflack stated that the asthma codes are still in progress and that Charles Douglass is working on them.

Clarification was needed from Dr. Richerson concerning questions she had on tubal ligations for pregnant women and immunization reimbursement rates. Dr. Richerson clarified that the tubal ligation question concerned the restrictions for Medicaid women to receive a tubal and she asked for a copy of this regulation. Dr. Richerson stated the immunization question was around the Kentucky VFC administrative rate being lower than surrounding states and wanted to know if that could be reviewed.

MCO Updates on PIPs:

ANTHEM: Ms. Mary Maupin reported that on the behavioral health PIP, there is not a huge denominator in the population yet and the MCO is continuing to build the non-HEDIS measures within their software. On the oral health initiative, work group is looking at recipient incentives for dental screenings and ways to make a child's first visit to the dentist more pleasant and less traumatic. For the emergency utilization PIP, the "Know Before You Go" magnets have been made for distribution to promote the nurse call line.

Ms. Maupin noted that a Teen Advisory Board is being developed to get input and feedback from the teenage population concerning health issues; and for the smaller children, immunizations, well-child visits and provider education are being addressed. Mr. Crowley noted that with effective July 1, Anthem will be in all regions across the state.

COVENTRYCARES: Ms. Kimberlee Richardson reported that she had the behavioral health data that was asked for. She noted that the prior authorization and claims information was pulled from January 1 to June 30. Specific to child data, they had 954 claims that were fully approved requests, 220 that were partially approved and 89 that were denied. The appeals data was not available at the time of the meeting. Ms. Richardson stated the MCO would need more information as to what the TAC wants concerning Reports 59 and 61.

Ms. Mendy Pridemore stated that the number of enrolled in foster care currently is 4,022. She stated that approximately 580 were receiving antipsychotic medications and that outreach is being done to the family members and caregivers of these foster care children.

HUMANA: Dr. Vaughn Payne stated that a provider webinar will be conducted to discuss the antipsychotic medication topic and that he will look into the idea of providers receiving CME's for attending. He noted that claims data is still being collected and interventions are beginning to take place. Dr. Payne stated that

due to time constraints of the meeting, he had lengthy reports concerning enrollment, new enrollees, prior authorizations and claims that he would not discuss but these reports were furnished to the TAC.

**PASSPORT:** Dr. Liz McKune stated that the MCO is working on building an improved data analytics tool that will aid in pulling information about the asthma population and to help support the goals for the asthma PIP. For the antipsychotic monitoring, the MCO is looking at building a comprehensive tool to better pull data for the six measures they are measuring for at this point. The MCO has been looking at an alternative charts' auditing process for the upper respiratory infection and pharyngitis infection. The MCO has been working with Louisville Metro EMS to look at how they respond to non-emergent calls that result in ER visits.

Dr. McKune handed out a PowerPoint presentation that covered the general data, prior authorization, claims and appeals, the quarterly grievance activity, substance abuse treatment and foster care membership.

**WELLCARE:** Ms. LeAnn Magre stated that the data is still being analyzed on the PIP updates and that a report will be submitted on September 1. She noted that the antipsychotic medication PIP interventions are still being formulated and not completely confirmed to date.

Discuss Recommendations to MAC:

No formal recommendations were made.

Other Committee Business:

There was no other committee business.

A motion was made by Dr. Haney to adjourn the meeting. The next meeting is September 9, 2015.

(Minutes were taped and transcribed by Terri Pelosi, Court Reporter, this 15th day of July, 2015.)

## Home Health Recommendations

Presented at May 28, 2015 MAC

1. With the changes to HCBW/MWMA the goal was to care for patients with services started by a provider as soon as possible but yet with the roll out of the program there are built in delays. Cautioned Cabinet to watch this time line and beginning of care very carefully as we feel it is time that is not necessary to begin services especially with Presumptive Eligibility HB 144
2. Was addressing the EPSDT change and rates to be reimbursed ( this is now on hold but the rates and changes with the MCOs have not been discussed)
3. Upon signing the new contracts with MCO have the penalties for MCO noncompliance in place that has "meat" to it rather than a wrist slap.
4. Not allowing the MCO to change the process in place when contracts are signed. Example = the change one MCO has made after doing business since November of 2011 now require signed MD orders for starts of care as well as for verbal orders which is not at all possible and without those signed orders will not give Prior Authorization for services. This is an impossibility due to the fact that the conditions of participation with CMS state that orders have to be signed in 21 days and many times ordered are received while the staff are in the patient's home and it is impossible to have that order signed.

