

CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

September 25, 2012
10:00 A.M.
Room 125, Capitol Annex
Frankfort, Kentucky

APPEARANCES

Ron Poole, R.Ph.
CHAIRMAN

Richard L. Foley
Donald R. Neel, M.D.
Elizabeth Partin, ANRP; NP
Susie Riley, D.M.D.
Peggy Roark
Oyo Fummilayo
Sheina C. Murphy
Sharon Branham
Susanne Watkins, O.D.
COUNCIL MEMBERS PRESENT

CAPITAL CITY COURT REPORTING

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1 CHAIRMAN POOLE: I'll call the
2 meeting to order. The first item of business is approval
3 of last meeting's minutes. And unless there is any
4 objections, Sharley is just going to provide an
5 electronic copy since all of us have an email account.
6 That way you can keep on referring to them and find them
7 easier.

8 DR. NEEL: So moved.

9 MS. BRANHAM: Second.

10 CHAIRMAN POOLE: All those in
11 favor, say aye. Any opposed?

12 Now we'd like to, first of all,
13 introduce our new Commissioner, Commissioner Lawrence
14 Kissner, and have him come up and just give us his
15 comments on how things are going.

16 REPORT OF CABINET FOR HEALTH AND FAMILY SERVICES,

17 DEPARTMENT FOR MEDICAID SERVICES:

18 COMMISSIONER KISSNER: Thanks for
19 inviting me. I have been on the job since July 1st of
20 this year. I think things are going. Things are going
21 well in some areas and not so well in others.

22 And I'm just talking off the cuff
23 here. Where I have taken the Department for Medicaid and
24 I'm focusing the team on a couple of three important
25 strategies. One of those is I've asked every director

1 help me.

2 Eighty percent of the work happens
3 all the time. How do we handle it? What is the process?
4 And I want to accomplish two things with this. One is I
5 want to see it in paper, see it down in a picture.

6 The second this is I want to say,
7 well, how has that changed with the introduction of
8 managed care? So, where is the MCO box in your process
9 flow?

10 And the third thing is I want to be
11 able to educate everybody within the Department as to
12 what's generally, you know, the Accounting Department,
13 how do we handle customer service calls. They don't need
14 to know how to do it completely. They just need to know
15 generally when somebody calls up and says, hey, my claim
16 wasn't paid, where should that go so that it can get
17 resolved in a timely fashioned, can get logged in, can
18 get tracked, trended and resolved because our world has
19 changed.

20 We went from basically Passport as
21 the only managed care to being, in essence, almost
22 700,000 of our 820,000 people are in managed care. So,
23 how has that changed?

24 I'll give you a good example. When
25 we looked at the process flow of a doctor calls up and

1 says my claim wasn't paid, we would check the MMIS
2 system, which is our system that HP runs for us. We
3 would go through a series of steps, and at about step
4 four or five, we said, well, is this a managed care
5 member? Well, eighty percent of the time the answer is
6 it's a managed care member. That should be question
7 number one.

8 So, how is our process flow? That
9 should be the first question we ask because we wouldn't
10 have paid the claim if it was a managed care member and
11 the provider would have had a contract with the MCO.

12 So, that's sort of a simple example
13 of some of the changes that we've seen. I was pleasantly
14 surprised that most everybody, director and manager, has
15 process flows. That's how they train people in their
16 departments when they hire somebody new, and we have
17 taken into consideration the impacts of the MCO's.

18 And, like I said, I want to be able
19 to know where is the funnel that we start at the top of
20 this process? And I do this all the time. I get
21 something from CMS and I say, what do I do with this?
22 This is an important document. It seems like an
23 important document. Where does it go and what do we do
24 with it and what's the response? So, that's one.

25 The second thing is we're going

1 through and looking at the State Plan Amendment, the
2 document that we file with CMS. There's our regulations,
3 and almost everything we do is set in reg. There's our
4 policies and procedures, mostly just procedures. There's
5 physician and provider billing manuals. And I'm going
6 through those major documents and saying do they all
7 align? Are we doing exactly the same thing, that we
8 start with what we said from CMS all the way through?

9 So, we're going through and
10 assessing that and we've identified a few inconsistencies
11 or
12 vagaries. So, we're trying to clean those up over time
13 and we'll get that done.

14 We have created an MCO contractual
15 performance dashboard report, and we went through the
16 contract and we said, here's everything that's in the
17 contract that you said you would do. You have to pay
18 claims in 95% of claims in thirty days from a clean
19 claim. That's in the contract. You have to answer the
20 phone in "x" amount of time, the average speed to answer.
21 You have to have 5% or less abandonment rate of phone
22 calls.

23 So, we track all of that and we do
24 it by month and it's a simple report. It's either green
25 or red. So, if it's 5% and if you're at 6% abandonment

1 rate, it's red, and if you're at 4.9, it's green, and
2 that's the contractual performance.

3 So, we've gone through that and
4 we're probably on about Version 3 now. We've shared it
5 with each of the MCO's and we've gotten their feedback.
6 Sometimes we've made errors in the math and sometimes
7 it's been as reporting issue, but this is all information
8 that the MCO's provide us.

9 As a side note, they give us
10 somewhere around 140 different reports every month which
11 is amazing. It's a lot of data. It's tons and tons and
12 tons of data from all of the MCO's. So, we're actually
13 pulling the information from what they're reporting to us
14 and plugging it into the performance dashboard report.

15 Once we get it where we're
16 confident that the report is clean and accurate and the
17 MCO's--you know, the purpose of this is (a) to be visual
18 so we can hold it up and I can hold it up to you guys and
19 at this distance, you would be able to tell the
20 difference between green and red.

21 What we see is sort of at the
22 beginning, there was some red on various things which you
23 would expect as the contracts are getting up and running
24 and they're working through their systems and hiring
25 staff and building out their various structures.

1 to the next one and say, well, there is a hospital within
2 twenty miles but is it a contracted. So, we can go down
3 the chart and we can do a really quick assessment as to
4 the severity of a termination.

5 I will tell you that every hospital
6 contract termination that has been announced has been
7 deemed by me to be considered significant. Now, when I
8 deem it to be significant, there's a series of
9 contractual things that sort of levers that drop into
10 place, and one of them is the MCO's have to mail to the
11 affected members a letter to their home thirty days prior
12 to the date of the contract termination.

13 So, we did have some contract
14 terminations that impacted 11/1 of this year. So, all of
15 those will be communicated in writing to the members by
16 10/1, and that's still in the middle of open enrollment
17 period.

18 So, that's the other big thing
19 which is going on which is we are in the middle of the
20 open enrollment period for about 520,000 people. We
21 mailed out 345,000 packets to every recipient's home.
22 And obviously you've got moms and kids. So, you don't
23 have to send a packet to every person, all 520,000, but
24 it's over 300,000 packets. They're allowed to make a
25 call and they just do it over the phone, call us and say

1 I want to change. So, we upped our call staff. We
2 outsourced for a sixty- or ninety-day period with a
3 vendor to help us with the overflow calls. So, we have
4 been taking literally thousands of calls a day. There's
5 been some shift, a net of about thirty or forty thousand
6 at this point. People have actually changed their MCO.

7 We sort of expected that there
8 would be about that level of activity, of people changing
9 from one MCO to another. So, we've staffed up for that
10 and we're right in the middle of that. That ends October
11 19th is when the open enrollment period ends. So, up
12 until that point, we're taking calls and we'll still be
13 taking calls.

14 We actually extended our service
15 hours and we're going a little longer in the evenings and
16 a variety of things, but we're just making it easy for
17 the members to deal with that, to make a change.

18 I can't answer anything about
19 Region 3. I don't know anything about Region 3. I have
20 been walled off from all of that activity. I don't even
21 know who bid.

22 CHAIRMAN POOLE: Appreciate your
23 comments. We're going to have some comments from Peggy
24 here in a second from the recipient population out there.

25 Without having to go back through

1 history, recent history, since you're new, in my talks
2 with Secretary Haynes, she has left it up to you to
3 decide on what you need from this committee here. And
4 obviously all of us, regardless if you're a provider or a
5 recipient or an advocacy group, all of us do want to be
6 able to affect change. And in the past, it seems like
7 for the most part a lot of frustration because it seems
8 like we've not had any affect on change.

9 So, I don't know if you've had time
10 to talk to the Secretary about our conversation I had
11 with her earlier this month, but obviously by statute,
12 I'm sure--have you looked at the statute that tells
13 basically what this Council advised on?

14 COMMISSIONER KISSNER: Yes.

15 CHAIRMAN POOLE: And what do you
16 see as to what you need from us because I realize you
17 have the Managed Care Oversight Branch. You talked about
18 Tom McMann earlier. First of all, is that kind of in
19 flux now to either replace the person who is no longer
20 on there or is that Oversight Branch going to grow and
21 where do we go from there with it?

22 COMMISSIONER KISSNER: With the
23 Oversight Branch specifically, it really was built
24 because I think legislatively it was suggested that we
25 build that team which we did. This was back early on

1 when it was first implemented.

2 The structure of Medicaid will
3 change. The Department of Medicaid will change. I just
4 don't know what it's going to look like yet. We've hired
5 a consulting group which is a public consulting group,
6 and they've come in and they're doing an assessment of
7 each of the departments.

8 They've done some deep dives into
9 what kind of activity do people do on a daily basis, and
10 they've also met with other Cabinet level commissioners
11 and directors to say how do you guys interface with the
12 Department for Medicaid. What do you do and what do you
13 need from them and what kind of reports do you get and a
14 variety of different things.

15 By year end, they will produce a
16 report that says here's how we think you should be
17 structured in a post-managed care world. As an example,
18 we used to pay claims on 800,000 people and now we pay
19 claims on basically 120,000 or so people. So, what
20 should Medicaid look like and how does it change over
21 time to reflect more of a regulatory and oversight
22 contractual compliance and a variety of other things.

23 And, so, it will change. And when
24 we get those recommendations, we'll share them with you
25 as to what it looks like. They've done this work in a

1 variety of other states and have helped sort of
2 reconfigure Medicaid Departments, so, we're working on
3 that.

4 Going forward, there's a role for
5 compliance oversight but I don't know if the compliance
6 should be, as an example, should be distributed across
7 every--you know, our nurses should be doing compliance
8 oversight of the nurse activities and our financial
9 accounting department should be doing compliance and
10 oversight of the financial data that comes to us. Maybe
11 it should be distributed more rather than centralized.

