

CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

REGULAR MEETING

December 15, 2011
10:00 A.M.
Room 111, Capitol Annex
Frankfort, Kentucky



APPEARANCES

Ron Poole, R.Ph.
CHAIRMAN

Donald R. Neel, M.D.
Elizabeth Partin, ANRP; NP
Carla Rodriguez, D.M.D.
Peggy S. Roark
Oyo Fummilayo
Jerry W. Rogers
Richard L. Foley
Chris G. Carle
Barry A. Whaley
Susanne Watkins, O.D.
Sharon A. Branham
Sheina C. Murphy
COUNCIL MEMBERS PRESENT

CAPITAL CITY COURT REPORTING

TERRI H. PELOSI, COURT REPORTER
900 CHESTNUT DRIVE
FRANKFORT, KENTUCKY 40601
(502) 223-1118

APPEARANCES
(Continued)

Ms. Barbara Witty
COVENTRYCARES

Ms. Jean Rush
KENTUCKY SPIRIT

Mr. Mike Minor
WELLCARE

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CHAIRMAN POOLE: Welcome, everyone, to the Advisory Council for Medical Assistance. We will call the meeting to order.

(INTRODUCTION OF COUNCIL MEMBERS)

CHAIRMAN POOLE: Thank you. In your packet, we've got our minutes from the last meeting, October 27th. Does anybody have any additions or deletions that we need to make? If not, do we have a motion to approve?

DR. NEEL: So moved.

MR. WHALEY: I'll second.

CHAIRMAN POOLE: We've got a motion and a second. All in favor say aye, and motion carries to approve the minutes.

Next we have Acting Commissioner Neville Wise to report on the implementation and how things are going.

REPORT OF CABINET FOR HEALTH AND FAMILY SERVICES,
DEPARTMENT FOR MEDICAID SERVICES:

COMMISSIONER WISE: Good morning. As Ron said, Neville Wise, Acting Commissioner of Medicaid.

MS. BANAHAN: Carrie Banahan, Implementation Director for Medicaid Managed Care.

COMMISSIONER WISE: As we all know, we're about six weeks, seven weeks into managed care now.

1 As a general statement, things are kind of going as we had
2 expected them to go. I'm sure we'll hear here today other
3 issues that we need to work with the MCO's to address and
4 things we need to correct and straighten out with various
5 provider groups.

6 As I mentioned before, that's one of
7 the reasons we have these meetings, to hear what's going on
8 out in the member and provider world and what issues those
9 individuals are facing. And that's more important now than
10 it's ever been for Medicaid to get out as much as we can
11 and talk to groups like yourselves.

12 I just want to give a few general
13 updates of issues that may affect multiple groups that we
14 have here. We had talked about at last meeting kind of
15 closing out old Medicaid that we had dis-enrolled some
16 members from our KenPAC Program prematurely, and primarily
17 in September and October, we had stopped making management
18 fee payments to providers for certain members who had come
19 in that month and renewed their eligibility with Medicaid.

20 We will announce today that we will
21 be restoring those payments for the months of September and
22 October prior to managed care starting. And what that
23 means is if that member was assigned to a provider prior to
24 September and the member maintained eligibility for the
25 months of September and October, we will be paying the

1 management fee to that provider for those two months prior
2 to managed care starting.

3 We're also making our federally-
4 mandated payments to primary care centers, rural health
5 clinics and federally-qualified health centers. Just to
6 recap, under federal rules, those what sometimes the feds
7 call safety net providers who have those centers are under
8 managed care required to be basically made as close as
9 possible to whole as to what Medicaid would have paid them
10 under their existing rate prior to managed care starting.

11 So, those providers get a supplement
12 from Medicaid itself, not from the MCO's, that represents
13 the difference between what their rate was with Medicaid
14 and what the MCO's are paying them. The MCO's are required
15 to pay them as they would pay any other primary care
16 provider, physician and such.

17 Another issue we are addressing and
18 we have a solution - this solution is taking longer than we
19 had hoped - is Medicare crossover claims. We have the
20 issue of where what used to happen in Medicaid, just to
21 recap, is if Medicare was the primary payor on a claim,
22 that that claim would be sent by Medicare to Medicaid and
23 we would go ahead and pay the Medicaid or the member's
24 share, whatever was left to pay on that claim without the
25 provider having to be involved.

1 We have been working with Medicare
2 for several months to get that transaction split so that if
3 the claim goes to any of the three MCO's, that that claim
4 will go almost directly from Medicare, pass through us
5 directly to the MCO's so they can pay the Medicare
6 crossover and deductible payments.

7 We're very close on that process. We
8 think it's any day now. And since November, we will have a
9 process where we go in and try to scrape off claims that we
10 may have denied and sent to the MCO's, and we're going to
11 try to produce claims to send to the MCO's so that the
12 providers won't have to take the extra administrative step
13 of getting a denial back from Medicaid, filling out a paper
14 claim and sending it to the MCO's.

15 So, we'll have a process to take care
16 of that in the future. And hopefully when Medicare gets
17 their tape situation straightened out, that will be more of
18 a no impact to providers.

19 Just to go ahead and address another
20 concern that we have, I just wanted to explain a little bit
21 about the time frame for paying providers. Just to recap,
22 several years ago, Medicaid used to take up to thirty days
23 to pay providers. And as you might recall that when
24 federal stimulus dollars became available, we sped up
25 payments. We basically paid a claim as quickly as we could

1 get it in and paid on the following Friday and the check
2 was mailed out the following week.

3 The MCO's are operating under the
4 same basic requirement that Medicaid had in that claims
5 must be paid in thirty days. They're not required to pay
6 them as quick as Medicaid was directly before managed care
7 implementation. They're required to pay them thirty days
8 like most insurance claims are required in the state.

9 We expect to hear and we have seen
10 examples of where the thirty days may have been exceeded
11 and we're willing to look - not willing - we do look at all
12 those examples and get to the root of what caused that
13 problem.

14 We're not saying everything is
15 perfect, but I wanted to not have all the complete onus on
16 the MCO's to pay as quick as Medicaid had been paying prior
17 to MCO implementation. They are not required to do that
18 contractually. Basically all insurers, it's the 30-day
19 requirement that they have.

20 Our call center is up and running and
21 has been working extra hours for a long time. Our volume
22 which had ran six to seven thousand calls a day is now
23 averaging about thirty-five hundred calls a day helping
24 members deal with issues, providers also, working with
25 members to deal with issues. So, we've seen some volume

1 reduction there.

2 And one of the things that I always
3 talked about was members having choice and being able to
4 move between plans for any reason, that they didn't like
5 the plan's coverage, that they had a provider on the other
6 plan who they wanted to switch to because they liked that
7 provider, had a history with that provider.

8 And we're still in the middle of that
9 process where members can change plans either based on what
10 they know or something they experienced in their initial
11 period with the plan they were assigned to. It's a 90-day
12 period which began in November, ends January 31st, and I
13 wanted to give you some statistics on that.

14 Approximately 68,000 members have
15 changed plans in the first forty-five days after managed
16 care implementation. That's about 13% of the 530,000
17 individuals approximately who are in managed care today.
18 So, that option is out there. Members are taking advantage
19 of it and it's still something they have the option to take
20 advantage of until January 31st, and annually they have a
21 chance to change their plan they're assigned to also. So,
22 that process is ongoing and we're still there.

23 That's all the opening remarks I had
24 to update the committee on things that are going on. I'm
25 sure as we go through the meeting, we'll have testimony

1 from various individuals that will either have a response
2 to or will say that's an issue we need to take back and
3 work on. So, at this point, I'll open it up for questions
4 from the committee and we'll be here to answer questions
5 that we can.

6 CHAIRMAN POOLE: If you don't mind,
7 please stay seated and let's let the three MCO's give their
8 reports and then we'll go through the panel here and have
9 questions, if you don't mind.

10 So, in no particular order, however
11 you all want to do it.

12 MR. MINOR: Mike Minor, WellCare. I
13 think I would start with last month we talked a little bit
14 about the outreach that we were doing to members as far as
15 the health risk assessments. I just wanted to provide a
16 quick update.

17 Overall, we have just over 87,000
18 calls that we've made to our members. We've made contacts
19 with 30,000 households. Again, that's households, not just
20 individual members. So, there's more medicaid recipients
21 per household there.

22 We have completed over 7,000 health
23 risk assessments. And, again, as our process, some of
24 those have been in person, especially for ABD and members
25 with chronic conditions.

1 Within that process, too, as far as
2 getting Medicaid recipients who need higher case
3 management, we now have over 5,400 Medicaid recipients in
4 case management where one of our nurses across the state
5 are following, coordinating care with providers and helping
6 to get Medicaid recipients to necessary services.

7 At last month's report, too, we
8 talked about the upcoming community advocacy that we were
9 doing. And since that time, we have completed seven town
10 halls across the state. These are also health connection
11 councils, sixteen community events. We have additional
12 events scheduled throughout the state in January.

13 Within some of those member forums,
14 we now have made nearly 250 referrals into what we're
15 calling our social safety net since November 1st. What
16 this is is we have over 200 community partners, and these
17 are partners with other funding agencies who we work with
18 to coordinate care for services that may not be strictly
19 healthcare-related but they're services that people need to
20 perhaps eliminate barriers in order to get care.

21 Moving to customer service, we
22 received 47,000 calls in the month of November. I would
23 tell you that the majority of those are for PCP changes as
24 members either find additional primary care providers or
25 they are moving to historical primary care providers.

1 claims. We're working with providers who have addressed us
2 with issues as far as making sure that claims are being
3 received, claims are being paid, if there were
4 authorization questions, and we anticipate that we'll
5 continue to do that until we get to a steady state. Thank
6 you.

7 CHAIRMAN POOLE: Just a point of
8 reference here, I was given a message here so we can get it
9 on record. I know, Mike, you've already introduced
10 yourself again, but could the three of you introduce
11 yourselves and who you represent and then go ahead with
12 either Coventry or Kentucky Spirit. We just need that for
13 the record.

14 MS. RUSH: I'll give an update next.
15 I'm Jean Rush. I'm the CEO of Kentucky Spirit and I'm
16 happy to be here with you today to provide an update and
17 also to respond to any questions that you might have.

18 Similar to the other two MCO's, it's
19 been a busy month after going live on November 1st. As you
20 probably know, when we were pulling together the health
21 plans in anticipation of the November 1st date, a lot of
22 our focus was on the network development.

23 And similar to WellCare, we are
24 continuing to build up that network and we have seventy-one
25 hospitals under contract now. But we are continuing to

1 reach out and work with hospitals and physicians and
2 ancillary providers across the state and continue to bring
3 them into our network. So, while that was a full court
4 press in anticipation of our November 1st date, we are
5 continuing to round out the network as we move forward.

6 From a servicing perspective, we
7 started off on November 1st with a lot of activity. I
8 think all of the MCO's had a tremendous call volume. We
9 were getting in over 5,000 calls a day into our member and
10 provider call centers. That number has drifted down and we
11 have stabilized it about 8,500 a week, which we would
12 consider to be normal levels of call volume to receive.

13 The call centers are doing very well
14 in terms of metrics, being able to answer the phone in a
15 timely manner and respond to the questions that are
16 presented.

17 At the beginning of the
18 implementation, we did see a spike in volume for prior
19 authorization requests. Because this was a new process, we
20 did develop a little bit of a backlog, but that backlog has
21 since been brought completely under control and we are able
22 to process those requests now within about a day, a day and
23 a half of receipt, and that's against a two-day timing
24 standard.

25 Similar to Mike's report, our case

1 managers are working with our members now. The primary
2 focus is on completing the health risk assessments and the
3 health risk screenings. And from that, we are moving
4 members into the various care management programs. And
5 that is occurring both on the medical side, the behavioral
6 side and also on the pharmacy side.

7 And we're starting to see some
8 success stories. One situation that really peaked my
9 interest that I wanted to share with the group because I
10 think this really represents some of the value that managed
11 care can bring to the Commonwealth of Kentucky is we had a
12 situation where a case manager identified that we had a
13 single member who was taking over twenty different
14 prescriptions. And, unfortunately, nine of those
15 prescriptions were interacting with each other.

16 And it was the situation where,
17 because they had four different doctors, no one was seeing
18 that full picture. But because it was coming in now to a
19 single point of contact, we were able to catch that and we
20 were able to go back to them through our case manager with
21 recommendations on changes they should make so that we got
22 that under control, that we reduced the number of
23 medications and, more importantly, eliminated the ones that
24 were interacting with each other.

25 So, we are starting to move from the

1 flurry of implementation into true operations where we can
2 start making a difference in the health and well being of
3 the members of our health plan.

4 From a provider relations'
5 perspective, very similar to WellCare, we are also reaching
6 out to all of our provider groups. We do have a dedicated
7 group of provider relations' specialists who are out and
8 about across the state meeting with provider associations,
9 hospitals and individual practitioners and also responding
10 to inquiries that come in.

11 I think the biggest ah-ha for us over
12 the past couple of weeks has been the need for education.
13 This is a really new process for all of us. And, so, there
14 are a lot of questions. And one of the things that we've
15 come to realize is that not only is this a new process, but
16 we have three different managed care organizations whose
17 processes may be a little bit different. So, we are really
18 doubling down on the education efforts so that we can
19 respond to the providers' requests.

20 From a claims' perspective, we are
21 processing claims on a weekly basis and are moving those
22 claims as quickly as possible through from date of receipt
23 to actual check distribution.

24 I will say the first couple of weeks,
25 we did hold back some claims for a few days, and that's

1 because we wanted to make sure we were doing very thorough
2 quality checks. This is a big implementation. And, so, we
3 did take a little bit of extra time to review those checks
4 before they went out the door, but they are flowing
5 smoothly now and providers should be receiving
6 reimbursement for their submissions.

7 So, I think that's probably the
8 latest and greatest and definitely open to any questions
9 that the group has.

10 MS. WITTY: Hi. My name is Barb
11 Witty. I'm CEO of CoventryCares. So, I'm going to just go
12 through the same things.

13 We are doing the same things Kentucky
14 Spirit and WellCare are, reaching out as far as case
15 management, identifying folks that need to be in case
16 management, completing the HRA process.

17 As Jean mentioned, we did have a
18 flurry of calls in the beginning. And, so, we had a little
19 bit of an issue with our pre-auth department in turning the
20 authorizations around. All those backlogs have been
21 cleared up and we are now focusing within the time frames
22 that we should be doing. We're getting back to everyone,
23 both on the concurrent review side as well as the
24 authorization side.

25 Our call volume is coming to normal

1 levels in our customer service organization; and similar to
2 WellCare, most of the calls are PCP change calls that are
3 coming in.

4 On the outreach side, we are doing
5 over 400 outreach visits per month to the community
6 agencies. And for the five-month period, we had over 2,000
7 visits within the State of Kentucky. We have an outreach
8 person in each region and we are definitely out and about
9 in the community doing different health fairs and
10 screenings and whatnot there. We sponsor baby showers and
11 we try to be very visible in the community to partner with
12 our membership as well as the community organizations.

13 We continue to grow our network. We
14 have a very robust network where we continue to work with
15 some of the folks, some of the remaining hospitals that did
16 not contract prior to November 1st. I have a couple of
17 contracts sitting on my desk right now I'm trying to
18 finalize to get those things done. I think that's going to
19 be a constantly evolving process as time goes on, but we
20 feel like we have a very robust network and we're not
21 having any adequacy issues at all.

22 As Jean mentioned, it is a big
23 change. It's a change for all of us. So, we are out there
24 doing our provider orientation meetings in accordance with
25 our contract with the Commonwealth. We are at a ton of

1 meetings. We have weekly calls with some organizations.
2 We have regularly scheduled meetings with the providers as
3 best we can. We're bringing our subcontractors in to meet
4 with like the Dental TAC and to be visible with all of our
5 constituencies to try to answer as many questions as we
6 can.

