

**BEHAVIORAL HEALTH TAC RECOMMENDATIONS
TO THE MAC – MARCH 27, 2014**

RECOMMENDATION: That representatives of the Behavioral Health TAC (or their designees) be invited to attend a meeting of the MCO Medical Directors convened by Dr. John Langefeld (DMS) to discuss this issue of inconsistency of forms and procedures across MCOs, in order to seek some resolution which would reduce administrative costs and burden for providers and facilitate service provision.

PREVIOUS RECOMMENDATION: The requested data for PA's and their outcomes for psychotropic medications has not yet been completed by DMS, but will be forwarded to the Behavioral Health TAC within the next month – six weeks. Once that data has been received and reviewed by the BH TAC, further recommendation to improve medication access may be forthcoming.

RECOMMENDATION: That Kentucky DMS review carefully the comments made by providers in response to the published rates, and in particular, examine the rates for services such as intensive case management and outpatient therapies which could prevent higher-cost, more restrictive treatment approaches from being needed.

Finally, the Behavioral Health TAC wishes to state again this recommendation made a year ago:

RECOMMENDATION: That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

BEHAVIORAL HEALTH TAC RECOMMENDATIONS TO THE MAC – MAY 22, 2014

PREVIOUS RECOMMENDATION: The requested data for PA's and their outcomes for psychotropic medications – as well as other requests made by our TAC as far back as July, 2013 were approved by the MAC in January and submitted to DMS for response. That response and initial data was received by me from Beth Partin, MAC Chair, late yesterday, May 21st. In a very brief review, I noted that the table prepared by Ms. Guise of DMS regarding Prior Authorizations of services did not address our question, as it creates a single category for Mental Health & Substance Abuse Services and does not break out the individual services. Our question was about specific services and whether PAs were required, as well as whether PAs were differentially required, depending on whether the service was being provided by a CMHC or by a private provider. Obviously, the Behavioral Health TAC has not had an opportunity to read, review or digest the response from DMS nor the data provided. A number of the data tables were illegible and I will contact Erin Hoben at DMS to obtain clean copies for our review. Once that material has been thoroughly reviewed by the BH TAC, further recommendations to improve medication access and to address other issues may be forthcoming.

RECOMMENDATION: That DMS immediately post on their website and disseminate basic information about the Open Enrollment Period now underway. This information, at a minimum, should be sent to the MAC members, all of the TACS and to the advocacy and provider groups typically notified by DMS about the MAC meetings. I have attached a copy of the announcement flyer and of the accompanying MCO information that is being disseminated through the KY Mental Health Coalition and other advocacy groups for this purpose.

PREVIOUS RECOMMENDATION: That representatives of the Behavioral Health TAC (or their designees) be invited to attend a meeting of the MCO Medical Directors convened by Dr. John Langefeld (DMS) to discuss this issue of inconsistency of forms and procedures across MCOs, in order to seek some resolution which would reduce administrative costs and burden for providers and facilitate service provision.

RECOMMENDATION: That Kentucky DMS carefully monitor the hospitalization/institutionalization/out-of-state placements of Medicaid members and re-evaluate the reimbursement rates for services such as intensive case management and outpatient therapies in light of this data.

➤ Finally, the Behavioral Health TAC wishes to state again this recommendation made more than one year ago:

RECOMMENDATION: That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

**BEHAVIORAL HEALTH TAC RECOMMENDATIONS
TO THE MAC – JULY 24, 2014**

RECOMMENDATION: That Kentucky DMS carefully monitor the hospitalization/institutionalization/out-of-state placements of Medicaid members and re-evaluate the reimbursement rates for services such as intensive case management and outpatient therapies in light of this data. Specific data on readmission rates for individuals needs to be tracked and analyzed to get a full picture of what is happening to members with behavioral health needs.

➤ Finally, the Behavioral Health TAC wishes to state again this recommendation made more than one year ago:

RECOMMENDATION: That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Steven L. Beshear
Governor

275 East Main Street, 6W-A
Frankfort, KY 40621
P: 502-564-4321
F: 502-564-0509
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

November 19, 2014

TO: Medicaid Advisory Committee (MAC) Board Chairwoman Partin and MAC Board Members

RE: Response to Behavioral Health Technical Advisory Committee (TAC) Testimony Presented at the March 27, 2014, May 22, 2014 and July 24, 2014 MAC Meetings

Dear Chairwoman Partin and MAC:

We are writing to address testimony presented by Dr. Sheila Schuster, spokesperson of the Behavioral Health TAC, at the MAC meetings on March 27, 2014, May 22, 2014, and July 24, 2014.

Behavioral Health TAC March 27, 2014 Recommendations:

1. That representatives of the Behavioral Health TAC (or their designees) be invited to attend a meeting of the MCO Medical Directors convened by Dr. John Langefeld (DMS) to discuss this issue of inconsistency of forms and procedures across MCOs, in order to seek some resolution which would reduce administrative costs and burden for providers and facilitate service provision.

RESPONSE: The appropriate forum for TACs to discuss issues and make recommendations is the process that is currently in place where TACs submit their recommendations to the MAC for DMS to respond. The Director of the Division of Program Quality and Outcomes, Patricia Biggs, has convened a workgroup, which includes medical directors or representatives from all MCOs, to research the

possibility of utilizing a common prior authorization form, although there may be some limitations in implementing a common form. She will provide an update to the MAC at the next MAC meeting.

2. The requested data for PA's and their outcomes for psychotropic medications has not yet been completed by DMS, but will be forwarded to the Behavioral Health TAC within the next month – six weeks. Once that data has been received and reviewed by the BH TAC, further recommendation to improve medication access may be forthcoming.

RESPONSE: DMS will respond to any forthcoming recommendations from the Behavioral Health TAC when brought forth by the MAC at a meeting in which quorum is met.

3. That Kentucky DMS review carefully the comments made by providers in response to the published rates, and in particular, examine the rates for services such as intensive case management and outpatient therapies which could prevent higher-cost, more restrictive treatment approaches from being needed.

RESPONSE: DMS will review the comments made by providers in response to the published rates. DMS will also continue to monitor utilization to determine if changes to fees or regulations are warranted.

4. Finally, the Behavioral Health TAC wishes to state again this recommendation made a year ago: That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

RESPONSE: The CHFS has an ombudsman for the entire Cabinet who deals with issues related to all the programs administered by the Cabinet regardless of subject matter. By law, this office serves as an advocate for all citizens and works to ensure those seeking various public services are treated fairly. The Office of the Ombudsman answers questions about CHFS programs, investigates customer complaints and works with CHFS management to resolve them, advises CHFS management about patterns of complaints and recommends corrective action when appropriate. Currently, the office consists of three branches: Complaint Review, Performance Enhancement and the Institutional Review Board. We are working to integrate all the functions of the Ombudsman's Office within a proactive, data-driven agency whose contributions to the Cabinet will be essential to overall quality improvement. The Ombudsman may be contacted through an online form at <http://chfs.ky.gov/dail/kltcopcontact.htm>, by phone at 1-800-372-2973 or 1-800-627-4702 (TTY), through email at AndreaT.Day@ky.gov or by mail at:

*The Office of the Ombudsman
Cabinet for Health and Family Services
275 E. Main St., 1E-B
Frankfort, KY 40621*

In addition, it is important for members to follow the proper appeal process for denied services as outlined in the member handbook provided by the assigned Manage Care Organization. DMS continually monitors the appeals to ensure MCO compliance and to determine if there are areas of concern.

Behavioral Health TAC May 22, 2014 Recommendations:

1. The requested data for PA's and their outcomes for psychotropic medications – as well as other requests made by our TAC as far back as July, 2013 were approved by the MAC in January and submitted to DMS for response. That response and initial data was received by me from Beth Partin, MAC Chair, late yesterday, May 21st. In a very brief review, I noted that the table prepared by Ms. Guise (sic) of DMS regarding Prior Authorizations of services did not address our question, as it creates a single category for Mental Health & Substance Abuse Services and does not break out the individual services. Our question was about specific services and whether PAs were required, as well as whether PAs were differentially required, depending on whether the service was being provided by a CMHC or by a private provider. Obviously, the Behavioral Health TAC has not had an opportunity to read, review or digest the response from DMS nor the data provided. A number of the data tables were illegible and I will contact Erin Hoben at DMS to obtain clean copies for our review. Once that material has been thoroughly reviewed by the BH TAC, further recommendations to improve medication access and to address other issues may be forthcoming.

RESPONSE: Leslie Hoffmann, the Behavioral Health Policy Advisor for DMS, will convene a meeting with DMS and the appropriate representatives from each MCO to discuss their prior authorization (PA) process for behavioral health services and will present an update to the MAC at the next MAC meeting. Legible data tables were presented in print to the MAC at the March MAC meeting and included in the binder. Because the TACs do not receive the binders from the MAC, Erin Hoben will be sending larger copies to Sheila Schuster.

2. That DMS immediately post on their website and disseminate basic information about the Open Enrollment Period now underway. This information, at a minimum, should be sent to the MAC members, all of the TACS and to the advocacy and provider groups typically notified by DMS about the MAC meetings. I have attached a copy of the announcement flyer and of the accompanying MCO information that is being disseminated through the KY Mental Health Coalition and other advocacy groups for this purpose.

RESPONSE: DMS has posted information about open enrollment on their website. That information can be found here:

<http://www.chfs.ky.gov/dms/member+information.htm>. Additionally, DMS mailed the attached provider letter regarding open enrollment to all Medicaid providers and notified advocacy groups of open enrollment through an email notification.

3. That representatives of the Behavioral Health TAC (or their designees) be invited to attend a meeting of the MCO Medical Directors convened by Dr. John Langefeld (DMS) to discuss this issue of inconsistency of forms and procedures across MCOs, in order to seek some resolution which would reduce administrative costs and burden for providers and facilitate service provision.

RESPONSE: DMS convened a workgroup with the MCOs to explore opportunities for consistency among forms and processes. The workgroup is being led by Patricia Biggs, Director for the Division of Program Quality and Outcomes. DMS will report back to the MAC when it has more information to share about the workgroup's progress.

4. That Kentucky DMS carefully monitor the hospitalization/ institutionalization/out-of-state placements of Medicaid members and re-evaluate the reimbursement rates for services such as intensive case management and outpatient therapies in light of this data.

RESPONSE: DMS is continually monitoring utilization of behavioral health services and will consider changes to fees and regulations as necessary.

5. That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

RESPONSE: Please see response to Recommendation 4 under the March 27, 2014 recommendations.

Behavioral Health TAC Recommendations July 27, 2014:

1. That Kentucky DMS carefully monitor the hospitalization/ institutionalization/out-of-state placements of Medicaid members and re-evaluate the reimbursement rates for services such as intensive case management and outpatient therapies in light of this data.

RESPONSE: Please see response to Recommendation 4 under the May 22, 2014 recommendations.

2. That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

RESPONSE: Please see response to Recommendation 4 under the March 27, 2014 recommendations.

Sincerely,

Erin Hoben
Chief Policy Advisor
Commissioner's Office
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services
Neville Wise, Deputy Commissioner, Department for Medicaid Services
Lisa Lee, Deputy Commissioner, Department for Medicaid Services
Mary Begley, Commissioner, Department for Behavioral Health, Developmental and Intellectual Disabilities
Dr. John Langefeld, Medical Director, Department for Medicaid Services
Leslie Hoffmann, Behavioral Health Policy Advisor, Department for Medicaid Services
Barbara Epperson, Resource Management Analyst III, Department for Medicaid Services



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Steven L. Beshear
Governor

275 East Main Street, 6W-A
Frankfort, KY 40621
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

To: All Medicaid Providers
Provider Letter A-97

Date: October 1, 2014

Re: **Medicaid Managed Care Open Enrollment**

Beginning October 27, 2014 and ending December 12, 2014 the Commonwealth of Kentucky Medicaid Managed Care members will be in their Open Enrollment period. All Medicaid members will have the option to change MCOs or remain with their current plan. The MCO choices are: Anthem (not available in the counties in Region 3 – Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble and Washington) Coventry Cares, Humana, Passport, and Wellcare. MCO changes made during this Open Enrollment period will be effective on January 1, 2015. **Note:** If a member does not proactively change their MCO during the Open Enrollment period, they will remain with the same MCO for 2015.