12 I don't know. I don't know what
13 recommendation they're going to come back with, but
14 they're good at what they do. So, hopefully we'll get
15 some feedback and we'll share that with you.

16 CHAIRMAN POOLE: Have you had a
17 chance to look at the role that you want this Council to
18 play?

19 COMMISSIONER KISSNER: Yes. We
20 like honest feedback on how the program is going. I
21 think it's incumbent on the board to try to get balanced
22 feedback, to represent both the constituents and members,
23 physicians and providers of all types. So, we want your
24 feedback. We want to take that and act on that. So, how
25 we can improve the program, how we can move forward.

1 That's what we're looking for.

2 CHAIRMAN POOLE: I want to get into
3 Peggy's report. It's my intentions and hopefully the
4 Council's intentions here that the most paramount people
5 we can hear from are the recipients. And the reports
6 that she has got talk about problems not only with MCO's
7 but also problems with providers.

8 So, if you want to give us your
9 report there, Peggy. And I also encourage Sheina and Ms.
10 Fummilayo, too, to chime in after she's done. Did Barry
11 ever show up? Barry is not here today, but, anyway, go
12 ahead.

13 MS. ROARK: Good morning. I'm
14 Peggy Roark, a medical recipient, and I've got like three
15 different stories, but I'm going to touch on this one
16 briefly and I can make some copies if you want to read it
17 further.

18 This is from a parent that had a
19 son in Northern Illinois. He was in there September,
20 2011, was abruptly discharged August 17th due to no
21 incidents which was wonderful, however, with zero
22 transitioning from the most structured setting to the
23 home and public school with two days notice.

24 We were given a three-day supply of
25 his meds. The prescriptions for all of his meds except

1 two - Stratera 60 milligrams so he could sleep at night,
2 and his Intuniv 2 milligrams - were not filled due to
3 WellCare demanding preauthorization from the doctor's
4 office that refused to respond to my calls, the pharmacy
5 calls and even the nurse's unit or Wellcare's calls
6 necessitating I pay out of pocket for his Intuniv.

7 To add insult to injury, my local
8 CVS pharmacy charged me \$18 per day to give him one day's
9 dose of his Intuniv because they read the prescription
10 wrong and printed out a label that listed I administer
11 twice the dose the prescription called for. This would
12 have been prevented if only the prescribing doctor could
13 have bothered to follow up with a call. I was even told
14 WellCare would reimburse the money I was out upon
15 preauthorization.

16 This was a regime that had been
17 well-established during his hospitalization, so, to
18 demand it be justified at this point to justify it being
19 covered seemed absurd to me. You don't just eject a
20 child who has shown little tolerance to transitioning
21 well and then not cover his meds. I felt abandoned in
22 helping my son. Thankfully he's done remarkably well,
23 but I suspect that was an act of God.

24 Thank you sincerely for any
25 measures you can take to prevent the reoccurrence of this

1 measures you can take to prevent the reoccurrence of this
2 happening to anyone.

3 And I have another letter from a
4 patient about CoventryCare. We have received a letter
5 from Our Lady of Peace Hospital that states their
6 contract with CoventryCares has stopped without cause.
7 This is a hospital many people use for their children
8 with mental health issues. Not only Our Lady of the
9 Peace but several hospitals were listed on the letter.

10 My partner had a mass in his
11 stomach that was discovered on x-rays and the MD ordered
12 a stat CT scan which means immediate. The order was made
13 at 9:00 a.m. CoventryCares refused to order until after
14 speaking with the MD personally. This MD runs a very
15 busy office alone and was unable to speak to them
16 immediately. The CT scan that was ordered was not done
17 until 5:00 p.m.

18 Here attached is a letter from Our
19 Lady of the Peace as to why they have denied coverage for
20 their clients. I will try but cannot promise to attend
21 the meeting in September. If I am unable to attend,
22 please speak loudly for so many.

23 And then I have one more here from
24 a pain clinic. Our records indicate your insurance is
25 currently provided by CoventryCares of Kentucky. During

1 this time of open enrollment, and in order for you to
2 make an informed decision regarding your healthcare, we
3 want to make you aware that Dr. Fred Coates, Dr. Paul
4 Clark and Dr. Leonard Durrett are not participating
5 providers with CoventryCares' network.

6 Additionally, we continue to
7 experience difficulty obtaining authorization from
8 CoventryCares for pain services deemed medically
9 appropriate and necessary by our physicians and staff.

10 Please understand that if you
11 continue to choose coverage with CoventryCares, your
12 access to care may be affected by these issues. Should
13 you choose to change insurance carriers, please bring new
14 insurance information at your next appointment. If you
15 are currently a patient of one of the above-referenced
16 physicians and wish to remain with CoventryCares, you
17 will need to request a transfer of care to one of our
18 participating physicians.

19 CHAIRMAN POOLE: Is that all of
20 them?

21 MS. ROARK: Yes. Thank you.

22 MS. FUMMILAYO: And there are
23 similar stories that come from Medicaid recipients that
24 I've heard as well.

25 I'm sorry. I'm Oyo Fummilayo and I

1 do represent women, minorities and children. My
2 daughter's friend has a child who has special needs. He
3 was born and he had several seizures at birth and he has
4 seizures off and on all day long. He has the Michelle P.
5 Waiver and he also had Kentucky Spirit as one of the
6 insurance companies that paid for his Medicaid.

7 And, then, one day she went to pick
8 him up from the child care provider that works in caring
9 for children who have fragile medical needs and they told
10 her that Kentucky Spirit would no longer cover her
11 payment for the child care.

12 And because of that and it took her
13 such a long time to get transferred to another provider,
14 she lost her job. And in losing her job--well, in losing
15 that insurance, she also lost the ability to pay for his
16 medication. And when she signed on to the second--well,
17 she has just signed on to the second company which is
18 WellCare now, but Kentucky Spirit at the time would only
19 pay for the medication that her son, who is now four,
20 takes, but they wouldn't pay for the aspirator that he
21 has to push it up his nose.

22 So, I asked her, I said, so, how do
23 you give it to him? She said, well, I just kind of lay
24 him down and sort of pour it in his nose and tell him to
25 sniff. So, the medicine won't do him any good if he

1 constantly stopping in the middle of the street prior to
2 him having a seizure and pouring medication down his
3 nose. That's just nuts. That's the only way I can see
4 it. It's just nuts. So, she is having that particular
5 difficulty.

6 I personally am having difficulty
7 with having some of my medical bills paid for. I had to
8 have a round of physical therapy that lasted for almost
9 six or seven months, and I have been getting a \$600 bill
10 where my physical therapists are not being paid. And all
11 I told the clinic was, well, come and take your physical
12 therapy back because I can't pay you. If you can take it
13 back, you can have it.

14 I have been turned over to an
15 agency for collection, and I told them, I said, well, I
16 guess you're just going to have to suck it up out of my
17 disability because I can't pay you either. So, that's
18 \$600 that I just don't have.

19 So, I want the people that we
20 serve, one, to be able to have what they need when they
21 need it and in a timely manner. They're not getting it.
22 I don't want to owe anybody \$600, let alone somebody I
23 have a medical bill with because chances are I may not be
24 able to get medical care again from that particular
25 clinic because I haven't paid a bill. And I'm old and

1 God only knows what might break on me next.

2 So, it's a difficult thing to have
3 to maneuver all the time and decide what's more
4 important, whether you're going to pay your house payment
5 or your doctor bill, whether you're going to be outside
6 or be able to lift your arm, whether she's got to pour
7 medicine down her baby's nose or just let him seizure
8 out. No one should have to make those decisions.

9 CHAIRMAN POOLE: Do you have
10 something, Sheina?

11 MS. MURPHY: Yes. I recently
12 experienced with my doctors, I have a neurological
13 condition called Guillain-Barre' Syndrome in addition to
14 my mental health diagnosis, and I had been seeing an
15 internist regularly.

16 And I think we had done a pretty
17 good job of integrating my physical and mental
18 healthcare, but his office at that time stopped taking--I
19 was originally assigned Kentucky Spirit and they had
20 stopped taking Kentucky Spirit. So, at that time, I had
21 to find another doctor which I was not comfortable with.

22 I'm very open about my diagnosis of
23 schizophrenia for educational purposes, but I don't
24 necessarily want every medical doctor I see to know that
25 because there is a difference in the way you're treated

1 back to WellCare. And, like I said, I'm dreading
2 November 1st because I don't know if I'm going to be
3 covered by both of them or neither one of them. I can't
4 wait to see what's going to happen.

5 And this is happening to a lot of
6 people. We've got the open enrollment period that we
7 have to use, but these contracts are fluid throughout the
8 year and you're just chasing paper and chasing doctors
9 and chasing an insurance company.

10 And on another note, and I don't
11 even know if this is the proper venue to bring this up,
12 but something that has been draining a lot of my
13 attention lately is the KHIE, the Kentucky Health
14 Information Exchange. And I'm not sure the interaction
15 with the MCO's with that. I know Medicaid is involved
16 with them.

17 But they've developed a consent
18 form where they're wanting people to give consent to have
19 their mental and substance abuse records in this
20 database, and I have a lot of problems with that. The
21 main problem with it, on the consent form itself, for
22 people who can sign the consent form, it specifies parent
23 of child, legal guardian or other representative.

24 And other representative is far too
25 vague because when you're struggling with a mental

1 illness and you have a bad spell, people come out of the
2 woodwork to be your representative. I'm not comfortable
3 with the consent form the way it's written, and I have
4 been in contact with the KHIE office. And if anybody
5 here could give some clarification on that. I noticed
6 Mr. Wise was shaking his head. So, he's pretty well
7 aware of it, but that's all I had to add.

8 CHAIRMAN POOLE: Do you want to,
9 just on that particular point, clarify? I think it's the
10 fear that she's got access into that network, Kentucky
11 Health Information network, who is able to access that
12 and who is able to share that information.

13 I know they're still into HIPAA
14 compliance and I know that's also a program that's still
15 trying to get off the ground in the whole state, too.

16 COMMISSIONER KISSNER: So, the big
17 picture, our healthcare system is disjointed. If you go
18 to a primary care and then you go to a cardiologist, the
19 cardiologist does an EKG of your heart and the primary
20 care does your blood work up; and in many instances,
21 those files never communicate.

