

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: PRIMARY CARE TAC MEETING

January 10, 2019
10:00 A.M.
CHR Building
Cafeteria Conference Room
275 East Main Street
Frankfort, Kentucky

APPEARANCES

Barry Martin
PRESIDING

Promod Bishnoi
TAC MEMBER PRESENT

David Bolt
Mary Elam
Noel Harilson
Rachel Fitzgerald
KENTUCKY PRIMARY CARE
ASSOCIATION

CAPITAL CITY COURT REPORTING

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

APPEARANCES
(Continued)

Carol Steckel
Stephanie Bates
David Gray
Lee Guice
Sharley Hughes
MEDICAID SERVICES

John Akers
WELLCARE

Christine Drake
PASSPORT

Jacqulyne Pack
Rich Schultz
AETNA BETTER HEALTH

Jennifer Smith
Ken Groves
ANTHEM BCBS

Cathy Stephens
Bethany Day
HUMANA-CARESOURCE

Heath Martin
ROBINSON, HUGHES &
CHRISTOPHER, CPA's

Stephanie Wilson
Darryl Wilson
BARBOURVILLE FAMILY HEALTH

Shelia Bowling
PRIMARY CARE CENTERS

Jordan Peters
Amanda Dannison
BLUE & CO.

AGENDA

1. Call to Order	4
2. Establishment of Quorum	4
3. Review and Approval of November 1, 2018 Meeting Transcript and Minutes.....	5
Remarks by Commissioner Steckel	6 - 28
4. OLD BUSINESS:	
A. Provider enrollment process, timely loading of new FQ's and RHC's back to date of approval by CMS - An update is requested from PE and DMS	5 - 6
B. Report on wrap/crossover claims cleanup July 1, 2014 to June 30, 2018	22 - 29
C. Updated fee schedule release and any new codes added to the fee schedule	29 - 32
D. Clarification on video conferencing	32 - 33
E. Other Old Business	33
5. NEW BUSINESS	
A. Appointment to the PCTAC	33 - 34
B. Updates or announcements from MCOs	34 - 40
C. Consideration of recommendations to MAC and DMS	40
D. Other New Business	40
E. Next Meeting date is March 14, 2019	40
F. Adjournment	40

1 MR. MARTIN: It is 10:01 and
2 I'd like to start the meeting. I'd like to introduce
3 myself. I'm Barry Martin. I'm the sit-in for Chris
4 Keyser, Chair of the TAC, and I'm the Vice-Chair and
5 I'm honored to be her replacement.

6 To get things started, we have
7 a quorum with Yvonne. She is on FaceTime.

8 COMMISSIONER STECKEL: She has
9 to be here.

10 MR. MARTIN: She has to be
11 here?

12 COMMISSIONER STECKEL: She has
13 to be here.

14 MR. MARTIN: Well, then, we do
15 not have a quorum.

16 MR. BOLT: Excuse me. When was
17 that determined, video conferencing?

18 MS. HUGHES: There has not been
19 a determination. Our understanding is that Facetime
20 is not, according to open records and the Attorney
21 General's Opinion. So, therefore, she would have to
22 be here to count as a quorum.

23 MR. BOLT: You can go back to
24 moving your office.

25 MS. AGAN: I can go back to

1 moving my office.

2 MR. BOLT: Yes.

3 MR. MARTIN: So, we do not have
4 a quorum, so, we can't make any decisions or
5 recommendations but that will not stop us from having
6 the meeting.

7 If anybody wants to review the
8 minutes or if they have reviewed the minutes and any
9 recommended changes, we can hold that until the next
10 meeting for approval.

11 Under Old Business, provider
12 enrollment process, timely loading of new FQ's and
13 RHC's to the date of approval by CMS - an update is
14 requested from PE and DMS.

15 MR. BOLT: I think that issue
16 has been resolved. What is not clear is, and in
17 talking with John, there were two clinics. Both have
18 been--well, we're still working on one but there's
19 been agreement on a date. That's still under
20 discussion.

21 And, Commissioner, for your
22 information, it became a policy issue because it was
23 a significant change in the way that new FQHC's and
24 RHC's were loaded into the system.

25 And what happened with one in

1 particular, they were recognized as an RHC in
2 December. They were licensed in I believe January
3 and recognized by the OIG and submitted their MAP for
4 the changeover in late February or early March.

5 And they kept calling and kept
6 calling Provider Enrollment and got no answer and
7 finally in September received notice that they needed
8 to make some corrections which could have been made
9 much, much earlier. And, consequently, they gave
10 them a start date of like October 8th, so, almost
11 nine months later.