Should you have questions about this Open Enrollment period, please contact the Department for Medicaid Services Call Center at 800-635-2570. Should your patients have questions or wish to make a change to their MCO, please refer them to our Call Center. For those members who came into Medicaid through the Kentucky Health Benefits Exchange - *kynect*, they can return to the *kynect* website to make MCO changes. The web address for *kynect* is: kynect.ky.gov Please also know that members can make their MCO changes on a *kynect* Kiosk. These kiosks are located in many of our Commonwealth's hospitals, for the member's convenience.

Should you have questions, please contact the Division of Provider and Member Services, Provider Services Branch at 855-824-5615. Many thanks for providing services to our members. We appreciate everything you do for the citizens of this Commonwealth.



Behavioral Health TAC Oral Report to the MAC September 25, 2014

Good morning. I am Sheila Schuster, giving an oral report from the Behavioral Health TAC. The BH TAC did not meet prior to this MAC meeting because of the Medicaid Managed Care Provider Forums held across the state in the past 6-8 weeks.

We do note, however, that our priority concerns have not changed...and have not been addressed. They are:

- #1. Lack of access to medications continues as top priority. At least one MCO confirmed that individuals must fail on two different medications before getting the more expensive medication.
- #2. Inconsistency of forms being used across the MCOs continue to be frustrating and to drive up administrative costs for providers.
- #3. We have always argued for being carved out of managed care; we're only 3% of the total budget...and our people are being hurt under managed care.
- #4. We don't see integrated care happening (which was the reason given for carving us in to managed care).
- #5. Medication alone doesn't do the full job; our consumers need therapy, need support services in the community – services that are being denied.
- #6. Each MCO has a different formulary and different PA process, creating confusion for prescribers and members; in addition, the formularies are changing constantly

Mr. Van Lahr (Pharmacy Rep) – I have a big concern about the January 1st beginning with new patients in different MCOs and not being able to get mx.

Mr. Carle (Hospital Rep) – What indicators could MCOs provide on the dashboard to see that the continuum of care is actually happening between the medical side and the BH side? What could the BH TAC recommend as indicators so that we could track and see how they are actually doing? (I note that the MCO contracts require a communication from BH provider to PCP 1x/3 months)

Mr. Carle – I would like to request that the MCOs report admission rates to psych hospitals, average LOS and re-admissions to psych hospitals. Also, request that they report denials of inpatient care and denials of IOP care.

Dr. Neel (Physicians) – Lack of behavioral modification and behavior therapy to refer ADHD kids to. I reply that BH network has opened up, but credentialing is slow, not clear what areas of the state providers are in and whether they are child clinicians or not. Deloitte workforce study was hampered by poor licensure board data in many cases

Ms. Branham (Home Health) – How was access to service for these BH folks before managed care? (I reply – much, much better). She strongly states that Medicaid is going backwards in dealing with people with behavioral health issues. BH needs to be carved out!

Dr. Beth Partin (Chair; Nursing) – The MAC is asking DMS to respond to this issue of carve out in writing for the next meeting. Mr. Van Lahr – and add the issue of imposing consistency across the MCOs!

BEHAVIORAL HEALTH TAC REPORT TO THE MAC – NOVEMBER 20, 2014

Good morning. I am _____, serving today as the spokesperson for the Technical Advisory Committee on Behavioral Health (BH). Our TAC had its most recent meeting at the Capitol Annex on November 5, 2014. We invited all five (5) of the Medicaid MCOs and their Behavioral Health representatives to attend. Four of the five MCOs were represented at the meeting. In addition to the MCO representatives and the four TAC members who were present, we had other members of the behavioral health community in Kentucky, including members of the KY Mental Health Coalition. We also had staff from KY Department for Medicaid Services in attendance. The KY Department for Behavioral Health, Intellectual & Developmental Disabilities had been invited to send a representative, but none were in attendance.

A summary of the Behavioral Health TAC oral report made to the MAC in September of 2014 and the discussion with MAC members at that meeting was disseminated and briefly discussed.

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

In addition to the “usual” topics of access to medications and behavioral health therapy services, we would like to address these issues:

- What indicators do you report to show that your members are receiving integrated physical and behavioral health care? What are the outcomes you are looking for?
- How many behavioral health professionals outside of the CMHCs are now credentialed with your MCO? What is their distribution across the state?

All of the MCOs discussed their approach to integrated care, although only Passport provided in writing a description of the relevant HEDIS measures. It appears that there are a number of reports submitted by the MCOs – some monthly, some quarterly, some semi-annual and some annual – which contain data relevant to integrated care. We discussed the difficulty in “tracking” a member who is receiving both behavioral health and physical health services and identifying instances where their care was being integrated. WellCare described its pilot project with 50 members having an SMI or SED diagnosis. With a team approach and chronic case management services, inpatient costs decreased and outpatient services and pharmacy costs increased for a net savings. Humana/CareSource includes their UR in weekly case conferences, with either Behavioral Health or Physical Health taking the lead, depending on which is the more pressing issue. Anthem also includes UR and case consultations with both BH and PH case managers.

One of the issues raised was that while all of the MCOs are now paying for Peer Support Specialist services – and the general consensus of discussion in the meeting appeared to be that the use of the peer specialist would be particularly helpful in implementing an integrated care delivery system – the MCOs apparently do not see it as their role to initiate the introduction of a peer specialist with these individuals! One wonders whose responsibility it is to initiate that service. Why it is not being initiated in the case conferences which the MCOs are conducting with their behavioral health and their physical health case managers?

There was also discussion about the status of KY Peer Specialists and whether they were considered to be “certified” or not, the lack of any oversight or regulatory board and the uncertainty of required CE programs being offered. Also, there are 8 peer specialist centers

being established around the state, but not all will become BHSOs, so it is unclear how their specialists will be used and reimbursed. These are questions that will be posed to BHDID.

In terms of behavioral health providers outside of the CMHCs, Anthem reported 1,600 credentialed (but they include CMHC staff). MHNNet reported 1400 BH providers, 1100 of which were not CMHC. WellCare reported 884 BH providers, 795 of which were outside the CMHCs. Passport reported 509 BH providers outside of the CMHCs, plus 288 prescribers.

The Brain Injury Alliance of KY rep asked about providers of neuropsychological, neuropsychiatric and neurology services in network. The MCOs reported a sufficient number, with some of them handling these services on the BH side and others handling them on the Physical Health side.

The Children's Alliance rep asked about the inconsistency across MCOs in billing units, especially for group therapy and for family therapy. The MCO reps indicated that Dr. Langefeld was hosting a call with them in the near future to discuss the National Correct Coding Initiative Edits. The Impact Plus program lost their waiver from the NCCI and the MCOs are awaiting further direction from DMS on this issue. The Children's Alliance rep will direct a letter to Dr. Langefeld, indicating their concerns and asking for a quick resolution.

There were several questions for the MHNNet representative, one having to do with a provider not being able to get other providers in her office credentialed because the Aetna network was "frozen". The MHNNet rep indicated that he would take care of this, as there had been apparently miscommunication from staff to the provider, not correctly indicating that KY's network was exempt from the freeze. The other question had to do with when we could expect to see a change in the Medical Necessity criteria from MHNNet (Coventry) to the one used by Aetna. The rep had left the meeting at that point in time and the question will be asked later. If the MHNNet rep is present now, could we have an answer to that question?

RECOMMENDATION: That a Behavioral Health Ombudsperson be established to provide easily-accessed personal responses to consumers who are experiencing difficulty with the Medicaid managed care system. This would allow consumers to share their personal health information (PHI) as they discuss directly with the Ombudsperson the issues that need to be resolved with the MCOs in order for them to access the care that they need.

RECOMMENDATION: That DMS work with the BH TAC and with the MCOs to further discuss appropriate reporting and measures for documenting integrated care and its outcome.

RECOMMENDATION: That the NCCI billing edits inconsistency be resolved quickly.

RECOMMENDATION: The Hospital recommendations were reviewed and the Behavioral Health TAC is endorsing these recommendations: To waive the IMD Exclusion; To have the MCOs report on admissions to psych hospitals, re-admissions, Lengths of Stay in psych hospitals, and denials of IOP and Partial Hospitalization services.

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

KENTUCKY DENTAL TAC MEETING MINUTES
Transportation Cabinet
Mero Street
Frankfort, Kentucky

June 18, 2014
8:00 a.m. EST.

The meeting of the Dental Technical Advisory Committee (TAC) was called to order by Dr. Susie Riley, Chair.

The TAC members in attendance: Dr. Susie Riley, Dr. Garth Bobrowski, Dr. Wayne Lose and Dr. Neil Rush. Dr. John Tompson, Executive Director, Kentucky Dental Association.

Medicaid staff in attendance: Dr. Ken Rich, Ms. Carrie Anglin, Mr. Charles Douglass, Ms. Cindy Arflack, Ms. Stephanie Bates, Ms. Veronica Cecil and Ms. Jennifer Moore. Dr. Julie McKee, State Dental Director, Kentucky Oral Health Program.

The Managed Care Organization (MCO) representatives in attendance were: Dr. Fred Sharpe, Dr. Jerry Caudill, Ms. Carol Brenner and Ms. Melissa Reynolds with Avesis; Ms. Pat Russell with WellCare; Mr. Jason Trudeau, Ms. Bonnie Reynolds and Ms. Carol Brenner with Passport; Ms. Lisa Sweeney and Ms. Cheryl Lighthart with Scion Dental; Mr. Ken Groves with Anthem Kentucky; Dr. Vaughn Payne, Ms. Christian Bowlin and Ms. Kim Howell with Humana – CareSource; Ms. Morgan Stumbo with MCNA.

Guest: Dr. Corey L. Hamm

A motion was made by Dr. Bobrowski and seconded by Dr. Lose to approve the minutes of April 4, 2014. Motion passed.

The corrections or additions to the 2013 reports were in the packets that were distributed to the TAC. Ms. Carrie Anglin stated the first quarter of 2014 data is not available yet. Ms. Anglin or Mr. Kurt Godshall can be contacted if there are any questions concerning the reports.

Program Integrity: Ms. Veronica Cecil, Director of the Division of Program Integrity, addressed the TAC concerning provider eligibility problems that have occurred and reiterated that it's a provider's responsibility to ensure that their license is up to date, to submit an Annual Disclosure of Ownership, and to notify DMS of an address change. She stated it is a federal law to revalidate every five years and it's a state law to do it annually. Dr. McKee asked if DMS receives license updates from the Board of Dentistry. Ms. Moore stated that DMS did not get one this year but they are working with the Board to begin getting monthly feeds instead of every two years.

Dr. Sharpe stated he thought there were three corollary issues occurring at the same point – the state licensure issue; the certification-of-ownership issue; a communications issue of dental practices whose corporate offices are not in Kentucky receiving information about updates and not passing this on to the appropriate Kentucky dental offices; and the taxonomy code issue.

Dr. Bobrowski asked Ms. Cecil if she would send out a letter to providers explaining what happened in March when many providers were dropped from the program and what steps DMS is taking to improve the provider eligibility process. Ms. Cecil stated that DMS is working on an online provide portal with a launch date early next year, possibly February, for individuals that should streamline the eligibility and re-validation process for providers.