7 We know that as Jean mentioned, there
8 are some changes. We struggled in the beginning with the
9 hospitals telling us who was in the hospital. They had
10 some confusion about which MCO the member belonged to. But
11 I think as time has gone on, as the weeks have gone by,
12 they're starting to recognize our nurses who are onsite, as
13 well as the people that are in the office, and the
14 communication is beginning to flow a lot better than it was
15 in the beginning.

16 We got a lot of, well, why do I have
17 to tell you this and I shouldn't have to tell you that.
18 So, we've tried to educate and work with folks to help them
19 understand why we need the information, not just the
20 information that we need, so that we can make sure that all
21 the authorizations get put in and that the claims' payments
22 are going out on a timely basis.

23 Our membership grew in the month of
24 December. We actually grew by quite a bit in the month of
25 December as we see people exercise, as Neville said, their

1 freedom of choice. We have one more month left to go with
2 that. And through December 9th, at this point, we've cut
3 125,000 health claims for \$12 million, four hundred - I'm
4 sorry - yeah, 125,000 health claims for over \$12 million,
5 400,000 Rx prescriptions we've paid Medco for for \$25
6 million. We've had 3,500 mental health claims processed
7 and 8,000 dental claims processed. So, the claims are
8 definitely flowing and going out there.

9 We did do the same as Kentucky Spirit
10 mentioned. We were slow in the first couple of weeks to do
11 pretty sound quality checks because it's very important to
12 not just pay a claim but to pay it right the first time so
13 we don't have issues with denials going out unnecessarily.
14 We are scrubbing that data.

15 We have been very I won't say lenient
16 but we've worked with the providers a lot on the
17 authorization process, knowing that it's a whole new thing
18 in some respects as far as the authorizations go.

19 So, we're trying to look at medical
20 necessity and not just the authorization requirements,
21 although that will be coming to an end, but we've been very
22 liberal with our authorization requirements for the first
23 couple of months to try to acclimate everybody to our
24 standards.

25 I think that's most of everything

1 that I wanted to bring up today. So, if anybody has any
2 questions also on that, that's why we're here, to answer.

3 CHAIRMAN POOLE: I wanted to go ahead
4 and kind of go off our agenda just for a second. It seems
5 now that we've got a very good showing today from the MAC
6 to allow our recipients to give a report of what they're
7 hearing and what their experiences have been and our
8 advocacy groups here, too.

9 So, Barry or somebody, if you want to
10 go first.

11 MS. FUMMILAYO: Are you deferring to
12 me?

13 MR. WHALEY: I'm deferring.

14 MS. FUMMILAYO: Good morning. Oyo
15 Fummilayo. When we were here last, we made some
16 suggestions about getting back out there and really revving
17 up the communications' process.

18 And what I'd like to do is actually
19 commend you on the very visibility of each one of you in
20 different communities across the state. I've talked to
21 quite a few people across the state in the recipient area
22 and they are now aware of you. I'm talking Central
23 Kentucky, some out of Eastern Kentucky and some of out of
24 Western Kentucky. They're now aware.

25 And just going through Lexington, I

1 do see that there are advertisements on the side of buses
2 and I hear on the radio and see on the television that
3 there are also advertisements. And I'd like to commend you
4 on your efforts for listening to us and getting back out
5 there.

6 So, we're not just here to beat up on
7 you, honestly. When you do things right, you need to be
8 commended for it, and I think you've done a great job and
9 you're moving toward letting everybody know who you are.

10 Then there's this other side.
11 There's always another side. And that is that I'm also
12 hearing that some pharmaceutical issues are opening up
13 where some people are not getting their meds in a timely
14 fashion. Some of their meds are not available, especially
15 in the mental health community. So, there are those
16 things.

17 And while I was sitting here and
18 taking the numbers from Mr. Minor, I like numbers because
19 they're solid and you can judge what's going on. So, from
20 Kentucky Spirit and the other managed care organization, if
21 we could get numbers from you. I see, Kentucky Spirit,
22 seventy-one hospitals, 8,500 calls per week. I like that,
23 but I would like to also know how many touches have you
24 done out in the community, sort of like what Mr. Minor gave
25 for both the other managed care organizations. I'd like to

1 know that because that really measures. That's a
2 measurement for me from one time to another time
3 where I can see how things are going up or down. I like to
4 deal in those particular concretes.

5 I don't know what a robust network
6 is. So, if you could explain. What is robust in numbers?
7 That's not from Kentucky Spirit. Is it Coventry? What is
8 a robust network? How does that translate into numbers?
9 Robust could mean healthy.

10 MS. WITTY: In our world, what we did
11 was we took a look at all the current Medicaid providers
12 and we matched our network up against the current Medicaid
13 provider network and also added a few additions to that.
14 So, as we can say, we're consistent with the historical
15 managed care or the historical Medicaid network. We feel
16 that we're very strong. We, too, have over 17,000
17 providers.

18 MS. FUMMILAYO: See, I think that's
19 what I need to hear.

20 MS. WITTY: And we continue to, as we
21 went live, the Commonwealth had to certify that our network
22 met adequacy according to CMS standards, and we have met
23 that.

24 The other way I would respond to that
25 is we don't get requests for out-of-network services. So,

1 when we know that we're not getting a large amount of
2 requests for out-of-network services, we know that we're
3 actually meeting that work adequacy standards and our
4 members are able to find a provider within our network, and
5 that's our goal.

6 MS. FUMMILAYO: So, basically you're
7 meeting our needs.

8 MS. WITTY: I would like to think so.
9 That's not just my opinion but in my world, yes.

10 MS. FUMMILAYO: Right. I mean, if
11 you're talking in numbers as far as the numbers that you
12 have, you're meeting the needs of the people that you're
13 serving.

14 MS. WITTY: Correct. And as we
15 receive any issues or concerns or requests from different
16 people to build up the network in a different area or for a
17 particular provider, we act upon those.

18 MS. FUMMILAYO: And I do like from
19 Ms. Rush when you said you had the ah-ha of education is
20 the key. That's what I've been saying for six months -
21 education is the key. So, thank you. Thank you very much
22 for the work that you're doing. You're here with us.

23 And whether we like you or not,
24 you're here with us, and that's important. You're here and
25 you're doing what you said you were going to do, and I do

1 appreciate that, and you will look forward to hearing from
2 me a little bit more later on. Thank you very much.

3 MS. RUSH: One quick follow-up to
4 your comments. You mentioned metrics, and I think all
5 three of our companies track literally hundreds, if not
6 thousands, probably thousands of metrics.

7 So, one thing that might be helpful
8 for us is to know what particular things you'd like
9 reported because we would be glad to bring that. And maybe
10 for it to be meaningful, I think it would be most useful if
11 we, meeting after meeting, reported on the same metrics.
12 So, if there are certain things that you'd like us to bring
13 back with us, let us know and I'm sure we would be glad to
14 do that.

15 MS. FUMMILAYO: You can get with Mr.
16 Minor because I think he had everything I liked.

17 MR. WHALEY: I just want to echo what
18 Oyo was saying is that I have heard that things have gone
19 as smoothly as possible. I think the only issue, and I
20 don't know to which area to address it, would have been the
21 issue with waiver recipients receiving letters asking for
22 provider change. And I'm not quite sure how that happened.

23 MS. BANAHAN: There was a system
24 glitch and several hundred waiver members were assigned to
25 an MCO in the month of November. And as soon as we became

1 aware of that, we removed them effective December 1. So,
2 that problem should no longer exist.

3 COMMISSIONER WISE: It was more of a
4 startup problem.

5 CHAIRMAN POOLE: Peggy, would you
6 like to give your comments now?

7 MS. ROARK: I'm Peggy Roark and I
8 have a question for CoventryCares. I'm getting feedback
9 that patients are having problems getting their medications
10 that's over 100 in quantity, like blood pressure, seizure
11 and pain medications.

12 MS. WITTY: We've identified those
13 issues. We've actually been very active in a lot of
14 different phone calls with different groups. And, so, we
15 have adjusted our quantity limits for a 30-day supply and
16 that was effective two weeks ago.

17 MS. ROARK: Also, I took my son to
18 the dentist and I asked what feedback and they said they
19 were having a hard time getting approved for the nitrogen
20 sedation for children, for the gas from CoventryCares.

21 MS. WITTY: The nitrous oxide?

22 MS. ROARK: Yes, that they're having
23 a hard time getting it approved.

24 MS. WITTY: Yes. And we actually
25 have a representative from Avesis here with us today. So,

1 Nicole, I don't know if you want to give a quick update on
2 that.

3 MS. MITCHELL: Good morning. My name
4 is Nicole Mitchell. I'm the Director of Government
5 Services for Avesis. We are the dental administrator for
6 CoventryCares. And one of the things that we've discovered
7 as the MCO's have indicated is that we're out needing to
8 additional provider education, particularly surrounding the
9 EPSDT special services program under which the sedation and
10 the nitrous oxide are both covered.

11 So, we work very diligently with our
12 provider community. We actually have some updates that we
13 have published to them in regards to obtaining that
14 information. And we are working particularly with the
15 EPSDT special services providers to ensure that they're not
16 in a position where they're having to reschedule or have
17 people come back for prior authorization but to work with
18 us on those services for retrospective review so that once
19 they have the member there in the office, they're able to
20 do those services without obtaining the prior authorization
21 and we're able to just review for EPSDT special services on
22 the back end.

23
24 MS. ROARK: I was wondering about the
25 acronyms.

1 MS. FUMMILAYO: Yes, the acronyms,
2 I'm not familiar with what they mean.

3 MS. MITCHELL: Sure. There's a
4 program in the Commonwealth called EPSDT. And EPSDT stands
5 for Early Periodic Screening, Detection and Treatment. And
6 underneath that special services program, it enables
7 children, members under age of 21, to access services that
8 are not normally covered under the program based on medical
9 necessity or special needs or anything along those lines.

10 And, so, providers actually enroll
11 separately to participate in that program. And once
12 they're enrolled in that program, they have access to
13 request services that again are not normally covered under
14 the stated benefit for the Medicaid Program.

15 COMMISSIONER WISE: EPSDT is kind of
16 the catch-all. If there's a service that doesn't really
17 fall under one of Medicaid's programs but it's a service a
18 child needs, that service can be asked for under the EPSDT
19 program if it's medically necessary.

20 MR. CARLE: On those same lines from
21 a hospital perspective, we have been having some issues
22 where the dentists and oral surgeons can't necessarily do
23 those procedures in their office, getting them credentialed
24 in the hospital and getting those patients preauthorized in
25 the hospitals. There are a few hospitals throughout the

1 state that actually do those extractions under full
2 sedation, and I just wanted to piggyback onto Peggy's
3 question before.

4 MS. MITCHELL: That would actually be
5 a question for the managed care plan. They manage the
6 facilities.

7 MS. WITTY: This issue I can speak
8 for CoventryCares - and I don't know if the question is for
9 all three of us or just for CoventryCares - but we actually
10 have met several times with Avesis talking about how we can
11 do this handoff in a much better manner.

12 So, if it's in a facility, we're
13 authorizing those. There were some confusion in the
14 beginning about does that go to Avesis or does that go to
15 the health plan. And, so, my understanding is we've worked
16 with Avesis. We've put the procedures in place. If you're
17 still hearing of issues, be sure to let me know, but my
18 understanding is that's been resolved.

19 MR. CARLE: Thank you.

20 MS. ROARK: Yes, I would like to hear
21 from Kentucky Spirit and WellCare for the same question.

22 MS. MITCHELL: Relative to the
23 hospitalization?

24 MS. ROARK: With getting
25 preauthorized. I had a dentist tell me that with Kentucky

1 Spirit, if your tooth was infected, it had to be infected
2 before they would pull it.

3 MS. RUSH: I'm not familiar with that
4 particular situation, but what I'd like to do, what I have
5 found with a lot of these issues is the devil is definitely
6 in the details. So, if you have the information on that
7 particular patient, I would be glad to take it back and
8 then respond back to you rather than just answering
9 globally but I'd be glad to look into that for you.

10 DR. RODRIGUEZ: I think the issue -
11 and correct me anyone who knows better - I think the issue
12 is that with third molar extractions, you can only get
13 prior authorization for the removal of a third molar if it
14 is infected. So, if I'm an 18-year-old with one infected
15 third molar, I can get sedation and prior authorization for
16 removal of that third molar but none of the other three
17 because they're not infected. So, that in my mind is
18 malpractice. There's a real issue there.

19 MS. RUSH: I'd be glad to look into
20 that for you. Do we have anybody from our dental
21 organization here? I don't know the details on that. No
22 one from dental? Similar to Coventry, we use a company by
23 the name of MCNA who does all the credential work for us.

24 And Carla and also the lady at the
25 end, if I could get your contact information, I'd be glad

1 to research that and get back to you.

2 MS. ROARK: Thank you. I've also
3 been hearing feedback about the dentists couldn't even get
4 their contract with WellCare, they couldn't even get on the
5 website or nothing.

6 MR. MINOR: I know that we've seen an
7 increase in the number of dentists since 11/1 to where
8 we're at today. If it is a non-contracted dentist, we have
9 to have a special process in order to allow the dentist to
10 access those records, almost in a please try us out and see
11 if you like us capacity. Again, there's additional
12 education there as well.

13 I would speak to the first question
14 which is the professional component of the bill should the
15 dentist do the procedure at the hospital, that would be a
16 situation where DentaQuest would pay the professional
17 component. WellCare pays the facility component as we have
18 the contract with the hospital.

19 What we think would help is for the
20 dentists that are doing those procedures in the hospital
21 and doing a high volume is to find out where they are
22 allowed or where they would like to do the procedure there
23 so we can reach out to the facility and kind of work
24 through a better process so no one has any confusion about
25 who is authorizing what or what is authorized.

1 MS. ROARK: I also have a question
2 for all three. How many visits do you allow for a patient
3 to go to the mental health?

4 MS. WITTY: It varies. It varies
5 depending upon what their needs are. I have Chris Locomb
6 (sic) here today; and if there's a real detailed question,
7 Chris can come up to the table and answer some questions on
8 the behavioral health side.

9 But we look at the individual. It's
10 not a one size fits all. They try to go ahead and
11 authorize what they know for sure will be the number of
12 visits that someone will need and then after that,
13 continuing to check in and authorizing as necessary. Does
14 that answer your question? It's not like you always do ten
15 or five or three.

16 MS. ROARK: So, are they charging
17 late payments? Suppose you don't make it to your
18 appointment. In the past, you had to pay a \$10 late fee.
19 Is that still the same?

20 MS. WITTY: We aren't imposing that,
21 not to my knowledge.

22 MS. BANAHAN: That shouldn't have
23 been allowed. If you could give us some information.

24 MS. ROARK: Well, in the past, my
25 son, I've taken him to a counselor and something came up

1 and I couldn't make it and I've been charged \$10 for not
2 coming. And they said if I didn't pay the \$10 and it
3 started building up, he wouldn't be back in to see the
4 doctor or the psychiatrist or counselor or anything.

5 MS. BANAHAN: If you could give us
6 that information after the meeting, we'll follow up on
7 that.

8 MS. ROARK: Really?

9 COMMISSIONER WISE: And that points
10 out what we can deal with in the best in any of this is
11 when there's a specific story to tell of this member was
12 wanting this service and this happened.

13 MS. ROARK: Also, I had a problem
14 with my son went into The Ridge and he got released and he
15 had to go a whole day without his medication. I didn't get
16 any feedback. The pharmacy, we tried to call and it was
17 the weekend. So, I was really scared that my son was going
18 to go without medication and I was really upset with that.
19 These children get prescribed medication and then it's
20 dangerous to go off of it cold turkey and your hands are
21 tied. And the pharmacy can't loan you medication because
22 it's a controlled substance, so, there you are.