12 That had not been the process
13 and the policy and the procedure previously. So,
14 what we have discussed is in situations like that
15 where there's a change and picking a date moving
16 forward so that you all don't get caught in a lot of
17 backfilling, but it is a problem. It is an issue and
18 I think we've got it worked out. We did at least for
19 the FQHC which is a lookalike but we've still got
20 this one outstanding rural health clinic.

21 MR. MARTIN: And let me go
22 back. I think it would be a good idea for us all to
23 introduce ourselves so we'll know who is here.

24 (INTRODUCTIONS)

25 MR. MARTIN: Thank you all.

1 Going back to an appropriate or an approved method of
2 acknowledging what would be----

3 COMMISSIONER SECKEL: Mr.
4 Chairman, if you wouldn't mind, can I address the TAC
5 because we're making some changes?

6 MR. MARTIN: Yes, please.

7 COMMISSIONER SECKEL: And if
8 you don't mind, I'd like to go over it. Everyone
9 will be getting an official letter, but we are
10 revamping the TACs because one of the things that I
11 would like to see and this reflects that to a degree
12 is getting away from claims processing issues and
13 one-off issues and use the skills and the talents of
14 this TAC to help us develop policy.

15 So, we would ask and we will
16 enforce that the agenda reflect that. If you've got
17 an issue with your specific provider, there are ways
18 to address that and more timely ways to address it
19 than the TAC meeting.

20 Sharley is putting together a
21 list for all the TACs of who to contact if. So, we
22 will be handing that out so that you know if you've
23 got a problem about "x", this is who you should call
24 or this is the website that you should contact and
25 then we can work on it.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

And understand that when you all submit, like if you submit an issue with your FQHC or with your community health center, we address that specifically but, then, we also look is this representative of a systemic problem.

So, we're not just fix that, now we're done. So, it does help us to have that, but it helps us when it goes through the correct system.

So, what we would like to use the TACs for is true policy discussions. What is it that we're working on that we can present to you all to get your input? What is it that you would like us to look at in a policy front to address and improve the Medicaid agency and the services that we all provide for the Medicaid beneficiaries?

The Attorney General, to your specific point, the Attorney General has been clear that in order to comply with the open meetings' requirement, it has to be in person.

So, I know the MAC has said that they were going to ask for an Opinion from the Attorney General which is their right. And until we get that, meetings have to be held in person.

So, what you will find, and

1 obviously by us being here, you all are already
2 complying with this, but we are bringing all the TACs
3 back to this building. So, there won't be TAC
4 meetings offsite.

5 What we're hoping to accomplish
6 by that is that people like me and Stephanie and Lee,
7 senior leadership can start participating in a more
8 robust way with the TACs.

9 MR. MARTIN: We would really
10 appreciate that.

11 COMMISSIONER STECKEL: And I
12 can't promise it will be every time but I don't have
13 the ability to go off campus and then come back as
14 much as I would like to. So, we're doing that.

15 Only TAC members can address
16 the MAC. So, one of the things that you all will
17 have to do - and I appreciate Dave's work and
18 everything that he does with us and for you all -
19 it's been fabulous - but a TAC member will have to
20 make the presentation to the MAC.

21 And it is a presentation only
22 of the recommendations, not of the discussion. They
23 get the minutes and they could ask questions if they
24 have questions about the minutes.

25 What else am I leaving off?

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

MS. HUGHES: The agenda two weeks in advance.

COMMISSIONER STECKEL: And it can be updated up till ten days before the TAC meeting. So, we're going to start enforcing that.

And understand that that helps us be more responsive to your request. If we've got the agenda, then, we can either call to clarify what exactly and, then, which DMS people need to be at the meetings. So, that's why we're doing that.

MS. HUGHES: That covers most all that I can think of.

COMMISSIONER STECKEL: I think that that covers the major things.

MS. BATES: Two meetings at the same time, but not for this one, I don't think.

COMMISSIONER STECKEL: For the same reason as getting the agendas and having the meetings here, we are not going to allow two TACs to cross over so that we're not having to figure out, okay, we need one person from DMS to be at both meetings. How do we split that person?

So, there are a couple of meetings - you all are not one of them - but that we're going back to the two TACs and asking one of

1 them to reschedule.

2 So, I think that that's pretty
3 much it but you will get a letter outlining
4 everything, but please understand the reason we're
5 doing this is that we want this to be a robust
6 discussion about how do we improve the program for
7 our beneficiaries, how do we make the work that we're
8 doing here more efficient so that you all are having
9 an easier time to participate with us.

10 We won't always agree but I
11 hope that we will come in to this room respectfully
12 and understanding that all of us are committed to the
13 beneficiaries.

14 I know I'm rambling now, but
15 the other thing I promise you all, I've told several
16 other TACs, how many of us like it when our mom and
17 dad said because I told you so. So, you won't be
18 getting those answers.