Ms. Cecil stated that currently the average processing time for eligibility is forty-seven working days. If providers have not heard from DMS within that time frame, she encourages them to call DMS. Ms. Cecil stated that the applications need to be as complete and correct as possible and that applications are reviewed on a first-come/first served basis, not by provider type. Ms. Cecil also stressed the importance of using the most current form of the applications that are found on the DMS website. Dr. Rush suggested that Ms. Cecil hold seminars at the two dental schools to educate dental students on provider eligibility requirements.

Individual sessions were held with each MCO representative and their subcontractors.

COVENTRYCARES/AVESIS: Dr. Sharpe stated that the reports requested by the TAC have been turned over to CoventryCares but that CoventryCares has not given their blessings to distribute them. Dr. Sharpe will confer with Russell Harper as to what happened with this. Mr. Harper was not present today and reports were not presented at the 4/20/2014 meeting. So, there have been no reports from CoventryCares since 2nd quarter, 2013.

There was discussion about emergency adult patient visits. Dr. Sharpe stated that emergencies are covered as necessary without restriction. Routine non-emergency care and preventive services are available one time per month. He stated he would put out a memo to providers clarifying this.

Dr. Riley asked about the shortage of oral surgeons in certain regions of the state as of 3/28/2014 that was reported on the network adequacy report on DMS' website. Dr. Sharpe stated he was not aware of any categorization of something being negative and that he will look into the details of this.

Dr. Riley asked about x-ray limits. Dr. Sharpe stated that providers can take new x-rays up to the limit of four x-rays for that member per provider and that this information can be found on the grid. Dr. Caudill asked for examples of when a claim has processed otherwise and he will look into it.

Dr. Riley asked what it means by orthodontic transfers and Dr. Riley discussed a situation of an out-of-state Medicaid person relocating to Kentucky and seeking orthodontic dental services. Dr. Sharpe stated CoventryCares has a standard continuity-of-care program and they're obligated to not expend more than what is the equivalent of one case fee per member for orthodontics. He discussed the Orthodontic Continuation of Care Form that was distributed to the TAC.

Dr. Bobrowski and Dr. Thompson complimented both Dr. Sharpe and Dr. Caudill for working closely with them on issues involving dentistry in the state.

Dr. Sharpe stated that he and Dr. Caudill have brought four dental issues to the Medical Directors to attempt to have them involved through their MCO's to solve them:

- (1) Non-payment of UK's Oral Pathology Department
- (2) Attempt to get more discipline on mobile and portable dental units
- (3) CT scans being authorized for oral surgeons
- (4) Working with Public Health Department

PASSPORT/AVESIS: Reports were given to the TAC. Dr. Sharpe stated that a caveat to one of the reports is the number of dentists submitting \$10,000 or greater from the Passport network is quite low because the program is in its infancy in seven regions. Dr. Lose asked if the report could reflect payment of claims of \$10,000 or greater instead of submitted claims of \$10,000 or greater. Dr. Sharpe stated this would have to go back to Passport's management.

Mr. Trudeau addressed the issue of oral surgeons outside of Region 3. He stated that Passport would submit all claims containing 18 CPT codes just to Avesis on the dental end and not submit those claims on the medical end with a rollout date of August 1st. After August 1st, if any claims are submitted on the medical end containing those 18 codes, they will be denied. There will still be a few CPT codes that will go to medical. This will mirror what providers are already accustomed to outside Region 3.

Dr. Lose asked about the turnaround time for payments to providers. Dr. Sharpe stated that Passport has a claim certification process that it uses which might slow the payment process some but not more than one day.

Dr. Riley asked what the time frame was for acknowledging appeals. Dr. Sharpe stated he would have to see what the letter generation program is. Dr. Riley stated that when a post review is done, a written response is not received by the provider. Dr. Sharpe stated written responses are a good idea and they will look into this. Dr. Riley further requested that Passport send approval letters to patients – not just denial letters.

HUMANA - CARESOURCE/MCNA: Dr. Vaughn Payne was introduced as the new Medical Director for Humana - CareSource. Kim Howell, Provider Relations Manager with Humana-CareSource, stated she would need the

formats for the reports requested by the TAC. Ms. Anglin will provide those to Ms. Howell.

Dr. Riley asked about prompt pay. Ms. Howell stated that they have been meeting the prompt pay requirements per their contract, but she will be contacting a CareSource claims analyst to seek clarity on their percentage of pending claims and what the reasons are for this. Ms. Christina Bowlin with CareSource stated that the portal has been updated to now include the taxonomy code. Dr. Riley asked if a claim is now entered in the portal, when will payment for that claim be expected and Ms. Howell stated anytime within thirty days.

Dr. Riley asked about the adequacy of the oral surgery network. Ms. Howell stated she was not aware of a Region 3 issue of finding surgeons and that their focus at this time is on Regions 1, 2, 7 and 8 for access standards. Dr. Lose stated that until the issue with preauthorization of surgical extractions is cleared up, this problem will continue, and Dr. Bobrowski spoke about the number of oral surgeons that are dropping out of the program due to this restriction.

ANTHEM/SCION: Lisa Sweeney introduced herself as the Chief Financial Officer of Scion. Dr. Riley stated that she understood the first quarter has just ended and Ms. Sweeney hasn't had contact with Ms. Anglin, but Dr. Riley suggested that Ms. Sweeney get the quarterly and annual report formats from Ms. Anglin for future reports to be given to the TAC.

Ms. Sweeney gave a Powerpoint presentation that covered provider relations, network recruitment plans, geo access of providers, credentialing, the provider web portal, authorization review, claims processing, claim denials and appeals. Ms. Sweeney will provide an electronic version of this presentation to Ms. Anglin as well as the full geo access report. TAC members were very impressed with the graphs and charts that were included in the presentation and

Dr. Riley asked if Scion could query CAQH concerning the credentialing process. Ms. Sweeney will also provide a screen shot of the Claim Estimator to the TAC. Ms. Sweeney reported that the new State Dental Director is Dr. Susan Feeley.

The TAC members were complimentary of the Powerpoint presentation and the charts and graphs included and Dr. Lose asked if Scion would be willing to share a template of this presentation with the other MCO's. Ms. Sweeney agreed to do this and will provide it to Ms. Anglin.

WELLCARE/AVESIS: Dr. Riley asked about the 2013 reports that were being vetted by the Legal Department for WellCare. Pat Russell, Director of Provider Solutions for WellCare, stated she was not aware those reports were still needed but she will get the reports to Ms. Anglin within the next seven to ten days.

Three reports distributed to the TAC were the first quarter 2014 paid claims, the network and area access, and a series of percentages for patient-based and provider-based services. Dr. Sharpe will do a comparison of the first quarters for years 2012, '13 and '14 of the relative ratios between extractions and restorations to see if it's changing.

Dr. Riley asked when providers will be notified about guidelines regarding when nitrous oxide reviews are required. Dr. Shape will get a publication out to inform providers about this. Dr. Riley asked if a new grid will be produced that clarifies emergency visits and x-ray limits. Dr. Sharpe stated the grid today states per patient per provider and Avesis will email a memo to providers informing them of this. Dr. Riley asked whether the report of doctors who have gotten paid claims in excess of \$1,000 per month has been vetted yet by legal. Dr. Sharpe stated there was no answer to that at this time.

OLD BUSINESS: Dr. Rich stated that draft dental regulations have been written, but due to the budget crisis, nothing is moving forward. Dr. Riley reported that she did move forward with the recommendation to the MAC that a no-show failure code be developed and is waiting for a response from the Commissioner. Dr. Caudill stated he has also brought this up to the MCO Medical Directors.

NEW BUSINESS: The date of the next meeting will be September 24, 2014, 8:00 a.m., location to be determined. The meeting was adjourned.

(Minutes were taped and transcribed by Terri Pelosi, Court Reporter, this the 27th day of June, 2014.

KENTUCKY DENTAL TAC MEETING MINUTES
Transportation Cabinet
Mero Street
Frankfort, Kentucky

September 24, 2014
8:00 a.m. EST.

The meeting of the Dental Technical Advisory Committee (TAC) was called to order by Dr. Susie Riley, Chair.

The TAC members in attendance: Dr. Susie Riley, Dr. Garth Bobrowski, Dr. Wayne Lose and Dr. Matt Akridge. Mr. Todd Edwards, representing the Interim Executive Director, Kentucky Dental Association.

Medicaid staff in attendance: Dr. Ken Rich, Ms. Carrie Anglin, Mr. Charles Douglass, Ms. Cindy Arflack, and Ms. Stephanie Bates. Dr. Julie McKee, State Dental Director, Kentucky Oral Health Program.

The Managed Care Organization (MCO) representatives in attendance were: Dr. Jerry Caudill and Ms. Emori Campbell with Avesis; Ms. Pat Russell with WellCare; Mr. Jason Trudeau with Passport; Ms. Lisa Sweeney and Mr. Craig Dalton with Scion Dental; Ms. Peg Patton with Anthem Kentucky; Ms. Christian Bowlin and Ms. Kim Howell with Humana – CareSource; Ms. Morgan Stumbo with MCNA; Mr. Russell Harper with CoventryCares. Also in attendance: Ms. Lisa Martin and Ms. Karen Ehalt with Commission for Children With Special Needs.

A motion was made by Dr. Lose and seconded by Dr. Bobrowski to approve the meeting minutes of June 18, 2014, with the typographical errors noted by Dr. Bobrowski. Motion passed.

NEW BUSINESS:

MEDICAID ROUNDTABLE: There was a discussion of the Medicaid Roundtable held on July 28, 2014. Dr. Rich stated he felt it was a good meeting and there was good dialogue and that the next step would be for the Cabinet to come back with responses to provider suggestions. Dr. Bobrowski felt the providers conveyed the message of their willingness to work with the MCOs and DMS on developing policy and guidelines and at the same time trying to help dentists see patients. He noted that various groups may convene another meeting with Secretary Haynes in mid to late October. Dr. Rich will find out if this meeting will be open to any provider to attend and suggested that Dr. John Thompson of the KDA be asked this as well. Dr. Caudill stated there was discussion of the mobile and portable issue at the Roundtable meeting as well.

Dr. Bobrowski noted that Richard Whitehouse has accepted the position of Executive Director of the KDA, and Dr. Bobrowski will furnish Ms. Anglin his contact information.

MEDICAID FORUMS: Dr. Riley noted that there was very little dental participation in Region 3 or 31 and she attributed that to the lack of promotion and publicity. Dr. Rich noted he attended two forums and the dental participation was very light. Dr. Caudill attended seven of the eight forums, and in speaking with providers, he said they were unaware of these forums taking place.

CREDENTIALING: Dr. Riley stated that members of the KDA got an email blast stating there would be an extensive new application required for credentialing that's a CMS requirement and she had emailed Ms. Veronica Cecil inquiring about this but had not received a response. Dr. Rich said there will be a response from Ms. Cecil but that the information that went out is not accurate, and Ms. Cecil is making corrections and getting better information that will be disseminated.

Dr. Rich noted that DMS is on track to have a portal where credentialing can be done electronically and this may occur by the end of the year. Dr. Lose asked if this can be tied in with the CAQH. Dr. Rich stated that the MCOs can but the information that's on the CAQH is not necessarily the information that the State requires. He further noted that the ADA is in the process of trying to put together a state-specific CAQH lookalike.

MCO'S/SUBCONTRACTORS: Ms. Anglin stated that since these meetings are open to the public, it will not be necessary for attendees to leave the room. If the MCOs have proprietary information, it is to be forwarded to Dr. Riley.

PASSPORT/AVESIS: Mr. Trudeau noted that the Passport reports were not in the booklet that was distributed to the TAC, however, he did have copies of the reports to distribute. Dr. Riley asked about the success of the rollout and

how oral surgeons are now being treated. Dr. Caudill stated that Passport is now expanding statewide due to the billing change concerning dental versus medical and more oral surgeons are signing on.

Dr. Riley asked if Passport has made a decision whether to send approval letters on EPSDT. Mr. Trudeau said he would follow up with this.