22 If you were to go to some other
23 doctor, they may do the exact same test. They may do the
24 same blood test and not have access to the results of
25 that information.

1 where they come in and they have a laptop in the room now
2 or a computer - very common - they're using some type of
3 electronic medical records and they're entering your
4 data. They're entering your prescriptions. All that
5 sort of stuff is on there. When they talk to you and you
6 answer questions, it's all going into the computer which
7 is part of your medical record.

8 The magic is linking that medical
9 record up with all of the medical records that are into
10 this sort of global database. So, it's still voluntary
11 participation at a member level and that's where they've
12 developed the form where you say I want all my doctors to
13 have access to my medical records or I don't, and it's an
14 independent decision.

15 MR. WISE: There are special
16 protections, as you probably know, for behavioral health
17 and substance abuse data, and that does require special
18 authorization to release that data into the electronic
19 health record. That's why I was nodding my head. I said
20 you're right.

21 I hadn't heard the issue with the
22 form you were talking about but I know it does take a
23 special release for that kind of data to be shared out
24 there in the network.

25 MS. MURPHY: The documents I had

1 seen regarding this, they stated that some groups
2 including Medicaid recipients had had their records
3 stored in the KHIE for the last three years. And my
4 initial question was, okay, since my internist, I mean,
5 he uses a laptop while I'm talking to him, and he's
6 always known about my diagnosis of schizophrenia.

7 So, my question is, if he made
8 mention of that in his records and they have been
9 collected for three years, is not my diagnosis of
10 schizophrenia already on there without my consent?

11 COMMISSIONER KISSNER: Let me back
12 up. Just because the doctor has a laptop in the room
13 with him doesn't necessarily mean they're participating
14 in KI and have all the information uploaded. That's one.

15 Most doctors just to practice,
16 they're not doing it with a paper and pencil. Somebody
17 somewhere is entering stuff in a computer for their
18 office records. They keep individual files of member and
19 patient files.

20 But if you have agreed that your
21 medical records will be part of this, then, I would say
22 the answer is probably yes.

23 MR. WISE: But behavioral
24 health----

25 COMMISSIONER KISSNER: Behavioral

1 health is not part of the----

2 MR. WISE: It wouldn't be out
3 there. There is a specific document signed about that
4 with your internist.

5 COMMISSIONER KISSNER: So, overall
6 it's a good program. It's the right thing to do. It's
7 the way we want to go as a nation. We want to eliminate
8 duplicate testing because the test was done last month.
9 You got a blood work-up and we know your HDL and LDL and
10 cholesterol and your hemoglobin A1C and all that sort of
11 stuff, we know the data. It was just done. It's still
12 valid. So, having that reference point is good for other
13 physicians if you agree that you want your records for
14 all of your physicians that you see to see your records.

15 DR. NEEL: Good morning,
16 Commissioner. I don't know how well you know Neville but
17 I know him very well, and I can tell you that Neville
18 nods this way to everything, even when he doesn't agree
19 with you. His neck doesn't go this way. Am I correct,
20 Neville? Everybody else in the room, do you know,
21 Neville? Right. He always nods this way.

22 Commissioner, my name is Don Neel.
23 I'm a pediatrician in Owensboro. I have been there for
24 forty-two years supplying care to children of Medicaid
25 for that period of time. So, I have been around a little

1 while. I have survived so far. I don't know if I'm
2 going to survive this or not.

3 I would welcome you to Kentucky,
4 the second sickest state in the nation, and I understand
5 you came from the sickest state in the nation. Am I
6 correct about that?

7 The reason I make the point of that
8 is that it's a real challenge to take care of the
9 citizens of this state and to provide healthcare, and
10 it's a particular challenge to take care of those in
11 Medicaid for the very reasons of, as one of my Council
12 members has already said, she didn't get the letter. And
13 I can assure you that there's a challenge just in
14 delivering information to our members out there. That's
15 a real problem.

16 But I would like to change gears
17 just a little bit and talk a little bit about philosophy
18 on a couple of things, if I could, and ask you about it.

19 We on this Council, and I've only
20 been on the Council a couple of years, have been quite
21 concerned about what our function and what our role is.
22 And the way we read the statute - and I'll just read you
23 very quickly just one of the sentences which says: The
24 Council shall have the opportunity for participation in
25 policy development and program administration and shall

1 advise the Cabinet for Health and Family Services on such
2 matters.

3 To us, the legislation that created
4 the MCO's and managed care in Kentucky was quite a change
5 in policy and administration, and we felt that we should
6 have been involved in that. Whether it was our fault or
7 not, we missed a meeting in December at the time the
8 legislation was being introduced and starting. And by
9 the time we had our next meeting, it was already pretty
10 well set in stone.

11 And we were quite concerned about
12 that because all of us are busy practitioners or
13 recipients, as the case may be, and we feel that we don't
14 have the time to just receive reports. We'd like to be
15 involved. And I think that's what Ron was saying earlier
16 is that we would like to adhere to our statutory purpose
17 and we think that is to be involved in a closer way with
18 you and the Department in managing Medicaid in Kentucky.

19 So, I would just like your
20 comments. I think your answer to Ron's question before,
21 maybe you didn't completely understand the question. But
22 I think we really seriously feel that we'd like to be
23 more involved in, if nothing else, oversight in some way,
24 and I guess we would ask you how do you feel about that
25 in addition to what you said?

1 for immunizations and how is it reimbursed and how often
2 are we doing it and what is our immunization rate and are
3 we the worst in the country or are we somewhere better
4 than above Mississippi in our immunization rates for
5 children because I would say that we want to improve our
6 immunization rates for children. I can stand right here
7 and say flat out we want to do that. That's a goal of
8 the Cabinet.

9 Secretary Haynes has told me many
10 times in the last two and a half months that when her
11 tenure is done, she wants to be able to say here are the
12 things that we improved. We actually improved outcomes.
13 We improved immunization rates and mammogram rates and
14 obesity or diabetic rates. I mean, there's data out
15 there right now that I've seen by county on a diabetic,
16 as an example, where you should get your eyes checked,
17 your feet checked. You should know your hemoglobin A1C.

18 Now, every doctor in the United
19 States has agreed, the AMA has agreed, the Kentucky
20 Medical Association has agreed, these things are
21 important and we should know them for a diabetic, but
22 when you look at the actual rates by county, it's
23 embarrassing. We have some counties where it's 10%, 20%
24 of the diabetics in the county have their feet checked
25 over a 12-month period. Hemoglobin A1C could be 50 or

1 60%, sometimes 70%, but it really should be 100%, right,
2 or 90%. There should be a number where we need to know.
3 That's the number one thing is your blood sugar is out of
4 whack.

5 So, at the end of her tenure, she
6 said I want to be able to say we actually improved
7 healthcare outcomes in Kentucky. So, that's the goal.
8 We want more transparency in the results because
9 transparency leads to good decisions being made. It's an
10 understanding of there's an issue and how do we get all
11 the constituent groups together and say how do we fix the
12 issue. So, I'm supportive of that.

13 DR. NEEL: My second question,
14 then, is a discussion or a question to you on the
15 definition of managed care. I don't know how much you
16 know about Medicaid in Kentucky before you came, but we
17 actually were a model program for managed care in the
18 beginning, providing a medical home and we incentivize
19 physicians through a KenPAC Program to do that.

20 We have part of that now but that
21 was not included, which I think was a mistake, but that's
22 my personal opinion, in the contracting with the MCO's.

23 The question I really have is, how
24 do you see the managed care? In other words, I see that
25 as a physician that I manage the care. The provider

1 actually manages care and provides the medical home. The
2 MCO is being touted as the manager of care, but neither I
3 nor my recipients or patients, if you would, understand
4 that that's the real role of the managed care
5 organization. They see them more managing costs and
6 utilization than they do managing the quality of care.
7 That seems to fall back to me as the person to have the
8 medical home.

9 And I would submit to you that
10 that's the direction we should go and that appears to be
11 the direction that the federal government is going to
12 take no matter the result of the election in November, if
13 you would, that primary care is going to be incentivized
14 to provide the medical home, as it's defined now, the
15 patient-centered medical home.

16 And I just wondered your thoughts
17 on that and where we have been and where we're going with
18 that.

19 COMMISSIONER KISSNER: I'm not sure
20 I can speak to the past. I kind of understand the KenPAC
21 Program. There was a per member per month payment that
22 was going to physicians to help manage the care.

23 I can tell you coming from the
24 other side, there are a number of positive examples where
25 care is being managed what the MCO's do.

1 Then we get the home health care
2 nurse back. The house is clean. She says, okay, we
3 bugged it and she is delivering home health care. This
4 was a year ago November. December, I get a call and
5 somebody stole the wheelchair ramp, and I thought it
6 would have been for somebody that--hopefully they have a
7 loved one that needed a three-step ramp. And one of my
8 people said, well, maybe they make good skateboard ramps.
9 Well, that's not the case.

10 Anyway, we found a company for \$800
11 that had an aluminum ramp that you put four lag bolts
12 into the concrete and they installed it. Well, one day
13 in the hospital, one day, not getting her out of the
14 hospital when she should have been released was about
15 let's say \$1,400, \$1,500, that's the cost.

16 So, I'm looking at and saying I'm
17 making all this investment to get her home, to get her
18 home health, and I'm still to the good. Then, a month
19 later, she moved, which there's no requirement that says
20 you have to live someplace forever. So, she moved
21 apartments.

22 So, we paid that same company to
23 come and take that ramp and move it to the next house so
24 she could still be mobile and still do what she needed to
25 do and have a home-based environment which was good for

1 her and the continuity of care and things like that.

2 So, that's all stuff that was done
3 from a managed care perspective that helped a person. We
4 would troll the data as a managed care company and say
5 give me everybody who has been to the emergency room
6 twenty times.

7 Now, you don't have that data as a
8 pediatrician; but if somebody has been to the emergency
9 room twenty times, they got a call and said what's going
10 on? Do you have a primary care physician? What is the
11 driving factor of using the emergency room because maybe
12 that should be done by primary care work or maybe we
13 could we head off some of those things.

14 So, when the person is in your
15 office, the managing of care is there. You've got the
16 prescriptions. You're seeing the patient and you're
17 absolutely delivering the care and managing the care.
18 Then there's the cardiologist which you may have referred
19 to and getting that information back to your files and
20 making sure that was there and making sure they went to
21 the cardiologist.