# Home Health TAC

## Recommendations to MAC

**July 23, 2015**

1. The deadline to transition Individuals into MWMA has been extended to August 17th. The HH TAC respectfully request that that deadline be moved to AUGUST 31, 2015 due to the amount of incorrect data which populated the on boarding system, the software glitches of the onboarding and general overall ability to enter patients demographic information into the onboarding portal.
2. That recipients of HCBW who have been identified in the Pickle Amendment receive a written letter from the Cabinet containing information that they have been identified as individuals who should have not been required to pay the liability for their services and their reimbursement would be calculated and monies reimbursed to them via their service provider.
3. Step by Step procedure from the Cabinet in writing to home health agencies on how to respond and to whom to respond to in order to obtain reimbursement for liability charged to HCBW providers. There has been different staff identified as to whom to submit the letters agencies have received as well as no amount placed on that letter which the agency is responsible to reimburse the client.
4. That DAIL have in place for on boarding MWMA clients so DAIL, Care Wise, and agencies know if the client has been entered and to whose provider number that has begun the contact/demographic information/ provider identification so that the information trying to be submitted through the portal will just not be rejected.

Number one is indeed the time sensitive request for the MAC.

**Technical Advisory Committee on Intellectual and Developmental Disabilities  
Summary/Recommendations to the Advisory Council for Medical Assistance  
July 23, 2015 – 10:00 a.m. Capitol Annex**

The Technical Advisory Committee on Intellectual and Developmental Disabilities met on July 10, 2015 at 10:00 a.m. in the Cabinet for Health and Human Services Building in Frankfort. The IDD TAC membership is composed of consumers who participate in a nonresidential community Medicaid waiver program; a consumer who participates in a residential community program; a representative of a family member who participates in a community program; a consumer representative of a family member residing in an ICF/ID facility, all of whom are appointed by the Governor; a member of The Arc of Kentucky, a member of the Commonwealth Council on Developmental Disabilities; a member of the Kentucky Association of Homes and Services for the Aging/Leading Age; the Kentucky Association of Private Providers/one nonprofit and one for-profit. Attending the meeting were representatives from Cedar Lake Lodge/KAPP, The Arc of Kentucky, Commonwealth Council on Developmental Disabilities, Independent Opportunities/KAPP, Employment Solutions/KAPP, Kentucky Association of Regional Programs (KARP), Parent Representative of MPW Recipient, the Division of Community Alternatives, the Division of Program Quality and Outcomes, the Division of Community Alternatives, the Department for Aging and Independent Living, and the Division for Developmental and Intellectual Disabilities.

Discussion at the July meeting included:

- (1) The lack of an appropriate assessment tool for children applying for the Michelle P. Waiver. Suggestions were that members meet with the Department of Medicaid Commissioner and to also research pediatric tools being utilized in other states.
- (2) IDD/TAC members needed – there are currently three open positions with one application pending in the Secretary's office.
- (3) The Michelle P. Waiver waiting list of 4,342 was discussed along with the number of additional slots to be allocated this summer. Concern was expressed over the quickly growing number on the waiting list and again stressed the need for an assessment tool for children.
- (4) The 40 hour/week regulation in the Michelle P. Waiver/CDO was discussed. As of April 1, 2015, CDO recipients were notified that services are limited to cumulative 40 hours per week and requests for more hours will be denied. The IDD TAC suggests clarification of the regulations as the flexibility needed in the number of hours does not increase ones budget.
- (5) The EPSDT change from MPW to state Medicaid has resulted in disruption of services for some, concern regarding the reduced number of therapy hours annually, and the assessment requirement change from six months to three. It was stated that providers can continue to use

the prior authorization number to avoid disruption in services and anyone having problems should contact the Department for Medicaid Services directly.