HUMANA – CARESOURCE/MCNA: Ms. Howell stated she has ordered detailed claims reports from IT and as soon as she receives them, she will forward them to the TAC. She did note that the other reports requested are contained in the booklet.

Dr. Lose and Dr. Akridge noted that there are some providers still listed on the Provider List who no longer are in the network. Ms. Howell stated she would look into this. Dr. McKee asked if CoventryCares only recognizes two types of dentists, and Ms. Howell will pull the number of NPIs that are participating and at the next TAC meeting will have a revised list.

Dr. Lose asked if the wisdom teeth issue was ever settled concerning prior authorization, and Dr. Riley asked if it was just third molars or any surgical extraction that needs to be prior- authorized. Ms. Stumbo stated that the Humana CareSource manual says that all surgical extractions when reported on primary teeth need to be preauthorized as well as the surgical extractions of third molars. Dr. Riley noted that the way it is currently being applied is across the board with a 7210 or above. Ms. Morgan will look into this and get back with the TAC.

Dr. Bobrowski discussed the paperwork involved with doing extractions and PA's, and Ms. Stumbo noted that their team is looking into this. Dr. Akridge noted that he is not a provider with Humana because of this issue. Dr. Riley asked if the provider manual does not say that every surgical extraction needs to be prior-authorized but only primary teeth and third molars, what is the provider's recourse other than to write an appeal. Ms. Howell stated she would get back with the TAC on this issue.

ANTHEM/SCION: Ms. Sweeney noted that all reports have been furnished to the TAC and that volumes have increased significantly from the first quarter to the second quarter. She reviewed the Powerpoint presentation in the booklet and explained the Claim Estimator which allows providers to know if a procedure will be paid for and what the payment will be before the procedure is rendered.

Mr. Dalton noted that at the last meeting, it was asked if Scion could query CAQH concerning the credentialing process. He stated all that is needed is the CAQH number and Scion can query the database and pull any information from there. Dr. Riley asked what the average turnaround time was for credentialing new providers and what other information is needed in order to expedite the credentialing package. Dr. Dalton stated that if everything is included in the CAQH outside of the Disclosure-of-Ownership information, that nothing else should be needed.

Dr. Lose asked about a new dentist who was trying to get signed up with Scion. The new dentist was on the web portal but he could not bill until certain forms were submitted. Mr. Dalton told Dr. Lose he would speak with him after the meeting to discuss this.

Ms. Patton disclosed that that effective January 1, 2015, Anthem's new dental vendor will be DentaQuest.

COVENTRYCARES/AVESIS: Dr. Caudill stated all the reports were provided in advance and he was available to answer any questions.

Dr. McKee asked about the data not being available on the percentage of pregnant women that receive a dental visit in a reported year. Mr. Harper noted that since this information is in two different systems, there was not enough time to pull this information together. Dr. McKee also asked about the percentage of Hospital Emergency Department presentations with a dental aspect. Dr. Caudill noted that he has put the ADA in touch with the Medical Directors and Dr. Langefeld to discuss how to integrate the two together. Dr. McKee asked about the significant jump in sealant services from the first to the second quarter, and Dr. Caudill noted that Avesis' mission is to increase sealant use across the state.

General Discussion: Dr. Riley asked about the quarterly reports that Dr. Sharpe was going to run to compare the ratio of extractions to restorative procedures. Dr. Caudill stated there is an explosion in extractions due to the Medicaid Expansion. Dr. Lose said the problem is that oral surgeons are either no longer taking Medicaid patients or are limiting their services to people under the age of 21. Dr. Caudill stated that part of the problem is due to the fee schedule and Avesis has gone to its partners with proposals on how to address this issue. Dr. Bobrowski noted that the KDA has sent

a letter to DMS requesting a 25% increase in reimbursable fees across the board for all procedures.

Dr. Riley brought up the issue of credit card reimbursements. Dr. Caudill stated that the virtual credit card program provides a streamlined approach to the payment disbursement process and provides better security. He did note that the provider letter that went out could have been clearer in explaining the payment program. It was clarified that if a provider does not want to participate in the credit card reimbursement system, the provider can call a Provider Services' rep to opt out of the credit card payment.

WELLCARE/AVESIS: Dr. Caudill stated that the reports were provided in advance. Ms. Russell noted that the second quarter information did not appear on the reports in the booklet and she will supply this to the TAC.

Dr. Akridge stated that WellCare is the only MCO that requires multiple teeth to be impacted in order to get orthodontic approval. Dr. Caudill stated that the Kentucky Revised Statute reads teeth, not tooth, and Dr. Akridge wanted it noted in the minutes that he would prefer it say any impacted tooth in the mouth other than a third molar.

Dr. Bobrowski asked why fee reimbursements were reduced 17 to 22% for posterior composites. Ms. Russell said she did not have an answer but would get a response back to the TAC within seven to ten days. Dr. Bobrowski noted that on the grid, there were two categories of D0150 codes with different pay amounts. Dr. Caudill stated that was because the KAR does not address D0120, therefore, the D150 has to be submitted twice but the second one for each year will be paid at the 120 rate as a recall visit.

OTHER GENERAL DISCUSSION: Dr. Riley noted that the TAC had some reports from DMS but no one from DMS was present to address the reports. She requested that the TAC would like to have the utilization reports either by procedure code or by service type, and Ms. Anglin stated she has forwarded that request.

ISSUES TO BE DISCUSSED:

NETWORK ADEQUACY: Dr. Riley noted that this has been addressed by the MCOs.

ORAL SURGEONS: Dr. Riley noted that this has been discussed.

NON-PAYMENT OF CLAIMS RELATED TO TAXONOMY: Ms. Howell of CareSource stated that every provider enrolled with Medicaid needs to make sure the taxonomy on their claims is what is on file with DMS. She noted that CareSource will start administratively adjusting claims if there is a one-to-one match.

Ms. Howell informed the TAC that ADO's expire April of 2015 and NPI's expire October 30, 2014. Dr. Rich noted that there is most likely going to be legislation proposed to extend the time limit and he suggested that the KDA may want to advocate for this. Dr. Caudill stated that DMS approved a change form to allow providers to supply the information to Avesis who scrubs the information and then, in turn, sends it to DMS, and Ms. Howell stated that CareSource does this as well.

NO SHOWS/FAILURES: Dr. Rich stated the only places where there has been a reduction in this or any success has been areas where there is a community outreach person in place. Dr. McKee noted that the Department for Public Health and the Cabinet are applying for a State Plan Amendment to allow the State Plan to underwrite the services of a community healthcare worker that would include dental navigation.

Dr. Riley reported that her take-away from the MCO forums was that providers think that if MCOs now use gift cards to incentivize members to get their annual dental exams, they could also use the gift cards to motivate members to show up for a certain number of treatment appointments without fail. That incentive would improve healthy outcomes for members, decrease emergencies, and be a win/win for all.

A motion was made by Dr. Akridge and seconded by Dr. Lose to adjourn the meeting. No date was set for the next meeting.

(Minutes were taped and transcribed by Terri Pelosi, Court Reporter, this the 8th day of October, 2014.

9/23/14 HH TAC Meeting Notes

Housekeeping

- Appointment of Billie Dyer to fill 5th position on HH TAC
- Kathy Clements- Coventry, Holly Garcia-Coventry, Matt Fitzner-Anthem, Peg Patton- Anthem, Helen Homburger- Humana, Mary Hyatt- Humana, Nicky Martin- HP, Pam Smith- HP, Greg Stratton- HP
- Susan motions to approve minutes from July, Billie seconds, minutes approved. Minutes were posted on the website.

Meeting Content

- Pam Smith updates fee for service, providers have to enroll as the new PDN provider even if they are a licensed home health agency. Two are currently enrolled, other than that, no one else. Sharon requested the enrollment application to be sent to her. Once received, KHCA will send out to the membership. (Should be forthcoming and will be sent to the list serve as soon as possible. You can also do attendant care under PD as well).
- Susan Stewart asked how long the application takes to get approved, and Pam said she would have Veronica or someone from provider enrollment send that out.
- For PDN there are rates that are max fees per unit. There are actual rates. A supply schedule with a fee. Traditional fee for service. Prior authorization has to be obtained for supplies and PDN.
- Sharon asked if there are many patients enrolled in this, and Pam answered that she only has one.
- Incident reporting has always been mandated but can be maintained in a log book or on your EMR under incidents as long as a policy indicates that is where you will maintain and all staff understand how to access.
- Prior-auths: Anthem will fax back as well as give paper documentation other MCOs are following suite.
- Sharon asked where are we in the process of Open Enrollment. Pam Smith says they are working on printing letters. We don't know the exact dates yet. Someone will email it to Sharon. UPDATE: Anthem received email back during meeting. Current Open Enrollment is October 27th-December 12th.
- Never get approval for 6 weeks on PICC lines even though that is what the physician usually orders. Is there some way that it can be communicated or

worded to get the approval. Billie says this will also come into play with anything high risk that will put a patient back into the hospital. Holly Garcia said she will take that back with her and work on it. Matthew Fitzner said they will be happy to try and work something out.

- Susan brought up a waiver plan of correction from survey for 10, 11, and 12. Greg Stratton says they were behind. Eleanor says she believes the homepage on the DMS website says to look there first because she thinks it doesn't go back all the way to 10, she thinks it started in 12.
- **Revalidation letters received from Provider Enrollment needs to be acted upon quickly or your CMS 855 if its in the past 24 months or they will suspend you.**
- Pending Authorizations were handed out to all MCO's from a provider agency, asking that they all reach out to the staff who submitted those issues. All MCOs were involved. Sharon asked how to best handle a situation where a family wants to request more supplies. Eleanor says the caps were put on incontinence supplies for that very reason. An agency has the ability to provide one to two cases per month with prior authorizations.

Updates from the MCO's:

- Coventry says they will be switching over the Aetna's system as the New Year approaches and all information will be provided as it comes available.
- **Anthem says prior to 1/1 people will be seeing a new logo, the blue cross blue shield will still be there but they will be branding the Medicaid members differently. Effective 10/1 is when they will start sending payments for Medicaid on a separate remit.**
- Humana doesn't have any major announcements that they can share. Something new will come out in 2015 but she cannot share yet.
- Nothing from HP
- Wellcare was not present (but information given to Wellcare at the MAC meeting two days later.)

Next meeting: November 18th at 11am

KENTUCKY HOSPITAL TAC MEETING MINUTES
Health Services Building
275 East Main Street
Frankfort, Kentucky

October 30, 2014
1:15 p.m. EST.

The meeting of the Hospital Technical Advisory Committee (TAC) was called to order by Carl Herde, Chair.

The TAC members in attendance were: Carl Herde, Russ Ranallo (phone), Danny Harris (phone), and Michelle Lawless (phone). Ex officio members either in attendance or on the phone were: Tandi Keeling, Kyle White and Nina Eisner. Other provider representatives in attendance or on the phone were: Elaine Younce and Jeff Presser.

Medicaid staff in attendance was: Neville Wise, David Dennis, Barbara McCarter, Brian McFarland, Veronica Cecil, Samantha McKinley, Leeta Williams and Trista Chapman.

Others in attendance were: Renae Blunt, Scott Simerly, Tara Clark, and Jon Galliers, Myers & Stauffer; Nancy Galvagni and Steve Miller, Kentucky Hospital Association; Candice Bowen, WellCare; Prentice Harvey, lobbyist for Norton Healthcare.

Mr. Herde called the meeting to order.

NDC'S – Status of Subcommittee: Mr. Herde asked Samantha McKinley, Pharmacy Director at DMS, what information she would need prior to a meeting that David Dennis will be setting up to discuss NDC's. She noted she would like to have the information and data that came from the committee that had met in the past and she requested that a statement be prepared outlining the issues to be addressed.