19 If we say we can't do
20 something, it won't be just because we say so. We'll
21 explain it and we'll walk you through why. You still
22 may disagree with us but at least you will understand
23 what we are going through and what we're thinking
24 through.

25 I'm excited about the power of

1 these TACs. I am convinced that when you get like-
2 minded people together and you work through issues,
3 you can resolve them. You may not get everything you
4 want, I may not get everything I want, but we can
5 resolve them to the point that it's good for everyone
6 and most importantly for our beneficiaries.

7 So, Mr. Chairman, I think I
8 answered your question about the video conferencing,
9 but, then, thank you for the time to address the TAC.

10 MS. BATES: One more thing
11 about the MCOs. Historically, and I don't remember
12 for this TAC, if the MCOs were on the invitation, but
13 the MCOs now have been told and are expected to look
14 at the website with the meetings posted; and if they
15 choose to attend per the open meeting rules, they can
16 attend.

17 So, we aren't from the Cabinet
18 going to just send MCO invitations.

19 COMMISSIONER STECKEL: And this
20 meeting is not a meeting for us to mediate between
21 you all and the MCOs. So, again, back to policy. If
22 you have issues with the MCOs, you should talk to the
23 MCOs.

24 Now, if it's a systemic policy
25 issue, that's one thing; but if it's an issue that is

1 contractual-based or between the community health
2 centers and the MCOs, then, we fully expect it not to
3 happen at this meeting but for you to work with the
4 MCOs directly.

5 MR. MARTIN: I know Dave has
6 got a lot to say, but I appreciate everything that
7 you're saying.

8 I've been a part of the TAC for
9 probably about twenty-two, twenty-three years and the
10 role of Medicaid and the Association has kind of went
11 up and down and there's been a lot of participation
12 at times from the Commissioner's Office and, then,
13 not a lot at times.

14 We really appreciate when it is
15 a lot because we get more done it seems like when we
16 can talk and make decisions and understand each
17 other. There's not a lot of miscommunication. So,
18 we appreciate that.

19 And as far as policy, I think
20 most of the stuff that we do talk about is policy-
21 related. And we appreciate the fact that you will
22 bring policies to us because sometimes that does not
23 happen. Sometimes we get a policy that's been posted
24 for a thirty-day review or whatever and we didn't
25 know it was even going to exist.

1 So, we would like to be a part
2 of that so we can help give some comments and be
3 ready for it, for the change. A lot of times we're
4 not, and a lot of times it's a change that goes
5 totally against the grain of what's already being
6 done. So, we welcome that for sure.

7 As far as the rates and stuff,
8 I mean, we have issues ongoing. We have a major
9 issue with the reconciliation. I know that's a word
10 that nobody wants to really talk about but the bottom
11 line is it's a reconciliation and maybe we need to
12 figure out what avenues.

13 Whenever we have issues with
14 the MCOs, there's not a lot of standardization with
15 the MCOs like formats of codes and what they pay and
16 how they pay. We don't have any control of that
17 either.

18 We need to figure out maybe
19 some avenue to be able to discuss with Medicaid
20 because we've been wanting to have a conversation
21 with Medicaid and the MCOs so we can get together and
22 figure out the problems.

23 Right now it's we have an issue
24 with the MCOs and they say it's Medicaid. We have an
25 issue. We go to Medicaid. Medicaid says it's MCO.

1 COMMISSIONER STECKEL: Shame on
2 you all. It's never Medicaid's fault.

3 MR. MARTIN: That's because Mom
4 says so.

5 COMMISSIONER STECKEL: I wish
6 that were true and I hear what you're saying.

7 I know that the Hospital
8 Association meets with the MCOs once a month. So,
9 that may be an idea that you all should do.

10 MR. BOLT: I don't mean to
11 interrupt you but we have routine ops meetings once a
12 month with all of the MCOs. In between those, we
13 have ops calls on claims only.

14 And, again, I've been involved
15 with the TAC/MAC thing longer than Barry. I have
16 been through the erosions of MAC and TAC input.

17 And this Association, this
18 group of people has out of necessity brought together
19 the MCOs and DMS in one common discussion point, and
20 sometimes heated, so that we stop pointing fingers at
21 this, that or the other.

22 I think to erode the ability
23 for us to discuss in this room - and I'm not going to
24 ask the MCOs to say one way or the other - but we
25 have identified issues here jointly that we all need

1 to work on, not just the MCOs.

2 And the MCOs will tell you and
3 the clinics will tell you, I tell people, if you want
4 to point the finger of blame, let's just stand in a
5 circle because you never know what it is.

