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

IN RE: HOME HEALTH TECHNICAL ADVISORY COUNCIL

August 13, 2019
11:00 A.M.
Medicaid Commissioner's Conference Room
Cabinet for Health and Family Services
275 East Main Street
Frankfort, Kentucky 40601

APPEARANCES

Rebecca Cartright
CHAIR

Annlyn Purdon
Susan Stewart
Billie Dyer
TAC MEMBER PRESENT

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APPEARANCES
(Continued)

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Judy Theriot
Sharley Hughes
David Gray
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Holly Owens
ANTHEM

Henry Spalding
PASSPORT

Amy Cummins
Cathy Stephens
HUMANA-CARESOURCE

Sammie Asher
Lisa Lucchese
AETNA BETTER HEALTH

Appearing telephonically:

Kathleen Ryan
ANTHEM

AGENDA

1. Call to Order

2. Welcome and Introductions

3. Approval of Minutes

4. Old Business
   * Telehealth reimbursement
   * Supplies
   * Physical Exam
   * MCO visit limitations

5. New Business

6. Next Meeting - October 22, 2019

7. Adjournment

MS. CARTRIGHT: We will go ahead and call the meeting to order and go around the room and introduce ourselves.

(INTRODUCTIONS)

MS. CARTRIGHT: So, we need to approve the minutes. Has everybody looked at the June minutes?

MS. PURDON: I'll make a motion to approve.

MS. STEWART: I'll second.

MS. CARTRIGHT: Susan seconded. And, then, we needed to go back to April as well. So, can I have a motion to accept April's minutes?

MS. STEWART: I'll do that one.

MS. PURDON: I'll second.

MS. CARTRIGHT: All right. Moving right along to Old Business with the telehealth reimbursement. I know that there's the new regulation that came out but it really didn't address the remote patient monitoring for home health and I think that's what we wanted to look at.

MR. REINHARDT: The language is in there but there's no way to fund it. So,

there's no reimbursement for remote monitoring, and we confirmed with I think it was Stephanie Bates from DMS that there isn't a plan to have any reimbursement at this time.

And our thought is based on our conversations - and I'll let the group chime in - that we think that's a really important service and something that will have a huge return on investment for Medicaid in particular in terms of preventing avoidable hospitalizations.

So, I think that's our thought process there. I didn't know if anyone has anything else they want to throw in on that.

DR. THERIOT: So, in funding it, you mean reimbursing the service?

MR. REINHARDT: Yes. Telehealth, the new reg talks about how basically a doc can receive reimbursement just like it was an in-person visit. We're not even asking for that.

We're just saying can we have some form of reimbursement for remote monitoring because it isn't the same thing as telehealth. We're taking all the data from the person and analyzing that data, usually at our end undergoes that, sort of the observation of the data that come

in. And the idea would be to be able to pay for the equipment or the service and for the R.N.'s time in order to focus on that process which the other states that have implemented telehealth or remote monitoring reimbursement, that's what they've paid for.

MS. HUGHES: Based upon what Stephanie has told you is that right now the decision is that we're not going to do that at this point in time. It would be under consideration later on, but for now it's not going to be put in there.

MR. REINHARDT: Right.

DR. THERIOT: I mean, I can see reimbursing for the service but not reimbursing for equipment and the whole operational process of getting that up to speed.

MR. REINHARDT: So, let me make sure I understand. So, you wouldn't pay for the equipment or the infrastructure. You would just pay for the R.N.'s time?

MS. HUGHES: Not at this point.

DR. THERIOT: Not at this point but, I mean, I can see that as a business

model.

MS. HUGHES: I don't think we're now covering for any doctors to purchase the equipment for telehealth. They have to purchase that themselves.

MS. PURDON: I think with telehealth, there's actually a visit or a face-to-face something to where monitoring----

MR. REINHARDT: Yeah, just like they were in their office.

MS. CARTRIGHT: We are remotely monitoring patients seven days a week.

MS. HUGHES: Right, but I don't know that Medicaid would ever reimburse for the equipment for you all to do that is what he was indicating, I think. The only thing we would do would be to reimburse for the service, not the equipment.