23 MS. RUSH: Maybe just to respond to
24 that generically. I think answering your first question
25 and maybe tying the two together, your first question about

1 the number of visits that's preauthorized. Similar to
2 Coventry, ours is going to be case by case because we are
3 dealing with so many different situations and diagnoses and
4 it's not one size fits all, but I think the key to that is
5 in the managed care world, we would assign a case manager
6 to that individual.

7 And that really transitions or
8 segways over to your second question about the missing day
9 of meds. Our philosophy is when a member enters a
10 facility, on day one, we want to start getting engaged with
11 the facility and the provider and the member to start
12 talking about discharge planning.

13 And it's not because we're looking to
14 get them out but we want everybody to start thinking about,
15 when that day comes, what do we need to be thinking about.
16 And the example you gave is a prime example of something
17 that needs to be thought though ahead of time. If the
18 person is going to be leaving on a weekend and they need to
19 get medicines, how do we make sure that we're getting
20 approval for those ahead of time.

21 We do have a nurse line that is
22 available 24/7, but we also want to make sure that we're
23 thinking things through ahead of time and mapping out a
24 care plan for that person for when they leave the facility.

25 And, so, I think that's one of the

1 benefits that comes with managed care is really tapping
2 into those case managers and utilizing them to coordinate
3 amongst all of the players.

4 MS. ROARK: Thank you. I have one
5 more. My father is terminally ill with cancer and he's
6 with Kentucky Spirit and he lives in the Breathitt County/
7 Jackson area. And he loved Kentucky Spirit and everything
8 and all of a sudden, when he gets back home, he can't go to
9 the doctor, the hospitals or nothing because they're not
10 accepting it. So, now he's had to change. So, he's had to
11 go without medication and it's just been a mess.

12 MS. RUSH: I think that the response
13 I would have there is I'm sorry that we lost him as a
14 member. One of the things that we have struggled with a
15 little bit is, in negotiating with certain facilities to
16 come into our network, our philosophy is that we do want
17 all of the hospitals and the physicians to be part of our
18 network. We would like them to join in.

19 However, we do need to make sure that
20 we do it on terms that are financially beneficial for both
21 parties, and we have had some situations where we haven't
22 been able to come to terms yet. We're still coming back to
23 the table. We are keeping the door open on those
24 conversations. In fact, just this week, we talked about
25 going back to all of the facilities that haven't signed

1 with us and putting an offer back on the table with them.
2 But it does take two to tango and we do need to make sure
3 that they can come to terms that are acceptable to us as
4 well.

5 MS. ROARK: Thank you all for your
6 feedback, and I do hear your commercials and hear it on the
7 radio. So, I think it's going to be a positive change.
8 It's just slowly getting it maneuvered.

9 CHAIRMAN POOLE: Thank you, Peggy.
10 Ms. Murphy.

11 MS. MURPHY: I'm glad to be here. As
12 most of you all know, I have schizophrenia. And in the
13 year 2000, I was living in a nursing home with a state
14 guardian costing the State \$1,200 a month. That's not even
15 counting my medication because I got very little treatment
16 while I was there.

17 We have over 6,000 people being held
18 prisoner in personal care homes in the State of Kentucky
19 right now. Kentucky was 48th in mental health in the
20 nation before you guys showed up.

21 Now, if we're going to talk about
22 hospital admissions and lengths of stay being decreased, to
23 begin with, the severely mentally ill population, I've
24 heard terms like malingers. What you guys need to realize
25 is we don't want to be in the hospital. We usually have to

1 be chased down with a net to be put there.

2 And if you're not going to pay for
3 crisis stabilization units, my suggestion would be that we
4 decorate them in pink and blue and call them baby showers
5 and maybe we could get it paid for.

6 It has taken me years to find the
7 right medication to where I could function. The wrong
8 medication can make somebody incompetent. They don't call
9 it chemical restraint for nothing. You put people on
10 Haldol and Thorazine and stick them in a personal care
11 home, to begin with, it's actually a civil rights' issue.
12 It's a violation of the Americans With Disabilities Act.
13 And if we in Kentucky don't improve things very soon, the
14 feds are going to come in here and improve them for us, and
15 I hate to see that happen.

16 I understand that you all had
17 promised to put consumers and family members on advisory
18 groups. I think that's an excellent idea. If you want to
19 know what works in mental healthcare, ask people who are in
20 recovery. If you want to know what doesn't work, ask
21 people who are in recovery.

22 And I've heard the phrase devil in
23 the details; and every time I hear it, I cringe. Taking me
24 off of my Geodon and putting me on Haldol is not a detail
25 I'm willing to discuss with people. Now, if I'm put on

1 Haldol, I'm going to jail because I am not taking Haldol
2 ever again. I have a mental healthcare advanced directive
3 which is a legal and binding document in the State of
4 Kentucky. And there are other people out there who have
5 done the work and they've recovered and they've done
6 everything they know to do to take responsibility for their
7 illness.

8 And I'm just wondering if you have a
9 mental healthcare advanced directive like mine and it says
10 no Haldol, no Thorazine, no electric shock therapy
11 treatment, if that's all you all are willing to pay for and
12 that's what I get anyway, who do I sue?

13 MS. RUSH: I think maybe first a
14 clarification, and I'll jump in first and then the other
15 MCO's can respond.

16 I think from the standpoint of
17 behavioral prescriptions, we do obviously have some
18 preferred drugs like any MCO does. However, if your
19 provider has tried other prescriptions for you and they
20 have not been successful, we will absolutely talk with
21 them, get that information, and then can authorize you to
22 stay on the prescriptions that have been effective.

23 So, there does need to be a little
24 bit of a process there in communication, but the intent
25 would not be to mandate a change. We want to open up the

1 conversation; but if those are the prescriptions that are
2 working for an individual, then, we're going to honor that
3 and we'll authorize it. You have to go through the
4 authorization process but it will get authorized.

5 MS. MURPHY: If it's working, I don't
6 understand why there has to be an authorization process.
7 That's between a person and their provider, and it's taken
8 some of us years to get it right.

9 MS. RUSH: Oh, and we absolutely
10 understand that and appreciate that. I think the key
11 is----

12 MS. MURPHY: What I think you don't
13 understand and appreciate is that a matter of days without
14 the right medication, I'm not in any shape to talk to
15 anybody about authorizing anything anyway. Chances are I'm
16 going to be in jail because, in Kentucky, you don't have to
17 do anything violent to be arrested if you have a mental
18 illness. All you have to do is act a little funny and make
19 people uncomfortable. Disorderly conduct covers a wide
20 range; and once you land in jail, you don't get treatment
21 in jail.

22 With severe mental illness, you just
23 can't go playing with people's meds like that. We just
24 can't have that.

25 MR. CARLE: If I may add to that.

1 Jean, I was glad to hear that you said that we need to have
2 that extra level of communication. For those inpatient
3 acute care hospitals that also run psych units, we've had
4 issues with the formulary where an individual comes in and
5 they've had success with certain meds, but that's not in
6 your formulary, so, there's just really no access to the
7 appropriate meds at that time.

8 So, I'm really glad that she brought
9 this up, and hopefully we'll have that increased level of
10 communication and the accessibility for the drugs for the
11 patients that actually work with the experience that
12 they've had. So, thank you.

13 MS. MURPHY: And your crisis
14 stabilization units and your TRP's, which is therapeutic
15 rehabilitation treatment, that's what keeps people out of
16 the hospital, and now they're talking about titrating
17 people down from TRP activity. If they're not going to
18 TRP, they're going to be somewhere that day, probably
19 walking down the street acting funny.

20 The general public is so ignorant
21 about what mental illness is and is not. We can' go much
22 further backwards from 48th.

23 CHAIRMAN POOLE: If everybody would
24 allow me to do this, we do have a specialist here today
25 that is going to testify on behalf of this topic today.

1 And if he wouldn't mind to come forward now, Dr. Suess and
2 introduce yourself.

3 DR. SUESS: My name is Dr. Larry
4 Suess. I am an osteopathic physician boarded in adult
5 psychiatry and child psychiatry and practice child,
6 adolescent and family psychiatric medicine in rural West
7 Kentucky for approximately twenty years.

8 I voice my concerns with Kentucky's
9 rapid movement into managed Medicaid which is now becoming
10 a harsh reality. Central to my concerns was the added
11 stressors of a clinically challenging population who are
12 attempting to obtain healthcare from a more restricted pool
13 of providers, thereby, jeopardizing timely access to
14 treatment.

15 Because of the added requirements
16 necessary to continue to see recipients in Medicaid under
17 managed care, several physicians in my area are choosing
18 not to participate in managed Medicaid programs or are
19 limiting their practices to one or two managed care
20 organizations.

21 I have been told by these
22 practitioners the reasons for this was because medical
23 decision-making is managed beyond the control of the
24 healthcare provider. This has a negative influence on the
25 very existence to provide medical services to recipients in

1 Medicaid.

2 My training does not preclude
3 advocating for patients. I am an AOA Health Policy Fellow
4 and an APA Mead-Johnson Fellow and I'm U.S.-trained,
5 educated, along with having a Ph.D. in nursing from the
6 University of Texas at Austin. My area of expertise is
7 Medicaid.

8 I know time is of the essence. So, I
9 will list the problems currently being reported to me by
10 members of the Kentucky Osteopathic Medical Association, of
11 which I am president, and other clinicians I have spoken
12 with from my area and those issues I've experienced myself.

13 One - failure of communication.
14 Early requests by physicians and pharmacies for medication
15 formularies were not honored by you. They were not. In a
16 couple of instances, written request was given by myself
17 for a peer-to-peer review. Mental health is familiar with
18 managed Medicaid. We are familiar with the prior
19 authorization process. These denials to date for peer to
20 peer have not been even acknowledged in writing by myself.

21 Depending on the MCO depends on the
22 formulary that covers the medication which has already been
23 covered and PA'd or did not require a PA from Kentucky
24 Medicaid previously. We now have three formularies with
25 three different sets of requirements.

1 Prior authorizations. This results
2 in patients not having medication or having lapses in
3 medication coverage which has caused clinical
4 decompensation.

5 Last night I saw a 12-year-old male
6 who has been stabilized on his medication within the last
7 month. The medication he was stabilized on, mind you, he
8 had been through a myriad of different medications. So,
9 when I hear - and I'm sorry my voice is shaking because
10 it's of just complete amazement - this is a public forum.
11 This is being recorded. And when I'm being told and from
12 what I've seen in minutes of previous meetings, that's not
13 happening, people, period.

14 My testimony was going to be
15 different, but last night I stayed up until 2 a.m., drove
16 two and a half hours to be here so that you all hear
17 firsthand what is out there. This 12-year-old had been
18 stabilized on Abilify. He was taking the Abilify because
19 of the weight gain that he had experienced on the
20 Risperidone.

21 I am NIMH-trained. I know my
22 pharmacology, people. If I say I feel somebody needs to be
23 on something, it's because idiosyncratic problems arose for
24 the need of the medication the person was placed on. I am
25 not one that believes in adding medications to problems

1 already there. I'm more likely to take kids off of
2 medication.

3 The GAO's report which was published
4 two weeks ago identifies major problems within the foster
5 care system with the number of medications, specifically
6 psychotropics.

7 The problem with this issue is that
8 this 12-year-old tried to hang himself in a closet with a
9 belt four days after he did not have medications. My
10 office was not notified but the grandmother was notified of
11 the denial. If there's a denial of medication by PA,
12 please let the physician know because we gave the
13 grandfather who drove an hour the medication needed and we
14 got the kid into the office. I am in my office very, very
15 long hours.

16 As you are aware from HRSA, Health
17 Manpower that the need for child psychiatry is one of the
18 most needed areas in the U.S. We are far and few.

19 It is crucial to understand that
20 medication and treatment is a delicate balance that can be
21 easily destabilized. And I take this clinical
22 responsibility extremely seriously and have done so for the
23 last twenty years that I have been here in the Commonwealth
24 of Kentucky. Prior to that, I was in Alabama and Texas.
25 Clinicians in my area are seeing a rise in denials for

1 requests of clinical studies even when standard of care
2 indicates the need for these studies.

3 Three - administrative burdens that
4 are increasing. All medical offices I have been in contact
5 with report a tremendous increase in the amount of
6 paperwork. Healthcare providers are educated to treat
7 people, not paper. We do not treat patients through paper.
8 We have the eyes on that sees the patient with the
9 symptoms. What might be to some people anxiety might be
10 EPS.

11 Even when offices are set with
12 electronic records, the MCO's do not have online mechanisms
13 to streamline this process. The cost of overhead is high.
14 It's extremely high. Anything that streamlines and assists
15 with quality assurance is extremely important to myself and
16 to my colleagues.

17 Physicians overall have the best
18 interest of their patients at hand as do the majority of
19 healthcare providers. We are trained to provide service.

20 Claims processing. A significant
21 number of healthcare providers are experiencing a failure
22 of being paid in a timely manner. This has resulted in
23 physicians taking out lines of credit to meet expenses in
24 order to stay open. I'm one of those physicians.
25 Psychiatrists are not when you take a look for the hours we

1 put in compensated adequately.

2 Six - fragmentation. This is caused
3 by misinformation and/or no information being given to
4 clinicians and patients by MCO's and also by Kentucky
5 Medicaid.

6 Established in 1965, Medicaid is a
7 joint federal/state entitlement program. In other words,
8 if you meet the requirements, you are entitled to it. It
9 covers mandatory eligibility groups and those eligibility
10 groups include certain low-income families, children,
11 pregnant women and individuals who are aged or disabled.

12 These mandatory eligibility groups
13 receive federally protected services which include
14 inpatient, outpatient, hospital, physician services,
15 skilled and intermediate care, nursing facilities, medical
16 transportation and the list goes on. Everybody in this
17 room who deals with Medicaid either at an administrative
18 level or have been around for many, many years, if they
19 don't know this, they're blind.

20 I want to reiterate certain things.
21 Referral process. Patients have been telling me that they
22 have been told that they need a referral. I want to
23 reiterate. That's untrue. Referral to certain federally
24 protected services do not need referral. That includes
25 mental health and also obstetrics.

1 Ownership. All Medicaid Program
2 participants are responsible for appropriate standard of
3 care and should be held to the same standard. This is
4 where I want to deviate somewhat.

5 As a child psychiatrist, my role is
6 to make sure my patients function at the highest and their
7 work is school. Kentucky schools receive Medicaid. It's
8 important for me to get psychometric testing. When I
9 request psychometric testing from various entities, I can't
10 get it because I'm told that the schools are responsible.

11 Most individuals who are healthcare
12 providers have to deal with things in a timely process.
13 The very diagnosis of ADHD means into two domains. We want
14 to hear independency and we want that information as
15 objective as possible.

16 The Kentucky District Data Profile
17 for school year 2010, which is part of the LRC, reported an
18 end-of-year fund balance of close to \$792 million. The
19 shortfall in Medicaid by the time this was instituted was
20 \$125 million.

21 One would think that these requests
22 would be honored in a timely way when any practitioner
23 requests from the schools or makes recommendations.

24 In closing, I recommend the following
25 to be immediately implemented to protect our patients.

1 One - streamlining the PA process which can be done online
2 and results within one hour of submission of the PA so the
3 physician at the point of dealing with the patient can make
4 changes. If the majority of physicians would have had,
5 including the pharmacies, would have had the medication
6 formularies, a large amount of this could have been
7 avoided. The healthcare provider should have the ability
8 to perform a peer-to-peer review immediately.

9 The reason you are hearing some anger
10 in my tone has to do with the 12-year-old boy that I saw
11 last night. It's very frustrating to any healthcare
12 provider, any healthcare provider when their patients
13 decompensate. Our job is to prevent hospitalization.

14 So, you understand how far we have
15 come in the Commonwealth of Kentucky. When I first came to
16 this state with the U.S. Public Health Service, we used to
17 hospitalize children for months, if not years. Our first
18 go-around with this was to move from that to two weeks, but
19 in order to make sure our patients survive is that they're
20 treated and have access to treatment in a timely manner by
21 the highest qualified individuals and those individuals who
22 are married to the process.