6 Now, what I also know is that
7 one of the roles the TAC used to play - and Barry
8 will remember this - is regulations were reviewed by
9 this body and we would make comments on it and
10 sometimes we even helped DMS avert some issues.

11 When we sat down to do the
12 reconciliation, I won't call what we're in now a
13 reconciliation and I know the reason, but what
14 happened as an example, DMS on its side came up with
15 a - I'm not kidding - a three-foot-long spreadsheet.

16 And what we did through the TAC
17 and discussions - and this was directly with DMS but
18 also we involved the MCOs in offline discussions -
19 DMS was requesting information that the clinics could
20 not possibly have gotten. So, working together, we
21 came up with a reasonable approach that helped
22 resolve the issue.

23 I think you'll note from a lot
24 of the recent recommendations that this body has
25 made, they have been policy-oriented; but in some

1 instances, the claims issues and the way claims are
2 paid, the processes are set up for payment of claims.
3 In fact, we've got one that's going to be talked
4 about today - and we've already talked with some of
5 the MCOs about it - looking at a common process
6 because if we just add on and add on and add on to
7 the misery of the clinics in having to take on more
8 complicated roles amongst five different MCOs, then,
9 we're adding to the cost and detracting from the
10 ability to provide services and improve the quality
11 of care.

12 So, I don't disagree with you.
13 We need to focus on policy and I think we have to a
14 large extent but I'd also encourage you and the MCOs
15 to continue to join this meeting so that we can work
16 on common issues in the generally jolly way we have,
17 not that there's not going to be an issue every once
18 in a while, but here we generally talk about higher-
19 level stuff.

20 Mary, you could pull out the
21 worksheets for her and show her what we do monthly
22 with the MCOs. Sometimes, yes, it is contentious and
23 that's going to happen but we're all, I think, headed
24 in the same direction.

25 So, the changes are fine. Me

1 not presenting to the MAC anymore, I knew that was
2 going to come eventually. That's fine.

3 COMMISSIONER STECKEL: And it's
4 not personal. What I'm saying here is, you know, if
5 I wanted to say something to you, I would say it to
6 you directly, but I'm saying the exact same thing to
7 every single TAC, and some are more guilty of the
8 claims issues than others.

9 MR. BOLT: We don't have
10 membership bringing in claims and that being the
11 agenda. We're trying to focus and the thing about
12 the non-reconciliation/reconciliation is, that's a
13 federal statute issue, a state regulatory issue and
14 something that affects the MCOs as well as the
15 clinics themselves.

16 And I really have to compliment
17 Steve Bechtel and the workgroup we've got working on
18 that to solve a common problem, but if that hadn't
19 been raised here jointly, I don't think we would have
20 gotten everybody's buy into it.

21 If we have to go to everyone
22 individually, if every clinic has to go to every MCO,
23 just in the IPA, there's eighty-some clinics, that
24 would be three hundred and what, four hundred
25 meetings a year. There isn't enough time in the day.

1 So, this becomes a gathering
2 place to work on consensus about how to approach
3 something and, then, there's some of us and including
4 the clinics that jump in and work with the MCOs or
5 with DMS or whomever to get the issue resolved at the
6 very base.

7 Again, without pointing
8 fingers, let's just get it fixed so we can focus on
9 improving quality and containing costs.

10 COMMISSIONER STECKEL: And I am
11 totally supportive of that. And one of the things
12 that we don't want to lose in trying to make these
13 changes is the facilitation function that we might be
14 able to provide, the fact that you all are here, the
15 MCOs can come and that kind of dialogue, but
16 understand this. We are not going to mediate a
17 contractual relationship.

18 MR. BOLT: We thoroughly
19 understand that and we've used dispute resolution a
20 number of times through the IPA. I don't have a
21 problem there.

22 And part of the issue that may
23 be brought up just for general discussion - and not
24 having a quorum, we can't do anything but I am going
25 to bring it up - but it is a process-oriented thing.

1 Again, if you will remember, a
2 lot of the recommendations this group made were
3 oriented toward contracts because of what this group
4 has learned over the last five years and the
5 knowledge some of them have working in other states
6 and what they've seen other places.

7 Again, they are suggestions.
8 We think it would be a good thing to take those
9 suggestions, but, of course, that's up to you all,
10 but just remember that we have to deal with it at the
11 ground level.

12 The thing we've learned over
13 the years is if we sit down and come up with a common
14 direction, things go a whole lot easier. Now, that
15 doesn't mean I don't yell at Johnny Akers or Rick
16 Schulz or anybody else at times, but I think we've
17 pretty well got it leveled out as to where we take
18 those one-offs directly to the MCOs and don't bring
19 them up here. It's higher-level stuff here that
20 really involves DMS.