MR. REINHARDT: No, no, no. We're just talking about how the current situation is, a hospital or another provider is paying for the equipment to get all of this and get everything set up and not being able to get paid for the nurse.

So, the expectation isn't that Medicaid would cut a check for the equipment. It's

just----

MS. HUGHES: Okay, because you had indicated----

MR. REINHARDT: Sorry for the confusion. Other states, they're paying a rate for that service.

MS. HUGHES: Right; but as Stephanie said, I don't think that's going to happen right now.

MS. STEWART: So, there's a reg that says you can do it on Medicaid patients but there's no funding by which to do it. Is that what I'm hearing?

MS. HUGHES: I haven't seen the reg, so, I don't know what's in the reg.

MR. REINHARDT: That's correct.

MS. HUGHES: But based upon what Evan has said Stephanie told him is that we're not going to reimburse for that at this time.

MR. REINHARDT: So, the reg authorizes reimbursement for remote monitoring services but there is no funding mechanism associated with that regulation.

MS. CARTRIGHT: To actually

pay for it.

MR. REINHARDT: So, it says Medicaid is allowed to pay for it but they don't have----

MS. STEWART: Medicaid is choosing not to.

MR. REINHARDT: Correct. Correct. It is a reimbursable service that doesn't have any reimbursement.

MR. GRAY: But if I could add. The telehealth piece is a decision we've made. We need to get an understanding of what the budget impact is going to be on that because there really isn't a budget for that.

MR. REINHARDT: Sure.

MR. GRAY: And, so, this is at least a first step in this. Medicare, what are they doing with regard to remote monitoring?

MR. REINHARDT: So, they will pay for it in the under-populated, under-served areas; but as a whole, Medicare doesn't pay for remote monitoring.

MS. STEWART: But you can take it off of your cost report.

MR. GRAY: Again, this is our

first step. This isn't the last step. One of the things, we have to have an offset somewhere. So, let's say we get to that point. Then, there really has to be a case study to say what the savings really are.

MR. REINHARDT: Sure, and we've actually sent some of that information along. So, the metric, at least similar populations in Indiana, we went from re-admissions from one in four to five to one in twenty just by implementing remote monitoring. So, that's just having a system in the home----

MS. HUGHES: And I think some of the information you sent actually was on telehealth. When we looked at the data, it looked like it was telehealth.

MR. REINHARDT: They use the terms interchangeably. So, in Indiana, it even says telehealth but it's actually remote monitoring. It's paying for the data to be compiled and sent to a hub and for the nurse to come and monitor that hub.

MR. GRAY: The other thing I would encourage the Association to do is certainly, as we look at the RFP and award for next year, July

1, to work with those MCOs because 90% of the Medicaid payments go through the MCOs. So, it may be more about convincing the MCOs or convince them that you can save them money and maybe even do some type of shared savings. From my perspective, I think you might get faster traction there than waiting for Medicaid to pay for remote monitoring.

MR. REINHARDT: We absolutely will travel down that path. The sticking point is the MCOs tend to say we're not going to pay for anything that Medicaid doesn't pay for, particularly in home health.

MS. HUGHES: Right. They don't have. They're not required by contract.

MR. GRAY: But there are things they provide - eyeglasses----

MR. REINHARDT: No. We want to have those conversations. It's just the reluctance to go out of the box, especially with home health, is what prevents us from getting there a lot of the times.

MR. GRAY: I think if you can convince them you've got a three-, four-, five-times' return, I think they would entertain that discussion.

MS. HUGHES: And I think at the last meeting, the Commissioner said she was not shutting the door on it but it was just that at this time, because of being unsure how much the telehealth was going to end up budget-wise, that we could not impose something else.

MR. REINHARDT: Originally, I think she thought that they were paying for this service. So, in our conversation, her impression of the reg was this was getting paid for because there's language on remote monitoring in there. Then, we went and reconfirmed with Stephanie Bates that there's no reimbursement for it. So, just a few thoughts on that.

MS. CARTRIGHT: Supplies. Susan, is this the issue with the fee schedule?