23 A single Medicaid formulary. It is
24 problematic as it is now that if somebody comes into the
25 office and on one formulary it says Vyvanse, the other

1 formulary says no Vyvanse, but come January, well, we're
2 going to have Vyvanse. If I have done my part to fill out
3 forms and my staff has done their part to fill out forms,
4 the most common courtesy is to respond to us, please.

5 A telephone hotline for healthcare
6 providers to arbitrate clinical impasses which can effect
7 and affect healthcare delivery.

8 Five - credentialing, common
9 credentialing. Credentialing is timely, people. I have
10 been credentialed by Medicare, hospitals, insurance
11 companies and a myriad of other things. I have now had to
12 be credentialed twice in this process when one single point
13 of entry would have saved time.

14 Fast payments for clean claims within
15 seven days. I understand here today thirty days, okay,
16 back to five years ago. That's the nature of the system.

17 Eliminating prior authorization for
18 basic and routine services specifically covered under
19 Medicaid. There should not have to be PA for services that
20 are mandated and specifically with EPSDT.

21 Accountability to all who receive
22 Medicaid, not just certain provider groups. As a
23 physician, as a nurse, as a father, as a teacher, my focus
24 is very clear in one direction.

25 And one last thing pertaining to the

1 mental health components. Medicaid informed me that there
2 would be no carve-outs. I have it in writing. I have it
3 in email. We have been having difficulty specifically with
4 Cenpatico. So, when I'm informed by you appearing here
5 pertaining to what you said, I can't even get to someone
6 there because I'm not or have not, even though both
7 Centene, doing business as Kentucky Spirit, and WellCare -
8 we're using Center Care - I went through that process. To
9 date, there has to be a bridge. WellCare, kudos.

10 I should not be wasting time on this.
11 I should not have to be here. I should not have to call
12 people. But as president of KOMA, Kentucky Osteopathic
13 Medical Association, I've heard from way too many members
14 who are having similar problems and heard some here.

15 I appreciate you allowing me to
16 speak. And if I can be of any assistance in the future,
17 but my job here is specifically for one group and one group
18 only - and let me be clear as for the well being of my
19 patients and their families and their functioning.
20 Pediatricians, child psychiatrists, those of us that deal
21 with Medicaid populations are doing it because we are
22 committed. Do not cut us off at our ankles and make us
23 unable to do so. Kudos to you.

24 I would like to end what I have to
25 say now. I thank you for your time.

1 have, but I guess I really kind of need to know. Could
2 some of these things have been circumvented had the MAC
3 committee been involved in the earlier part? I know we've
4 gone through and probably beat this horse until it's mud
5 deep right now, but do you think we could have saved the
6 good doctor a trip had we thought about some of these
7 things?

8 I mean I'm sure everybody up here has
9 probably thought about these things since our go date or
10 our previous go date, but these are real and very
11 important. I'm not saying it will but his passion should
12 not be just saying, okay, he's here, he's spoken, he's gone
13 now. I just need to know if any of this will be--will we
14 be reported to about these things? Will we know about
15 these things?

16 COMMISSIONER WISE: We can. There
17 are several issues that we are dealing with. I didn't give
18 an exhaustive list. We have various systematic things that
19 we're dealing with. And, yes, probably some things we
20 probably should have thought about and planned for better.
21 Other things, you may have to start the process and then
22 find out what problems are with the system.

23 MS. FUMMILAYO: Well, we see that.

24 COMMISSIONER WISE: So, you're never
25 sure how much planning is going to present every single

1 problem from happening when you start the process and see
2 what issues come to light and what deficiencies there are.

3 MS. FUMMILAYO: So, is it possible
4 for us to have a list of his recommendations also so that
5 we can probably keep up with them?

6 COMMISSIONER WISE: I had asked him
7 for a copy.

8 MS. FUMMILAYO: Thank you.

9 CHAIRMAN POOLE: Dr. Neel.

10 DR. NEEL: I'm going to give you a
11 report from the trenches. I have been a KenPAC physician
12 for twenty-five years from its inception and a Medicaid
13 provider for forty-one years. I have a large pediatric
14 practice which is about 75% Medicaid. So, I know what I'm
15 talking about as far as that's concerned - Medicaid. I
16 have worked with it for a long time.

17 A lot of what's been said in this
18 meeting and particularly earlier on is being said because
19 we implemented too quickly in my opinion. This Council
20 gave you their opinion that we should not start until the
21 1st of January.

22 It only got delayed a month because
23 the hospitals really said they were not ready to go, I
24 believe. Physicians had tried to say before that we were
25 not ready to go because that was the view from the trenches

1 at that point, but that fell on deaf ears and I won't
2 belabor that point.

3 But I think we were justified and I
4 think we should have waited until then because I think it
5 would have been better for the companies. The companies
6 have put on a brave front that they were ready to go, but I
7 think particularly one company was not and still not ready
8 to go in particular, and I won't mention which one at this
9 point but it may be obvious but they were not ready.

10 Contracts are still not finished.
11 Many in my area, physicians, hospitals, other providers are
12 still doing contracting, particularly hospitals. Now,
13 grant it, we may have above the minimum level but we still
14 have problems. And that's going to get worse as we get
15 into January if some have not contracted because at that
16 point, people are going to be out of network. Even some
17 simple services may require a prior authorization and
18 that's just going to be a disaster.

19 Patients were not ready. Many still
20 don't have ID cards and particularly from one company. And
21 the data apparently that came from Medicaid to at least one
22 company must have been flawed in some way because many
23 patients are now assigned three-year-old boys to
24 obstetricians, Walmart clinics, doctors who don't take
25 Medicaid, doctors who are dead or retired. We've had all

1 kinds of problems, and it's not just a few. It's hundreds
2 of these patients that are having problems. That's caused
3 all kinds of confusion.

4 Because everybody hasn't contracted
5 with every MCO which seems to be the assumption. And I
6 know that the federal government wanted to give recipients
7 choice, and I understand that; however, that's not the way
8 it's happening in reality, and that's creating a lot of
9 confusion, making a lot of people change companies and
10 still changing companies. And I think if wle had waited,
11 there would have been much less confusion.

12 The auto assignment created huge
13 problems. I know that seemed the way you all wanted to do
14 it, but that caused a lot of problems because people didn't
15 sign on with all MCO's. And, so, there's been thousands
16 more having to change. I don't know exactly what the
17 numbers are but they seem large.

18 I can tell you that for primary care,
19 particularly those of us who take care of a lot of Medicaid
20 patients, it's been a financial disaster. I don't know of
21 anybody who has not either had to go into their retirement
22 or get a line of credit from the bank or something. And
23 that's not the fault of the MCO's and not the fault of any
24 one entity I think in particular; but had we been closer to
25 ready to go with more contracts signed and more of the

1 kinks worked out, I think the financial transition would
2 have been much better. And to their credit, it appears
3 that they're not editing payments at this point and I hope
4 that they won't edit it in the future. We lived through
5 the edits that you all did years ago; but if they begin to
6 edit, it will be obvious and it will be more difficult.

7 I'm concerned whether we're really
8 moving to managed care or from managed care. And I realize
9 they're managed care organizations, and I hope that that's
10 going to work, but KenPAC was a managed care system and it
11 worked quite well. It could have worked better and I've
12 made that point before.

13 What I fear now is that since there's
14 no management fee in most cases for primary care providers,
15 that they will not have either the incentive or the
16 financial ability to manage the care like they would. I
17 think that there's a difference between a primary care
18 provider and one who provides a complete medical home to
19 patients.

20 And these Medicaid patients are very
21 different from the proprietary patients that are out there
22 in the regular insurance market. It's one in five of our
23 population; and I guess in 2014, it may become one in four.
24 I don't know, and we have to worry about that, but they're
25 much more difficult to manage - not the ones with chronic

1 care, just the ones that are the regular patients you
2 manage.

3 I saw fifty patients yesterday.
4 Fifteen didn't show up for care. You can't call them and
5 get them there. Their phones have been disconnected. They
6 don't answer. There are a lot of reasons. These are
7 different people from others, and I want everybody in this
8 room to understand that if they don't.

9 So, I'm concerned as we move to this,
10 and I know the managed care organizations are providing a
11 lot of assistance to us, but I'm concerned that there
12 certainly is not the financial ability for the primary care
13 provider to spend the time doing prior authorizations and
14 the kind of things that seem to be necessary with these
15 companies.

16 Either we're going to have to turn
17 the prior authorizations over to the patients themselves
18 who have time to wait for long periods of time to get the
19 authorizations or we're going to have to do it in a
20 different way as Dr. Suess as suggested. So, I'm terribly
21 concerned.

22 There must be a way other than just
23 limiting access to care for the managed care organizations
24 to make the profit that they deserve to make from this, but
25 I think that they're going to have to work very closely

1 with us if we're all going to be able to afford this
2 because the only way the primary care provider has been
3 able to provide good care to the Medicaid population
4 because of low reimbursement rates has been that extra
5 KenPAC payment.

6 And for those who are going to be out
7 of network in January, and there are going to be some
8 because they're not signing with all three, if those
9 payments, then, drop to 90% or less and prior authorization
10 is required, I don't see how that's going to happen for the
11 system.

12 I'm also worried as Dr. Suess was
13 about the three different formularies. I still don't
14 understand why we couldn't have had a common formulary and
15 possibly one even managed by Medicaid because in some
16 states they've done that so it could be your formulary.

17 I understand that money can be saved
18 with generics and that sort of thing, but that's what
19 physicians are using now. Except in mental healthcare,
20 we're using almost all generics, certainly in the pediatric
21 population. And I think that there's going to have to be
22 special care because the short-acting, older mental health
23 drugs that we use for ADHD just simply do not work well for
24 the kids that we're treating now with the newer drugs. So,
25 we're going to have to do something there.

1 And a final concern that I have is
2 that we're not seeing in our area - and I suspect this is
3 true in most area - almost nobody is taking adult
4 Medicaid, and I brought this up last time. The
5 pediatricians are taking care of the majority of children
6 on Medicaid and providing the best care they can, but we
7 have only one practice in our entire area that's seeing
8 adult Medicaid. And I'm hearing from your regional nurses
9 that are still working that it's just really a difficult
10 situation.

11 Now, grant it, that's a different
12 population fo people. They require more to take care of,
13 more money to take care of. They require more of the
14 physician to take care of them. And, so, there are very
15 few practices accepting them. So, I'd love to hear your
16 comments from you all and from the MCO's how we're going to
17 deal with that.

18 So, I'll stop now.

19 COMMISSIONER WISE: You're talking
20 about the ones who are still on Medicaid fee for service
21 and not in managed care or are you talking about within
22 managed care as far as the adults?

23 DR. NEEL: I'm saying that of the
24 physicians in our area who have taken care of adult
25 Medicaid in the past and participated with KenPAC and

1 Medicaid are not wanting to do that anymore. It's down to
2 one simple practice in our area that is accepting adult
3 Medicaids. And I think that's going to get worse instead
4 of better, and I don't know exactly what that number is. I
5 think of the 560,000 recipients that you put on Medicaid
6 managed care, about 65% are children, 35% adults.

7 COMMISSIONER WISE: That sounds about
8 right.

9 DR. NEEL: That's going to be a lot
10 of patients. I'm concerned that that's going to cost us
11 all more money because I think they're going to be going to
12 hospital emergency rooms. They're going to be going to
13 alternate places to seek care.

14 COMMISSIONER WISE: And that's
15 something the MCO's will be looking at. They're not happy
16 when they go to the ER either.

17 DR. NEEL: I understand that. Of
18 course, I guess the answer to that is pay the ER's what you
19 pay us. We have been able to restrict in the past where
20 our patients went. If they went to urgent care centers,
21 the urgent care center had to call to get permission. Now,
22 we've said maybe that hasn't been a true edict, but all the
23 urgent care centers think that and they call, so, they get
24 sent to us except for OB, mental health and ophthalmology
25 where they were unrestricted in the past. I wish we had

1 some way to restrict trips to the emergency room.

2 COMMISSIONER WISE: Do you guys want
3 to comment on your medical home model and how you do
4 primary care and address that piece of it a little bit?

5 MR. MINOR: I'll start off. And I
6 want to thank Dr. Neel because I know you had brought this
7 to the WellCare team just as a, hey, we need to look at
8 this from an adult primary care provider in certain areas.

9 And he's absolutely correct. If
10 there's not enough providers for adult care, the options
11 are to utilize the emergency room. And as we know, that's
12 not the medical home concept that we're trying to develop
13 that we want to work with primary care providers on. Dr.
14 Neel himself has after-hours, weekends and does many things
15 to make it as easy for his patients to see him as possible.

16 So, just getting to the root of that
17 is to go out as we have all done in different markets is
18 who else is there that may not take Medicaid today and what
19 do those conversations need to be in order to provide
20 greater access. And I don't think it's just in that area.

21 And I think as we're forty-five days
22 in, we all have different populations and different
23 concentrations within the state. And it's to everyone's
24 benefit to go out and to try to have as many primary care
25 providers as possible, and that may take the shape and form

1 of different quality incentives and things to increase the
2 access.

3 DR. SUESS: May I intercede here?
4 The medical home model has been around for about fifteen
5 years now. It was a joint venture by pediatricians, nurse
6 practitioners, Medicaid to get a single source.

7 But the true issue right now, even
8 though I'm hearing it, is really the accountable care
9 organizations that we're going to be moving to, the ACO's,
10 the joining of those individuals who are managing their
11 patients to the ACO's.

12 Isn't that what we're moving to or
13 I'm seeing we're moving to because we're talking about the
14 medical home model when we are actually talking about the
15 accountable care organizations or the ACO's who are
16 managing patient lives. And I know some people in here are
17 looking at me like, what is that, but the three of you
18 there should know about that. Do you not?

19 MS. RUSH: Oh, yeah.

20 DR. SUESS: Can you explain to the
21 panel the ramifications of that?

22 MS. RUSH: Well, I think the ACO
23 model is still evolving. As everyone knows, CMS has issued
24 their preliminary instructions and there are hospital
25 systems around the country that are beginning to develop

1 models. I think some are moving faster than others in
2 terms of moving to an ACO type model.

3 But sort of building upon what Mike
4 said, I think one of the things that we're doing in the
5 interim because those are not fully deployed yet is that we
6 are continuing to work through the primary care physicians.
7 And one of the first steps in our process has been to reach
8 out to the members to get them to select a PCP so that that
9 becomes their medical home.

10 And I don't disagree with you that
11 the ACO model is definitely evolving, and I think it will
12 shape some of the healthcare in the future; but currently
13 we are still working through the primary care physician and
14 looking for them to help us to manage that member's care,
15 including the topic of emergency rooms.

16 One of the things that we do through
17 our case management program is that when a member has gone
18 to an emergency room, we will reach out to them. If they
19 went for something that really should have been seen with
20 the primary care, we will reach out to them to try to find
21 out why did they go to the emergency room. Do they have a
22 PCP. If not, can we help them to get a PCP.

23 So, part of this process is really to
24 work through and identify what those root causes are so
25 that we can begin making sure that our members are getting

1 the right care in the right setting which is definitely our
2 collective goal.

3 DR. SUESS: But the future is
4 September, 2012, is it not?

5 MS. RUSH: For some.

6 DR. SUESS: Pending the outcome of
7 what happens in the Supreme Court, everything is contingent
8 upon that. But let's say it's upheld and we go our merry
9 way, we're talking about September of 2012. That is less
10 than a year away.

11 Likewise, when we went to managed
12 care, we did it in three months. We're now being given
13 warning ten months ahead of time. Dr. Neel is very, very
14 correct. I've known him since I've been in the state. His
15 hours are quite long, he's on weekends, similar to my
16 hours, similar to a lot of pediatricians' hours.

