ADAM H. EDELEN
AUDITOR OF PUBLIC ACCOUNTS

February 29, 2012

CoventryCares of Kentucky
Attention: Russell Harper and Lisa Chandler
9900 Corporate Campus Drive, Ste. 1000
Louisville, Ky. 40223

Kentucky Spirit Health Plan, Inc.
Attention: Brent Layton and Yvette Rowan
1019 Majestic Drive
Lexington, Ky. 40513

WellCare of Kentucky, Inc.
Attention: Michael Minor and Michael Ridenour
One Triton Office Place
13551 Triton Park Boulevard, Ste. 2100
Louisville, Ky. 40223

Passport Health Plan
Attention: Mark Carter
5100 Commerce Crossings Drive
Louisville, Ky. 40229

Cabinet for Health and Family Services
Attention: Neville Wise
275 E. Main St., 6W-A
Frankfort, Ky. 40621

Re: Kentucky Medicaid Managed Care Contracts

Dear Mr. Harper, Mr. Layton, Mr. Minor, Mr. Carter and Commissioner Wise:

The Auditor of Public Accounts recently made inquiries with the Cabinet for Health and Family Services, the four managed care organizations contracting with the Commonwealth on Medicaid, and the health provider community to better understand the new managed care system implemented by the Commonwealth on Nov. 1, 2011.

Based on the information received, we are making the following recommendations, which if implemented in a timely manner, should significantly reduce the problems incurred under this new system:

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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.

   The Cabinet, with input from MCOs and the provider community, should specifically identify the information necessary to adequately monitor and provide trend analysis for the claims process. This information should include defined data fields, syntax of the reports, and timelines for reporting. Specific to the data field definitions, the information required from each MCO should be uniform to allow comparisons among the MCOs.

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

   The Cabinet should expand the monitoring process in place currently to scrutinize the reporting related to the timeliness of claim payments in order to determine whether there has been improvement since the implementation of the MCO process on November 1, 2011. Should an MCO fall below the requirements set out in the contract or the Cabinet identifies a decrease in their timeliness of claim payments, the Cabinet should use its authority granted in the contract to report this deficiency to the MCO. The MCO should then provide corrective action plans to get claims payment timeframes either within those established with the contract or back up to those timeframes seen previously.

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.

   For pre-authorizations, the optimal process would be an automated system available to the providers and pharmacists to provide pre-authorization responses through a real-time, encrypted transmission.

   For reimbursements, MCOs should recommend the use of direct deposit and provide information concerning how to set up this process through their communication efforts to providers and pharmacists. For direct deposit to be useful for the providers and pharmacies, however, there needs to be sufficient information provided to allow the providers and pharmacies to reconcile direct deposits, which normally provide minimal identification information, back to the reimbursement being paid. Unless this type of reconciliation information is provided, it will be difficult for the providers or pharmacists to determine what claims have been paid and are still outstanding.

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 should utilize those systems to verify claims' status, correct errors, reduce duplicate claim submissions and speed the payment process.

The automated applications to submit and query claims and any other services available to the provider/pharmacist community need to be specifically communicated to all providers and pharmacists in the MCO networks. The MCO should also provide training on what services are available and how to properly use these services. This training could be through regional live sessions or through audio-conferences, webinars, or self-study tutorials. The training should be made available to all providers and pharmacists and should be updated as changes in procedure or regulations occur.

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.

   It is imperative for the MCOs to properly staff their Kentucky-based offices, in an on-going basis, to ensure processing of claims and pre-authorizations is performed efficiently and within the contractual response time-frames.

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.

   The MCOs and PBMs should provide information related to the appeal process for a denied claim or pre-authorization request and the appeal process for MAC pricing or dispensing fees in a format and location where it can be easily accessed by providers and pharmacists.

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

   The appeal process needs to be efficient for all appeals; however, it should be expedited in those instances where the health or safety of the member is at risk.

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.

   MCOs and PBMs should use all pertinent patient medical information provided within a claim to make decisions related to the claim's validity. Further, if a claim is being denied, detailed information should be provided concerning why the decision was made, what alternative(s) are available to the requested procedure or drug, and the appeal process available to the provider or pharmacist.

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.

There is a growing concern over whether specific classes of members receiving specialized medical services, procedures, and medications are being best served by the MCO model. The Cabinet should study information from the MCOs and PBMs to determine those instances where procedures, resources, and/or drugs for members are being systematically denied or pre-authorization is being delayed. Based on this information, the Cabinet should consider whether similar classes of members, such as Behavioral Health, would be better served under the Medicaid fee-for-service architecture administered by the Cabinet.

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

    The MCOS and PBMs need to streamline the pre-authorization process to ensure members are not being placed in a life-threatening position.

    In addition, the Cabinet should review each MCO's pre-authorization requirements to ensure the procedures/resources requiring pre-authorization do not put the member at risk and, for the prescriptions being claimed as refills requiring pre-authorization, disruption in medication would not cause a life-threatening situation. Further, the Cabinet should monitor the pre-authorization processing time-frames to ensure all pre-authorizations are processed within the 48-hour timeframe. Recommended changes to pre-authorization requirements should be made in writing to the MCOs and a corrective action plan required.

As the Auditor of Public Accounts, my number one priority is to ensure that tax dollars are spent wisely and efficiently. I am hopeful, as all of us are, that managed care is the right choice for Kentucky. If executed to the level our citizens deserve, this new system has the potential to both save taxpayer dollars and improve the health and well-being of our Commonwealth's most vulnerable citizens.

Your cooperation thus far with my office has been much appreciated, and I look forward to your continued cooperation as we establish our Medicaid Accountability and Transparency Unit and step up our efforts to maximize the long-term benefits of this new system to Medicaid members throughout Kentucky.

Sincerely,

Adam Edelen
Auditor of Public Accounts