21 MR. MARTIN: I do think this is
22 a good medium because a lot of times, we bring up
23 something that maybe Medicaid has not really realized
24 with the MCOs at times.

25 We understand the ground rules

1 that you're laying. I think we pretty much meet
2 those ground rules, but if we don't at times, then,
3 we understand if you kind of nudge us to the right
4 direction.

5 COMMISSIONER STECKEL: Thank
6 you. I think one of the things Dave will tell you,
7 one of the earliest relationships I've been able to
8 develop is with David, and I am not a shy and
9 retiring person.

10 MR. BOLT: No, she is not.

11 COMMISSIONER STECKEL: So, if
12 something is going on or bothering me, then, if it
13 involves you, you're going to know about it and I
14 expect the same from you all.

15 MR. MARTIN: And you will get
16 that.

17 COMMISSIONER STECKEL: And,
18 again, with the aura, I guess, of respect. We
19 respect each other. We may agree, we may disagree
20 but we all respect each other and we all have a
21 common goal of our beneficiaries.

22 And you all don't know me. A
23 lot of you don't know me yet but FQHC's and rural
24 health clinics have a special place in my heart. So,
25 the work that you do and the outreach that you take

1 for our members, our beneficiaries is phenomenal.
2 So, I want to make sure that we're enabling an
3 efficient and effective system to continue that work.

4 MR. MARTIN: We do, too.

5 MR. BOLT: Commissioner, I do
6 have one question. On the wrap/crossover claims
7 cleanup, that seems to us to be something that needs
8 to involve and what we had set up originally was a
9 small group of clinics to work with DMS on that
10 because you all have information that we don't have.

11 And we've talked about that
12 around the table with the MCOs on the threshold
13 reports and all that. We're not convinced based on
14 what we've seen that the threshold reports are the
15 total problem.

16 Again, part of the reason to
17 pull that together and to involve DMS is to get to
18 the root cause. It may be the clinics' problem. It
19 may be the MCOs' problem. It may be DMS' problem.
20 We don't know. It's not meant to point fingers.
21 It's to develop a process to meet the regulatory and
22 statutory responsibilities that Medicaid has to these
23 clinics.

24 COMMISSIONER STECKEL: And my
25 understanding is that group is working well and

1 working through the issue.

2 MR. BOLT: Right, but that was
3 stimulated here. And I'll have to say that the MCOs
4 have contributed heartedly to that, but that is
5 something that's in everybody's mutual interest.

6 Now, it's a claims' issue but
7 it is a policy/regulatory----

8 COMMISSIONER STECKEL: But it's
9 more of a systemic, big-picture issue. So, let me
10 raise you five and----

11 MR. BOLT: Can I borrow some
12 money?

13 COMMISSIONER STECKEL: One of
14 the issues that I would like to put on the table for
15 the next meeting but to give you all kind of a heads-
16 up so that you can start thinking about it is in our
17 new contract for our new MCOs that will start in
18 2020, I want us to get out of these reconciliations,
19 and I would like to require the MCOs to pay the PPS
20 rate and, then, that way, you all get out of having
21 to wait for us to do reconciliations, us having to
22 spend a lot of time, money and effort on those
23 reconciliations.

24 Now, I know that's easy to say.
25 I hope you were happy and not falling out of your

1 chair.

2 I told someone today that was
3 trying to explain the MMIS system, I said, look, I
4 understand. It's like saying we have electricity
5 because we turn on a light switch. I understand, but
6 that's what I would like to put on the agenda for the
7 next meeting and have you all talk to us about it and
8 where and how and what would we need to do, but,
9 again, understanding that my intent is that that PPS
10 rate be the floor.

11 Now, if you want to negotiate a
12 higher rate with the MCOs, that's between you and
13 the MCOs but you will get paid no less than what we
14 are statutorily required to pay you.

15 So, just FYI, that's one of the
16 policy issues I'd like us to talk about next time.
17 And I'm sorry. You had a question.

18 DR. BISHNOI: I was just
19 wondering. You had talked about the list of who to
20 contact if we had issues. I think the sooner we have
21 that list, the better it would be. Do you know when
22 that list would be out?

23 MS. HUGHES: Hopefully very
24 soon.

25 COMMISSIONER STECKEL: She is

1 tied up. We're having, if you can imagine, all week,
2 we're having at least two TACs almost every day.

3 MS. HUGHES: Three every day so
4 far.

5 COMMISSIONER STECKEL: So, it
6 will probably be next week but that's a priority for
7 us, yes, sir.

8 MR. MARTIN: We look forward to
9 having that discussion about doing the PPS rate but
10 it's going to entail a little bit more than just that
11 because we have some safety net issues like OB that
12 we need to talk about because a lot of people don't
13 provide that service and a few of us do, but, yes,
14 definitely we would like to talk about it.