17 But moving to the ACO model which
18 we're not hearing, and the majority of the people in this
19 room have some idea and some do not, mental health is still
20 carved out and mental health issues are now being treated
21 in jails.

22 So, what I'm hearing from individuals
23 who are part of the system as patients and those of us who
24 are treating them and those of us that advocate for them,
25 the Domenici-Wellstone Act clearly states parody. Ad I'm

1 not hearing that at all unless I'm not hearing something
2 I'm supposed to be hearing, because the minute you say
3 somebody has problems of the biologic, physiologic
4 functioning of the brain, it's not mental, and that gives
5 credence to carve it out and pretend it's not there.

6 So, like the advocates who are here,
7 you will keep hearing from me over and over. And part of
8 us who are dealing with children, we have to do it through
9 the schools. We're not getting anywhere, people, and we're
10 causing future degenerations to have the sequella for what
11 we could have changed earlier and that change is now.

12 I want to address one last thing.
13 The reason we're having problems with this rollout because
14 of time is because we're dealing with tertiary problems as
15 opposed to primary problems. Primary care, DO's are
16 primarily generalists and we're primary physicians. That's
17 how we've been educated and how we're trained.

18 It appears that those of us who are
19 giving treatment, giving care are somewhat excluded and
20 have been excluded over the years.

21 One-third of my time currently is
22 doing paperwork which is up from 25% five years ago which
23 is now up 5% and it goes over and over. And finally we're
24 going to be dealing with 5% patient care and 95% paperwork.
25 There's got to be a streamline. There must be a

1 streamline.

2 Standards of care are there,
3 researched standards of care. We have two major
4 universities in this state and we have three medical
5 schools in the state. We are resources.

6 On the nursing side, we have several
7 Ph.D. programs in nursing. And the Nursing Institute at
8 NIH has done research for many, many years on this. We do
9 not need to reinvent the wheel.

10 CHAIRMAN POOLE: Thank you. Go
11 ahead.

12 DR. PARTIN: I'll keep my comments
13 short. I wanted to reiterate the problem with the
14 formulary, that that's been very difficult for us in our
15 practice and other nurse practitioners that I've heard
16 from, trying to get the medications preauthorized and
17 trying to figure out which drugs you can use and which ones
18 you can't, and I think a common formulary would be very
19 helpful.

20 The other thing is that the
21 requirements with the MCO's are different. And, for me,
22 it's been very difficult to try and figure out what I'm
23 supposed to do because the requirements are all different.
24 And to be honest, I have not been able to read through all
25 of the provider manuals because it's volumes of material.

1 And I start to read it and then I get confused as to which
2 MCO is telling me which thing I can do or I can't do or
3 which procedures I have to follow. So, some commonality
4 there I think would be very helpful.

5 And, then, finally, when we're
6 talking about adult Medicaid patients, I do see adults.
7 And I was just informed that for the flu shots which we are
8 really pushing everybody to get flu shots, for adults,
9 Medicaid isn't paying for that. And, so, the shots that I
10 purchased I'm just going to have to I guess give that as
11 charity for my patients because anybody over eighteen I was
12 told wasn't covered.

13 That's all I have to say.

14 MR. WHALEY: Before we go on, I've
15 been thinking about Dr. Suess' comments for some time here,
16 and especially because he's put a human face on where we
17 are. We're talking about a kid who obviously was troubled
18 and obviously thought that he needed to take his own life.

19 Now, whether that is directly related
20 to MCO's or not, certainly there's a breakdown here
21 somewhere. There's a communication breakdown as Dr. Suess
22 had described either with case management or communication
23 with families, communication with the physicians obviously.

24 And it's troubling to me because
25 we're no longer talking about machinations of managed care,

1 we're talking about people, and that's extraordinarily
2 troubling to me. I don't understand how that could happen.

3 Certainly I don't understand how if
4 we see a problem, if we've identified a problem and it took
5 us quickly three months to roll out managed care, taking a
6 look especially at Dr. Sues's recommendations, in
7 particular, the single formulary issue which seems to be a
8 recurring theme here, certainly we can address that and we
9 can address it quickly. And I would hope we would do that
10 with the same expediency that we've rolled out the managed
11 care program.

12 MS. WITTY: I'd just like to say a
13 couple of things here. We take everything that we've heard
14 today very seriously. All three of us I'm sure have a list
15 to go back.

16 I think it's important to just talk
17 about a couple of things that were mentioned today. None
18 of us require a referral. So, I'm not sure where all that
19 is coming from. And, so, I want to be sure that we're also
20 dealing with facts. I know emotions can run high.

21 My own son has ADHD and I deal with a
22 lot of emotional issues. I deal with medication issues. I
23 deal with a lot of different things every day of my life.
24 It's a constant struggle to deal with him every single day.
25 So, I can relate to some of the comments that have been

1 made.

2 But by the same token, I want to be
3 sure that we focus on all the things that we're doing
4 right. You know, we come in here and I know there's always
5 going to be a case of some things, but we've had instances.
6 Jean talked about one success story. We also are doing
7 pharmacy analysis. We have one member that's on sixty-nine
8 different drugs.

9 And, so, we are trying to make the
10 world better. I mean, I understand there's going to be
11 some growing pains, but we're not just about saying no. We
12 had a situation where a mother wanted to take their baby
13 home with them and she felt like she was trained to take
14 care of the baby.

15 Our medical director did not feel
16 that that was a good situation for the child, reached out
17 to the doctor. And the doctor was like, oh, my gosh, I
18 didn't even realize that that was happening. So, we
19 arranged for a lot more home care visits for this child and
20 this baby.

21 We are very interested in hearing
22 about if there's an issue with our patient or a member, we
23 want to know about that because we want to make it right.
24 I'm a very big proponent of peer to peer. I talk to my
25 medical directors - I have three of them - all

1 board-certified physicians. We have doctors reviewing
2 cases. We don't have staff people doing that. We have
3 doctors doing this.

4 My Health Services Department is the
5 biggest FTE group that I have. I have certified case
6 managers. I have registered nurses. I have social
7 workers. I have doctors. I have a pharmacist sitting here
8 and I have a whole lot of people backing me up every
9 single day.

10 And, so, I really am interested in
11 hearing and I intend to call Dr. Sues. I'd like to talk
12 to Dr. Neel separately and offline about particular issues
13 with my members because we talk in broad generalities about
14 they are saying this and they said that and somebody said
15 this and somebody said that.

16 And the one thing that I have seen
17 here is a ton--I mean, there's just a lot of
18 miscommunication and non-fact-based conversations going on.
19 As Jean mentioned, we're all about taking specific issues
20 and trying to make it right. And, so, as much information
21 as we can get about particular issues, we're going to do
22 our darndest to try to make it be right for the member.
23 That's our goal.

24 Allen Wise, the CEO of my company,
25 was in Kentucky two weeks ago and he said I want to know

1 what we are doing for our members, and that's coming from
2 the top of a Fortune 500 company.

3 We all know there were a few bumps
4 and there's always going to be. But when I'm sitting here
5 taking care of 221,000 people and I have a handful of
6 complaints, I just have to go on record for saying I think
7 we're doing a lot of stuff right, not to say that we can't
8 always do better.

9 And I'm certainly not trying to
10 minimize any concerns that have been brought up today
11 because everybody has got my name and I'm certainly happy
12 to take a phone call or meet with somebody offline to try
13 to correct some of these things. But to what Dr. Suess
14 said, we are streamlining the preauth. Our requirements
15 are online. We are meeting standards that are set by the
16 Commonwealth.

17 We do have peer to peers and I
18 encourage those. I want our doctors to hear what's going
19 on. I don't want to have something go all the way through
20 the appeal process only to hit a reconsideration. That's
21 not good use of anybody's time.

22 As far as the formulary goes, we all
23 have national formularies. So, that is a little bit of a
24 challenge for us because we don't operate just in one
25 state. We operate in many states and we are using national

1 formularies that we do for our whole company.

2 I'm all over a common credentialing.
3 If there's a way for us to deal and have one set of
4 credentialing among the three MCO's, I'm all for it. I
5 have written it down. I intend to get with Jean and Mike
6 after this to figure out if we can work with the
7 Commonwealth to come up with a standard credentialing
8 moniker that we can just put in place because, to me, I
9 agree, it's 100% paperwork.

10 The fast claims' processing, we have
11 to pay claims within thirty days or we have to pay
12 interest. Now that we're on a regular roll, 99% of our
13 claims are paid with fifteen days. I encourage everybody
14 to do EFT. It makes everything a lot quicker and a lot
15 faster. So, if people can pay claims on an EFT basis,
16 that's going to help. That's really going to help.

17 As far as the prior auth process,
18 that, too, is something we constantly evaluate. We started
19 out in the Commonwealth with what we thought was a good
20 prior auth list. We intent and we do at a minimum
21 quarterly evaluate what's coming in on the auth list and
22 also to see what we never say no to because it's a waste of
23 everybody's time to authorize something that we never say
24 no to.

25 So, you have my personal commitment

1 that we're going to be looking at that auth list and trying
2 to figure out things that we can take off of it, especially
3 if it's a waste of everyone's time.

4 So, I welcome the feedback and we
5 want to be better. The way we get better is to hear the
6 feedback. But I also think it's really important focus to
7 focus on the things that we're doing right and not always
8 just everything that's going wrong.

9 DR. SUESS: The reason we are here,
10 the reason that you are receiving feedback is not based on
11 what's going correctly because that doesn't need to be
12 corrected. What needs to be corrected are the failsafes
13 that are not working.

14 What I heard from people here were
15 certain things were going correct; and if it was not
16 countered, we would not have this discussion right now.

17 Two, there's a difference between the
18 carve-outs and the mother ship. Mental health carve-outs
19 are not following necessarily what you are saying. So far,
20 I'm having it's okay so far with WellCare; so far with
21 Coventry, we're having our problems; but we cannot even
22 communicate with Cenpatico.

23 MS. RUSH: We definitely need to talk
24 after this.

25 DR. SUESS: I understand that, but

1 I'm here to go on record not to say push this through and
2 say, hey, everyone is saying everything is fine and not
3 address it.

4 EPSDT, it's diagnosis. People are
5 committed to patients. We are committed. It's not that we
6 don't want to work with you, but we have to have the
7 communication to work with you. It's not happening.

8 Minimization. You're talking to a
9 psychiatrist. Wrong thing because I look at words and I
10 reflect them back, and it's important to understand that
11 we're not minimizing. Nobody is minimizing. It is a
12 heated discussion. Healthcare is a full contact
13 discussion. And if you can't stand the contact, get out of
14 the game, people. We have to represent people. I must
15 represent my patients. I advocate for my patients.

16 If you really want to understand the
17 monetary issues, yeah, I'll take it to the back room and
18 explain it to you - we're having problems, but we knew
19 that. That's why we had a buffer. My buffer is coming
20 very closely to the end.

21 But those individuals who have never
22 had to deal with Managed care, never had to deal with
23 carve-out, never had to deal with prior authorizations,
24 they're now experiencing this for the very, very first
25 time. Mental health has been dealing with this for

1 twenty-odd years now.

2 Adversarial? No. I really don't want
3 to be adversarial; but when I call and call and call and
4 can't get an answer, I'm forced into a corner. It's my
5 patients and their well being, and the majority of
6 physicians will say that. The majority of healthcare
7 practitioners will say that.

8 And right now, dentists, you know,
9 there's a dentist in my area that deals with Medicaid
10 patients. She as far as I'm concerned is doing a bang-up
11 job when she sees people. She might not be paid but she's
12 treating patients and that's what we're here to do is treat
13 patients.

14 CHAIRMAN POOLE: Thank you. Let's
15 move on to the Technical Advisory Committee reports. First
16 of all, Children's Health.

17 REPORT OF CHILDREN'S HEALTH TAC:

18 MS. McNARY: Hello, everyone. My
19 name is Lacey McNary and I work with Kentucky Youth
20 Advocates, and I was elected Chair of the Children's Health
21 TAC at the meeting a couple of weeks ago, and I'm really
22 excited about this opportunity.

23 We have only met once. It was kind
24 of an initial planning meeting, talking about bylaws,
25 chair, that sort of thing. So, I don't really have too

1 much to report, although we are very interested in hearing
2 these sort of conversations and getting the various
3 representatives of the children's advocacy type groups at
4 one table to bring forth issues that are going on.

5 And we hope that the managed care
6 companies, we've gotten assurances that a lot of them can
7 be a part of that. So, we look forward to that, and
8 hopefully we have more to present next time.

9 CHAIRMAN POOLE: Thank you. Next up
10 is the Dental TAC.

11 REPORT OF THE DENTAL TAC:

12 DR. RODRIGUEZ: I'll go ahead and
13 represent the Dental TAC. We did meet this morning which
14 is good timing. You all might want to think about doing
15 that.

16 We had many, many people at the table
17 which was nice. Truthfully, with the confusion that's been
18 blurring my mind the last few weeks, I did nothing to
19 prepare for the meeting. So, it was great that everybody
20 was there.

21 Let me just say that we did meet the
22 Director for the State's Managed Care Oversight Committee,
23 and we understand now that also Carrie Banahan will be the
24 Implementation Director for Managed Care. So, it was good
25 to have those names to put to the group of people who will

1 actually be following this process.

2 One of the things that we asked for
3 was a flow chart of the organizational structure complete
4 with phone numbers and emails so that we can understand who
5 we need to go to when things don't work the way they're
6 supposed to, in addition to the MCO's who at the State
7 level should be contacted because it seems like we need to
8 talk to not only the MCO's but also the people at the State
9 level who are supposed to be watching out. If they don't
10 have specifics, then, they can't address the issues either.
11 So, that was driven home several times this morning.

12 So, we're expecting to have that flow
13 chart of the organizational structure with names and phone
14 numbers and emails very soon.

15 The other issues that came about were
16 the same things that we've been talking about this morning
17 so far - preauthorizations. The idea of an online,
18 realtime prior authorization is fabulous, and I can't
19 understand why we couldn't do that.

20 If I can send a periodontal charting
21 and a set of electronic radiographs to Avesis for
22 preauthorization, why can't they have somebody at the other
23 end looking at them saying, yes, I understand the patient
24 is in the chair and you can do that because I can see that
25 they have periodontal disease. Why would I want to wait

1 for one month to get them back in again because I can only
2 see that patient once a month?

3 So, that's just one little example,
4 not such an important example. A more important example
5 would be I'm an oral surgeon. I have a 13-year-old child
6 in the chair. They have an infected tooth. I can't get it
7 numb any other way. I need to give them IV sedation. I
8 can't do it because it has to be prior-authorized.

9 One of the oral surgeons that I work
10 with that I refer to who is a safety net oral surgeon
11 called me a couple of weeks ago, and he's a tough guy.
12 He's been in the business for forty years. He was
13 literally on the verge of tears because he had had a day
14 when he had had three patients and that was the scenario.
15 He couldn't do--well, he did them but he said I don't know
16 if I'll ever get paid but I did them because I have to do
17 them; but he said it makes for a very long day. Everybody
18 is unhappy. The staff is unhappy. The patient is unhappy.
19 The mom and dad are unhappy. Nobody is happy.

20 So, prior authorizations, prior
21 authorizations, prior authorizations. In this world of
22 electronics, why can't we get those online and realtime? I
23 think it's a great idea. Thank you, Doctor, for mentioning
24 that.

25 The only other issue was--well, maybe

1 not the only other issue but one other issue was timely pay
2 because we do know that we're in a state where you're
3 supposed to get paid in thirty days for a clean claim.

4 I have here a stack of claims, my
5 personal stack of claims for one of the MCO's that haven't
6 been paid. This particular, MCNA, in fact, I have been
7 paid for November 1. So, claims for November 1 have been
8 paid. I have not contracted with them because I want to
9 see how they're going to work before I sign on the line.

10 I do take my patients' lives into my
11 hands when they come into my operatory; and if I can't do
12 it right and the correct manner in the way that I believe
13 to be the correct manner, then, I don't want to do it.