(6) MWMA Portal/Deloitte – Training is being provided for traditional agencies but not for recipients that may be required to utilize the portal by year end 2015. It was stated the process will not be required by recipients, but will be on a voluntary basis.

(7) The state audit and provider recoupment of over 2.5 million dollars for lack of documentation identified in the Money Follow the Person was discussed. These dollars are to be sent back to CMS – 85% and 14% to the state. There is an appeal process in place. It was stated during the meeting document errors were minor ones i.e. lack of signatures, incorrect dates, etc. Some provider agencies are concerned that smaller providers may be forced out of business if they are required to pay recoupment costs.

#### Recommendations to the Advisory Council for Medical Assistance – July 23, 2015

- 1) The IDD TAC recommends that the Department for Medicaid Services immediately stop recoupment for minor documentation errors and examine the monitoring process for traditional providers that are involved in the Money Follow the Person funding and to look at another way to handle the infractions/recoupment.
- 2) The IDD TAC recommends that the Department for Medicaid Services develop an appropriate tool for evaluation of children's eligibility for the Michelle P. Waiver.
- 3) The IDD TAC recommends that the Department for Medicaid Services re-examine the Michelle P. Waiver/Consumer Directed Services (CDO) 40 hour per week limit to allow flexibility within the budgets. Those recipients using more than 40 hours are still within their budget.

Medicaid Advisory Council  
Recommendations  
July 23, 2015

**1. Limitation of 99214/99204 visits to two (2) per patient per year**

This limitation is arbitrary, unrealistic and forces providers to fraudulently down-code visits. There are several reasons to object to this unreasonable restriction. As the country and the individual states move toward reimbursement based on quality and outcomes and as providers are evaluated on meeting certain measures, accurate documentation of care provided is paramount. Providers must demonstrate that they are meeting specific goals and providing comprehensive care in the services they provide.

It is a well-documented fact that Kentucky has some of the highest rates of COPD, heart disease, diabetes, obesity, smoking and cancer in the country. Medicaid recipients suffer from some of the poorest health in the state and often have more than two chronic conditions; many have three (3) or four (4) chronic conditions. Patients with diabetes, hypertension, COPD, heart disease and other chronic conditions must be followed closely to help them maintain control of their diseases and to reduce the incidence of complications. These patients usually take multiple medications, which must be monitored for effectiveness and for side effects. Patients with chronic illnesses are usually seen in the clinic every one (1) to three months (3) and may be seen more frequently if their conditions are uncontrolled.

CMS provides explicit rules that govern how visits are coded. Specific criteria must be met for each level of coding. Level 4 visits (99214 or 99204) are considered moderate complexity visits. CMS defines moderate complexity visits as:

- One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment
- Two or more stable chronic illnesses
- Undiagnosed new problem with uncertain prognosis (e.g. lump in breast)
- Acute illness with systemic symptoms (e.g. pyelonephritis, pneumonitis, colitis)
- Acute complicated injury (e.g. head injury with brief loss of consciousness)

Proper coding of visits is important for correct documentation of a visit. Just as it is considered fraudulent on the part of a provider to falsely up-code a visit, it would also be considered fraudulent on the part of the payor to force a provider to falsely down-code a visit. Because of this arbitrary limit, Kentucky health care providers are being forced by Medicaid to falsely down-code visits in order to receive some payment for services rendered.

In instances where a provider has coded a visit as a level 4 visit and it is rejected by Medicaid or the MCOs, the provider is forced to re-open a signed off chart and change the E/M visit code to a lower code.

According to the American Association of Nurse Practitioners, no other state limits level 4 visits to two per year.