22 You could refer for a mammogram but
23 then you've got to follow up to make sure that they
24 actually got a mammogram and did you get the rest results
25 of the mammogram. And like we said earlier, in the

1 information exchange discussion, there's a lot of data
2 out there, and the managed care companies act as a
3 conduit and a repository of a lot of that data which they
4 then have some insights that maybe a primary care
5 physician doesn't have.

6 And those are all areas where the
7 managed care companies are helping to control costs and
8 get appropriate utilization. I could give you a lot of
9 different examples, but they do provide a service.

10 And I think we need to remember
11 that when this decision was made to go with managed care,
12 it was that or I think over a 30% reduction in the
13 Medicaid fee schedule because there was a state budget
14 issue that caused the need for managed care. It wasn't
15 out of the blue. There was a significant budget
16 shortfall for the biannual budget. So, we needed to
17 create some savings within the State of Kentucky and
18 that's how the State chose to do it.

19 MS. BRANHAM: Sharon Branham with
20 the Kentucky Home Health Association.

21 Interesting that you chose that
22 topic because that's my area of expertise. In Kentucky,
23 managed care does not give the ability to home health
24 agencies to provide a ramp or to fumigate a home or
25 anything like that. That's available in Kentucky under

1 paid to have homes fumigated to make the structure safe
2 for my nurses to even enter. I don't want home health
3 aides going in to try to provide care and come out with
4 roaches and fleas. So, we're talking about two
5 totally different things that are going on here in
6 Kentucky right now.

7 So, my experience has been I can
8 build a ramp and I can build a ramp for under \$200,
9 depending on the length of it. I can pay out of pocket.
10 My staff can make donations, and then we call
11 exterminating companies and we ask them to help us with
12 the deal for a particular environment.

13 I also can send in a nurse to
14 provide care if perhaps the MCO--but you have to
15 understand, you don't get waiver and be under MCO's,
16 okay? You have to choose.

17 The MCO's in Kentucky may let me
18 visit that patient twice after being discharged from the
19 hospital with a freshly amputated leg, maybe after some
20 therapy, but shortly thereafter because their goal is to
21 get them out of the hospital, after I spend a certain
22 amount of time on getting prior authorizations for the
23 nursing visits that were ordered and for the supplies
24 that were ordered to do the wound.

25 Now, the MCO's in Kentucky are not

1 going to reimburse me for those supplies. They're going
2 to reimburse me a percentage. And one currently doesn't
3 reimburse supplies. They say that's inclusive of the
4 rate less than \$85.

5 So, if I had the kind of money you
6 were talking about in Mississippi here to manage a
7 patient who came home like that, I could do some real
8 good.

9 What is happening right now is not
10 managed care. It is denying of services to families,
11 patients, recipients and providers. So, there's a lot of
12 work to do because what you've described - we're nearly a
13 year into this - has never occurred in Kentucky with the
14 MCO's.

15 We provided care before under
16 Medicaid, traditional Medicaid, and we did that with
17 prior authorizations and we've been under that for a long
18 time.

19 So, the level of frustration that
20 you sense from the members, we're trying to get you to
21 say that you want us as recipients and as providers, the
22 State of Kentucky, we want you to say that you want us to
23 work with you and the Department to make what we are
24 stuck with better because it's way bad. It's way bad.

25 Ron had the pleasure of an hour

1 Ron had the pleasure of an hour
2 meeting with Secretary Haynes. She has got a group of
3 people here that are dedicated and are ready to assist in
4 moving this project forward and causing less stress on
5 providers and recipients and we're not being utilized at
6 all.

7 I listened to you say what managed
8 care is. I think you're going to have to have some
9 education, whether it's from us or somebody else, because
10 that's not managed care in Kentucky. All they're doing
11 is managing costs. That's it. It's not about what we're
12 providing. It's not about what we're being reimbursed.

13 We've worked through our TAC's -
14 this is nearly a year now - and do you know we still have
15 the same issues and we're still trying to get paid for
16 services that relate back to November forward when
17 business was supposed to be usual which was the term that
18 was slung around here for about three months.

19 So, the level of frustration that
20 you feel from certain ones of us that are speaking out is
21 because we're in a situation that is in dire straits.
22 And we're here to help you and we have been ready to help
23 you, but you're going to have to utilize us because I
24 don't think you all really realize what's going on.

25 CHAIRMAN POOLE: Does anybody else

1 DR. PARTIN: I just wanted to make
2 a comment about the preauthorization process. It
3 continues to be a problem. It takes days and hours to
4 get something preauthorized through the MCO's, and not
5 only my time but my staff's time before I even get on the
6 phone to speak with somebody to do a peer-to-peer and
7 that was a problem. And that is fixed, Neville, and
8 that's great. I can do peer-to-peer now but I wasn't
9 allowed to do that initially.

10 In any case, the preauthorization
11 process is extremely burdensome, and I can give you an
12 example just recently of one of my patients. She has
13 spinal stenosis, she has bulging discs, and she has been
14 maintained conservatively with treatment, but her
15 condition recently worsened where she was having pain
16 going down her legs. She was having difficulty walking.

17 And, so, I wanted to get another
18 MRI to find out what was going on. She had had one done
19 two years ago. Well, after my staff did all of their
20 thing which took a couple of days, I was given the number
21 to call to get it preauthorized. And routinely you're
22 kept on the phone for a half an hour while you're waiting
23 to speak with somebody and you're given an option to
24 leave a call back number, but when you're in practice,
25 that doesn't work very well because when they call you

1 back, you're invariably in a room with a patient. And,
2 so, you have to sit there and wait until they answer the
3 phone.

4 So, anyway, I get to the point
5 where I finally get to speak with somebody and the MRI
6 was denied and I was told she had to go to physical
7 therapy. So, we had no choice but to do that because we
8 really needed the MRI and that was the only way we were
9 going to get it.

10 And, so, she went to physical
11 therapy once; and after that, she couldn't walk. So, we
12 had to cancel the physical therapy. We had to go through
13 the whole process again. I finally got on the phone with
14 somebody after waiting a half an hour to speak with
15 somebody, and then I told them the whole story again and
16 they said, okay, you can have your MRI. And it's like
17 this is crazy.

18 I should have been able to get the
19 MRI in the first place because she had documented spinal
20 stenosis and bulging discs and her condition was
21 worsening, and we told them that to begin with. And this
22 is not an isolated incident. This is just something that
23 happened last week. So, it's fresh in my memory but it
24 happens all the time and it's very frustrating.

25 CHAIRMAN POOLE: Commissioner, do

1 you have any comments before we get the TAC reports?

2 COMMISSIONER KISSNER: No.

3 CHAIRMAN POOLE: Thank you, sir.

4 MS. FUMMILAYO: I do, and this is
5 just really a spare of the moment. We've actually come
6 across today with quite a few issues. And what I'd like
7 to know is will we have any of these responded to before
8 we meet again? Will we get an email or will there be any
9 feedback? I'd like some feedback. I'd like to have
10 something to tell the people that I represent and I'm
11 sure you would, too. I just want to know if there's
12 going to be anything that we can rely on before we meet
13 again.

14 COMMISSIONER KISSNER: I think the
15 process is, Ron, you put together as an outcome a series
16 of questions that you want specifically responded to and
17 then we'll provide you with answers.

18 MS. FUMMILAYO: Thank you so much.
19 I just needed to hear that and know that it's going to be
20 worked on.

21 COMMISSIONER KISSNER: Yes.

22 MS. FUMMILAYO: Glad to meet you,
23 by the way. I hope you'll say the same for me in a
24 little while.

25 MS. BRANHAM: Commissioner, if I

1 could just have your attention for one more moment, I
2 want to expand on a couple of things that I said before
3 we get into the TAC reports.

4 I have only been on the committee
5 for about a year, but it's not just the MCO's that need
6 immediate attention. It's Medicaid as well because there
7 are other issues that we deal with, but we used to think
8 they were kind of big until we got into this and find
9 that they're absolutely hardly on the radar screen.

10 At any rate, we've got different
11 programs in Kentucky that are related to home health that
12 we provide care under. One of them is Consumer Directed
13 Option. So, the patient signs up, gets a sum of money
14 and pays for their care. There's no oversight on the
15 individuals providing the service. It's negotiated
16 between the recipient and the person providing the care.
17 A lot of them come through the Area Development
18 Districts.

19 I also do hospice. recently had an
20 experience, a woman who has a terminal diagnosis and
21 she's on CDO. Hospice can't bill for their services
22 because she can't lose her CDO money. She has been in a
23 home, her home paid for under HUD for two years in a bed
24 so grossly obese she hasn't walked. Now, she is in her
25 right mind, but she was given a sum of money to provide

1 care. Nobody is overseeing it. She is in a bed. There
2 are snacks and a small refrigerator within reach. That
3 individual has been paying her son to care for her.

4 Now, I don't know how anybody else
5 feels about it, but I think we have a certain
6 responsibility to assist our family members and not be
7 paid for it.

8 Now, if what this caseworker told
9 me was accurate, I could provide care under our home
10 health agency and save the State money rather than
11 through the MCO program. And I understand that probably
12 there are some recipients out there that are actually
13 receiving care, but I understand there are recipients out
14 there that are not receiving care.

15 Her money was gone for her
16 supplies. She was utilizing towels. She can't get up.
17 The home that she was allowed to stay in, we met with the
18 fire department. There will have to be a hole cut in the
19 wall when she expires, and I am providing this care, but,
20 yet, somebody else is getting more money than a home
21 health could do providing care five days a week.

22 And, so, when we talk about us
23 being the Council for Medical Assistance, it goes the
24 whole gamut. It's not just MCO's. And I know you've
25 heard a lot about MCO's today because our frustration

1 level, as I said, is so high in dealing with these same
2 issues that we tend to deal with over and over and over.

3 We cannot get anything concrete
4 settled. We have been working through our TAC's with the
5 MCO's for over a year now, and the issues that are there
6 are still significant, whether it's dual eligible
7 patients for Medicaid and Medicare, paying us for
8 services under a prior authorization and then sending a
9 demand letter for the repayment because they can't fix
10 their computer software system for those kinds of claims
11 to - I don't know - be recognized or whatever, but we've
12 already been paid but they want the money back.