15 COMMISSIONER STECKEL: And this
16 is the chance to raise unintended consequences, have
17 you thought about this because don't assume that
18 we've thought through it all. You all are on the
19 ground. You're operating it. You know it better
20 than we do. And, to me, this is a perfect example of
21 how we can work together on implementing a new
22 policy.

23 MR. MARTIN: Right, and we
24 definitely want to be involved in those discussions
25 and give you our opinions.

1 MR. BOLT: And I'm just sitting
2 here thinking about an incident long ago with the TAC
3 and a Commissioner where I proudly announced that
4 under the new process they put in place, that I could
5 bill and be paid the Medicaid rate for seeing a
6 patient. It was Mike Robinson. He all but
7 physically threw me out of his office.

8 Three days later, he called.
9 And we were pointing out a problem. Three days
10 later, he called me and apologized and fixed it.

11 So, again, that's really the
12 approach we have taken here. I think anything is fair
13 on the table. You may get a no from us, too, or from
14 the clinics, but I appreciate the relationship we've
15 developed so far. I hope it goes forward.

16 I hope you understand that the
17 whole intention is let's make this work. None of us
18 are always going to right. None of us are always
19 going to be wrong.

20 And, again, this has become a
21 pretty good forum. And if any of the MCOs don't
22 think it is, they don't have to show up but we're not
23 going to rely on you to invite them. We've got our
24 own mailing list and we'll note the ones that don't
25 show up. That's not a threat. That's a promise.

1 partnership. We want to make it a partnership with
2 DMS and the MCOs because that's the way it should be.

3 COMMISSIONER STECKEL:
4 Excellent.

5 MR. MARTIN: I forgot to say,
6 instead of reconciliation, I think I have now started
7 calling it a reckoning. I'll quit using the
8 reconciliation word but we really do need to work on
9 that and we continue to work on that, and I think we
10 do have a good team.

11 When do we expect to have any
12 kind of----

13 MR. BOLT: I haven't talked to
14 Steve recently. Shelia, have you had any contact
15 with him?

16 MS. BOWLING: No. I spoke with
17 two of the MCOs about our spreadsheets.

18 MR. MARTIN: But we are forging
19 ahead?

20 COMMISSIONER STECKEL: But it's
21 moving forward, yes.

22 MR. BOLT: I know with several
23 of the MCOs, that is moving forward with the
24 information we got. What would be helpful if we
25 could get the threshold reports electronically, if

1 you all could figure that out. Then KPCA could set
2 those up for the clinics to access. There's been
3 some problem in doing that because right now what
4 we're getting is a disk and sometimes it's kind of
5 mangled but that would help expedite that process.

6 But for the Commissioner's
7 information, we pretty well feel that with doing away
8 with the taxonomy requirement on the crossovers and
9 with the auto-posting that went into effect, that a
10 lot of this is cleaning up going forward without much
11 of a problem.

12 MR. MARTIN: Okay. Let's go on
13 to the next agenda item. Updated fee schedule
14 release and any new codes added to the fee schedule.
15 Do we have any?

16 MS. GUICE: The fee schedule
17 should be posted pretty soon. They are in the
18 approval process right now. So, they should be
19 posted in the next week or week and a half. I don't
20 recall any specific new codes or anything but that
21 doesn't mean that there--we haven't added any
22 services. We've replaced codes, okay, is what we've
23 done now for the last two or three years. We don't
24 add services necessarily. We just replace obsoleted
25 codes.

1 MS. BOWLING: I have one
2 concern. Currently, Medicaid has 99490 as the
3 chronic care management code; and when those claims
4 cross over from Medicare, they use a G0511, and the
5 G0511 up to this point has not been on the fee
6 schedule.

7 MS. GUICE: They change your
8 codes on your claims?

9 MS. BOWLING: We submit a G
10 code to Medicare rather than the 9000 code. It's the
11 same service, just a different code that we submit to
12 Medicare.

13 MR. MARTIN: So, is it causing
14 a problem in the crossover?

15 MS. BOWLING: Yes. When the
16 claim crosses over, Medicaid obviously doesn't
17 recognize that G code and does not process it for
18 that co-insurance or deductible.

19 COMMISSIONER STECKEL: So, Lee
20 will look into this.

21 MS. GUICE: What was the 99
22 code?

23 MS. BOWLING: The 99490 is the
24 chronic care management and G0511 is the Medicare
25 code for the same service. That will help our

1 patients with that coinsurance.

2 MR. MARTIN: Mary, do you have
3 any other issues with any coding?

4 MS. ELAM: No, I haven't seen
5 or heard any thus far.

6 MR. MARTIN: Okay. Appreciate
7 you looking into that.

8 MR. BOLT: Just to give you
9 another idea, a lot of the CPT II codes that are
10 required to pick up quality measures, we're seeing
11 they're not going through the clearinghouses. Mary,
12 is that correct?