**Recommendation:** Kentucky Medicaid take the necessary steps to remove the restriction on 99214/99204 visits.

## **2. Recoupments due to Retro-eligibility**

**Recommendation:** DMS disseminate a formal communication to all providers regarding recoupments due to retro-eligibility. Specifically, we recommend that this communication be in writing and include the following: 1) an explanation of the issue; 2) a description of how retro-eligibility is being addressed in the new contract; and 3) step-by-step instructions for how providers should handle these recoupments, including those that are outside the timely filing window and/or those that are being denied payment due to prior authorization requirements.

## **3. Disenrollment**

**Recommendation:** DMS disseminate a formal communication to all providers regarding disenrollment of Medicaid members due to inability to contact or returned mail (as described in section 27 of the new MCO contract effective 7/1/15). Specifically, we recommend that this communication be in writing and include the following: 1) a summary of the new contract provisions regarding disenrollment and how this will effect members, providers and MCOs; 2) an explanation of how disenrollment will be communicated to members, providers and MCOs; 3) a description of the disenrollment and re-enrollment process, including the warning period, who is authorized to update member information, and when updated information will go into effect; and 4) any recommendations DMS has for avoiding disenrollment of transient members that would be helpful for kynectors, providers and MCOs to know. One example of this would be letting the member know they have the option of authorizing a local DCBS office, shelter, church, etc, to collect mail on their behalf.

## Optometric TAC Recommendations for MAC – May 2015

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

The Optometric TAC would request that Medicaid ask all MCO's vision subcontractors how a provider is supposed to bill cataract co-management? Request specifics codes & modifiers to bill; as well if the claim needs to be billed directly to MCO instead of the vision subcontractor?

The Optometric TAC would also request the department receive a list of any codes that need to be billed directly to MCO instead of vision subcontractors? Do ophthalmologists bill the exact same way on any code that is found on the vision fee schedule?

The Optometric TAC would request that Medicaid receive confirmation from all MCO's vision subcontractors that they are following the Medicaid Vision Fee Schedule service of on routine exams of "1 exam, per year, per provider"?

The Optometric TAC would request that Medicaid receive explanation from all MCO's vision subcontractors on how to apply for a prior authorization if requested? As well as instructions on how to appeal a denied claim?

## Optometric TAC Recommendations for MAC – July 2015

Regarding Medicaid EHR incentive qualification, some optometrists experienced a problem qualifying after the MCOs took over. The doctors know that they have a high percentage of Medicaid patients in their practice. The first year when the data was provided by the Department, they had no problem meeting the encounter numbers to receive their money.

However, once they were dependent on the MCOs for data, they could not qualify. Evidently the problem had to do with whether the numbers were reported by individual or group NPI numbers. The TAC would request that Department require uniformity in methodology in the MCO reporting of provider data to qualify for their EHR incentive payments. Due to this issue, doctors were not able to get their incentive payment for the year.

Optometric TAC Meeting  
July 16, 2015 - Frankfort, KY  
Minutes

Called to order at 1:00pm EDT with a quorum present.

Present: Gary Upchurch OD, Steve Compton OD, , Brian Keplinger OD, Susanne Watkins OD, Karoline Munson OD, Mary Marcum, Kim Sizemore, Cindy Helman, Rebekah Matthews (eyeQuest), Jean O'Brien (Anthem), Lori Kent (Passport), Patti Smith-Glover (Humana CareSource), Rebecca Randall ( Wellcare), Dana Linton (Avesis), Dan Levy (Avesis), Fred Tolin (Aetna), Jeff Busick (MSS), Darlene Eakin, Sarah Unger, CJ Jones (Medicaid), Sheldon Robinson (Medicaid) and Charles Douglas (Medicaid)

Introductions of those in attendance.

Department was asked to have an update at the next TAC on the New MCO Contracts.

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

TAC discussed how to bill cataract co-management.

TAC discussed prior authorizations.

TAC discussed Medicaid EHR Incentive - Individual & Group NPI #'s Issues. Will report this issue at next MAC meeting.

TAC reported concerns about individual MCO's:

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

TAC discussed future meetings of Optometric TAC in 2016. Next meeting September 16<sup>th</sup> at 1pm at Transportation Dept. Set a date for November 5<sup>th</sup> at 1:00pm at Transportation Dept as well.