Behavioral Health: Ms. Veronica Cecil with DMS was present to answer questions. Ms. Eisner asked for clarification or interpretation concerning Medicaid's fee-for-service rate, the Behavioral Health Services Organization (BHSO) rate and how that interfaces with the previously published EPSDT Chemical Dependency-Intensive Outpatient Services' (CD-IOP) rate. Ms. Cecil noted that this was overlooked by DMS while working on Medicaid expansion and that DMS will take a closer look at it to see what can be done to make it more in line with the practice of Intensive Outpatient Services (IOP).

Ms. Eisner again asked that DMS consider ways to remove the Medicaid Institutions for Mental Diseases (IMD) exclusion for freestanding psychiatric hospitals to be paid for inpatient care delivered to adult Medicaid patients over 21 or under 65 so that the Cabinet can realize their vision of fully integrated care.

Ms. Eisner asked for clarification on the issue of hospitals being prohibited from offering crisis stabilization on their campuses. Ms. Cecil stated that DMS would take this into consideration and she would have to look into how CMS viewed this. Ms. Cecil also noted that hospitals can open a new line of business outside of their facilities.

Credentialing – Requiring MCOs to have payments retroactive to date of application and how credentialing process has been going with MCOs: Ms. Cecil stated DMS has not looked at what other states do about retroactive payments with an MCO but that DMS is willing to do this. She noted that one MCO had a concern that due to NCQA guidelines, the MCO was not allowed to pay a provider until the provider is credentialed.

Ms. Cecil stated that an MCO can have its own policy with regard to how they credential and contract a provider. She stated that DMS has been looking at other states to see what their best practices are and how to remove barriers to make this process easier. Ms. Cecil stated that early next year, DMS will be launching an online enrollment process to allow quicker processing of applications and this will be for initial enrollment and for maintenance documents. It will also include a more automated process for checking licenses so that providers no longer would have to send in their license for update.

DRG Regulation – Phase-in Recommendation: Mr. Wise noted that the regulation provided to the TAC is a draft that was prepared by Myers & Stauffer and that Stuart Owens is reviewing the draft. Ms. Galvagni noted an error on page 7 of the Definitions under hospital-acquired condition. She stated it's making a change to say that a hospital-acquired condition is one that's recognized by the APR-DRG grouper and it is deleting CMS, and she noted that that's

an error because DMS adopted a CMS list of hospital-acquired conditions.

Another concern brought up by Ms. Galvagni is getting the wording changed in the regulation on the rebasing. This regulation is stating that DMS will rebase only fee-for-service claims and this will not be statistically valid for calculating hospital rates.

Mr. Wise stated that the goal of DMS is not to have MCOs be dependent on DMS' rate-setting, and that it will be 2019 before the rebasing will be based on just the Medicaid population. Mr. Wise stated DMS will have MCO data to validate the numbers. Mr. Herde asked how many other states are doing their rebasing in this manner and Mr. Wise stated that Myers & Stauffer has not looked at that yet. Mr. Herde asked if this is information that could be provided to the TAC.

Ms. Galvagni asked that administrative costs to hospitals will increase by developing a fee-for-service only DRG system which will be unusable for the MCO population. This is because hospital contracts tie MCO payment to the DMS DRG rates, so every hospital contract with five different MCOs will have to be renegotiated. Many could be terminated, and even if new rates are set, it will be more work on hospitals to keep up with five different rate systems and the fee-for-service system for Medicaid patients. Ms. Galvagni noted that MCOs are always free to negotiate a different type of payment with providers, but by changing the fee-for-service system, it will force a change in all MCO rates. Ms. Keeling noted that the administrative burdens are becoming too great on hospitals in every aspect, and she stated that the more data available, the better off hospitals are to get a better rate with the MCOs.

Mr. Herde asked what the overall administrative cost of the Cabinet is as it relates to the management of Medicaid and would the administrative costs be lower since so much of the covered lives are now covered by the MCOs. Mr. Wise stated that as a percent of benefit expenditures, it's less than what it has been and that it has been flat-funded on the administrative side. Mr. Wise notes that DMS is the lowest or second lowest admin state in the nation as a percent of total benefits paid.

Mr. Herde asked how DMS will determine how much the MCOs get paid to manage the care with the assumption that DMS would need the claim data from the MCOs to set the funding that the MCOs are to receive. Mr. Wise stated acknowledged that DMS does receive claims data from the MCOs and stated that DMS is looking at the MCOs' encounter data and financial statements for 2012 and 2013 to set the rates that will be paid in July, 2015.

Mr. Ranallo stated that Owensboro Health's contracts are tied to the Medicaid rate and that if there is a change in the DRG rate, nothing goes in automatically and the MCOs will have to pay the old rate until there is an agreement on new rates which the MCOs will not do and this will cause termination of contracts. Ms. Lawless stated that The Medical Center echoes this opinion. Mr. Wise reiterated that it is over four and a half years before rebasing based on only Medicaid fee-for-service claims would affect the rate and that a lot could happen in that time frame.

Coding Adjustment: Ms. Galvagni stated KHA believes there is a fundamental flaw with the coding adjustment and requests this be taken out of the regulation. She stated that the claims that will be used to set the initial statewide Case Mix Index (CMI), October, 2014 through September, 2015 may be understated because ICD-9 codes will be used as the ICD-10 coding will not begin until October, 2015, thereby causing the target case mix index to which a 2% limit is applied to never be correct for future years.

Mr. Simerly of Myers & Stauffer stated that the expected outcome between ICD-9 and ICD-10 is within a quarter of a percent and that ICD-10 is used around the world already. Ms. Keeling noted that the United States is the only country that will be using ICD-10 for reimbursement purposes.

There was discussion by Ms. Galvagni concerning confusion in the language on page 26 of the regulation regarding when the APR-DRG relative weights would be adjusted. In between rebasing periods, the regulation states that base rates will be updated each July, but the regulation is worded to update the grouper every October which is when the weights could be reduced for the case mix limit. As written, the case mix limit would be calculated each July using claims on a federal fiscal year basis. Mr. Wise stated DMS could possibly change these time frames and stated the Department would review this language.

APPEALS: Ms. Galvagni stated that KHA is opposed to the changes in the Appeals' section of the regulation and that the language should remain as it is currently stated in the existing DRG regulation.

Ms. Galvagni asked about the timetable for the regulation. Mr. Wise stated DMS would review the comments made at the TAC meeting and the final version of the regulation would need to be submitted to the Administrative Regulation

Review Subcommittee by November 7, 2014. It could be shared with the TAC at that time.

No future meeting date was set. The meeting was adjourned.

(Minutes were taped and transcribed by Terri Pelosi, Court Reporter, this the 10th day of November, 2014.

Nursing Technical Advisory Committee
November 7, 2014

Summary of Agenda Items:

1. MCO Refund Requests

Many practices are receiving notices from the Medicaid MCOs requesting refunds for over payments. These requests arise after the MCOs audit their records and determine that overpayments have been made on regular visits or that the provider has been paid for more than two (2) level four/five visits. Some of the refund requests are for significant amounts. Practices run on a very tight budget and these unexpected requests for refunds could, in some instances, be enough to cause the practice to close. No one wins when that happens- not patients, not providers and not Medicaid.

It is almost impossible for providers to determine if they are being overpaid. The MCOs set their rates and the EOBs reflect the rate that the MCO has paid to the provider. The provider does not know that the rate recorded on the EOB is incorrect. Secondly, it is not possible for providers to determine if a patient has had more than two level four/five visits in a year.

2. Limitation on Level 4/5 Visits

Kentucky struggles to meet health standards (United Health Foundation, 2012). This is especially true with regard to chronic, complex health problems such as diabetes (41st), cardiovascular disease (43rd), premature death (44th), obesity (40th), and smoking (50th). Patients who have chronic problems require more attention and higher levels of scrutiny at health care visits. Kentucky providers are expected to provide evidence-based care and meet nationally accepted standards of care, or they will be penalized by the Physician Quality Reporting System (PQRS) if standards are not met. The Center for Medicaid and Medicare Services (CMS) has established national standards for level of care, documentation, and reimbursement for all patient visits. These standards are based on extent of history, physical examination, diagnosis, treatment and overall complexity of the visit. As previously noted, many people in Kentucky suffer from diabetes, heart disease, COPD and obesity. Providing appropriate care for these individuals is a Level 4 visit. While providers are required legally and ethically to provide the appropriate level of care to the patient and document that care, the situation created by this limitation continually forces providers to down code visits. The down coding results in inaccurate data on patient visits.

3. Physical Exams

Currently, Medicaid and the MCOs limit participants to one physical exam per year. Many people require more than one physical exam per year. This is particularly true for children who are required to receive school physicals and six months later may be required to receive a sports physical. Additionally, there are children who are placed in foster care who require a physical exam each time they are placed in a new home. There are a myriad of other reasons that a person may require more than one physical exam in a year's time. The requirements for some of the exams are different, so it is not a matter of providing a "one size fits all" exam.

Further, if the person has had a physical exam performed and billed by another provider, and the second provider is not aware of previous exam, the second provider's claim will be denied.

It was interesting to note that Anthem, in a recent DMS publication that compared the services of the MCOs, listed "Free annual sports physicals for members 6-18". This advertisement is encouraging parents to bring their child in for a sports physical, for which the provider may not be reimbursed.

4. Annual APRN License Renewal

Each year APRNs are required to renew their professional license. Nursing licenses expire on October 31 of each year. Medicaid requires APRNs to mail in notification of their license renewal via the postal service. If the notification is not received by DMS by November 1 of each year, the APRN is considered to have a lapsed license and therefore Medicaid patient prescriptions are denied at the pharmacy and payment claims are not accepted. Clearly, there are problems with this system. It is a huge waste of paper; 2000+ extra pieces of mail coming in to DMS in the month of October has to cause some sort of extra work and handling by staff; and mail can get lost. APRNs worry if their medication prescriptions will be accepted at the pharmacy on November 1, for there is no way to verify prior to that date if the license verification was received at the Medicaid offices.

5. Reimbursement

Kentucky is one of only four states that reimburse APRNs at 75% of the physician rate. The majority of states pay at 100%. If Medicare is the metric and pays at 100%, then private insurance pays 110-120% and Medicaid pays physicians at 73%. A 75% reimbursement rate for APRNs translates to 54.75% of the Medicare rate.

In order for APRNs to participate in Medicaid, the reimbursement rate must improve. Currently, APRNs receive about \$23.00 for a Level 2 visit, \$33.00 for a Level 3 visit, and about \$50.00 for a Level 4 visit (which are

limited to 2 per year). These fees are not sufficient to cover the overhead costs of running a practice.

The physician Medicaid rate of 73% is also a low national rate, and hasn't budged since 1993 (Jasper & Hunt, 2012). The Primary Care Medicaid Rate Increase, which applies only to physicians, will provide a temporary bump in payment in order to attract primary care physicians to Medicaid but will stop in 2015. In order to avoid a bait and switch fee system that leads to provider withdrawal and care disruption, Kentucky should consider adjusting the Medicaid physician reimbursement rate higher than the currently low 73% rate.

Low reimbursement levels have multiple bad effects—providers limit Medicaid patient caseloads, providers choose not to participate in Medicaid at all, or systems compensate by having providers just see more and more patients. Certainly it is part of the explanation for the fact that 63% of the primary care need is met in rural settings in Kentucky and that only 22% of primary care provider physicians accept Medicaid (Deloitte, 2012).

Lack of participation limits patient access. Lack of access to care leads to poor health outcomes and increasing health care costs. We are talking about increased hospitalizations, readmissions and use of the emergency room, which are significantly more expensive than outpatient visits.