14 I have claims here that are six weeks
15 old is what I'm trying to say, and I may or may not
16 contract with that particular company. I haven't even had
17 access to their website. So, I don't even know if I can
18 use it or not. Lots of questions.

19 Sorry. I lost my train of thought
20 there. The bottom line was that we did agree that if MCNA
21 would extend its transition period for thirty days - they
22 said they couldn't make that decision - that was a
23 higher-up decision - but if MCNA could extend their
24 transition period for thirty days from January 1 to
25 February 1 like DentaQuest has done, that we would be more

1 than happy to meet, we being the Dental TAC and some people
2 from the State, I guess the transition team or the
3 implementation team - excuse me - would be more than happy
4 to meet with the three MCO's sometime within the first two
5 weeks of January. I wanted to meet sometime in the next
6 two weeks and they said, Carla, you can't do that. It's
7 Christmas. So, I said, okay, the first two weeks in
8 January.

9 And that was it pretty much for the
10 Dental TAC. Does anybody who was there have anything to
11 add? Did I miss anything? Thank you.

12 CHAIRMAN POOLE: Thank you. I know
13 the DMRAB did not meet this last month. So, up next will
14 be Home Health Care TAC.

15 MR. KIP BOWMAR: Good morning. Well,
16 I guess good afternoon now. Thank you for the opportunity
17 to speak.

18 Our TAC has been working on a number
19 of issues, and I do want to commend the MCO's for being
20 willing to meet with us. We've been having a series of
21 meetings with them individually to try and work on issues,
22 and we are going to continue to do so, but there are a lot
23 of remaining issues to be worked out.

24 One of the issues is par versus non-
25 par contracts. A lot of agencies have submitted contracts

1 but haven't gotten them back. And one of the things that
2 we have requested is that if an agency has submitted its
3 contract, even if the MCO has not finalized it, for them to
4 still be paid at 100% coming January 1 instead of going to
5 90%.

6 The home health reimbursement rate
7 has not been increased in about eleven years. And if it
8 drops from 100% to 90%, I think you'll lose a lot of
9 providers and a lot of patients will lose access to care.

10 I will give kudos to WellCare. They
11 have made the commitment that if the agency has submitted
12 the contract, that it will be paid at 100%. We're still in
13 discussions with Coventry and Kentucky Spirit on that
14 particular issue.

15 Another issue is that two of the
16 MCO's have said that a particular service, home health
17 aides which is aides only which is currently a covered
18 benefit under Medicaid now will have to go through a
19 different standard in the future of medical necessity which
20 means that it will be more difficult for those services to
21 be approved.

22 One of the requests that we would
23 like to make is for their standard on that more mirror the
24 language of what's in the current Medicaid regulation so
25 that when agencies call in to try to get that service

1 authorized, for them not to be told, well, that's just not
2 a covered benefit; but if you want to go ahead and send it
3 in because there are some aide-only services that are being
4 approved; but with the PA staff sometimes telling folks
5 that that's not a covered benefit, they just sort of drop
6 it. And, so, sometimes the patient can lose access to
7 care, but that's an issue that we're also working on.

8 One of the MCO's has said that if a
9 home health agency calls in with verbal orders that it has
10 received from a physician to order home health services,
11 that they will have to have a signed order to get a prior
12 authorization; whereas, under the current Medicaid
13 regulation, the agencies have up to twenty-one days to get
14 that verbal order signed.

15 Even CMS allows for home health
16 agencies to do that, and Medicaid is a program that falls
17 under the purview of CMS as well as the Department for
18 Medicaid. So, we would certainly like for that to be
19 looked at because it can take so long for the physicians'
20 orders to get signed for the agency to get those back in
21 hand and it really delays the beginning of care which can
22 be very critical. And, so, that's certainly an issue that
23 we would like to be able to take a look at.

24 In terms of claims being paid, we
25 know that this has been an issue. There have been a lot of

1 agencies that have not tried to bill yet; but I know of one
2 agency that has submitted a total of 105 claims in the
3 month of November and has not been paid for a single claim
4 yet - and that's all three MCO's combined - and over half
5 of those are more than thirty days old. And, so, clearly
6 it's creating cash flow problems. And I think as our
7 agencies start to bill in December, if things aren't
8 streamlined in a better way, it will be difficult.

9 And, once again, I think that that's
10 an issue that if not fully resolved, it will once again
11 lead to providers existing the program which I think would
12 be a real shame if that were to happen.

13 One of the requests that we would
14 like to make is that whatever information that the MCO's
15 have that they're giving to their PA staff, if we could
16 also get a copy of that in regards to home health, and that
17 way we might be able to offer some constructive criticism
18 as a way to be able to improve that because I think there's
19 just a lot of confusion.

20 A lot of agencies have said it kind
21 of depends on what person they talk to on a given day when
22 they call in because they call in and they're told one
23 thing. They call back the next day and they're told
24 something else. I think that that is definitely an issue.

25 And, in addition, while we certainly

1 appreciate the MCO's meeting with us, we would also like
2 the opportunity that if you do have advisory committees,
3 that we be able to have a home health representative be
4 able to participate on that.

5 Also, one of the issues in regards to
6 the prior authorization process, sometimes the date that is
7 given on the prior authorization does not match up with the
8 plan of care. And when those don't match up, sometimes
9 when the State comes out and monitors the agency, they will
10 be cited for that. So, that's kind of an operational issue
11 that we would like to be able to see those dates of when
12 the PA is approved match up with the plan of care. Those
13 are some of the issues that we need to address.

14 And, then, I think in terms of the
15 metrics for future meetings, I think something that might
16 be helpful to know is the percentage of claims paid that
17 have been received - I think that would be helpful - and
18 also the average number of days from when a claim is
19 received until when it's paid.

20 I think those would be helpful
21 because I think that we're hearing from a lot of providers,
22 not just home health agencies, that that is a particular
23 issue. So, I think that's kind of an overview.

24 Sharon, is there anything
25 additionally you'd like to add?

1 MS. BRANHAM: Backing up to the par
2 and non-par and just to reiterate the fact that you need to
3 give some serious consideration because we've yet to be
4 able to obtain a list of agencies that have submitted their
5 contracts.

6 And we've heard a lot about
7 conversations and the reaching out to providers. And I
8 have not on a personal level with two agencies, I haven't
9 received a call or a letter to say welcome as a provider
10 and our MCO. Now, I have phoned to get my numbers so I can
11 start billing, although that's not helped me any.

12 I have submitted to one MCO the
13 contract three times with a signed registered receipt of
14 them receiving it, and I'm like, really. So, back to the
15 doctor's remark. This has been very time-consuming, very
16 burdensome on small providers providing services to
17 Medicaid recipients in the state the task of meeting all
18 the needs of each MCO's.

19 When we receive a PA back from the
20 MCO's, it says approved but it doesn't say what it's
21 approved for and we ask that we receive it back in writing.
22 If we submit a PA and we've asked for aide services two
23 times a week for sixty days, an RN one time a week and
24 medical/surgical supplies, we're getting back like PA
25 numbers, at least six or seven, and we can't put those on

1 electronic billing claims.

2 So, this is a real problem and we
3 don't know what's approved. We don't know if the aides
4 were approved, if they were approved for one time a week or
5 two times a week or for thirty days or for forty-five days.

6 And back to this, when we have a PA
7 on particular patients and they go into the hospital and
8 they have a two- or three-day stay, that PA that we spent a
9 lot of time on receiving for the services, when it comes
10 out, it's automatically cancelled.

11 And what happens is when we call to
12 get another PA for the services for resumption of care,
13 there is a specific CMS plan of treatment, a 485, that has
14 everything on it that's happening to the patient. That's
15 signed by the physician. Let's go for sixty days. It's
16 altered with verbal orders.

17 And for us to receive a second prior
18 authorization for services to be rendered when they come
19 back out of the hospital, then, it's like for thirty days
20 or thirty-two days. There's no set sequence. When the CMS
21 folks come in and the OIG folks come in to do our survey,
22 those orders have to precisely match up with the plan of
23 treatment. And what you're doing to us is causing us to
24 have some real administrative burdens when we're being
25 surveyed for our recertification for Medicare.

1 hand to go with the prior authorization.

2 And the prior authorization has been
3 a nightmare. Let me just reiterate this again to all three
4 MCO's. There's been communication with us from the MCO's.
5 Some of you we've not met with and some of them I think are
6 calling Kip to get us some meetings established.

7 So, I would like to say that the PA
8 process is just so burdensome, whether we get approvals or
9 whether we get denials, and everybody requires something
10 different. Again, you need to look at your process there.

11 What we're asking for are simple
12 visits to maintain that patient in the home or to carry out
13 a physician's order. Personal care, back to the home
14 health aide, personal care is a God-given right. And you
15 may have somebody in their home that they're staying in
16 their home because there's somebody that can check on them,
17 whether it's CAP service or whether it's a non-medical
18 service or whatever.

19 But declining personal care services
20 to help someone be clean and assist them is really, you
21 know, and the reimbursement is small. We're talking about
22 small money here, and I think that it's in the person's
23 best interest because you have somebody there looking at
24 their skin integrity, decreasing the possibility for UTI's
25 and things such as that. So, I really think you need to

1 look at that and give that some reconsideration as well.

2 Business as usual is what we heard
3 when we were here at our last MAC meeting, and it's been
4 anything but business as usual. I've yet to be paid on any
5 claim that I have submitted to either three of the MCO's.

6 I'm continuing to provide service. I
7 have dipped into my retirement because banks don't like to
8 give home health agencies lines of credit in Kentucky. So,
9 I've dipped into my retirement fund to fund your all's
10 care, and I'm at the end, as it was stated earlier.

11 It is care that we're providing to
12 longstanding clients. Bills are being denied for lack of
13 PA. Well, I may be lack of PA from you all but it's not
14 lack of PA from November 1 to November 20th from the
15 Department for Medicaid Services.

16 So, you all need to communicate with
17 your staff. I mean, it's like it's been denied because we
18 don't have a denial from Medicare. It's been denied
19 because you don't have a PA. And there is a host of issues
20 of why claims are being denied; and what you're
21 communicating with your staff is not what you're
22 communicating with the home health agencies or with the
23 Home Health Association.

24 So, we really need to work very
25 diligently because we don't have the money. As we said,

1 it's been eleven years, and reimbursement barely enables us
2 to break even when we take care of Medicaid patients. So,
3 you really need to look at some of your processes.

4 I strongly suggested that having
5 somebody on your advisory boards, it will enable you to
6 better understand since we seem to have some
7 miscommunication issues with home health agencies in the
8 State of Kentucky, which leads me up to supplies.

9 I'm putting supplies out the door
10 since November 1 with prior auths up to November 20th for
11 services that we're performing, whether it's a dressing
12 change, whether it's as Foley catheter insertion, whatever
13 the situation, an inch of tape, whatever it might be, and I
14 have no idea of how I'm going to be paid.

15 I'm going to hope that this good-
16 faith effort that you all have told us to hold closely is
17 going to cover the costs that I have when it comes to home
18 health supplies and that I am paying for out of my own
19 pocket but yet I'm not reimbursed and haven't been
20 reimbursed one penny on a medical supply.

21 So, this is something that we've
22 talked about big miscues when we went forward on a three-
23 month time schedule for this, but I really don't know
24 anybody else that would be willing to provide incontinent
25 products - and dressing supplies are quite expensive - to

1 Medicaid recipients with no idea on what that reimbursement
2 is going to be.

3 So, I would urge you to quickly get
4 something in writing to us. I know you reimburse other
5 agencies in other states. That's a starting point. Let us
6 look at it. Let us see what's going on. Let us see if
7 anybody is going to be able to go forward with this in
8 providing supplies.

9 Now, some agencies give supplies only
10 where Medicaid recipients are able to come in there and get
11 their red rubber catheters because they may self-cath and
12 things like that. So, we've got two entities - the
13 supplies that a nurse uses in her treatment plan ordered by
14 the physician and the supplies that are given to patients
15 because they need it to continue their medical care. So,
16 that's something that you need to look at.

17 And I guess, again, claims are not
18 being paid. You all need to talk to your billing staff
19 because claims are not being paid. None of us have a
20 problem really with managed care. That's not an issue.
21 The issue is all of the administrative burden.

22 I have a nurse full time tracking -
23 and I'm a small agency - trying to get prior authorizations
24 and then understanding. And then she passes it off to a
25 biller and we're like, oh, really, okay, let's see. What

1 did they approve? Well, you don't tell us what they
2 approve.

3 There are lots of good things with
4 SHPS and Kentucky Medicaid that it's unfortunate you all
5 didn't mirror when you were looking at prior authorizations
6 or when you were looking at supplies or whether you were
7 looking at covered services.

8 And I would reinforce what the doctor
9 said. If it's a covered service, I mean, really, nobody is
10 going out there and providing extra nursing care or extra
11 aide services because we're making money on it. Let me
12 just tell you that again.

13 When we call and we ask for a nursing
14 visit once a week and aide service twice a week, I mean,
15 that is for the patient's benefit. We provide care to
16 Medicaid recipients because they need the care. We're in
17 the business of caring. I have been in the business for
18 twenty-five years.

19 So, quit putting the burden on a
20 small provider or providers in having to jump through the
21 hoops to get some care for patients that you are covering.

22 CHAIRMAN POOLE: Anything else, Kip?

23 MR. BOWMAR: No.

24 CHAIRMAN POOLE: Thank you, Sharon.

25 Thank you, Kip. Hospital Care.

1 MR. MILLER: Good morning. I'm Steve
2 Miller with Kentucky Hospital Association. I'm filling in
3 today for Carle Herde who was unable to be here.

4 I guess first I'll give you a break
5 from a few non-MCO type issues that we are dealing with.
6 Two things that are ongoing right now that we're working
7 very closely with the Department on are one being the
8 reprocessing or re-adjudication of outpatient claims on a
9 new regulation that was effective on January 5th of 2009.

10 We will soon have almost three years
11 of outpatient claims that need to be resettled, hopefully
12 not re-adjudicated individually. We're still working on
13 that with the Department. That clearly is a big issue that
14 all the hospitals will be going through.

15 In addition to that, as you have had
16 pointed out before, there's approximately 10% of the
17 current Medicaid population that will not move to Medicaid
18 managed care. They stay on the traditional fee for
19 service.

20 The DRG system that we currently are
21 reimbursed on under the old traditional system comes up for
22 re-basing as of July 1. That clearly is a major issue and
23 something we will work very closely with the Department on.

24 Now, the MCO type issues. First, let
25 me say that our working relationship with the Department

1 and with each one of the three MCO's is good and continues
2 to get better. They have come to numerous meetings and
3 have always been willing to show up, work through the
4 issues, hasn't always brought about a quick solution, but
5 they have worked through the issues.

6 As has been said here a number of
7 times already today, one of the biggest issues we're
8 dealing with right now is the processing of payment of
9 claims. As Commissioner Wise pointed out earlier, that
10 Medicaid traditionally has paid on a 14-day lag. That's
11 for services that ended as of November 1st. Basically,
12 Medicaid has gone through the runoff of their claims.

13 Hospitals are telling me right now
14 that they are seeing very little as it relates to the
15 processing of payments coming in on new managed care
16 claims. Hospitals can't sustain that long. Our business
17 is open 24/7. We've got payrolls to meet every week, much
18 like what's been said from home health. We need the
19 dollars to flow through. I made some phone calls
20 yesterday. I've been told that is not happening.

21 In addition to that issue, as has
22 been said here numerous times already today, as it relates
23 to getting prior authorization, that process is far more
24 cumbersome than it used to be. What we're seeing as well
25 is that many times we're dealing with out-of-state docs who

1 are going to give that approval and just don't seem to
2 understand or appreciate some of the things we have gone
3 through.

4 Again, nobody is opposed to Medicaid
5 managed care. It's the process. It's the administrative
6 burden that you've heard time and time again today.