MS. STEWART: This is the issue that I emailed you the example of, the PluerX strains. I sent you a patient-specific example.

MS. HUGHES: And didn't we get back with you on that?

MS. STEWART: No. I didn't cc the entire group because I didn't want to share that lady's information unnecessarily but I felt it was okay to share it with you.

MS. HUGHES: Okay. I would have sent that on. Do you remember which MCO it was?

MS. STEWART: Well, it impacts all MCOs because Medicaid doesn't have a fee schedule for it. And what it was, it was a supply limit. If we had billed ten, we would have been fine, but we billed twenty at a time; and because there's no set limit, they denied all twenty.

MS. HUGHES: MCO's? I know this has been a topic now for about three or four meetings.

MS. STEWART: The last time we talked about it, it was like, well, we pay for it. We pay for it. And, then, when I give you the example, it was, no, it was a denial because we gave twenty instead of ten.

So, theoretically, the answer is, yes, they pay for it but you have to know what their cutoff is to be able to get them to pay it.

MS. HUGHES: Who is here from Aetna?

MS. ASHER: So, if the cutoff is ten and you're billing twenty, we just deny the entire claim and not pay you for ten. Is that what

you're saying?

MS. PURDON: Yes, and, then, you have to rebill for ten and, then, you're just out ten.

MS. ASHER: So, you don't know the limitations that's applied to those codes.

MS. STEWART: Right, because yours could be ten and theirs could be twelve and theirs could be fourteen because you can set your own.

MS. ASHER: Were there certain codes that you're talking about in general or do you want limitations for all your codes?

MS. STEWART: These are supplies that Medicaid does not have a fee schedule for. Am I talking right? It's MEU, MUE is the term that's used.

MS. HUGHES: And it's the PluerX bags?

MS. STEWART: PluerX is the big one.

MS. DYER: There's several brands of those. It's essentially a drain tube but it could be a different brand. PluerX happens to be one of the brands.

MS. STEWART: And the conversation has been can you re-use it? No, you can't.

MS. HUGHES: Can you get me what your policy is and what your quantity limits are?

MS. ASHER: Yes.

MS. HUGHES: Anthem?

MS. OWEN: I mean, do you have like specific codes that you're billing?

MS. STEWART: I sent it to Sharley. So, if you want to go through--I sent you a copy of her stuff if you want to go through that and send them that code specifically but it's bigger than PluerX drains.

It's 4x4's. Four by four's come in a box of forty. Some of you want to bill in increments of forty-seven. Some want forty-five and you don't know what that is. And if we bill one box of fifty, we get denied.

MS. HUGHES: So, are all five MCOs in this room?

MS. STEWART: No.

MS. HUGHES: Who is not?

MS. STEWART: WellCare is not

here.

MS. HUGHES: All right. The ones of you that are here, send me your quantity limits on your home health services.

MS. ASHER: On all?

MS. HUGHES: Yes. That way they will have them and I will request it from WellCare.

MS. STEWART: Regardless of whether there is a Medicaid fee schedule or not.

MS. HUGHES: Right. If you've got a quantity limit on something that's provided by a home health agency, send me those quantity limits and I will send those to the TAC members.

MS. STEPHENS: Are you going to send that request out in an email as well, Sharley?

MS. HUGHES: Do I need to since you're here and I have requested it?

MS. STEWART: Yes, because the ones that aren't here won't----

MS. HUGHES: Well, I was going to send it to WellCare, yes, but I can send an email.

MS. STEPHENS: If you don't

mind sending it to all. I don't know about you guys but it helps me distribute and get it to all the right places. Thank you.

MS. CARTRIGHT: The next thing was the physical exam. And what we were asking is language change because the OIG, when they come to survey, are looking for a physical instead of a screening. And we talked about that at the last meeting that if we could change the language to screening instead of a physical.

MS. HUGHES: And this is part of the OIG reg that they're doing?

MS. CARTRIGHT: Yes.

MS. HUGHES: Have you all sent that recommendation through the comments to OIG?