Recommendations

1. MCO Refund Requests
 - a. On the repayment of refunds, the TAC request that the payback period match the look back period; that payments retained by payers from future remits be equal to the total percentage of claims paid during the look back; and that payments not be withheld at 100% until fully refunded. This would aid with practice cash flows and not jeopardize the providers' ability to continue services.
 - b. The TAC requests that there be more transparency on rates paid to providers, with providers receiving a list of the reimbursement that the MCO is paying to that provider. MCOs should be required to honor the reimbursement rate noted on the EOBs sent to providers. The MCOs should not be permitted to decide two (2) years later that the fee paid and posted on the EOB was incorrect.

2. Limitation on Level 4/5 visits
 - a. The TAC requests a legal justification from DMs for limiting level four/five visits to two visits per patient per year, while at the same time requiring providers to meet nationally accepted standards in the provision of care.
 - b. If the limitation is to remain in place, the TAC requests real time notification from DMS or the MCOs that the patient has exceeded the two (2) visit limitation.
 - c. Does the two (2) level 4/5 visit restriction apply to any level 4/5 visits the patient may have had with any provider, or is it per patient, per provider, per year?

3. Limitation to one (1) annual physical per year
 - a. The TAC requests a report of claims denied for well child annual visits because an exam was already done.
 - b. Is the limitation per calendar year or is it a rolling date?
 - c. The TAC requests a minimum of two (2) physical exams per year be permitted
 - d. The TAC requests that providers be notified in real time if a patient has met their limitation on physical exams for the year.

4. APRN License Verification

The TAC requests that DMS reduce paper waste and improve utilization of staff time by accepting a single electronic file from the Kentucky Board of Nursing, within 30 days of the deadline for licensure renewal, that lists all APRNs who have renewed their license each year. TAC requests that DMS not automatically drop APRNs from Medicaid on November 1, but extend that deadline to November 30.

5. Reimbursement

The TAC requests that DMS and the MCOs provide improved reimbursement for APRNs at 90 % of the physician rate and increase the physician rate to 90% of the Medicare rate.

Respectfully submitted,

Elizabeth Partin DNP, APRN
Chair

Duane Parsons, Chair
Bob Oakley, President
Chris Clifton, President-Elect

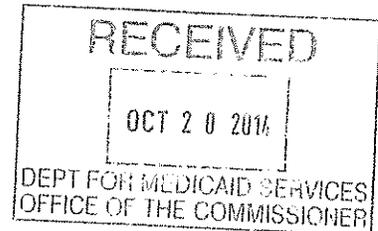


Brooke Hudspeth, Secretary
Glenn Stark, Treasurer
Robert McFalls, Executive Director

October 9, 2014

Commissioner Lawrence Kissner
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621

*FOR STAFF MTG
& MAC*



Re: Association's Appointments to Pharmacy TAC

Dear Commissioner Lawrence Kissner:

In accordance with KRS 205.590 the Kentucky Pharmacists Association is pleased to present the appointees for the technical advisory committee on pharmacy to the Advisory Council for Medical Assistance. The Kentucky Pharmacists Association Board of Directors appointed the following five Kentucky Pharmacists for appointment to the Committee.

Those names are:

- Cindy Gray
- Susan Francis
- Christopher Betz
- Jeff Arnold
- Robert Warford

If I can provide additional information or assistance please do not hesitate to call my office (502) 227-2303 or by e-mail at rmcfalls@kphanet.org.

I appreciate the partnership that we have with you and the Cabinet. With that in mind, know that we are available to assist you at any time.

With Regards,

Robert L. McFalls
Executive Director

cc: Samantha McKinley

Physicians' TAC Meeting

Date: 9/18/2014

Attendees:

Lee Guice
Charles Douglass
Tammy Ricks
Jeremy Armstrong
Lindy Lady
Jessica Williams
Stephanie Woods

Call In:

Dr. Don Neel, MD
Dr. Mitchell Wicker

A quorum was not present so no official business was conducted.

KMA will be appointing some new members-as soon as the letters go out-next two weeks

Topic: Medicaid and MCO update enrollment update

Discussion: Recertification of pediatric patients-patients are not being notified, is there auto assignment to a particular MCO, members being randomly placed with MCO, glitch in the enrollment process. Providers can check eligibility. Advise members to contact MCO to make any changes.

Topic: Retroactive Cards

Discussion: After recertification, the new card it is not retroactive back to the end of the last card. Upon recertification there was a box to check "are there any outstanding medical bills?" that box has been removed.

Topic: Coventry Issues

Discussion: Still having issues getting prior authorization for NEMT out of state travel for medical necessity. If patient has issues with treatment they must contact MCO to request any changes. Member can dis-enroll for cause by contacting MCO to make the change.

Topic: Wellcare Issues

Discussion: Copay listed on card, MD collected copay, in audit MD had to refund copay due to switch in MCO, MD must contact MCO for correction.

Topic: Future Reimbursements ACA & WRAP Payments

Discussion: ACA renewal for 2015. Would like to continue enhanced payments in future. Dr. Neel will discuss further at MAC meeting next week.

Recommendations to the MAC

Prepared by the Primary Care Technical Advisory Committee

Presented on September 25, 2014

The Primary Care Technical Advisory Committee met at 10:00 AM on Thursday, September 11, 2014. The only agenda items concerned the automated wrap payment, wrap payment reconciliation back to 11/1/11 and dual eligible payments to RHCs and Community Health Centers that CMS has determined is the responsibility of the State. DMS had been making wrap payments to the more than 150 Community Health Centers and Rural Health Clinics based on estimates calculated via a state recommended process tying eligible face-to-face patient encounters to MCO paid claims. On July 1, 2014 this process was automated by DMS and reconciliation for the previous 2 years and 8 months began. The automated system exposed a number of issues, not the least of which was that many claims paid by the MCOs were not in the DMS system. We see a number of reasons for this and actually are not pointing the finger of blame at any party. We view this as a partnership between the MCOs, DMS and the providers represented by the TAC and KPCA. And we believe it will take all of us working together to resolve the problems.

At the September 11 meeting, a majority of the TAC members were present, along with DMS staff. Additionally, four of the five MCOs were present for the discussion. The 5th MCO was in contact via e-mail during the meeting.

The affected providers and the Kentucky Primary Care Association were directed by DMS to bring the problem they perceived as incomplete claims data submission to the attention of the MCOs. This was done with a series of individual meetings, phone calls, personal discussions and a formal letter to senior management of each MCO by the Kentucky Primary Care Association requesting that the MCOs comply with claims data transmission requirements contained in the contracts between the MCOs and the State.

After a lengthy discussion with DMS and the MCOs at the TAC meeting the following recommendations are directed to the MAC:

1. The Primary Care TAC requests that DMS recognize and approach these issues in partnership with the providers and MCOs and work together on a commonly shared problem affecting over 180 clinics across the State.
2. The Primary Care TAC requests there be joint meetings between DMS, the MCOs and the affected parties to work on the resolution of the wrap and outstanding issues related to payment for Medicare/Medicaid dual eligible claims.
3. The Primary Care TAC requests that DMS deal with the resolution of the issue with Kentucky Spirit since there is a formal court ruling involving the contract DMS held with

Kentucky Spirit and the State and it does not appear the providers can intervene, even on their own behalf.

4. The Primary Care TAC recommends that a working group including the TAC, DMS and the MCOs be established to sample, test and resolve the reconciliation process (all claims prior to June 30, 2014) to assure all data is being captured, to avoid misunderstandings by any party and to avoid confusion, as well as duplication of effort which will only result in extending the length of time needed to resolve the matter.
5. The Primary Care TAC recommends that for the dual eligible claims, DMS instruct the MCOs to transmit a \$0 paid amount instead of a denial when the claim is processed to DMS.

Recommendations to the MAC

Prepared by the Primary Care Technical Advisory Committee

Presented on November 20th, 2014

The Primary Care Technical Advisory Committee met at 10:00 AM on Thursday, November 6th, 2014. A majority of TAC members were present, along with DMS staff. Additionally, four of the five MCOs were present for the discussion. Agenda items included:

- The automated wrap payment.
- Wrap payment reconciliation back to 11/1/11, including the reconciliation spreadsheet, timeline, Kentucky Spirit claims, and the claims resubmission process.
- Dual eligible payments to RHCs and FQHCs.
- EOB data received by clinics.
- Billing for 99211 nursing visits.
- Past recommendations accepted by the MAC.

Since September, significant progress has been made in addressing the automated wrap payment process. KPCA facilitated the scheduling of meetings between primary care providers, MCOs and DMS, which assisted all parties in identifying and resolving issues that were hindering the submission and processing of clean claims. As part of this process, DMS has asked providers to complete reconciliation spreadsheets for the months of July and August. This has been an incredibly time consuming task, but should improve the automated system moving forward.

Primary care providers have also been waiting for DMS to begin the wrap payment reconciliation process for dates of service going back to November 1, 2011 through June 30, 2014. We have been told that providers will begin receiving data on paid claims starting the end of November and will be asked to complete a similar reconciliation spreadsheet to identify any claims that are due a wrap payment. As part of this process, we discussed with DMS staff how to handle the reconciliation of Kentucky Spirit claims and the re-submission process for claims that were incorrectly denied or reimbursed.

The issue of dual eligible payments was also discussed. While CMS has determined that these payments are the State's responsibility, reconciliation has still not occurred. The primary concern raised by providers is that some claims that should be processed as \$0 pay by the MCO in order to receive a wrap payment from DMS have instead been denied. DMS requested that KPCA raise this issue with the MCOs at our monthly operational meetings.

One final issue that we want to raise before the MAC is the status of recommendations accepted by the MAC. We are concerned that formal recommendations made by the TAC and

accepted by the MAC are not being addressed or followed-up by DMS. We would appreciate clarification on this process.

The following recommendations were accepted by the MAC in September and have not been addressed by DMS to our knowledge:

1. The Primary Care TAC requests that DMS recognize and approach these issues in partnership with the providers and MCOs and work together on a commonly shared problem affecting over 180 clinics across the State.
2. The Primary Care TAC requests there be joint meetings between DMS, the MCOs and the affected parties to work on the resolution of the wrap and outstanding issues related to payment for Medicare/Medicaid dual eligible claims.
3. The Primary Care TAC requests that DMS deal with the resolution of the issue with Kentucky Spirit since there is a formal court ruling involving the contract DMS held with Kentucky Spirit and the State and it does not appear the providers can intervene, even on their own behalf.
4. The Primary Care TAC recommends that a working group including the TAC, DMS and the MCOs be established to sample, test and resolve the reconciliation process (all claims prior to June 30, 2014) to assure all data is being captured, to avoid misunderstandings by any party and to avoid confusion, as well as duplication of effort which will only result in extending the length of time needed to resolve the matter.
5. The Primary Care TAC recommends that for the dual eligible claims, DMS instruct the MCOs to transmit a \$0 paid amount instead of a denial when the claim is processed to DMS.

Finally, the Primary Care TAC submits the following recommendations to the MAC:

1. The Primary Care TAC recommends that DMS include additional identifiers on EOBs – such as: MCO Member ID, claim number, subscriber number and patient name – in order to allow clinics to reconcile payments more efficiently.
2. The Primary Care TAC recommends that DMS add a legend to the reconciliation spreadsheet to provide clear definitions for the column headers to ensure accuracy when completing the spreadsheet.
3. The Primary Care TAC recommends DMS extend the current timeline for providers to complete the wrap payment reconciliation process from 30 days to 60 days to allow clinics more time to review their data.



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

Steven L. Beshear
Governor

275 East Main Street, 6W-A
Frankfort, KY 40621
P: 502-564-4321
F: 502-564-0509
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

November 19, 2014

TO: Medicaid Advisory Committee (MAC) Board Chairwoman Partin and MAC Board Members

RE: Response to Primary Care Technical Advisory Committee (TAC) Testimony Presented at the September 25, 2014 MAC Meeting

Dear Chairwoman Partin and MAC:

We are writing to address testimony presented by the Primary Care TAC at the September 25, 2014 MAC meeting.