7 We are now being asked to continue to
8 do utilization review concurrent. Keep in mind that we're
9 being paid under a DRG. For ongoing stays, we are still
10 being asked to do utilization review for the third and
11 fourth day to get continued authorizations. We're paid on
12 basically a per-case basis.

13 Now, we're told that in many cases,
14 this is in preparation for possibly outlier payments that
15 will come at the end of the road. Outliers in the State of
16 Kentucky are somewhere in the neighborhood of about 3% of
17 the total admissions. This is a huge burden to deal with
18 that 3%.

19 As far as the meds, the formulary,
20 it's already been stated that what we're hearing from
21 hospitals and specifically from the behavioral health
22 facilities is the need to unify, uniform the formularies.
23 That is ongoing.

24 And, again, the one thing we hear
25 from behavioral health - and I know that has been dwelt on

1 already today - is the standpoint on the ongoing reviews,
2 getting one or two days authorized. They're saying they
3 don't do that for commercial managed care. Why is Medicaid
4 managed care trying to be that much more stringent? And,
5 again, it is creating a very strong administrative burden.

6 Any questions?

7 CHAIRMAN POOLE: Thank you, Mr.
8 Miller. Nursing Home Care TAC.

9 FOLEY: Nursing Facility TAC has no
10 report.

11 CHAIRMAN POOLE: Thank you, sir.
12 Nursing Services TAC.

13 DR. PARTIN: No report.

14 CHAIRMAN POOLE: The Optometric Care.

15 REPORT OF OPTOMETRIC CARE TAC:

16 DR. WATKINS: I have several things
17 that I wanted to present as some issues that we've seen
18 come up amongst our doctors and our patients there.

19 One thing I've not seen addressed or
20 heard from today, I've seen patients that have told me that
21 they have been issued cards from more than one managed care
22 organization, not by their request. like they were
23 assigned one managed care organization and then they got a
24 card from another managed care organization without them
25 ever asking to be changed from one to the other.

1 I do not have any idea as to why this
2 happened and it makes it difficult for us to tell them what
3 they need to do.

4 I've also seen cases where patients
5 have told me that they've called and asked to be changed
6 from one managed care organization to the other. I've
7 heard two different responses. One, that they're being
8 told that they are switched immediately to the other
9 managed care organization, and other cases where they've
10 been told that it will take effect the first of the month.
11 So, like if they make the request November 15th, they're
12 told that it's not made until the 1st of December.

13 I've seen many doctors' offices with
14 signs up saying they're not treating or taking Medicaid
15 patients until they have their proper card in hand, and
16 that is posted that they will absolutely refuse to see that
17 patient.

18 I myself, I'm not doing that. I'm
19 looking it up on the Medicaid site as to what the patient
20 has at that point in time as to who I file the services
21 with. And I hope to goodness that that is right because
22 situations where you're already waiting several days for a
23 payment to find out that they're not actually a member of
24 that managed care group could cause even further problems
25 from that. So, just some things that need to be addressed

1 with that.

2 And I have some specific issues with
3 each of the managed care groups that I wanted to bring up.
4 As with dental care, of course, we have our optometric
5 carve-outs for the vision services there that we are
6 working with.

7 And one thing that I've noticed in
8 particular with Coventry which is our VSP patients there,
9 you've reported that there was a 99% paid within fifteen
10 days and they're really working toward or encouraging
11 everyone to do electronic filing.

12 Our providers that were not VSP
13 providers prior to Medicaid who have now signed on to be
14 VSP providers for Medicaid are being forced to use paper
15 claims only. They are not allowed to file on the website
16 and I do not understand that whatsoever. It's taking a
17 much longer time for a turnaround there for those
18 providers.

19 We're also seeing with those VSP
20 patients that if we request a replacement pair of glasses,
21 their contract says that you can only spend \$150 of their
22 \$400 limit on one particular day. That's all it says.

23 We've had cases already where we've
24 tried to file for a replacement pair say fifteen days later
25 for a child, and there was a denial saying that they were

1 not eligible until the first of 2012. That money, that
2 \$400 limit is for an annual year. So, if they've not
3 reached that limit, they should be eligible the very next
4 day. There should not be anything telling us we have to
5 wait until next year.

6 That's making us believe they're
7 trying to move towards allowing only one pair per year
8 which is not the intent at all. So, there is some
9 miscommunication there as to how that's going on.

10 We've encountered with OptiCare
11 especially that we're seeing a much slower turnaround on
12 payment than what we have from the other MCO's. And I
13 realize there is some catch-up going on there but very much
14 concerned.

15 Like the other doctors have
16 reiterated here that cash flow is extremely slow and where
17 we've been used to receiving one singular Medicaid check on
18 Wednesday of every week that accounts for, in my case, 40%
19 of my income, now I'm waiting on three different checks -
20 who knows when they're going to come - and trying to pay
21 bills from that, and it's just making for a very difficult
22 situation for us all.

23 Through OptiCare, if you use one of
24 their frames, which they have a separate system which I
25 must explain a little bit differently. They're different

1 from the other two MCO vision products. They provide a
2 frame kit that the patient can choose from, or they will
3 pay for the doctor to use a frame off their board if
4 they're willing to take \$25 for that frame and cover it for
5 a year.

6 Frames are very difficult to acquire
7 something of quality that will last for a year and that
8 you're willing to stand behind for a year for \$25. But,
9 anyway, if you use one of the frames from their kit that is
10 provided, then, you have to send it to their optical.

11 And I have received reports of up to
12 nineteen days turnaround from their optical to get a pair
13 of glasses back to the patient, and that's just not
14 acceptable when you have a child waiting that needs their
15 glasses to see to go to school. That needs to be a much
16 quicker turnaround.

17 Grant it, if they choose a frame that
18 the doctor is willing to take \$25 for, they can make it in-
19 house and often turn it around on the same day. So, those
20 are the choices that we make as providers if we're willing
21 to try to get the patient in glasses much quicker, whether
22 you're not actually getting paid effectively for what
23 you're providing there.

24 We also had a particular case with
25 Avesis where they're trying to link the fact saying that if

1 you file for a 9200 code, which is what they consider a
2 routine eye exam code, that you cannot use a diagnosis of
3 headache and try to get paid for a visual field on the same
4 day.

5 A visual field is a test where we are
6 trying to determine the peripheral vision of a patient, and
7 we may be detecting a case where they might possibly have a
8 brain tumor that's causing that headache complaint, and
9 they may have come in and had some headache problems.

10 Many times we see patients on a
11 primary care situation that they've not presented this to
12 their family doctor yet and we have to determine whether
13 it's something that can be cured by prescribing the proper
14 pair of glasses or if it is something much more serious.
15 And sometimes time is of the essence as to you don't want
16 to try a pair of glasses for a month and see if, oh, they
17 might come back because it's not really better and let you
18 do further testing then. It's something that needs to be
19 handled right away.

20 So, trying to sort it out whether
21 it's medical or whether it's actually just related to
22 glasses or does require further testing at times, and if
23 it's just denied by a particular diagnosis, that's
24 something that makes it very difficult for us providers to
25 actually do the job that we know that we need to do.

1 Also, I've had numerous problems with
2 really all three MCO's not having access to answer provider
3 questions. We've called in, left messages, never have
4 those messages returned. If we email, we do have a better
5 response time, but it may still take several days to get
6 back and answer to an email.

7 So, that's something that needs to be
8 addressed because if you're claiming that the phone lines
9 are being answered and things are being taken care of, that
10 response time is not being seen by us providers.

11 I think I'll leave it at that for
12 now.

13 CHAIRMAN POOLE: Thank you, Dr.
14 Watkins. Physician Services.

15 DR. NEEL: The only thing, we have
16 Lindy Lady from KMA who has a brief thing to give.

17 MS. LADY: Thank you. My name is
18 Lindy Lady and I'm the Medical Business Advocacy Manager
19 for the Kentucky Medical Association which represents over
20 7,000 practicing physicians, residents and medical
21 students.

22 The transition into Medicaid manage
23 care has been a very important issue for our members over
24 the past few months. When the transition was first
25 announced, many members expressed concern about a variety

1 of issues, most notably a general unease over the
2 administrative issues that might occur when transitioning
3 from one Medicaid system to three separate systems.

4 Because of these concerns, KMA began
5 gathering data to assist in tracking and addressing
6 widespread administrative issues reported by KMA members.
7 KMA members have the option to submit an issue via the KMA
8 website to our advocacy help desk or fax requests for
9 assistance to a secure fax number.

10 Members provide a brief explanation
11 of the issue and provide contact information so that the
12 KMA and the appropriate MCO can follow up on the problem.
13 KMA also had conference calls during November with each of
14 the MCO's and allowed KMA member offices to ask questions
15 of the representatives from each of the companies.

16 Of the four separate calls that we
17 had - we did also have a call with Passport - some 200-plus
18 members called in and many questions were asked or
19 information was submitted about a particular issue. These
20 calls were very informative for our members, and I believe
21 they were informative for the MCO's as well.

22 Based on the system we have for
23 submitting issues, as well as the phone conferences we held
24 with the MCO's, KMA has been able to gather data on a wide
25 variety of issues highlighting many administrative problems

1 encountered by our members.

2 The KMA sorted the data into six
3 categories - prior authorizations requests which I know
4 everybody is tired of hearing about, customer service
5 complaints, credentialing, eligibility verification and
6 primary care assignments, electronic vendor issues, and
7 denied services and slow payments.

8 The prior authorization process by
9 far was the biggest issue cited by our members. Most KMA
10 members understand how to request a prior authorization for
11 services, but they reported it often takes more than one
12 telephone call or a fax in order to receive approval for
13 the prior authorization.

14 Last week we received this email. I
15 have tried numerous times to fax information regarding a PT
16 approval. I called the MCO and they advised me that I am
17 faxing to the correct number. I have time-sensitive
18 requests. Please help.

19 Yesterday, the KMA received a call
20 from a small physician practice treating a patient for
21 hepatitis. The drug the patient is receiving required a
22 prior authorization. The prior authorization was denied
23 which put the patient in jeopardy for liver failure.
24 The pharmacy agreed to provide a week's supply of the
25 medication while staff in the physician's office attempted

1 to sort out why the prior authorization was denied.

2 While we believe the State's policy
3 of granting the prior authorizations within two days is
4 helpful, our members continue to encounter issues
5 associated with how to submit the prior authorization
6 request. This is especially important given the fact that
7 many services now requiring a prior auth did not require
8 one from Medicaid just a few short months ago. We also
9 suggest limiting the number of services requiring prior
10 authorization.

11 During the first month of transition,
12 November, KMA members reported long wait times and
13 telephone disconnects. With the exception of the prior
14 authorization request, this issue does seem to be resolved,
15 although we continue to monitor it.

16 KMA members indicated confusion or
17 problems with the credentialing process that included
18 enrollment information that might have been sent to an MCO
19 but hadn't been processed. Without completed enrollment,
20 the physicians couldn't log onto the secured MCO portals to
21 check eligibility and other vital administrative
22 information.

23 In November, some members reported
24 that it was difficult to verify eligibility via the
25 telephone because of the long wait times. One member also

1 reported this is an issue we believe should be addressed in
2 order for the most basic administrative function,
3 eligibility, to be confirmed. Other members reported
4 confusion about primary care assignments, which we've heard
5 that today, too, and what patients needed to do to update
6 the primary care provider.

7 Members also reported problems with
8 the electronic submission of claims because the vendor they
9 were using may not have been compatible with the
10 clearinghouse that the MCO's were using. This needs to be
11 addressed, especially for those offices in rural areas with
12 high Medicaid populations.

13 One member reported that a covered
14 service was rejected for payment because the physician was
15 dual certified in neurology and psychiatry. During
16 enrollment, he was set up as a neuropsychologist which
17 caused the claim to reject, and his point was he should
18 have been set up as a medical doctor. The practice was
19 able to call, have the claim adjusted, although this
20 created extra administrative work.

21 Other practices reported that they
22 had not received any payments by the end of November,
23 although claims were submitted within the first two weeks.
24 Payment issues obviously concern us, and we would like to
25 see more consistency with the standard payment time frames

1 established so that physicians and other providers can plan
2 when they might receive these payments.

3 The KMA also received comments and
4 concerns about access to care. If hospitals and
5 specialists in certain areas have not signed with one or
6 more MCO's, patients will be faced with the burden and
7 expense of traveling to other counties for diagnostic tests
8 and specialty consults. Access to care is, of course, a
9 special concern for our Medicaid recipients who oftentimes
10 may have transportation issues.

11 We understand the difficulties
12 encountered by the State and the MCO's in making this
13 transition and that is why we want to continue to be a
14 conduit between our members and the MCO's.

15 I appreciate the time you have
16 provided me this morning and I would be happy to address
17 any questions you might have. Thank you all.

18 CHAIRMAN POOLE: Thank you, Lindy.
19 Podiatric Care. Primary Care TAC. And Pharmacy and
20 Therapeutics Committee. They didn't meet this month.
21 Normally I would give my report here. I'm just going to
22 make some quick comments.

23 PHARMACY AND THERAPEUTICS ADVISORY TAC:

24 CHAIRMAN POOLE: Obviously with
25 dealing in pharmacy, I can go over a litany of emails that

1 have been sent to me of problems and in my own world having
2 to stay on the phone for four hours for a two-year-old with
3 pulmonary hypertension trying to get something prior-
4 authorized. There are a lot of problems out there, but
5 I'll pass those along through Neville or to you guys.

6 The formulary issue, I have really
7 tried to educate Medicaid on that because Ohio shut down
8 their pharmacy benefit for a year over the multiple
9 formulary issue, and I brought that to everybody's
10 attention what kind of headache this would be, but we
11 wanted to live through it, I guess.

12 And the other more important thing is
13 regardless of what the MCO's think or Medicaid thinks,
14 profit is not a curse word. And in order for us to stay in
15 business, we've got to make a profit. And the ratcheting
16 down of everything that's been done - and you may think,
17 well, you're a little guy, you own three pharmacies.

18 Well, I'm on a board that we
19 represent a huge amount of a buying group. We buy over \$1
20 billion a year in drugs. We don't have a problem competing
21 with Walmart, we really don't, but, still, I also don't
22 have 110,000 other square foot of stuff to sell. I'm a
23 healthcare professional.

24 So, we've got to do something. We've
25 already got the reduction of hours that pharmacies are

1 open, a reduction of hours of employees, laying off of
2 employees, and pharmacies in Western Kentucky are in the
3 middle of being sold out right now.

4 So, yes, that doesn't mean anything
5 around the suburban areas and urban areas of Kentucky, but
6 in rural areas of Kentucky where there's one pharmacy for
7 two counties or whatever, when those go away, how are you
8 going to provide the care?

9 Right now the issues are on
10 deliveries, I've gotten calls from guys all over saying
11 we're just going to stop deliveries or have to charge for
12 deliveries. Medicaid patients can't pay for the delivery
13 cost, and that's something we've been providing for free
14 for years and years and years.

15 So, I hope the discussions can
16 continue on. I know Robert McFalls just came in, our
17 Executive Director of the Kentucky Pharmacy Association,
18 and we're going to be working with the three MCO's and
19 Medicaid on those other issues.

20 The only other thing I would like for
21 Ms. Schuster, if you would, to be able to make some quick
22 comments, please.

23 MS. SCHUSTER: I have three members
24 from the Behavioral Health TAC that would like to make a
25 very short statement.

1 MS. CATHY EPPERSON: I'm Cathy
2 Epperson, the Executive Director of the National Alliance
3 on Mental Illness, the Kentucky chapter, and I represent
4 the individuals and families affected by mental illness and
5 we have over 1,000 members in Kentucky.

6 And our number one concern is the
7 reduction of access to needy services and supports for
8 Medicaid members dealing with behavioral health issues, and
9 particularly with Eastern Kentucky. We have twenty
10 affiliates in Kentucky and we have NAMI Hazard in Hazard,
11 Kentucky, and we're very concerned with the ARH Hospital
12 not signing a contract with one of the MCO's.

