

KENTUCKY PRIMARY CARE CENTER MEETING MINUTES

Cabinet for Health and Family Services
Commissioner's Conference Room
275 East Main Street
Frankfort, Kentucky

May 7, 2014
9:00 a.m. EST.

The meeting of the Primary Care Center Technical Advisory Committee (TAC) was called to order by Chair Chris Keyser.

The TAC members in attendance: Chris Keyser, Chris Goddard, Eric Loy, David Bolt, Dean Shofner, Yvonne Agan, sitting in for William Wagner, Promod Bishnoi, and Dean Shofner, sitting in for Ancil Lewis. Mr. Joe Smith was present for the Kentucky Primary Care Association.

Medicaid staff in attendance: Teresa Cooper, Charles Douglass, David Dennis, George Hostfield, Steve Bechtel, Lee Guice, and Amy Simpson.

Others in attendance: Emily Beaugard and Rachael Fitzgerald, Kentucky Primary Care Association.

AGENDA ITEMS

Old Business:

- (1) An explanation of the reconciliation process – how the Cabinet is going to convert the claims from the MCOs to encounters and when the process will be completed

DMS stated that once the encounter situation is resolved with the MCOs, a final reconciliation will be processed. Mr. Bechtel stated to get a final reconciliation, encounter data is used to determine what should have been paid using the PPS rate minus what the MCOs paid minus any wrap payments/interim reconciliations paid by DMS.

- (2) An explanation of the automatic wrap payment system scheduled to start with “dates of service” of July 1, 2014.

DMS stated that going forward, these payments will automatically be issued off of the encounters DMS receives from the MCOs. The MMIS will use the encounter to determine what should have been paid, using the PPS rate minus what the MCO paid. ICNs will be systematically generated using Regions 85, 86, 87 or 88 and will be included in a facility's weekly remittance advice. Mr. Bechtel explained that Region 85 is the supplemental payment claims, Region 86 is supplemental adjustment, Region 87 is supplemental voids, and Region 88 is supplemental mass adjustment. Mr. Bolt asked if this could be put in written form to go out in a newsletter to members.

Mr. Smith asked what will happen for dates of service between now and June 30th. He mentioned Healthpoint and Corbin Pediatrics as examples. Mr. Bechtel stated he had received an email from Healthpoint and is looking at this and will also review the other facility and any other facility on a case-by-case basis.

- (3) Now that the Program has stated that they are responsible for Medicaid's share of the “dual eligible”, how and when can centers expect payment.

Ms. Guice stated there is still ongoing discussion within DMS and no decision has been made to date.

- (4) PPS rates for mobile dental services.

Mr. Dennis stated it is the same PPS rate with the same standards. Mr. Bolt asked about the contradiction between the restriction on dental services per month for children and the MCOs' push for more services per month. Ms. Guice asked if this question could be put in writing and submitted to DMS.

- (5) Number of interim rates which are longer than a year old.

Mr. Dennis stated there are fifty-one providers with interim rates longer than a year old. Draft adjustments have been mailed to eleven providers, ten providers' final cost reports have not been submitted, four are currently with OIG, and twenty-six providers' desk reviews are in process.

NEW BUSINESS:

- (1) Discussion and questions of the new payment State Plan Amendment.

Ms. Keyser asked what situation is driving the State's proposed SPA changes in regard to FQHC's and rural health clinics. Ms. Guice stated it would be helpful if DMS received written questions from the TAC, and Mr. Smith suggested that a special session be set up with DMS just to review the SPA in detail and the Chair asked Mr. Smith to facilitate getting this meeting set up.

- (2) Discussion of physician assistants for behavioral health which MCOs are currently considering.

Mr. Douglass explained that a PA in Kentucky can have their own practice but must operate under a supervising physician and that procedures performed by a PA must be billed under the supervising physician's Medicaid number. Ms. Cooper stated that of the practitioners that are being added because of the expansion of mental health, 90% of them have to bill under the supervising physician and there has to be modifiers for that and that's across the board for every program in Medicaid.

- (3) Same day billing for dental, BH/MH and medical encounters

Mr. Smith stated this is a new issue of being able to bill for more than one encounter. Ms. Cooper stated that a provider can bill for more than one encounter but Medicaid is only going to pay one PPS rate.

Mr. Smith noted that if a provider goes through a change-in-scope process, the rules to do so are not laid out in any clear, articulate manner. Ms. Keyser noted that her organization submitted a change-of-scope in 2004 and it is still not resolved.

Ms. Guice asked that questions concerning interim rates and reconciliations be put in writing and submitted to DMS.

GENERAL DISCUSSION:

There was discussion concerning issues to be addressed to the Medicaid Advisory Council: (1) The application of new CMS rules on multiple visits; (2) Resolution of outstanding interim rates; (3) Reconciliation of payments for dual eligibles; (4) Clarification of change-of-scope instructions, which may be addressed at the special meeting to discuss the SPA.

The meeting was adjourned. No date was set for the next meeting.

(Minutes were taped and transcribed by Terri Pelosi, Court Reporter, this the 15th day of May, 2014.