MS. CARTRIGHT: I thought we did.

MR. REINHARDT: I don't know if we have yet or not but that's our next step. We'd like to do that in terms of making that recommendation.

MS. STEWART: Do we do that via the MAC or do we do that via another conduit?

MS. HUGHES: You do that via another conduit which is outlined in 13A. There's

information on the regulation that talks about when there's a public hearing, that anyone can attend and make comments and recommendations there. And there's also an email address and so forth in which you can email your comments.

After the reg finishes, there's about ten pages that are like a signature page that the Commissioner and the Cabinet Secretary sign off on and, then, there's a public notice. It might be the first one right after the signature page and it's a public notice of when the public hearing is, which they're usually held over in the Public Health Building and where to send any comments or suggestions.

Then, that way they're addressed. They come back through to our reg writer and, then, he has to address each of those in writing back to LRC. Well, not our reg writer. In this case, it would be OIG's reg writer. I'm sorry.

MR. REINHARDT: Just to clarify, this is not a part of the private duty nursing regulation that's coming out. This is an existing reg that we're asking for a different interpretation of.

MS. HUGHES: Okay. So, this

reg has not been filed? It's not open to be filed?

MR. REINHARDT: It's current administrative code.

MS. HUGHES: But it's something that's due to licensing?

MR. REINHARDT: It's part of the expectations of a home health agency. If they hire an individual, in order to meet sort of the State version of Conditions of Participation, they have to have a physical exam which the OIG has interpreted to me a full-blown physical as opposed to just a screening.

MS. CARTRIGHT: A screening that we normally do.

MS. HUGHES: You would need to contact Stephanie Brammer-Barnes. She is the reg writer for OIG and I can send the TAC members the email address that can get her email.

Now, I don't know that they will necessarily open the reg just for this change. Has the reg been filed and they're interpreting it differently?

MR. REINHARDT: It could be as simple as an interpretation. They could interpret physical exam to mean just a screening, not an

entire physical. There's no detail in there.

MS. CARTRIGHT: The reg has been around forever. And, then, all of a sudden, everybody started getting cited because everybody was doing screenings and not these full-blown physicals. And, so, they were citing us on survey.

MS. HUGHES: Is this physical exam of employees or of the patients?

MS. CARTRIGHT: Of employees.

MS. STEWART: So, if we wanted an opinion on a definition of what that means, who would we get that from?

MS. HUGHES: Stephanie Brammer-Barnes from the OIG's Office and I will send you all her email address after the meeting.

MR. REINHARDT: Thank you. We will follow up with her.

MR. GRAY: I would recommend one person. I don't know if that's you, Evan.

MS. STEWART: It will be one of us.

MR. GRAY: Or Rebecca or Chair but to engage with her in that conversation I guess via email initially and then go from there.

MR. REINHARDT: Okay.

MS. HUGHES: And I apologize that more people are not here but we're kind of short on staff. The Commissioner is out of town at a meeting today and Stephanie is offsite, so, we don't have other people here. That's why.

MS. CARTRIGHT: So, the next thing on Old Business was MCO visit limitations.

MS. PURDON: Last time, that's where people were going to try----

MS. CARTRIGHT: That's what I was going to say. They were going to try and I've not received anything from any agency.

MS. PURDON: I've got mine. I mean, do we need to wait and compile everybody's?

MS. REINHARDT: We can get some more information. I haven't heard from Missy or anyone else either.

MS. PURDON: Because at the last meeting, most said it was like a 24-hour turnaround and it is not. I have one from Aetna. We submitted our request on July 16th and we got a phone call on August 7th and they weren't approving all of our visits and they didn't approve any past August.

And, of course, it was already

August before they told us and we were already doing the visits. So, now we have to go through the whole appeals process and maybe we'll get it and maybe we won't, but it took them from July 16th to August 7th to decide that.

MS. HUGHES: Aetna, do you have their email address?

MS. PURDON: Yes.

MS. HUGHES: Okay. Can you contact them with those questions?

MS. PURDON: Yes, but I think the whole thing is it's kind of a more overall issue.

MS. HUGHES: But you've got one, right?