13 That has to do with EOB's, meaning
14 that you must submit this because this is not an approved
15 service. And we've told the MCO's, told the MCO's, told
16 the MCO's, met with the MCO's, provided documentation,
17 and I don't know where the documentation goes that's been
18 provided, but every time it's like provide us, provide
19 us, provide us. It's like what are you doing with the
20 information that we provide? So, we've still got
21 historic issues that are unresolved.

22 We have been told to work through
23 our TAC's to settle MCO issues, and they've had so much
24 change in their leadership here in Kentucky, that those
25 meetings have kind of dropped off. So, we're not having

1 meetings have kind of dropped off. So, we're not having
2 those meetings anymore, if you care to know that.

3 We have supply reimbursement issues
4 with the MCO's because somebody forgot to include
5 supplies when home health information was given and the
6 bid was put out.

7 Anything that we've ever requested
8 from the MCO's like the dollars of paid claims or the
9 percentage of paid claims, nothing has ever been provided
10 that we've requested.

11 Suddenly, as of last week, I was
12 dropped as a provider with one of the MCO's, and until we
13 were called to get prior authorization, we found this
14 out. I went ahead and provided services Friday and
15 Monday, and I have been told prior to this meeting that
16 that was fixed, but that should never occur. I didn't
17 cancel the contract, and I guess today I'm told they
18 didn't either but, yet, I wasn't a provider and I
19 couldn't get prior authorization, but I went ahead and
20 provided the services. That should never occur either.

21 It's been, I don't know, twelve or
22 thirteen years since Medicaid had given us an increase in
23 reimbursement for any services under home health.

24 And, so, when we were talking about
25 the money that you had authorized to be utilized in

1 Kentucky that we could be paid to provide the services
2 and not lose money because the services that we provide
3 in the home are a lot cheaper than facility services
4 either on the acute side or the long-term care side. And
5 I would tend to think that you would look at wanting to
6 put your dollars on the in-home side versus the long-term
7 care side, plus there are not enough beds either, as long
8 as possible.

9 So, as I said, some of this stuff
10 is historical. We're still trying to work on it. We're
11 not getting anywhere, and I don't know what else is left
12 for us to do. Until someone starts listening to us and
13 allows our voice to be heard, I don't know what else
14 really we can do as providers in Kentucky.

15 CHAIRMAN POOLE: Thank you. Any
16 other comments?

17 MS. ROARK: I would like to say
18 when we come here, this is not a paid position and we get
19 a mileage check and we wait a month to get that, the way
20 gas prices are. So, in order to work together, you feel
21 like if your voice has not been heard, then, you get to
22 the point you get discouraged and why should I even be
23 here today.

24 CHAIRMAN POOLE: Let's start with
25 our Technical Advisory Committee reports, please. We

1 to attend a meeting with the new Medicaid Commissioner,
2 Larry Kissner. We appreciated Kentucky Voices for Health
3 in arranging this opportunity and are very grateful to
4 Commissioner Kissner for the time he spent with us.

5 We applaud the Commissioner for his
6 approach to increase accountability for the MCO's and for
7 the Department for Medicaid Services.

8 Along with the other TAC's and with
9 members of the MAC, we have repeatedly asked the Cabinet
10 to actually enforce the MCO contracts, and the
11 Commissioner's dashboard reporting approach is certainly
12 consistent with that.

13 We would respectfully request that
14 the Commissioner also track on that dashboard the number
15 of requests for services that are denied or reduced; the
16 prior authorization denials and their outcome; the number
17 of appeals that are made and their outcome; the number of
18 fair hearings and the results of those; the number of
19 non-formulary medication requests and their outcome; the
20 number of admissions and re-admissions to hospitals for
21 behavioral health issues, particularly for children, what
22 we have unfortunately labeled as the revolving door
23 syndrome; and the number of days of therapeutic
24 rehabilitation programming that are actually being
25 approved for our members.

1 Steve Shannon, who you all have
2 heard from in the past, always talks about the clients
3 that come to the community mental health centers, and he
4 reminds us that people have to spend their day someplace.
5 And if they don't have something productive, something
6 that leads to recovery, a program to go to, they will
7 find other places to spend their day. And our concern is
8 that they will end up getting into trouble, getting put
9 in jail, ending up homeless and so forth.

10 Back to Sheina's issue, we're
11 hopeful during this open enrollment period that the
12 networks of physical health providers that are described
13 by each of the MCO's are current and are actually
14 accurate, and we have our concerns about whether those
15 network descriptions are accurate.

16 As noted at the last MAC meeting,
17 we continue to be concerned about inaccurate network
18 descriptions and the variability of the networks as
19 providers decide to drop out. Both of these affect the
20 ability of the member to make an informed choice of an
21 MCO which will address both their physical and their
22 behavioral health needs.

23 The TAC also reviewed materials
24 from the Cabinet and from the Kentucky Health Information
25 Exchange, KHIE, with a proposed consent form for members

1 to sign which would release their behavioral health
2 information. TAC members and those present expressed
3 their concerns about the wording in the consent form and
4 the possible implications for the member in signing such
5 a release.

6 We also were concerned that the
7 cover letter from the Cabinet indicated that several
8 groups including Medicaid recipients have information
9 already stored in the Exchange, and we wondered whether
10 that included the behavioral health information.

11 We feel that more work needs to be
12 done in formulating the consent language and certainly in
13 addressing the questions of members regarding their
14 confidential information.

15 Our TAC members are also concerned
16 with the long waiting list for services for members who
17 have a traumatic brain injury or TBI, some of whom are
18 served in waiver programs and some of whom are served
19 under the MCO's. We ask Commissioner Kissner to meet
20 with representatives of the Brain Injury Alliance of
21 Kentucky to address those issues.

22 And last but certainly not least,
23 we return to the issue of integration of physical health
24 and behavioral health services. This is the primary
25 reason given for behavioral health services to be carved

1 for improving returned mail from the Cabinet to families
2 regarding their Medicaid coverage.

3 The next meeting will be December
4 12th at 2:00 p.m.

5 CHAIRMAN POOLE: Thank you. The
6 TAC on Consumer Rights and Client Needs.

7 The Dental TAC.

8 REPORT OF DENTAL TAC:

9 DR. RILEY: Good morning. I'm
10 Susie Riley, and I am the chair of the Dental TAC. We
11 met this morning and covered a number of issues.

12 Probably one of the major concerns
13 that we have at this point is a lack of quarterly
14 reports. We have been requesting since March to get
15 information regarding the number of services delivered,
16 the type of service, the number of providers, the things
17 that were covered in the previous reports that we
18 received quarterly from the State and that we can get
19 from one of the MCO's in the state.

20 We have been met with either no
21 response or very, very, very varied response, mostly
22 incomplete and insignificant response.

23 So, this morning we were successful
24 in enlisting the assistance of the Oversight Branch to
25 get us that information so we can make some comparison

1 from what happened in the past as to what is happening.
2 And by the time we get it, it will be almost a year.

3 There are a number of ongoing
4 issues that continue to concern us, one of which is
5 recoupment of payments after a claim has been paid
6 without real valid rationale in our opinion.

7 Say if a claim went in with five
8 items on it and one was incorrect, the other four were
9 paid, then, when that one item was corrected and the
10 claim for that one item was resubmitted, then, the
11 provider was asked to pay back the original four and then
12 resubmit everything again rather than just paying the one
13 item. So, things like that tend to be a little annoying,
14 to say the least.

15 There have been computer glitches
16 where patients have been inactivated on some of the MCO's
17 when they were actually still active with the State or
18 where a provider was inactivated, say, for a week or two
19 and not paid. So, satisfactory explanation hasn't
20 occurred. It's usually, oh, it was a computer glitch and
21 pretty soon your check will be there.

22 Now, those patients who were
23 inactivated without reason and really illegally
24 inactivation, then, that doctor was faced with a choice
25 of whether to cancel his whole day or to see them and

1 pray for payment, and he elected to not see the patients.
2 He rescheduled them for the following week. I think he
3 mentioned that there were nine scheduled. They were all
4 rescheduled. Seven of the nine no showed because
5 patients tend to be crisis-oriented, but they went
6 without services. And, of course, the MCO's save money
7 due to that computer glitch.

8 One issue that has come forward is
9 that the hospital contract termination by one of the
10 groups, with a hospital group has left some of the oral
11 surgeons in the Louisville area, and they're in
12 Louisville because the patients were not being able to
13 see an oral surgeon in their particular area and were
14 driving a great distance to Louisville, but now the oral
15 surgeons have no facility to deliver the service.

16 Most of these patients were served
17 by the Commission for Children. So, these are special
18 needs' patients who were kind of left languishing and
19 waiting for a resolution to the facility and contracting
20 issue.

21 They also had an issue with some of
22 the oral surgery codes falling through the cracks under
23 the new system. Under the legacy Medicaid system, there
24 was a delineation of some codes were paid under the
25 dental and some codes were paid under medical because

1 most oral surgeons are physicians as well.

2 And apparently under the new MCO
3 contracts, the MCO was allowed to separate those codes to
4 their benefit, but then now the oral surgeons are finding
5 that some of the codes have fallen through the cracks
6 because the medical side is saying, oh, no, that's
7 dental, and the dental side is saying, oh, no, that's
8 medical or collect it from the patient or file it under
9 EPSDT, neither of those solutions being valid if they
10 were historically covered under the system. They didn't
11 make up new codes.

12 Prior authorizations are still
13 creating concerns as with many of the other provider
14 types. Also some providers are getting recouped for
15 patients being stated as having third-party coverage and
16 they're unable to determine whether that's true or not.
17 They're not getting paid because it' listed that the
18 patient has third-party coverage.

19 The MCO is saying it's the State's
20 responsibility to update. The State says it's the MCO
21 responsibility to update. The provider is still out of
22 luck as far as payment goes.

23 We are anticipating what challenges
24 we will face when we have now, of the four MCO's in the
25 state, we will have one dental subcontractor representing

1 three out of the four but under three different sets of
2 rules and then the other one with their own rules. As of
3 January 1st when Passport goes global, it will be very
4 interesting. Thank you.

5 CHAIRMAN POOLE: Thank you. Did
6 the DMRAB Committee meet?

7 Just as an aside, the Pharmacy and
8 Therapeutics Advisory Committee is a voluntary role for
9 pharmacists and prescribers to be on to set formulary.
10 They review a lot of different medications and they set
11 the formulary.