13 MS. ELAM: Some of them.

14 MS. BATES: Is that a
15 clearinghouse issue?

16 MR. BOLT: Yes, it's a
17 clearinghouse issue. And the thing we've had to
18 learn to do in trying to hit the quality measures
19 which is the essence of a value-based approach, we're
20 having to slice and dice it not just from the
21 clinic's side of how they submit it but how it's
22 received by the MCOs and, then, even how it's
23 processed over at DMS.

24 MS. BATES: But the
25 clearinghouse is the provider's clearinghouse?

1 MR. BOLT: Yes, the
2 provider's--well, and here's the other problem. They
3 may sign on with one clearinghouse. That
4 clearinghouse may drop it to two other clearinghouses
5 before it gets to the MCO's clearinghouse.

6 COMMISSIONER STECKEL: But
7 that's a relationship between you and your
8 clearinghouses.

9 MR. BOLT: Yes, yes, but that's
10 how deep we're having to look at it rather than
11 blaming you all or the MCOs for not receiving it
12 correctly but that's the depth we're having to go
13 into and you have to consider it in that process, but
14 the CPT II codes are something you all just aren't
15 accepting in some instances and those are necessary
16 to pick up for quality measures if you all start
17 looking at that. The MCOs already do.

18 MR. MARTIN: Okay. The next
19 item we've kind of covered - clarification on video
20 conferencing.

21 I guess the one thing, once we
22 get clarification from the Attorney General, is there
23 any way that we could look at if they say that they
24 have to physically be here maybe the potential of
25 video conferencing? Maybe not FaceTime but have some

1 kind of video conference available?

2 COMMISSIONER STECKEL: It still
3 would be a non-quorum issue. Unless the Attorney
4 General tells us that we've misinterpreted this and
5 misinterpreted his rulings that we've looked at, it's
6 a physical presence.

7 MR. MARTIN: We typically don't
8 have that problem.

9 MR. BOLT: This is the first
10 time that I can remember.

11 MS. HUGHES: Just so you know,
12 the MAC, the Secretary was to specifically ask if
13 they can do FaceTime, Zoom, all of the technology-
14 based that we can use on our I-Phones. She was going
15 to get that specific when asking for clarification.

16 COMMISSIONER STECKEL: And, of
17 course, we would like more participation versus less
18 but we have to adhere to the law.

19 MR. MARTIN: Okay. Any other
20 Old Business?

21 Seeing none, let's go to New
22 Business - appointments to the Primary Care TAC.

23 MR. BOLT: Generally our
24 process as the new board is seated, TAC membership
25 will be revised and we'll be sending along new

1 notices of any changes in membership there.

2 MR. MARTIN: Updates or
3 announcements from the MCOs. Do we have anything new
4 and improved going on?

5 MR. GROVES: This is Ken Groves
6 with Anthem. I don't have a whole lot. I've got a
7 new rep for Region 4 and a new map should be posted
8 very shortly, some additional updates on that as
9 well, some additions to our Provider Relations.

10 So, basically, I handle not
11 only Medicaid but other lines of business as well.
12 So, fun times for me.

13 Another thing, we've
14 resurrected Kentucky HEALTH, so, look forward to a
15 webinar to be coming out very soon. That will be
16 ready for 4/1 implementation hopefully.

17 We put a notice about our
18 copays for Medicaid members. That's effective, of
19 course, 1/1/2019.

20 And, then, I just put together
21 a notification in regards to Medicaid crossover, that
22 we can accept crossover claims on a 1500 form or a
23 UB04. So, I sent that over to KPCA and that should
24 be posted.

25 MR. BOLT: We sent it out.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

MR. GROVES: Thank you and that's all I've got.

MS. PACK: Jacquelyne Pack with Aetna Better Health of Kentucky. Of course, copays effective January 1, 2019.

We want to let everyone know that this month, every Wednesday afternoon at 3:00 p.m., there is a webinar Aetna-specific for copayment education for our providers so that we walk you through the provider portal, how you will find a member, how you will see whether they do or do not have a copay and, of course, our website has been updated on the provider tab. On the left side, it says Copayment Changes. Click there and we have documents that will go through that in detail.

So, if you have any questions, of course, my name is Jacquelyne Pack. I'm the dedicated rep for KPCA. So, I would be glad to answer those questions for you.

MS. DAY: Hi. I'm Beth Day. We have also at Humana-CareSource realigned our Provider Relations' staff. Rather than basing it on the traditional affiliations of the regions as set forth by the Department of Medicaid Services, we have based it on membership assignment to the various

1 providers in any given region. So, hopefully that
2 will balance our workload better so that you can see
3 a better response time for everything.