MS. PURDON: Yes.

MS. HUGHES: So, I mean, one is a problem; but with all the patients--you know, I'm not taking away from the value of the one. That shouldn't have happened. But in all the patients, if you've only seen one, it's not a--is it a huge problem?

MS. PURDON: Yes.

MS. STEWART: It is. If she had ten visits, it's $1,000.

MS. PURDON: And this is one and it happens often. We were just tracking since the last TAC meeting.

MS. ASHER: Do you have Lisa's email address?

MS. PURDON: No, but I will get it. So, I guess we need to get more information from everybody because I think the Commissioner said she wanted to see like how long it took to get the approvals. I was having my people just track a month. DO I need to tell them to keep tracking it?

MS. CARTRIGHT: Yes, I would.

MS. PURDON: Okay.

MS. HUGHES: I know $1,000 would be bad, but I'm saying of all the patients that she saw, she's had one that they were late getting a PA back on. So, it's not the sky-is-falling situation overall for all of the home health agencies is what I meant. It is important for you all.

MS. PURDON: Oh, yes, most all of them are more than twenty because I think last time, most MCOs said everything was reviewed----

MS. OWENS: In two business days.

MS. HUGHES: And it has taken more than two for a lot of your patients?

MS. STEWART: One, two, three, four, five, six, seven, eight, nine, ten. The majority, Sharley.

MS. PURDON: We hardly ever get anything in----

MS. HUGHES: Is it all from one MCO or multiple MCOs?

MS. PURDON: No. All of them. It's everybody.

MR. REINHARDT: So, the August example was the most egregious, though.

MS. PURDON: Yes, just because we were already doing----

MR. REINHARDT: Your average turnaround is like three to five days?

MS. PURDON: Yes.

MS. HUGHES: Okay. Can you all get with your folks back at your office and find out why it's taking so long to get the PA's done.

MS. OWENS: And I'm the lead for the Utilization Department, too, in Anthem and ours is a strict two business days.

MS. PURDON: And we don't do

Anthem. So, I don't have any Anthem on there.

MS. HUGHES: Okay. So, you all work on it and hopefully we won't have this issue the next TAC meeting but try to figure out what's taking so long on the PA's.

MS. CARTRIGHT: New Business.

MR. REINHARDT: We have two new items. One was the PDN regulation. Our purpose in requesting OIG presence was more just to have this group be aware of the proposed regulation for private duty nursing which comments aren't due until I think August 23rd.

So, we're still in the middle of that process, but we do have some concerns about what that would do to potentially open up areas of service to patients that might not have the oversight that we would encourage and expect to have from a home health perspective.

So, I'll let the group talk more about that but that's our purpose in bringing that regulation up was we wanted Medicaid to be aware that both the reg is out there and that our concerns exist related to what sort of consequences might happen from eliminating the four-hour continuous requirement in particular within private

duty nursing.

MS. HUGHES: If you can write up something and send to us of how that is going to impact Medicaid or how you all think it's going to impact Medicaid, not necessarily comments on the reg because those are going through that process.

But if you're concerned about how that is going to impact Medicaid because of something OIG is changing, then, if you want to send that to me, I can send it that to the Commissioner because they send those out to the different departments for us to review them; and if there is an issue that something is going to impact Medicaid, then, we can get with Stephanie and say, hang on a minute, let's re-look at your reg.

Our folks at DMS have reviewed that reg before it was filed. Now, I didn't, so, I don't know what the reg says and how it is changing; but if one of the TAC members wants to write up something to let us know what your concerns are as far as how that reg is going to impact Medicaid recipients, then, we can get it back to the Commissioner.

MS. STEWART: Basically, it allows for non-certified individuals to provide

skilled nursing in a home without credentials.

MS. HUGHES: But Medicaid is not going to pay for non-skilled. Our State Plan says it has to be either a licensed registered nurse or--no, an R.N. or an L.P.N. for private duty nursing.

MS. STEWART: Right.

MS. HUGHES: So, we're not going to pay for someone who is not qualified.

MS. STEWART: But the term of home health is intermittent skilled need.