12 The DMRAB Committee sees what that
13 utilization is, sees how effective the formulary is. So,
14 again, it's a voluntary professional role to play.

15 So, I don't know why, but the
16 Legislative Research Committee did a review of the
17 policies of the Medicaid Advisory Council because it has
18 defined by statute all the Technical Advisory Committees
19 that are on.

20 For some reason, in July of this
21 year, they left off Pharmacy TAC, just plain Pharmacy
22 TAC, because Pharmacy TAC is not represented by the DMRAB
23 or the PTAC, the Pharmacy and Therapeutics, because those
24 are just professional voluntary roles where the Pharmacy
25 TAC, I've asked Secretary Haynes to reinstate that

1 because it's going to allow us to voice concerns just
2 like the Dental TAC just did and just like other ones do.

3 But that's just an aside to let
4 everybody know that that's what I'm trying to do is get
5 those reinstated, and I have addressed that with the
6 Secretary.

7 MS. FUMMILAYO: Ron, will the
8 Pharmacy TAC be a part of the DMRAB or will they combine?

9 CHAIRMAN POOLE: No.

10 MS. FUMMILAYO: They are two
11 separate?

12 CHAIRMAN POOLE: In my personal
13 opinion, and this has to be done by statute, I guess, to
14 me, the DMRAB and the PTAC should be under a different
15 heading. I know right now we have a part-time Medical
16 Director. To me, that needs to be under the Medical
17 Director's report - DMRAB and Pharmacy and Therapeutics
18 Advisory Committee - because that committee sets
19 formulary and they don't discuss issues with being a
20 provider. They discuss drug management and what's going
21 to be the best formulary to set.

22 MS. FUMMILAYO: The TAC.

23 CHAIRMAN POOLE: The Pharmacy and
24 Therapeutics Advisory Committee does. The DMRAB reviews
25 what's going on with formulary, reviews what's going on

1 with the policies in Medicaid and just gives their
2 opinion on if changes need to be made to policies.

3 So, I've already asked Secretary
4 Haynes to reinstate what was left off in July for just
5 the Pharmacy Technical Advisory Committee which is to
6 allow pharmacy to voice its opinion on things going
7 right, wrong or indifferent with pharmacy.

8 So, next up is Home Health Care TAC
9 report.

10 REPORT OF HOME HEALTH CARE TAC:

11 . MR. BOMAR: I'm Kip Bomar with the
12 Kentucky Home Care Association, and our TAC met in July.
13 And we've run into many of the same issues that have been
14 identified both by recipients, as well as other TAC
15 providers.

16 Speaking of EPSDT special services,
17 I'm working with one particular agency right now that has
18 had to stop providing services to 47 children with
19 Kentucky Spirit because they're owed under \$100,000 from
20 just that one service with just that MCO, and these
21 claims date back six months.

22 And, so, it's really a shame but
23 they've had to have been just a number of times where agencies,
24 because of the difficulty in getting the benefits
25 authorized and then the length of the amount of time that

1 it takes, have either had to stop providing services to
2 patients or limit the Medicaid population that they see.
3 And considering that this is frequently the most
4 vulnerable population that we have in the State of
5 Kentucky, I think that that's a real shame.

6 I do appreciate Commissioner
7 Kissner coming here, presenting to the MAC today and
8 pledging to work with us. A request that we would have
9 is that as that dashboard scorecard is developed and
10 shown is to share that publicly so that we can measure
11 what those outcomes are.

12 Sharon alluded to this earlier.
13 One of the things that we have been trying to get for a
14 long time is the percentage of the dollar amount of
15 claims billed versus the percentage of the dollar amount
16 of claims paid because one of the things that the MCO's
17 have been doing is paying a percentage of claims and
18 counting it as "a paid claim."

19 I had an agency tell me that on a
20 particular set of claims that they turned in, it was
21 close to \$1,000 and they received \$87.15 in
22 reimbursement, and the MCO was counting that as a paid
23 claim even though it was only 8% of what had been
24 submitted.

25 We have been asking for that

1 all of the MCO's in together. Passport has been great to
2 work with. We certainly appreciate them. We think that
3 that's a very good model for the other MCO's to be able
4 to follow, but there are a lot of issues that we are
5 continuing to face. Our next TAC meeting will be October
6 10th.

7 CHAIRMAN POOLE: Thank you, Kip.

8 Next is Hospital Care TAC.

9 REPORT OF HOSPITAL CARE TAC:

10 MS. GALVAGNI: I'm Nancy Galvagni
11 with Kentucky Hospital Association here to give the
12 Hospital report.

13 Our TAC has been meeting. One of
14 our big issues has been to update our reimbursement rates
15 for hospitals. They're paid on a DRG basis and they had
16 not been re-based since 2004 when the system was put in
17 place. So, that was a major initiative. And, so, all
18 the hospitals have recently gotten new rates.

19 Just to kind of let everybody know,
20 the percent of cost coverage really has not changed.
21 Under the new rates, the average hospital is only still
22 going to paid about 75% of their actual costs for
23 Medicaid patients. So, no one is getting well paid under
24 Medicaid.

25 We continue to spend a lot of time

1 dealing with MCO issues. We don't actually deal with
2 those issues through out TAC, but we had set up meetings
3 back in February at the direction of the former Secretary
4 because of the significant problems that hospitals were
5 having with getting their claims paid.

6 We have been meeting on a weekly
7 basis, inviting hospitals to the meetings, and we've had
8 staff from the Department there, as well as the MCO's.
9 And those have been ongoing and then went to a bi-weekly
10 basis a few months ago.

11 We have these meetings. We are now
12 holding them in the venue of the MCO's with an attempt to
13 get more of the actual claims' people at the meetings to
14 work through some of the problems.

15 The hospitals, we actually keep a
16 log of all of the issues that are raised by the
17 hospitals, and the hospitals present specific examples of
18 what they're claiming to be in error. They're actually
19 giving the proof so that these issues can be researched.

20 We appreciate the Commissioner's
21 continued support for those meetings. We have ver good
22 attendance. We have hospitals, of course, where it would
23 be difficult for them to drive. And, so, we have dial-in
24 numbers and we have very excellent participation.

25 And the issues keep coming.

1 There's not a day that goes by that I don't get people
2 emailing me problems that are ongoing that they either
3 can't get through to their provider reps. They aren't
4 getting answers fast enough. They're not getting call
5 backs from the MCO's and they just can't seem to get
6 anyone's attention of resolving it. So, these meetings
7 have been helpful to elevate these issues to a higher
8 level to get the attention that's needed on them.

9 I also appreciate the comments of
10 the Commissioner with respect to the transparency around
11 what's going on because we have been in these meetings.
12 We continue to ask for written policies and criteria and
13 we haven't really been able to get that. So, we look
14 forward to maybe that changing as we go forward.

15 Hospitals continue to have
16 significant problems with their accounts receivable,
17 very, very high compared to pre-MCO's. We're actually
18 going out with a survey now to document that. We are not
19 having our claims paid per the prompt pay law, which, by
20 the way, is every clean claim paid within thirty days,
21 not some percentage to be paid within thirty days. We
22 have hospitals still having to liquidate their resources
23 to make their cash flow.

24 We are continuing to work through
25 those issues. We continue to identify claims' problems,

1 system errors with all three MCO's where they're having
2 to go back and continue to fix problems in their
3 processing system to reprocess claims, and some of them
4 going back, as you say, in some instances back to
5 November of last year.

6 We also have a concern with the
7 adequacy of the networks. I think it's been mentioned
8 here before that at least one of the MCO's is out
9 terminating a large number of providers, and we think
10 that it does create access problems for many patients
11 having to travel even more than the distances that the
12 State has in their contracts.

13 It has to be realized that a
14 hospital is a hospital is a hospital and not every
15 hospital provides the same level of services. So, we
16 definitely are having patients having to travel far for
17 certain services.

18 And we're also concerned about
19 inaccuracies and how those networks are being portrayed.
20 We check the online directories and we know that there's
21 hospitals that have been terminated that are still listed
22 as in-network hospitals. So, we are concerned about
23 that.

24 In addition, one of the big issues
25 going on right now for the hospitals is that all three of

1 the MCO's have put into place new policies to deny full
2 payment for emergency room visits. And that's a real
3 problem for hospitals because we have a federal law
4 called EMTALA that requires us to do a medical screening
5 for every person that presents to the emergency room to
6 determine whether they have a true emergency.

7 And, so, emergency room doctors
8 have to necessarily run tests in many instances. If
9 someone comes in, they don't always know that they don't
10 have a broken bone and maybe it's a sprain until you run
11 an x-ray. You can't just always assume by looking at
12 someone whether they have a bad headache if it's an
13 aneurysm or it's not.

14 So, there are certain protocols
15 that have to be followed when you screen people, and we
16 can't treat Medicaid patient differently and send them
17 out of the emergency room, and, yet, we're seeing those
18 types of examples being denied full payment by the MCO's
19 and wanting to pay hospitals just a \$50 fee when they've
20 had to run all these tests.

21 And, so, it's creating quite a
22 problem and it's something the hospitals have not agreed
23 to, to be paid a \$50 fee, and, again, that's something
24 where we're asked for what the criteria is and we've yet
25 to have somebody provide it to us. So, that's an ongoing

1 issue.

2 The Department is working with us.
3 We're going to be providing them with these specific; but
4 at the end of the day, not paying a hospital isn't
5 keeping anybody out of the emergency room. It's not
6 telling the patient don't go to the emergency room just
7 because you didn't pay the hospital and the doctor for
8 doing tests that they have to do to comply with federal
9 law.

10 So, it gets back to a managing of
11 costs, not a managing of the care, and we have really yet
12 to see that from the MCO's.

13 On the behavioral health side, I
14 would support the comments that you've heard earlier.
15 Many of our issues are on the behavioral health side of
16 things.

17 We have problems with the out-of-
18 state reviewers. A lot of the people that are reviewing
19 the care are in California and Texas. They have no idea
20 that Eastern Kentucky doesn't have a lot of resources.
21 And we have seen violations where care for children is
22 being reviewed by people that aren't even psychiatrists
23 or maybe they're a geriatric psychiatrist reviewing a
24 child. It's a violation of federal rules but nobody
25 seems to be holding the MCO's to those standards.