Meeting adjourned at 4:00pm

## **Physicians TAC Recommendations**

Presented to MAC on May 28, 2015

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

## **Recommendations to the MAC**

Prepared by the Primary Care Technical Advisory Committee

Presented on May 28, 2015

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

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

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

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

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

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

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

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

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

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

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

1. To improve the automated wrap payment process and decrease administrative burden on providers, the Primary Care TAC recommends that DMS upgrade their system in order to have the capability to provide all EOBs electronically. For auto-posting, EOBs should contain

at least the following identifiers: MCO Member ID, claim number, subscriber number and patient name.

2. In addition, the Primary Care TAC recommends that DMS meet with the MCOs to determine the best way to reprocess claims for dates of service after 7/1/14 that have not received a wrap payment due to MCO or DMS errors. We recommend these be reprocessed in a way that will be least burdensome on providers.
3. To avoid placing the burden of eligibility-related recoupments on providers, the Primary Care TAC recommends that DMS's provider portal should be considered the official record for member eligibility. As such, any service provided to a patient who is listed as "eligible" on DMS's portal on that particular date of service should be subject to payment by DMS or an MCO.
4. Additionally, the Primary Care TAC recommends that DMS implement a "statute of limitations" for eligibility-related recoupments. Specifically, we recommend that the timeframe for recoupments should be the same as timely filing for claims.
5. In order to improve the effectiveness of the MCOs' various lock-in programs and avoid unnecessary denied claims to providers for unknowingly treating patients who are locked-in to another provider, the Primary Care TAC recommends that DMS work with the TAC and MCOs to adopt a more consistent and effective approach to lock-in notification.
6. Finally, in order to improve the MCOs' and providers' ability to effectively outreach to members and provide appropriate care based on patient demographics, the Primary Care TAC recommends that DMS develop a form that will allow providers and MCOs to collect corrected or updated information with the patient or guardian's approval. We suggest a form that collects the following information: Name (correct spelling and hyphenation), full address and zip, phone number, email address, date of birth, sex, residency status, citizenship status, immigration status, relationship status. This form can be faxed to the local DCBS office to update the system. Local offices will need to be informed by DMS at the State level that this method of updating demographic information is officially sanctioned.

## **Recommendations to the MAC**

Prepared by the Primary Care Technical Advisory Committee

Presented on July 23, 2015

The Primary Care Technical Advisory Committee met at 10:00 AM on Thursday, July 9th, 2015. A majority of TAC members were present along with representatives from each of the MCOs. There were fewer DMS staff in attendance than usual and none of the agenda items could not be addressed by them. As a result, TAC members accepted minutes from the May meeting and adjourned. Since these are standing meetings, we have requested that DMS notify us ahead of time if the appropriate representatives cannot be in attendance in order to allow us to reschedule for a more convenient time.

**Since there wasn't a quorum at the last MAC meeting, the Primary Care TAC re-submits the following recommendations for the MAC's consideration:**

1. To improve the automated wrap payment process and decrease administrative burden on providers, the Primary Care TAC recommends that DMS upgrade their system in order to have the capability to provide all EOBs electronically. For auto-posting, EOBs should contain the following identifiers: MCO Member ID, claim number, subscriber number and patient name.
2. To avoid placing the burden of eligibility-related recoupments on providers, the Primary Care TAC recommends that DMS's provider portal should be considered the official record for member eligibility. As such, any service provided to a patient who is listed as "eligible" on DMS's portal on that particular date of service should be subject to payment by DMS or an MCO.
3. Additionally, the Primary Care TAC recommends that DMS implement a "statute of limitations" for eligibility-related recoupments. Specifically, we recommend that the timeframe for recoupments should be the same as timely filing for claims.
4. In order to improve the effectiveness of the MCOs' various lock-in programs and avoid unnecessary denied claims to providers for unknowingly treating patients who are locked-in to another provider, the Primary Care TAC recommends that DMS work with the TAC and MCOs to adopt a more consistent and effective approach to lock-in notification.
5. Finally, in order to improve the MCOs' and providers' ability to effectively outreach to members and provide appropriate care based on patient demographics, the Primary Care TAC recommends that DMS develop a form that will allow providers and MCOs to collect corrected or updated information with the patient or guardian's approval. We suggest a form that collects the following information: Name (correct spelling and hyphenation), full address and zip, phone number, email address, date of birth, sex, residency status, citizenship status, immigration status, relationship status.