Primary Care TAC Recommendations:

1. The Primary Care TAC requests that DMS recognize and approach these issues in partnership with the providers and MCOs and work together on a common shared problem affecting over clinics across the State.

RESPONSE: DMS continues to work together with the MCOs, the TAC, and numerous providers to address all issues pertaining to the WRAP. MCO representatives have been present at the last two Primary Care TAC meetings. DMS identified the issues of this process as being a global issue and we are working with the MCOs and the providers toward rectifying the issues.

2. The Primary Care TAC requests there be joint meetings between DMS, MCOs and the affected parties to work on the resolution of the wrap and outstanding issues related to payment for Medicare/Medicaid dual eligible claims.

RESPONSE: As stated in the previous response, these issues are being addressed with the attendance of the MCOs at the TAC meetings. With regard to the dual eligible (AKA crossover) claims, DMS discussed this with each MCO that the claims should be sent as a \$0.00 paid claim. The automated wrap payment system does not look at denied claims, it only considers paid claims. While generally the MCOs pay little to nothing on these claims, the encounters must still be allowed to process so they can be considered for the wrap payment. If the MCO deems the Medicare paid amount is above its customary charges, then the MCO should pass that on to DMS as a \$0.00 paid claim, not a denied claim. DMS brought this to the attention of the Primary Care Association as well as providers that have inquired about this matter so they are aware of the direction given to the MCOs. See #8 and #9 of the attached Wrap History document.

3. The Primary Care TAC requests that DMS deal with the resolution of the issue with Kentucky Spirit since there is a formal court ruling involving the contract DMS held with Kentucky Spirit and the State and it does not appear the providers can intervene, even on their own behalf.

RESPONSE: We are currently in litigation with Kentucky Spirit and cannot discuss this matter with the TAC at this time due to legality issues. However, DMS is addressing it by allowing providers a 30-day review period of the reconciliation data and to identify any claims as missing from the data (including Kentucky Spirit). A letter will be going to providers in the near future regarding this process. -See #12 and #13 of the attached Wrap History document.

4. The Primary Care TAC recommends that a working group including the TAC, DMS and the MCOs be established to sample, test and resolve the reconciliation process (all claims prior to June 30, 2014) to assure all data is being captured, to avoid misunderstandings by any party and to avoid confusion, as well as duplication of effort which will only result in extending the length of time needed to resolve the matter.

RESPONSE: This will be difficult to achieve in a timely manner. In lieu of a working group, DMS is working one-on-one with the facilities by sending the facility the reconciliations and the encounter data, having the facility identify inconsistencies with their data, and then DMS and the facility will work with the MCO to get the data corrected and updated.

5. The Primary Care TAC recommends that for the dual eligible claims, DMS instruct the MCOs to transmit a \$0 paid amount instead of a denial when the claim is processed to DMS.

RESPONSE: Please see response to Recommendation #3.

Sincerely,

November 19, 2014

Page 3

Erin Hoben
Chief Policy Advisor
Commissioner's Office
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services
Neville Wise, Deputy Commissioner, Department for Medicaid Services
Lisa Lee, Deputy Commissioner, Department for Medicaid Services
Dr. John Langefeld, Medical Director, Department for Medicaid Services
Tammy Branham, Director, Division of Financial Management, Department for
Medicaid Services
Barbara Epperson, Resource Management Analyst III, Department for Medicaid
Services

1. In November 2011, Managed Care was implemented and the Managed Care Organizations (MCOs) were allowed to set their own rates. However, that placed the responsibility on the Department for Medicaid Services (DMS) to pay the difference in what was paid to the RHC/FQHC facility and their PPS rate.
2. DMS first addressed this issue in November 2011 by beginning to issue monthly supplemental payments based upon each facility's historical average payment. In addition, the Department started looking into ways to modify the Medicaid Management Information System (MMIS) to automate this process to make this a seamless process for the facilities.
3. The planning and development stages of the automated payment process took time to design as there were many facets to the process that needed to be considered and addressed. In June 2013, the automated process was turned on to test the process but had to be terminated in September 2013 after the payment amounts were processing far less than anticipated. However, DMS continued to process the supplemental payments during this entire testing phase of the automated process and the months that followed.
4. DMS received several complaints from facilities stating that the monthly supplemental payments were not enough so DMS completed "Interim Reconciliations" for all facilities for the November 2011 through September 2013 period using the facility's self-reported information in an attempt to make them whole. The intention was to process "Final Reconciliations" for this period using the MCO encounter data sometime around August 2014. DMS did not intend to process an Interim reconciliation for facilities for the 10/1/13 through 6/30/14 time period but planned to process a Final reconciliation for that time period beginning in March 2015. The reason for this delay was to ensure all claims were incorporated to constitute a "Final" for that time period. DMS needed to allow for the timely filing of claims. The timely filing period with the MCO's is 6 months, therefore in order to ensure DMS incorporate all claims for the time period, DMS needed to wait until after December 2014. The MCO's then have up to 30 days to forward the corrected encounter to the Department which is why March 2015 was stated as the anticipated date.
5. This anticipated process sparked multiple complaints from many facilities and the TAC. After the Primary Care TAC meeting on 7/21/2014, DMS decided to change this process. A new "Preliminary Reconciliation" will be processed using the MCO encounter data that the Department has received from each MCO's and will now incorporate the claims with dates of service 11/1/2011 through 6/30/2014. Then, DMS will pull the data again (approximately March 2015) for the exact same time period for a "Final Reconciliation" as planned to bring in any timely filing claims we have received since the preliminary reconciliation was processed.

DMS advised the MCO's that the encounter data needed to be addressed and that DMS would be implementing various penalties and withholds on the MCO capitations to further address the encounter issues. The automated process was turned back on in July 2014 for services since July 1, 2014. The facilities were given multiple versions of notifications from DMS and the Primary Care Association advising them the supplemental payments were stopping and the automated process was scheduled to be implemented on July 1, 2014. Upon implementing the process, it was discovered that some providers were not properly enrolled with DMS' Provider Enrollment. DMS worked with these providers to get the, enrolled correctly and had the payments issued.

6. Several facilities also asked for a face to face discussion with DMS pertaining to the data used for the reconciliations. DMS met with approximately eight providers to discuss their situations and to provide them a complete listing of the encounter data. After they had ample time to review the data, they were to follow up with DMS on any issues they noticed with the data.
7. Based upon research of sample claims submitted to DMS by various providers, it was determined that some encounters were being submitted to DMS with only the rendering provider information and that Dual Eligible claims were being sent in as denied claims when they should have been sent in as \$0.00 paid claims. The exclusion of the Billing Provider information makes it impossible for DMS to tie the paid claim to the FQHC/RHC facility. This is the main contributing factor to the absence of claims on the reconciliations as well as providers not receiving any wrap payments for paid claims via the auto payment process that was implemented in July 2014.
8. Commissioner Kissner and Deputy Commissioner Wise met with all of the active MCO's individually to escalate attention to the FQHC/RHC wrap situation as well as to address the submission of correct data to DMS. As a result of this meeting, a spreadsheet was sent to the MCO's to populate with data for claims paid to any PCC, FQHC, and RHC for dates of service between November 1, 2011 and June 30, 2014. It took the MCO's a couple of weeks but the data was received from all MCO's, with the last one submitted on Thursday, 10/2/2014.
9. A review of the data was completed to ensure that DMS can correctly identify the facility that received reimbursement by comparing the submitted NPI, Taxonomy, and/or Tax ID to the data DMS has within the MMIS. Due to the size of the data, this review did take some time but DMS staff worked around the clock as this was considered a high priority.
10. The results of DMS' review of the MCO submitted data dump of claims determined that the data was too flawed to use and maintain the integrity of the data. DMS determined to use the encounter data again.

11. DMS pulled the encounter data again and worked up the database to be delivered to Myers & Stauffer to restart processing the Preliminary Reconciliations. DMS will use the Kentucky Spirit encounters currently in the MMIS during the reconciliation process.
12. The reconciliation database was delivered to Myers & Stauffer on Friday, November 14, 2014. The Preliminary Reconciliations will be processed for the PCC's first due to satisfy date constraints within current litigation. Then Myers & Stauffer will process the Preliminary Reconciliations for all FQHC/RHC facilities. As part of the reconciliation process, a disk of the claims and a spreadsheet layout will accompany each summary sheet sent to the facilities. If there are still any claims that the facilities have identified as missing from the data (including Kentucky Spirit), the facility will have 30 days from the date of the letter to forward the information to DMS for consideration. If additional time is needed, DMS will consider an extension on a case by case basis. Facilities need to understand that this information is subject to future State and/or Federal auditing. A final reconciliation will still be processed in 2015 to consider any timely filings.
13. DMS is also working with the MCO's to clean up their data for dates of service July 1, 2014 and after to address certain issues (such as the rendering versus billing provider information) that are preventing the processing of the wrap during the auto payment process. There are also issues that may require interaction between the facility and DMS provider enrollment to update the provider profiles. As part of this process, DMS has requested all FQHC and RHC facilities to complete a spreadsheet with all claims they have received payment from the MCO. DMS is using this data to identify and issue any payments due to facilities from DMS and to identify any further issues with the encounter data received and/or not received from each MCO.

**Kentucky Technical Advisory Committee on Therapy Services
June 19, 2014 Meeting Notes**

Advisory Committee Meeting 9:00 am-10:00 am

Members in Attendance: Dr. Beth Ennis

Members Attending via Conference Call: Teresa Justice, Leslie Sizemore, Sherry Hoza

Others in Attendance: Courtney Cundiff, Deborah Simpson, Helen Homberger, Tammy Ricks, Bob Hamilton, Jennifer Moore, Vaughn Payne, Debbie Moorhead and Catherann Terry

Conference Call Attendees: Fred Tolin, Mendy Pridemore, Pam Marshall, Scott Sageser, Kim

Purpose of Meeting: Purpose of the Therapy TAC; Progress re Recommendations to the Cabinet; Provider Enrollment; Therapy Assistant rate differential; Constituent Issues

Introductions

Minutes

January to May 2014 meeting minutes were considered and approved.

Discussion of Therapy Services Prior Authorization and Recertification Fee For Service:

Dr. Beth Ennis reported that Erin Hoben planned to respond to the question about therapy services 30 day recertification periods. The Committee members and participants discussed the impact of the abbreviated preauthorization to recertification interval, reporting that precertification is often delayed by 2-3 weeks after provider submission, with authorization delayed up to 1-2 weeks prior to submission of the required 30 day recertification. Members and participants indicated the abbreviated preauthorization to recertification interval doesn't allow the provider time to implement and evaluate the treatment plan for recertification. The Committee requests something in writing from the Cabinet about the timeline for pre- and recertification. The Committee stated the concern applies to fee for service members only.

Multiple Service Same Code Denials

Dr. Beth Ennis reported denials of authorization requests from therapy services providers using the same code for different services. One service request for the codes may be authorized but a request from another discipline will not eg. authorizing PT services request for 97530 but not OT services request for 97530. The Committee reports this concern applies to both fee for service and managed care, too.

Provider Information Needs

Dr. Ennis noted providers need a list of managed care representatives by region. She noted the Therapy association plan to develop FAQ sheets for Medicaid provider enrollment and troubleshooting. Teresa Justice reported MCO representatives are changed without update.

OT Exclusion

Leslie Sizemore and Dr. Beth Ennis discussed the status of recommendation to remove the OT Exclusion from the regulation. Ms. Sizemore reported the recommendation is in committee in process.

**Kentucky Technical Advisory Committee on Therapy Services
June 19, 2014 Meeting Notes**

EPSDT Constituent Issues

Jennifer Moore related that providers can participate to provide EPSDT SS as subcontracted providers or enroll in new provider types including group and individual provider types since expansion. Problems with new provider type enrollment were discussed.

No restriction has yet been placed on EPSDT Special Services enrollment. Members and participants discussed the benefits of enrolling as a EPSDT Special Services provider.