1 We also see repeated violations
2 where people are being denied inpatient care and being
3 told to go to an outpatient service that doesn't exist in
4 the rural parts of our state. And, so, that's a big
5 concern for us and that's an ongoing problem.

6 What we are having is a lot of
7 increased burden on the hospitals having to file appeals
8 for all these types of issues. The hospitals have been
9 very diligent in doing this, going to these state fair
10 hearings. I believe in most cases, in all cases where
11 they've gone to these fair hearings, the hearing officers
12 are siding with the patient and the provider.

13 But it certainly is increasing the
14 burden, and I think some of our members feel that it's a
15 tactic by the MCO's to think that nobody is going to
16 appeal and that they can just deny and it's certainly an
17 uphill battle for you to get that turned around.

18 We believe that the State should
19 take a harder line in enforcing the contract. We're
20 happy to see that the Commissioner has put this grid
21 together to look at what those issues are.

22 We're going to be doing that on our
23 end as well. We're going out to the hospitals collecting
24 not only the AR data but some of the other data, looking
25 at re-admission rates because we hear that that's going

1 on. And, so, we're going to have our data also to be
2 able to share with the Cabinet as to what these problems
3 are.

4 That's pretty much what's going on
5 with hospitals.

6 CHAIRMAN POOLE: Thank you.
7 Intellectual and Developmental Disabilities TAC. Nursing
8 Home Care TAC.

9 MR. FOLEY: The Nursing Facility
10 TAC has no report.

11 CHAIRMAN POOLE: Nursing Services
12 TAC.

13 DR. PARTIN: No report.

14 CHAIRMAN POOLE: Optometric Care
15 TAC.

16 REPORT OF OPTOMETRIC CARE TAC:

17 DR. WATKINS: After consulting with
18 the Kentucky Optometric Association home office this
19 morning, our main concern lies with our Medicare/Medicaid
20 crossovers. We're having some difficulties because the
21 managed care organizations have decided that all care,
22 whether it be medical- or vision-related, must go through
23 the vision care providers.

24 For those of you who don't know, in
25 optometry, if someone comes in with a red eye, by their

1 third-party insurance, that's considered to be a medical
2 emergency and treated by their medical insurance. If
3 they come in and say I need a new pair of glasses, then,
4 that is covered under vision services.

5 Traditionally, Medicaid covers both
6 for children up to the age of 21, and adults, they cover
7 the medical services only.

8 Currently with the MCO's, all
9 things must go under the vision services, meaning that if
10 you are a diabetic patient and you come in, it's still
11 filed under the same company as provides glasses for
12 children. So, our claims are all directed in that
13 fashion.

14 But if it's something that is to be
15 paid by Medicare, we send it to Medicare first and
16 Medicare automatically forwards it to Medicaid. Until
17 the MCO's came along, that worked quite well. That was
18 seamless.

19 Now that it's going to the managed
20 care organizations, it's going directly to Coventry or
21 directly to WellCare or directly to Kentucky Spirit
22 instead of going to OptiCare or Avesis or Vision Service
23 Plan which is their vision providers.

24 So, that means that it's being
25 denied by those companies and then it comes back to us

1 and we have to file a paper claim and sending it to the
2 correct company that it's supposed to go to which more or
3 less just extends out the service.

4 Now, I will say that many of those
5 times, if it's something that Medicare has paid on, then,
6 Medicaid is going to tell us it's denied anyway because,
7 under federal law, if Medicare has already paid the
8 amount that Medicaid would have paid, Medicare does not
9 have to pay the 20% difference that normally a third-
10 party insurance would cover. So, that amount is still
11 going to be paid at zero, but it is our responsibility to
12 file that to see if there is any difference there.

13 So, at this current time, I have
14 been told that that's being worked on and we are seeing
15 some very slow progress, but it's still a difficulty that
16 the MCO's are having.

17 CHAIRMAN POOLE: Next up is
18 Physical Therapy.

19 REPORT OF PHYSICAL THERAPY AND THERAPY SERVICES TAC:

20 MS. ENNIS: I'm Beth Ennis. I'm
21 the chair of the Therapy TAC. And I want to point out on
22 your agenda again, the Physical Therapy TAC and the
23 Therapy TAC are actually one. So, they have been listed
24 separately again.

25 Very briefly, we're still having

1 constituents come to us with difficulties with
2 reimbursement rates, being told that they have to use a
3 single code which reimburses at about \$22 a visit which
4 is a challenge, denial of young children related to
5 eligibility in First Steps, denial of equipment as
6 experimental, things like standards of new trainers and
7 other things, difficulties with provider sign-ups, long
8 wait lists for Medicaid recipients.

9 So, we're trying to work through
10 some of the issues there, making contacts with the MCO's.
11 We thought we were making headway getting a contact
12 person at each MCO to have constituents get in touch
13 with. That's kind of stalled but we're still working on
14 it.

15 And we will be meeting on October
16 15th for our next meeting to put together all the
17 resources that we've gathered and hammer out some
18 suggestions for proposed regs that we will then send back
19 to the MAC.

20 CHAIRMAN POOLE: Okay. Sounds
21 great. Thank you. Physician Services TAC.

22 REPORT OF PHYSICIAN SERVICES TAC:

23 DR. NEEL: The Physicians TAC did
24 not meet since the last meeting but we have a carryover
25 of a huge problem that's as bad as it was or getting

1 worse, and that is the assignment of patients to PCP's.

2 It appears anecdotally that
3 Coventry is not particularly assigning PCP's, at least in
4 my experience. Kentucky Spirit is assigning them on a
5 selective basis and seems to be more accurate in its
6 assignment of PCP's. WellCare has been the real
7 challenge in that they are assigning everybody to a PCP.
8 The challenge is who they are getting assigned to.

9 And this brings up the question of
10 data, and I assume they work off data supplied by the
11 State. And, so, I'd like for somebody to speak to that
12 if they could because I as a pediatrician continue to get
13 patients assigned to obstetricians, primary care doctors,
14 Walmart clinics, geriatric nurses, people who have been
15 dead for a year people who have been retired for a couple
16 of years. There doesn't seem to be a particular pattern.

17 But the way this affects care is
18 terrible because the patients think that they are
19 assigned to their primary care physician but fortunately
20 they don't look at their card because they know that I or
21 somebody else are their doctor. But we're trying to
22 figure out how do these people get assigned as primary
23 care providers when in many cases they're not. Not many
24 of the obstetricians in my area take care of children and
25 not many of the pain care physicians do that.

1 data? In other words, the person is put on the medical
2 card by somebody for the Department for Community-Based
3 Services or whatever. That data then I guess goes to
4 Medicaid. Then does that data go to the MCO?

5 MR. WISE: We're not putting PCP's
6 on our Medicaid medical card anymore. That's on the
7 MCO's card.

8 DR. NEEL: No. I understand.
9 There's nothing on that card.

10 MR. WISE: Right, which comes from
11 the MCO's, that card does.

12 DR. NEEL: Yes. The card coming
13 from the MCO's has the name of a PCP. Where do they get
14 that name? Does that come from data provided by the
15 State?

16 MR. WISE: The only place it would
17 come from data provided by the State is when members
18 enroll at a DCBS office, they have the option of
19 submitting that they want this PCP provider, and that's
20 carried through on our field to the MCO's. But, again,
21 it would be the MCO's list of PCP's that they would use
22 to tell members which PCP's they could choose from and
23 assign to. That's not really a State function other than
24 passing through the members' choice that they made when
25 they enrolled.

1 MS. FUMMILAYO: So, almost, it's
2 like if the member is probably choosing a dead physician
3 and then it goes forward and then the MCO would look on
4 their list to see if this doctor or physician was
5 available.

6 MR. WISE: If the member didn't
7 know the doctor was deceased at the time that they made
8 the choice, that could happen, yes.

9 COMMISSIONER KISSNER: Don't we
10 also send additional claims history as well, a year's
11 worth of claims history?

12 MR. WISE: Right.

13 COMMISSIONER KISSNER: So, the
14 MCO's know what providers the beneficiary has been using.
15 So, it's not brand new starting from scratch. We give
16 them data.

17 DR. NEEL: Well, that's been given
18 us as an explanation before, Commissioner. And the
19 problem is claims data can't be produced by children that
20 were seen by pain care doctors and obstetricians.
21 Somebody needs to drill into that because it's affecting
22 access to care and it needs to change. It's not getting
23 better.

24 MR. WISE: I think with most MCO's,
25 changing your PCP is a fairly easy process.

1 our Technical Advisory Committee reports, please. We
2 have Behavioral Health.

3 REPORT OF BEHAVIORAL HEALTH TAC:

4 DR. SCHUSTER: Good morning. I'm
5 Dr. Sheila Schuster serving today as the spokesperson for
6 the Technical Advisory Committee on Behavioral Health.

7 Our TAC had its second meeting on
8 September 10, 2012 at the Capitol Annex with five of our
9 six members present, as well as two other individuals
10 from the behavioral health community.

11 We continue to hear, as we've heard
12 again today, from members and providers of the behavioral
13 health community about the difficulties with all three of
14 the MCO's with regard to burdensome prior authorizations,
15 particularly for medications, insufficient days in the
16 hospitals for stabilization and treatment, particularly
17 for children, and denials or reductions of service
18 requests.

19 It is frustrating to consumers, to
20 their family members, to advocates and providers that
21 these same barriers to care continue to exist.

22 We appreciate the efforts of the
23 Medicaid Department to take on the solution of these
24 problems one by one, but they continue to exist at a
25 systemic level.

1 reason given for behavioral health services to be carved
2 into the MCO responsibilities.

3 We urge the Department for Medicaid
4 Services to request that each of the MCO's develop a
5 performance improvement plan around integrated services
6 and make that plan known to the behavioral health
7 community so that we could all actually work together to
8 integrate care and to move the needle on this important
9 issue.

10 The TAC on Behavioral Health will
11 meet again on November 26. Thank you.

12 Next up is Children's Health.

13 REPORT OF CHILDREN'S HEALTH TAC:

14 MS. LEE: Hello. I'm Lisa Lee and
15 I work with the Department for Medicaid Services. Lacey
16 McNary is the chair of the Children's Health TAC and
17 she could not be here today. She asked that I pass along
18 information relating to their last meeting that was held
19 on September 12th.