13 And we really do encourage you all to
14 work out the issues you're facing to make sure that we have
15 that psych hospital available to individuals that need it.

16 However, I want to thank the
17 Department for Medicaid, Commissioner Wise and Carrie
18 Banahan for their efforts in helping individuals currently
19 in the hospital continuing receiving the services they
20 need. We really appreciate it. We really think that you
21 all understand what we need and you work diligently to make
22 sure that happens.

23 But our concern is that we don't need
24 to be working on the back end. We need to work on the
25 front end to make sure these issues don't happen on the

1 back end. It causes a lot of headaches, a lot of problems.
2 So, we need to get those resolved up front.

3 Medicaid seems to be working
4 diligently to clean up the problem with managed care. We
5 call and we had a conference call and I appreciate your
6 response of getting back with me, but why can't the MCO's
7 be equally engaged and be proactive. We don't need to be
8 reactive. We need to be proactive.

9 Like I said, we need to fix things on
10 the front end, not the back end. Like with a common
11 formulary, that's an easy thing to do. Why don't we go
12 ahead and do that? You've heard that mentioned many times
13 today. And the prior auths, we need to streamline that.
14 Why do we have to have prior auths if it's already an
15 approved medication on the old Medicaid?

16 We want individuals with mental
17 illness be able to access psychiatric inpatient services in
18 their home community so they can have family support. As
19 we all know, family support is critical in the recovery
20 process.

21 ARH serves twenty-one counties.
22 That's why it's so important and critical that ARH maintain
23 the services they currently provide to individuals with
24 behavioral health issues like the inpatient psychiatric
25 services.

1 So, the MCO's need to be working with
2 the providers in that region to make sure those services
3 are available before they're discharged from the hospital,
4 before you decide they have to be discharged.

5 Medicaid MCO's need to ensure that
6 appropriate services are available before discharge and
7 make sure they have the services they need.

8 And we've heard a lot about
9 medications, but Medicaid has ensured me that individuals
10 be grand-fathered on their current medications for a period
11 of time, but I hear this is not happening. Prior auths,
12 they're taking way too long, thus, causing, Sheina said
13 today, people not able to get their medications. And I
14 hear that very often that people are not able to get their
15 medications timely because of the prior authorizations.
16 That needs to change.

17 We need to be humane about this issue
18 of managed care. I'm not for managed care. I am for
19 managing care. I believe and the good thing about the
20 managed care concept is what I was so excited about was the
21 holistic approach of looking at your whole person, as me as
22 an individual, looking at me as a whole person, taking care
23 of my physical and behavioral needs and getting me the
24 right care and not have to take twenty-eight medications
25 maybe, but that's not happening. It's taking way to long.

1 When people get out of the hospital,
2 they need their medications immediately. And if I'm in
3 recovery, like Sheina said, I talk with individuals on a
4 daily basis that they've worked ten years to get the right
5 medications. It's taken them that long to be in recovery.
6 Why do you want to change that?

7 We need to make sure they stay in
8 recovery because the cost in the long run, it's going to
9 cost you more money because people are going to end up
10 homeless, in jails, ER's. The State is going to pay one
11 way or the other. Either pay now or pay later.

12 Another thing I'm hearing is on the TRP's
13 and the community mental health centers, that the MCO's
14 have described their intent to titrate the utilization of
15 day treatment programs, limiting access to these services.
16 And I know there's more evidence-based services out there
17 than TRP's, but where are they? Are there services
18 available? I don't think they are. We would love to see
19 supportive employment available because I think a lot of
20 individuals would go to work if we could pay for supportive
21 employment, peer support. All those services are greatly
22 needed but they're not available right now.

23 So, if you're going to take away one
24 service, make sure there's something to replace that
25 service, and it may be a better service, and I think there

1 are better services. Not people need TRP but some people
2 do. Some people could do supportive employment, peer
3 support. So, if you're going to take a service away, make
4 sure we have services to replace those. If you don't,
5 you're going to see an increase in hospitalizations,
6 corrections and homelessness.

7 Another thing is we have been talking
8 for a long time that MCO's are promising that we would be
9 represented on advisory groups so we could keep them in the
10 loop about problems occurring and to hear you tell us
11 what's happening and you can say we don't know the facts.
12 You can tell us what the facts are. Are those in place? I
13 mean, I haven't heard of anything of advisory groups.

14 So, we need to implement those so we
15 can keep you in the loop and you can tell us the facts so
16 we know the true facts when we talk to people when they
17 call in.

18 The bottom line, individuals'
19 behavioral health issues are going backwards, thus losing
20 ground in their recovery. They work so hard to get in the
21 recovery process. Why do we want to take that little piece
22 of mind away from them? I mean, why do we want to do that?

23
24 To me, it's not humane putting
25 unnecessary stress on them but also on their families.

1 Family members go through a lot dealing with individuals
2 affected by mental illness. I hear them every day. They
3 call me so upset. They just don't know where to turn to,
4 but they're frustrated. They don't know what to do. They
5 had never heard of mental illness.

6 So, why are we causing undue burden
7 on family members and individuals and also more financial
8 costs in the long run and certainly more emotional,
9 behavioral and physical costs to the individuals? Why? I
10 just don't understand why. Thank you.

11 MS. VALERIE MUDD: My name is Valerie
12 Mudd and I am the Consumer Programs Coordinator for NAMI
13 Lexington, the National Alliance on Mental Illness. And I
14 have also been a former member of the NAMI Kentucky Board
15 for several years, and I am also the Director of
16 Participation Station in Lexington. That's a peer-run,
17 peer-operated center for folks with mental illnesses.

18 First of all, I would like to say,
19 and I am a consumer of mental health services myself, our
20 lives are at stake here. Our recovery is in jeopardy.

21 I consider this a high-stake game
22 that we're losing, we are really losing. I don't know what
23 I would do or any of my people that I work with would do
24 without their medications, without the correct medications,
25 the ones that work.

1 I kind of feel like - and maybe I'm
2 wrong - but I get the feeling that the MCO's do not
3 understand what grand-fathering is because anybody who has
4 had their medications and have them work for years, why
5 would you want to take them off of that and put them on a
6 cheaper medication? I do not understand that.

7 We need the best medications for what
8 we're dealing with. I mean, we're dealing with enough as
9 it is having mental illness. Why would we have to deal
10 with trying to get the right medication if we have
11 something that works? Sheina hit the nose on the head with
12 that.

13 The side effects with the new
14 medications, of course, are lower, if nonexistent. There's
15 more hospitalizations if you use the less effective
16 medications if we're able to get in the hospital, if we're
17 able to get days in the hospital.

18 My doctor can't seem to have choice
19 in that, of what medications that I'm allowed to have
20 because of the prior auths. And I know we've talked about
21 that a lot today, and I appreciate Dr. Suess' comments.
22 They just hit the nail on the head. I was very impressed
23 with his comments. Thank you, Dr. Suess.

24 With the TRP's, there are a lot of
25 people out there that need TRP's. It's like the stepdown

1 from being in the hospital or getting into the recovery
2 process and it has to be in place.

3 Without the services we need, there's
4 going to be an increased risk of suicide. And I myself
5 have been suicidal in different situations for not being
6 able to get my meds. It's terrible to be in that place to
7 think I don't have any other choice.

8 I know someone, for an example,
9 because of a preauthorization process, he had
10 schizophrenia, he went to the pharmacy to pick up his
11 medication because his doctor said this is what works for
12 you, you should go get this at the pharmacy. They had to
13 do a preauth.

14 He thought, well, this means my
15 people have said I don't need this medication because they
16 have to get a different medication. He said he wouldn't
17 take it because it was a special medication.

18 Denying state-of-the-art treatment
19 like the long-acting injectables is something I just think
20 is unbelievable. Long-acting injectables for folks with
21 schizophrenia and SPMI's, severe and persistent mental
22 illness, are lifesavers, absolute lifesavers. People who
23 don't want to take their medication on a daily basis but
24 they could take a shot every two weeks or they could take a
25 shot once a month, that is a lifesaver, I'm telling you.

1 If we get rid of those, I don't know what we will do.

2 Using outdated therapies is just
3 totally unacceptable and I feel like it's unethical.
4 Family members, consumer advocates like myself, we won't
5 tolerate any narrowing of these services.

6 Pharmacies and community-based
7 services that we need are on the risk of destruction. We
8 need these services to stay alive, literally stay alive.
9 Where will we go for services without the CMHC's? I get
10 the feeling that the CMHC's, if they don't have enough
11 money to run, we may lose some CMHC's in the process.

12 Of course, we've heard about children
13 and their families having difficulties with getting their
14 medicine and their days in the hospital. It's all about
15 access. We have to have access to our services.

16 The MCO's in Kentucky have rolled out
17 the services so quickly, like grease lightening as I call
18 it, that we're in dire straits already.

19 I know that in other states, they've
20 actually had more time to work out the kinks with the MCO's
21 before they came live and they've had catastrophic outcomes
22 as well. We just need to fix this.

23 Again, we've been told that consumers
24 would be included on advisory boards. And I remember this
25 back in August when you guys talked to us, that you said we

1 would have consumers on the board. And I do remember a
2 comment that was said that said, well, we have difficulty
3 getting consumers on the board because a lot of them aren't
4 well enough to be on the board.

5 Well, I'm here to tell you we are
6 well enough to be on that board. And I'm just curious if I
7 missed my invite yet because I haven't got one and I don't
8 think Sheina has either. The Governor appointed me to the
9 Technical Advisory Committee and I feel like I should be
10 involved, I really do. I think that's why I'm here.

11 Again, we've just got to fix this.
12 And I say we because I want us to work together. I think
13 that we can. We deserve more than survival on medications.
14 We need to thrive. Thank you.

15 MR. STEVE SHANNON: Steve Shannon.
16 I'm with the community mental health centers. I learned
17 long ago don't improve upon things you can't do. I don't
18 think I can improve much upon what Cathy and Val said.

19 I'm not going to talk about services
20 very much because they really addressed those in a way
21 that, as Val says, hits the nail on the head. She really
22 does give the message. And, so, I'm not going to repeat
23 that story, but I can tell you stories if you want me to
24 about pharmacy and formulary. I can tell you those
25 stories. I can tell you about access to services. We can

1 do that.

2 But I'm with the mental health
3 centers, and initially I'm going to talk about the
4 administrative burden, and you've heard about the
5 administrative burden from many folks today.

6 Let me tell you the growth industry
7 in community mental health centers. First of all, let me
8 tell you what it's not. It's not new clinicians, it's not
9 new psychiatrists, it's not new and innovative programs.
10 The growth industry at the twelve participating community
11 mental health centers is clerical support. That's the
12 growth industry.

13 On average, the twelve mental health
14 centers have hired three or four, sometimes five additional
15 clerical support people, what's called utilization review
16 coordinators. These folks just track outpatient treatment
17 requests. So, our growth industry is clerical.

18 Clerical support is an invaluable
19 thing, I don't want to demean that, but the reality is
20 we've had to bring in three, four, five people times
21 twelve, somewhere between thirty-six and sixty new hires.
22 So, it is an economic opportunity just to handle paper,
23 just to handle paper. That's what we've done - three,
24 four, five people.

25 We've had some centers who have a

1 dedicated fax line just to handle paper. It isn't clinical
2 outcomes. It isn't innovative programs. It isn's
3 supportive employment. We're not hiring people to work in
4 the communities. It's to handle paper. I can get to a
5 million dollars' worth of salary at thirty-five, forty,
6 fifty people when you compound the hourly rate plus a
7 benefit package - a lot of money invested in handling
8 paper, and we are handling paper.

9 So, the other growth industry is
10 delivery. We're getting a lot of reams of paper shipped to
11 mental health centers because we have to fax a lot of
12 documents. We're faxing a lot of stuff to people. Some of
13 those things are mailed back, believe it or not. We get
14 postage, letters in the mail approving OTR. So, we get
15 them approved. We're happy about that, but they come in
16 the mail. They come in the mail.

17 I tell people that Scully learned to
18 land a plane on the Hudson River electronically. We can't
19 approve services in the same format. We can't do that.
20 You can land a plane on water but you can't send a piece of
21 paper electronically, Dr. Neel, and have it come back to
22 you with a thumbs up or thumbs down. If it's a thumbs up,
23 we'll put it in the mail. It gets mailed.

24 And the good news is, a lot of
25 providers are getting OTR's approved because we receive

1 them for other people. So, we've got OTR's approved for a
2 variety of providers. Hopefully, we sent that out to you
3 all who need those. So, we've gotten those as well. It
4 comes back on a fax machine. So, we're burning up fax
5 lines. We're doing that.

6 So, for us, the first real impact has
7 been the administrative burden, learning how to get
8 approval for services that we've done for forty-five years.
9 I was at a dinner Monday night. Forty-five years. Now
10 we're getting approval of services first time ever.

11 So, for us, the first impact is how
12 do we submit a claim, how do we get paid. I've been doing
13 business with Medicaid a long time. Our partners, the
14 MCO's, have been receiving and paying claims for a long
15 time. It's like it's all brand new come November 1. It's
16 all brand new, Commissioner Wise, all brand new.

17 So, that's where we're at, sending
18 faxes, getting faxes. You all experience the same thing.
19 I can talk formulary, we can talk all night, but the
20 reality for us at the outset has been how do you manage
21 this? We have people who just track outpatient treatment
22 requests. Prior auth is all they do, three, four, five a
23 center. So, for us that's the first story.

24 The next story will be clinical
25 impact, and I expect I'll be back in two months to talk

1 about that, Mr. Poole, but the reality is right now is
2 hiring support staff to send and receive faxes, and that's
3 the impact for us.

4 That's not a good investment in my
5 opinion. That's not what we should be spending our money
6 on. I would love to hire community-based supportive
7 employment counselors. They're about the same cost and it
8 would be a much better investment for us. You've got to
9 take care of the home fire first. We've got to make sure
10 we understand what's going on.

11 So, that's the CMHC perspective right
12 now, sir.

13 CHAIRMAN POOLE: Thank you all very
14 much.

15 I have to go over this, but any Old
16 Business that we've not covered?

17 New Business. You've got a schedule
18 of our dates for next year. Those could change, depending
19 on what our needs are. And I apologize for everybody's
20 extra time this morning, but I think it was time well-spent
21 obviously in my opinion. Hopefully people got a lot out of
22 it.

23 Do I have a motion to adjourn?

24 DR. RODRIGUEZ: Excuse me. Can I
25 just ask for one thing? Can we get a very real list of

1 reports that we want to get from the MCO's that will be in
2 the same format? Is that something that you----

3 CHAIRMAN POOLE: I'm sorry. I was
4 going to take the initiative there and just email
5 everybody. Let's put it together ourselves and then I'll
6 get it to Neville and then to them, if that's okay.

7 DR. RODRIGUEZ: Great.

8 CHAIRMAN POOLE: Motion to adjourn.

9 DR. RODRIGUEZ: So moved.

10 DR. NEEL: Second.

11 CHAIRMAN POOLE: Thank you all very
12 much.

13 MEETING ADJOURNED

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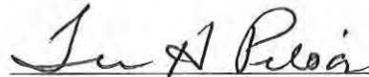
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STATE OF KENTUCKY

COUNTY OF FRANKLIN

I, Terri H. Pelosi, a notary public in and for the state and county aforesaid, do hereby certify that the foregoing pages are a true, correct and complete transcript of the proceeding taken down by me in the above-styled matter taken at the time and place set out in the caption hereof; that said proceedings were taken down by me in shorthand and afterwards transcribed by me; and that the appearances were as set out in the caption hereof.

Given under my hand as notary public aforesaid, this the 19th day of December, 2011.



Notary Public
State of Kentucky at Large

My commission expires February 10, 2013.