KENTUCKY THERAPY TECHNICAL ADVISORY COMMITTEE

July 6, 2015, NOTES

MEMBERS IN ATTENDANCE: DR. BETH ENNIS, CHAIR (PT)

MEMBERS ATTENDING VIA CONFERENCE CALL: LESLIE SIZEMORE (OT), BETHANY BERRY (SLP), LINDA DEROSSETT (OT), LINDA GREGORY (SLP).

MEMBER ABSENT: CHARLIE WORKMAN, (PT)

OTHERS IN ATTENDANCE: CJ JONES (DMS), EDDIE NEWSOME (DMS), JEANA JOLLY (DMS), CINDY TOLL (DMS), MARY HIEATT (HUMANA CARE SOURCE), DELL FRAZIE, (PASSPORT), PAT RUSSEL (WELLCARE), FRED TOLIN (COVERNTRY CARE), PEGGY HAGAR (ANTHEM).

OTHERS ON CONFERENCE CALL: CHARLES DOUGLASS (DMS), STEPHANIE BATES (DMS), LISA MILL (DMS), SALLY HARPER (DMS) , JENNIFER HOWE (KIDS CLUB CENTER).

APPROVAL OF PREVIOUS MINUTES: NO CORRECTIONS: ACCEPTED AS WRITTEN.

PREVIOUS MEETING ISSUES:

FEE FOR SERVICE MEDICAID 30 DAY CERT: Update –DMS staff states this is implemented and providers should be getting 90 days now.

EPSDT TRANSITION: Chair announced that the July 1<sup>st</sup> EPSDT has been postponed, if providers have provider number, they should use that number for billing. Caller voiced concern that those that got ready for the transition are being treated unfairly as the rates under EPSDT are higher than under Fee for Service. It was reported by DMS staff that the decision was made by Cabinet Secretary due to concerns for network adequacy and that DMS was looking at all aspects. Chair requested that concerns be forwarded on to her to send to DMS and Cabinet.

Chair asked if an official letter went out to MCO's. DMS staff response was that an official letter had not gone out at this time and would follow up.

CERTIFICATE OF NEED: Chair announced the draft regulations were released. The concerns from the three therapy organizations do not appear to be addressed.

PT FEE SCHEDULE CODES – TIMED VS VISIT: Chair asked if members had reviewed SLP/OT & PT fee schedules. Chair presented billing codes 97112, 97113, 97116, 97124, (codes should be timed codes but are visit codes on PT free schedule) DMS staff will follow-up.

Reported Speech Therapy Association met with Commissioner Lee in May to discuss rates, members felt was productive. KTPA met with Director Guice about differential which may take a SPA change.

ON LINE PROVIDER ENROLLMENT: Charles Douglass states progress is being made but still having issues with this program.

SPEECH CFY AND LICENSE: Discussed at meeting with Commissioner and Veronica Cecil state you must be licensed – not temporary. Association to send other states information to Veronica Cecil, as CFY's are considered licensed in other states.

NEW BUSINESS:

WELLCARE: Working on CareCore issues.

FEE For Service: Concerns were voiced about Fee for Service prior authorization inconsistencies; providers are being asked to submit certain forms, expecting certain words, etc. Examples will be sent to chair to forward to DMS.

QUESTIONS FOR MAC MEETING: No new concerns – Next MAC meeting is July 23, 2015

NEXT MEETING: Therapy TAC will continue to meet every other month. Meetings set for remainder of 2015; September 2, 2015. 8:30 A. M. Transportation Conference Center 200 Mero, Room 110 Frankfort, KY, and November 4<sup>th</sup> 2015. Dr. Ennis asked members to email her any new concerns.

ADJOURNED