20 The TAC discussed waiting periods
21 for enrollment of children. They're developing a
22 recommendation related to this topic.

23 They also discussed reviewing data
24 relating to managed care and health outcomes for
25 children, both in the aggregate and at the MCO level.

1 DR. NEEL: It's easy except it
2 takes time and a form and it ruins the efficiency of a
3 busy pediatric office or internist or primary care doctor
4 and it's recurring over and over and over.

5 DR. PARTIN: Just another aspect of
6 that problem as well is some of our patients will tell us
7 that they've called and requested that we be listed as
8 their primary care provider, and they're told that we're
9 not on the list.

10 But then when we call and say
11 you're paying us, we're on the list somewhere, and they
12 say, oh, yeah, you're on the list, but we're not on the
13 list for the patients to choose. And, so, I think that
14 that's just another aspect of the confusion that's going
15 on.

16 MR. WISE: The MCO's are taking
17 note of that problem.

18 MS. FUMMILAYO: Are the MCO's in
19 here today?

20 MR. DeANDRE: I'm Hank DeAndre. I
21 represent Passport Health Plan.

22 MS. HUGHES: They were all supposed
23 to be here. Do we have some from all of them?

24 MS. HELEN HOMBERGER: I'm Helen
25 Homberger with Kentucky Spirit Health Plan.

1 MR. DAVID BOLT: David Bolt with
2 WellCare of Kentucky.

3 MS. FUMMILAYO: Stop hiding. Get
4 on up here where you're supposed to be. That's your end
5 of the table.

6 MR. RUSSELL HARPER: Russell Harper
7 with CoventryCares.

8 CHAIRMAN POOLE: Did you all want
9 to comment on why that's a consistent issue?

10 MS. HOMBERGER: I'll comment on
11 what Kentucky Spirit uses as a process. The first thing
12 that we have done from the very beginning is to use that
13 claims file, go back through it. That is if there is not
14 a designation made by the member.

15 Once we have that identified, who
16 from the best of our knowledge, if the member doesn't
17 identify their primary care, we do state that that is the
18 primary care physician.

19 The next thing we do is we do a
20 welcome call. We try at least three attempts at doing
21 that. We ask the member during that welcome call here is
22 who we have as your primary care physician. Is this your
23 primary care? Is this the correct selection? Is this
24 who you would like to have as primary care? So, it's the
25 file. It's the member designation and then it's the

1 member welcome call.

2 We also change PCP's over the
3 phone. If the member calls and says that's not the
4 correct PCP, it can be done over the phone and we're not
5 requiring any kind of form at this point in time.

6 CHAIRMAN POOLE: David, is that
7 what you all do?

8 MR. BOLT: That's very similar to
9 our process.

10 MS. HUGHES: Ron, can we have them
11 to sit at the table so they can be recorded?

12 CHAIRMAN POOLE: Okay.

13 MR. DeANDRE: I can tell you from
14 the Passport perspective, I'm not sure if it's much of a
15 problem in our region. I know that's not one of the top
16 complaints we get, but I do know that members do have a
17 choice to choose a PCP; and if not, they're auto-assigned
18 one.

19 The algorithm or the process method
20 for the way in which we do that I'm not completely sure.
21 I can certainly get that to you all if you're interested.

22 CHAIRMAN POOLE: Yes, sir.

23 MR. HARPER: I think Dr. Neel's
24 question was more or less about how the setup is taking
25 place. A lot of it depends upon how the provider

1 themselves fills out our individual contracts. I can
2 just tell you from a specific example, in the last couple
3 of days, we've been working with a provider in Western
4 Kentucky. And I will say his name is Dr. M, just out of
5 respect of his last name because I don't want to
6 mispronounce it, but originally he was set up as a rural
7 health provider, rural health clinic provider and he
8 wanted to become a PCP but it was also on his contract as
9 well, but he wanted that to be the primary, and he's also
10 a pulmonary doctor as well.

11 So, a lot of it depends upon how
12 they set themselves up with you contracts, and that
13 probably wasn't communicated very well in the beginning.
14 And, so, I think that's where some of the frustration is
15 coming from.

16 And, then, also we rely upon the
17 providers themselves to notify us if there's any changes,
18 for example, if there's a death in the practice or
19 whatever. And we ran into that problem in Eastern
20 Kentucky not too long ago where we have discovered that a
21 provider has been deceased for over six months and we
22 haven't been notified of that until one of the members
23 actually called and said I'm not getting the person that
24 I thought I was supposed to get.

25 DR. NEEL: If this is claims data,

1 I don't mean to burden us again, but if it's claim data,
2 I still don't understand how it can be that, particularly
3 in pediatrics, if these kids couldn't possibly have been
4 seen by some of these people. So, how is that data
5 generated? Can anybody answer that?

6 MR. WISE: It was a paid claim is
7 what we send to the MCO's. We send a one-year history
8 for each member who is assigned and look at paid claims.
9 You not necessarily can tell from a paid claims listing
10 that a certain provider on that is a PCP. You can tell
11 that that provider is enrolled with you as a general
12 practitioner or a family practitioner, but that's not
13 exactly where the link is made. That just was brought
14 out as that's how we attempt to match or the MCO's
15 attempt to match members with providers who they have
16 historically seen.

17 I think what they do, if they see a
18 PCP on that list of providers that members historically
19 have seen, that's who they default the member to. You
20 can't necessarily tell from the data that that's a PCP.
21 That would be extra information that I think, as we're
22 talking about, that that's the way--the contract, as
23 signed between the MCO and the provider, says I want to
24 be a PCP.

25 So, it's a variation of things that

1 come together, but from the encounter data, from the
2 claims data, you can't necessarily tell that.

3 DR. NEEL: Okay.

4 CHAIRMAN POOLE: Anything else?
5 Did you have anything else?

6 DR. NEEL: No. That's it.

7 CHAIRMAN POOLE: The Podiatric Care
8 TAC. The Primary Care TAC. And we've gone over the
9 other two already.

10 MS. HAWKINS: I have a report from
11 PTAC. I'm Tina Hawkins. I'm a Clinical Program Manager
12 for Magellan Medicaid Administration.

13 The last PTAC meeting was on July
14 19th. It was one of our larger meetings as far as
15 classes that we reviewed, but some of the larger classes
16 that we reviewed - statins, proton-pump inhibitors, the
17 NSAIDS, narcotics.

18 New classes that will be added to
19 our PDL are the GI antibiotics as well as anti-
20 arrhythmics.

21 We're planning to implement those
22 changes that have been approved by the Commissioner
23 probably the end of October, the first of November. So,
24 provider notices should be going out probably by the end
25 of this month. Thank you.

1 DR. WATKINS: Does the PTAC have
2 anything to do with the formularies that the MCO's set or
3 is this just traditional Medicaid?

4 MS. HAWKINS: No, ma'am. This is
5 fee-for-service Medicaid only. The MCO's have their own
6 formulary that they set.

7 CHAIRMAN POOLE: And also, Neville,
8 on the DMRAB, do they just review everything for the fee-
9 for-service?

10 MR. WISE: Yes.

11 CHAIRMAN POOLE: Okay. I just want
12 to make sure.

13 Under Old Business, in your packet
14 today, you've got a response to the questions. We'll be
15 able to review that and obviously get your comments back
16 to me on that.

17 Under New Business, I will be
18 submitting to Commissioner Kissner the payor scorecard
19 that you all got in the email. I wanted to get
20 everybody's input and I did it at the last hour.

21 So, all the different provider
22 groups, and then I also have recipient questions that are
23 fielded by Medicaid and kind of a breakdown of how many
24 you field in a month and give us a breakdown of the
25 problems or the problems related to provider, MCO's,

1 access problems or prior authorization.

2 He's going to take that into
3 consideration and see how difficult that would be to
4 report.

5 So, if I can get a motion to
6 approve that scorecard to be submitted to Commissioner
7 Kissner.

8 MS. BRANHAM: I so make the motion.

9 DR. NEEL: Second.

10 CHAIRMAN POOLE: All those in
11 favor, say aye.

12 MS. FUMMILAYO: Ron, I'd like to
13 ask, and I know you think I'm into killing trees but I'm
14 not. I was wondering if the TAC's could actually submit
15 some of their comments in writing. I know they are
16 recorded--oh, okay. So, never mind. Not killing trees.

17 CHAIRMAN POOLE: And this is a
18 follow-up from the suggestion Commissioner Kissner came
19 across.

20 I would like to make a motion for
21 my association, Kentucky Pharmacists Association, to be
22 working on and to submit ideas for programs for the MCO's
23 to provide pharmacy services such as medication therapy
24 management to reduce utilization, eliminate duplications,
25 reduce costs and to assist prescribers and the health

1 care team in managing disease states such as diabetes,
2 hypolipidemia and breathing disorders. These are already
3 out there with Medicare Part D already being performed.

4 The Kentucky Pharmacists
5 Association already does the Retired Teachers' program
6 with medication therapy management. I know Coventry
7 right now is working with a pilot project with the
8 University of Kentucky I believe around the Morehead
9 area, if I'm not mistaken, on an issue like this.

10 So, I would like to make a direct
11 motion for the Pharmacy TAC to work on this. Do we have
12 a second?

13 MS. FUMMILAYO: Second.

14 CHAIRMAN POOLE: All those in
15 favor, say aye. Any opposed?

16 Does anybody else have any more new
17 business to go before our Council today?

18 I want to thank our Council here
19 for a good showing again. I want to thank the new
20 Commissioner for his comments today, candid comments. I
21 want to thank all of our managed care organizations for
22 showing up.

23 Certainly in the future, if you
24 come in late, I know you're busy people, just go ahead
25 and take a seat. Don't worry about interrupting

1 anything. So, just have a seat. You're certainly
2 welcome.

3 So, do I have a motion for
4 adjournment?

5 MS. FUMMILAYO: So move.

6 MS. BRANHAM: Second.

7 CHAIRMAN POOLE: All those in
8 favor, say aye. Thank you.

9 MEETING ADJOURNED

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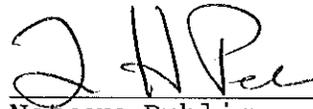
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STATE OF KENTUCKY
COUNTY OF FRANKLIN

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 day of October, 2012.



Notary Public
State of Kentucky at Large

My commission expires February 10, 2013.