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Edelen makes recommendations to improve Kentucky's new Medicaid managed care system

New unit in his office will bring greater accountability and transparency to the $6 billion program

FRANKFORT, Ky. (Feb. 29, 2012) – Auditor Adam Edelen on Wednesday issued 10 common-sense proposals aimed at providing immediate fixes to the state's new Medicaid managed care system and announced the creation of a unit in his office to monitor the long-term effectiveness of the program that provides health care to more than 700,000 Kentuckians.

On Feb. 3, Edelen requested information from the state's managed care organizations (MCOs) after hearing widespread complaints from health care providers and patients that claims for reimbursement were not being paid in a timely manner and treatment was being delayed or denied.

"The three new MCOs are sitting on more than a quarter of a billion taxpayer dollars while small-town doctors, hospitals and other health care providers have had to open or extend lines of credit to keep their doors open," Edelen said. "That requires an explanation."

The MCOs have received $708 million from taxpayers while paying out just $420 million to providers as of Feb. 15, Edelen said.

The review was a preliminary analysis of information provided by the MCOs and not an official financial audit.

The Cabinet for Health and Family Services on Nov. 1 transitioned 560,000 individuals to three MCOs to save an estimated $1.3 billion in taxpayer funds over the next three years. A fourth MCO – Passport Health Plan – already provided health care to more than 170,000 individuals in the Louisville metro area and surrounding counties and was not the target of the majority of complaints.

“Managed care is the right approach for Kentucky, provided it’s done right,” Edelen said. “Squaring the deal for taxpayers, providers and patients is the primary focus of the involvement of my office in this important issue.”

An initial review of information shows that the Cabinet failed to learn the lessons of the difficult transition to Passport 14 years ago and was ill-prepared to monitor and enforce its contracts with the new MCOs, Edelen said.

Those organizations, in turn, did not appear to have adequate systems, staffing or communications in place despite assurances they were ready to launch the program last fall.

And to a lesser extent, Kentucky’s health care providers and their third-party billing organizations were not prepared to properly bill MCOs for services provided.

To maintain a future focus, Edelen said his office has made 10 preliminary recommendations to improve the current system as a prelude to an expansive review to be conducted later in the year. Edelen has shared the recommendations with the Cabinet and MCOs for their consideration.

The recommendations are as follows:

1. The Cabinet, MCOs and provider community should develop an agreed-upon metric for measuring and reporting the timeliness of provider reimbursements and implement action plans to resolve identified deficiencies in a timely manner.

2. The Cabinet should better monitor and enforce the governing MCO contracts, specifically as they relate to the timeliness of billing.

3. MCOs and pharmacy benefit managers (PBMs) should use secure, modern technology to process pre-authorizations and reimbursement claims and transmit information to providers and pharmacists.

4. MCOs should train providers and their billing agents to use the automated systems in place to track the submission of claims and their status in real time; providers and pharmacists should utilize those systems to verify claims’ status, correct errors, reduce duplicate claim submissions and speed the payment process.

5. Each MCO should adjust staffing as needed to clear existing backlogs in claims and pre-authorizations and ensure that processing of claims and pre-authorizations adheres to the time frames in the contracts.

6. MCOs and PBMs should better communicate to providers and pharmacists the process for appealing denied claims and, related to specific prescription costs, the process for appealing the maximum allowable cost and dispensing fees.

7. MCOs and PBMs should streamline and expedite the appeal process to reduce the risks to the health and safety of patients.

8. MCOs and PBMs should more diligently review claims to ensure relevant patient information is considered before making final decisions and provide detailed explanations when claims are denied.

9. The Cabinet should study whether behavioral health patients and others who receive specialized medical services would be better served under the Medicaid fee-for-service structure administered by the Cabinet.

10. MCOs and PBMs should streamline the process for a more timely execution of pre-authorizations.

In addition to the recommendations, Edelen said he is shifting existing resources within the auditor's office to establish a Medicaid Accountability and Transparency Unit. The cross-departmental effort will focus on making the state's Medicaid system more effective, efficient and honest.

"It appears to be the first time in the history of the auditor's office that a unit has been created to monitor a specific area of state government," Edelen said. "There are more people on Medicaid than there are children in our public schools and it is the second-largest expenditure of our government. We can outsource the functions of Medicaid, but we cannot outsource the responsibility."

Edelen said he recognizes MCOs are taking steps to improve the managed care system and appreciates their cooperation in his office's requests for information.

"All parties involved in managed care, from the state to providers and their billing agents to MCOs, must work together to provide our most vulnerable with a reliable health care system that is fair and accountable to taxpayers," he said.

Click here to read the letter of recommendations to the Cabinet for Health and Family Services and MCOs.

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