4 And we have kind of moved a
5 little bit of our seasoned reps around to some of the
6 higher-volume areas that have a little bit more
7 complex need to their issues. So, hopefully you'll
8 see some ease in your response time and we are also
9 hiring an additional rep for Region 3.

10 So, currently there are two of
11 us kind of balancing that; and once that rep has come
12 on board and has their county assignment, we will be
13 sending out a notification and with a new map of who
14 the Provider Relations Representatives are with the
15 link to that on our website.

16 MR. AKERS: John Akers,
17 WellCare. A couple of things. I echo what my
18 colleagues with the other MCOs said about copays.
19 I do a biweekly webinar for anybody in the market on
20 copays.

21 We have a platform called
22 WellCare Works and our members are educated on
23 WellCare Works which is an online platform that helps
24 them with job and volunteer search, online career
25 assessments, resume' assistance, job interview tips.

1 So, it's a very robust platform. It educates members
2 so that when Kentucky HEALTH rolls out, we will have
3 engaged them if they are in that category where
4 they're required to do volunteer or employment.

5 So, I just wanted to share that
6 with everybody. And we are engaging our members on
7 WellCare Works. So, we're happy to be able to offer
8 that service to them.

9 And as a part of that, we have
10 a Community Connections Program throughout the state.
11 So, we engage with not-for-profit organizations.
12 We're going to educate them as well as if members
13 have an issue with transportation, our Community
14 Connections' folks, they network with various
15 agencies throughout the state to help members that
16 are having transportation issues. So, I just want to
17 share that with everybody.

18 MR. BOLT: Has all of that been
19 sent out, John?

20 MR. AKERS: Yes.

21 MR. BOLT: Thanks.

22 MS. DRAKE: Christine Drake
23 with Passport. So, I am newly appointed for KPCA
24 statewide. I am the Provider Rep. So, pretty much
25 the same with facility, same thing with copays. We

1 have online provider training that's available to
2 providers. And, then, we do have our E-News that
3 have been coming out for any updated information.

4 MR. BOLT: Ken raised an issue
5 that's come up from several different sources. We
6 know with RHC's and FQ's, the copay is three bucks.
7 The question that has come up is if the patient has
8 an x-ray onsite but it's read by a radiologist
9 offsite who bills separately, is there a second copay
10 for the patient?

11 MS. BATES: I'll take that.
12 I'll send you the logic that all of the MCOs have
13 that's down to the code level that will answer that
14 exact question for you because I'm sure you will have
15 more questions outside of that.

16 MR. BOLT: Is it two or three
17 pages of logic?

18 MS. BATES: But it is not
19 subject to negotiation.

20 MR. BOLT: There's been quite a
21 few questions raised about that, and getting that out
22 will make everybody's life a lot easier. I know I'll
23 stop getting phone calls on the weekends because I
24 know I can't call any of her staff on the weekends.
25 I get chewed out.

1 MS. BATES: And it is very much
2 a provider document and not meant for the recipients
3 because of obviously the reading level and all of
4 that but the MCOs have the same exact document and
5 actually used it to code their systems.

6 I did make it a little bit
7 easier to understand, but just know that it will be
8 updated as codes come and go and all of that, but you
9 will see what I'm talking about.

10 MR. BOLT: So, what is the
11 simple answer?

12 MS. BATES: I don't know. I
13 would have to look at that document.

14 MR. BOLT: You can look at the
15 document but just give me the simple answer.

16 MR. MARTIN: We have the same
17 thing with pathology.

18 COMMISSIONER STECKEL: Well,
19 no. I'm sorry. That's the purpose for sending out
20 the document is that we wouldn't have to do one-offs.
21 So, if you get it and you can't follow it----

22 MR. BOLT: I've got smarter
23 people than me that I will let look at it.

24 COMMISSIONER STECKEL: I don't
25 mean to be terse.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

MR. BOLT: I understand.

MS. BATES: It is down to the provider type level. So, you won't have to like read the whole thing. You will be able to see. You will see what I'm talking about.

MR. MARTIN: We're just wanting to know if radiologists are going to start telling us that we're going to have to pay that for them.

COMMISSIONER STECKEL: Sure.

MS. BATES: I understand.

MR. MARTIN: Okay. Anything else? Any more updates or announcements from the MCOs?

Of course, we don't have any consideration of recommendations to the MAC - we don't have a quorum - other than the outstanding ones that we've had before.

Any other New Business? Our next meeting date is March 14th.

Anything else before we go? Thank you all for coming. Have safe travels back and meeting adjourned.

MEETING ADJOURNED