Leslie Sizemore noted that some MCOs require provider to be enrolled with Medicare prior to enrollment. Ms. Sizemore forwarded Anthem information about the requirement to the OT lobbyist. She reported another example of enrollment challenges: Passport required certification for certain therapy provider disciplines but not physical therapy when enrolling group providers and said the group doesn't meet facility requirements so can't enroll.

Scott Sageser asked if the Certificate of Need requirements for Certified Rehab agencies had been removed. Dr. Ennis stated the question had been posed to the MAC. The response has been to enroll in therapy discipline groups ie. PT group, OT group and SLP group. Ways to enroll multiple therapy services professionals under one owner were discussed. CON would be necessary and Medicaid enrollment would need to be permitted.

Pam Marshall asked about the benefit of fee for service or EPSDT Special Services reimbursement versus CORF. Dr. Beth Ennis responded that CORF and Certified Rehab involves third party payment for adults and children not eligible for Medicaid. Ms. Marshall noted increased reimbursement under EPSDT Special Services provider type enrollment for therapy services rates. Ms. Marshall asked questions about SCL II transition, MP Waiver services billing and multi-specialty group services billing: How is SCL II billing different for therapies for children under 21 years of age? Passport provided a contact, Courtney Cundiff, for Pam Marshall.

Rate Differential

Members recalled discussion about inconsistency in provider billing for the rate differential, ie. that hospital claims default to the reimbursement rate for the therapist in cases when assistants have performed the services. Scott Sageser reported learning in a meeting with the Commissioner that the differential will not change until the Cabinet knows whether funds will be available.

Other Issues

Leslie Sizemore reported seeing evidence of successful billing. This was affirmed by Dr. Ennis, acknowledging bumps experienced by other practitioners. Sherry Hoza will check with Linda Gregory about experiences with billing Speech Therapy codes. Scott Salyer indicated problems with billing 2014 codes had now been fixed. Pam Marshall conveyed concerns with prior authorization for the new codes and with the rates, ie. the speech therapy rate is very low and compared the new rates to the EPSDT Therapy Services rates. Dr. Ennis will forward Ms. Marshall's concern to Catherann Terry by email. Mr. Salyer reported the Commissioner stated there were no monies to address the rate concern. Dr. Beth Ennis noted cost savings can be considered for benefit of remaining EPSDT Special Services with Supported Community Living provider status. Teresa Justice will ask her agency billing office if Speech Therapy services are getting paid.

**Kentucky Technical Advisory Committee on Therapy Services
June 19, 2014 Meeting Notes**

Membership

Dr. Ennis not the TAC will need to get recommendations for 3 new members, 1 for PT, 1 for OT and 1 for SLP, with plans to rotate membership among the 3 organizations. Sherry Hoza will contact KSHA for a nominee. KPTA is working on a nomination and KOTA will work on one with Leslie Sizemore to bring to KOTA attention.

Next Meeting

The next meeting will be scheduled prior to the MAC at 8:30 am on July 24th.

DRAFT

Kentucky Technical Advisory Committee on Therapy Services July 24, 2014 Meeting Notes

Advisory Committee Meeting 8:30 am-9:30 am

Members in Attendance: Dr. Beth Ennis

Members Attending via Conference Call: Teresa Justice, Leslie Sizemore

Others in Attendance: Joni Connelly, Courtney Cundiff, Lyris Cunningham, Stacie Grant, Helen Homberger, Cynthia Lee, Vaughn Payne, Roberta Price, Rebecca Randall, Scott Sageser, Deborah Simpson, and Catherann Terry

Conference Call Attendees: Pam Marshall, Lara Peyton, and Michelle Sanborn

Purpose of Meeting: Purpose of the Therapy TAC; Membership; Progress re Recommendations to the Cabinet; Provider Enrollment; Therapy Assistant rate differential; Constituent Issues

Introductions

Minutes

June meeting notes will be emailed to members for approval at the next meeting.

Purpose of the Technical Advisory Committee on Therapy Services:

Dr. Beth Ennis reviewed the purpose of the committee as the advisory body on therapy services to the Medical Assistance Committee. She noted an increase in individual provider issues and observed challenges in getting right resources and finding solutions. Dr. Ennis stated specifics are needed, ie. to refer to the right resources.

Membership:

Catherann Terry will send the TAC application for new members to Dr. Ennis for forwarding to KPTA and KOTA. Bethany Berry has been recommended by KSHA to replace Sherry Hoza. The KPTA and KOTA do have recommendations for replacement of Physical Therapy and Occupational Therapy representatives on the committee. The following members are leaving the TAC and will be replaced by new members: David Boyce (Physical Therapy appointment), Leslie Sizemore (Occupational Therapy appointment) and Sherry Hoza (Speech Therapy appointment).

Meeting Changes:

Dr. Ennis proposed changes to the meeting times, to move the times to a different day of the week during months when the MAC is not meeting. She stated members would be polled for dates and times. Catherann Terry reported responsibility for meetings of the committee will transition to the Division of Policy and Operations in the near future.

Cabinet Response to Therapy TAC Recommendations:

Dr. Beth Ennis provided the following update: The Cabinet reported there should not be 30 day recertification periods for therapy services. Recertification should not be needed before 20 visits are used. Fee for service is still applying thirty day recertification. Case examples were requested from meeting participants.

Constituent:

Pam Marshall asked if any agency is successfully billing and getting payments for the new fee schedule services provided to children under the new DMS provider types. Ms. Marshall stated Fee for Service and Managed Care billing and payment is not working, ie. new provider types are not getting paid for services. Dr. Beth Ennis requested that Ms. Marshall forward specifics to her by email. Pam Marshall reported CoventryCares, when asked to find out why one Supported Community Living (SCL) provider had to rebill a

Kentucky Technical Advisory Committee on Therapy Services July 24, 2014 Meeting Notes

claim 4-5 times, found a SCL provider was not contracted corrected. Pam Marshall indicated her agency had stopped all Fee for Service.

Dr. Ennis asked participants if other providers are having success in billing straight Medicaid member services. She noted most may still be billing EPSDT Special Services. Dr. Beth Ennis planned to discuss therapy services overlap with Autism Services with the chairman of the Technical Advisory Committee on Behavioral Services.

Members noted problems involving transition in enrollment changes from waiver and straight Medicaid to MCO plan assignment. Teresa Justice reported issues with preauthorization involving timelines from submission to getting the response back, but was researching potential provider causes. She noted a previous issue involving change from CoventryCares to WellCare was resolved.

Members indicated no concerns with provider enrollment at this time, noted many providers are choosing not to enroll in new provider types to avoid challenges with Medicaid billing, and reported enrollment takes six months if application is correct and timely.

Leslie Sizemore reported therapy services billing is working for adults. Is it working for children? She stated plans to clarify whether straight and MCO billing is working for the new provider types.

Occupational Therapy Exclusion:

Dr. Ennis provided the following update: Stuart Owen reported the regulation was approved in place on 7/7/2014. Catherann Terry will check with Stuart for details.

Rate Differential

Dr. Beth Ennis and Teresa Justice discussed the hospital default to the reimbursement rate for the therapist in cases when assistants have performed the services. Ms. Justice reported the hospital rate defaults to the therapist although the COTA performs the service. Members asked the MCO participants to respond to the question about which MCOs are applying the differential. Teresa Justice reported WellCare and CoventryCares are applying the rate differential.

Pam Marshall noted MCO contracts are different and may bill differently. Scott Sageser reported the new provider types are not set up yet in the system, there are issues to work through, so many claims are processing there will be some errors but not continuous denials.

Other Constituent Concerns:

Members discussed whether a Certificate of Need is required before a therapy services provider can participate in Medicaid as a Multiple Specialty Group provider. Dr. Ennis suggested an information sheet be developed for new provider types to include responses to provider questions about provider qualifications, CON requirements, and differences MCO enrollment of individual and group providers. She requested policy requirements for provider enrollment from each MCO.

Next Meeting:

Dr. Ennis stated three new members will be approved by the next meeting. At today's MAC meeting, she plans to address provider fear of billing fraud related to the rate differential.

Members will be polled by email about August meeting times to avoid Thursdays.

The September meeting will be at 8:30 am on 9/25/2014 prior to the MAC.



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR CHILDREN AND FAMILIES**



275 East Main Street, 6W-A
Frankfort, KY 40621
502-564-4321
502-564-0509
www.chfs.ky.gov

Steven L. Beshear
Governor

Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

November 19, 2014

TO: Medicaid Advisory Committee (MAC) Board Chairwoman Partin and
MAC Board Members
RE: Response to Questions Presented at the September 25, 2014 MAC Meeting

Dear Chairwoman Partin and MAC:

We are writing to address questions presented at the MAC meeting on September 25, 2014.

1. That DMS respond in writing by the November meeting as to why behavioral health should not be carved out of managed care.

RESPONSE: Behavioral health services are not carved out of the managed care system to ensure individuals receive effective coordination of care which fully integrates physical and behavioral health. While DMS understands the concerns for this vulnerable population, behavioral health services were only recently added to the Medicaid State Plan for all individuals. DMS contends that the most vulnerable population requiring intensive behavioral health services are currently enrolled in waiver programs that are carved out of managed care. Additionally, having the behavioral health services included in the managed care system increases the effectiveness of cost to the Commonwealth of Kentucky. DMS will monitor utilization and implement any necessary changes to ensure members are receiving medically necessary services.

2. That the MCOs report admission rates to psych hospitals, average LOS and re-admissions to psych hospitals. Also, request that they report denial of inpatient care and denials of Intensive Outpatient (IOP) care.

RESPONSE: DMS is working with internal staff to compile the requested information. Leslie Hoffmann, Behavioral Health Policy Advisor, will provide further information at a future MAC meeting.

3. That DMS respond to the request that it impose consistency across the MCOs with regard to formularies, prior authorizations, etc.

RESPONSE: DMS convened a workgroup with the MCOs to explore opportunities for consistency among forms and processes. The workgroup is being led by Patricia Biggs, Director for the Division of Program Quality and Outcomes. DMS will report back to the MAC when it has more information to share about the workgroup's progress.

4. There was also a question about what indicators the MCOs are providing to see that the continuum of care is actually happening between the medical side and the behavioral health side.

RESPONSE: DMS is continually monitoring the utilization of behavioral health services as well as physical health services. Since the behavioral health services are still expanding and evolving the exact reporting and measurements to ensure the continuum of care have not been finalized. Leslie Hoffmann, Behavioral Health Policy Advisor, will provide the MAC updates to this issue in future meetings.

5. Concern was expressed about patients getting their prescriptions beginning on January 1st when there will be new patients in the MCOs or patients will have changed their MCO. What has been done to assure that patients will be able to have their prescriptions filled and providers and pharmacists will know to which MCO the patient has been signed [sic].

RESPONSE: Medicaid open enrollment concludes at the close of business on December 12, 2014. All newly enrolled individuals as well as individuals changing their enrollment to a different MCO should receive new MCO identification cards and Welcome Packets from the MCO prior to January 1, 2015. Providers and pharmacists will be able to verify an individual's MCO enrollment and eligibility through the KyHealth-Net System.

Sincerely,

Erin Hoben
Chief Policy Advisor
Commissioner's Office
Department for Medicaid Services

cc: Lawrence Kissner, Commissioner, Department for Medicaid Services
Neville Wise, Deputy Commissioner, Department for Medicaid Services
Lisa Lee, Deputy Commissioner, Department for Medicaid Services
Mary Begley, Commissioner, Department for Behavioral Health, Developmental and Intellectual Disabilities
Dr. John Langefeld, Medical Director, Department for Medicaid Services
Leslie Hoffmann, Behavioral Health Policy Advisor, Department for Medicaid Services
Barbara Epperson, Resource Management Analyst III, Department for Medicaid Services