MS. CARTRIGHT: And that's what is in the private duty reg.

MS. STEWART: So, you're robbing Peter to pay Paul kind of.

DR. THERIOT: So, where does the four hours come into that because you mentioned that?

MR. REINHARDT: That's the previous requirement. So, private duty used to have to be four hours continuous, and all of that has been removed from the current regulation. So, they can provide skilled nursing in the home for any duration.

MS. HUGHES: And that's for

them to get licensed, correct?

MR. REINHARDT: No. They are already--so, a private duty agency that already is up and running would be able to do this as they saw fit.

MS. HUGHES: Okay, but the Medicaid reg states that in order to provide private duty nursing, they must be an L.P.N. or an R.N.

MS. CARTRIGHT: And I think that it's not so much that we're concerned about it being an R.N. or an L.P.N. It's more that they're not going to be under the same scrutiny and regulations that a typical home health agency is. They're going to be doing what we do but have less oversight.

MS. STEWART: In essence, they could do the same thing that we do by removing that term, and all the regs and Conditions of Participation that we have to follow, they don't have to follow them.

MS. HUGHES: So, to me, it sounds like it is an OIG concern that you have. I'd have to look to see, but in my thinking, if our reg, DMS reg on private duty nursing - and I know our State Plan says in order to do private duty nursing,

it must be performed by an L.P.N. or an R.N.

MS. STEWART: We're fine with that part.

MS. HUGHES: So, it's not going to really impact Medicaid. then.

MR. REINHARDT: It's the oversight to the agency. It's the oversight to the agency. So, a home health agency is often going to be participating with JCAHO or ACHC and they're going to have accrediting standards that they have to meet. A private duty agency doesn't have to meet those same standards. They can just hire a nurse and go out and provide the service without having to meet----

DR. THERIOT: So, that's how it is now, right?

MR. REINHARDT: Correct. And this change--so, the difference between home health and private duty was four hours continuous was private duty. Home health was you could do both home health and private duty underneath the home health license.

Now we no longer have this four hours' continuous requirement. So, these same Medicaid patients will be served by whichever agency

they happen to select or be referred to or whatever the circumstances are. One agency is going to be a home health with accreditation and Conditions of Participation standards. The other is a private duty agency without any of those standards that they have to meet.

MS. STEWART: So, I could go out today and open up a private duty nursing company with no oversight, no regulations except for R.N. and L.P.N. I don't have to be accredited. I don't have to be anything.

But the same thing that I do as a home health agency, I have to be licensed. I have to be accredited. I have to follow all these rules that over here, if I opened up this other company, I don't have to follow them.

MS. HUGHES: So, we're back to the license.

DR. THERIOT: But you still need to sign up for Medicaid and you still need to go through the hoops of participating with insurance carriers.

MS. STEWART: I'm talking about care delivery. There's more to an R.N. and an L.P.N. than just being an R.N. or an L.P.N. There's

background checks. There's quality things that you have to monitor, competencies that's not required over here in private duty. It's Susan Stewart could open up private duty today and hire some L.P.N.'s.

DR. THERIOT: I mean, that sounds like that's an ongoing thing between the two different----

MS. STEWART: Well, it wasn't an issue until they removed the four hours because if it was intermittent skilled need, we had to be the provider; but now that you remove that, anybody can be the provider to Medicaid.

So, if they were in there for eight hours doing XYZ and the patient all of a sudden needed wound care, they would call home health to do it because that's an intermittent skilled need. Under the new reg, they won't call us. They will take care of it themselves.

MS. HUGHES: So, the concern seems to be that it's taking business away from the home health agencies and----

MS. STEWART: No. That's not our concern.

MS. DYER: I think it's safety of the patient and delivery of care. It's been my

experience at this TAC or whenever we've all been that it is, Sharley, a Medicaid issue when safety of the patient comes up.

So, I think that's the overriding concern is that while we all may complain about regulation or following Conditions of Participation, that we know it's important to have those things in place for the safety of the care delivery.

So, what we see is that has opened up and done away with pretty well because the private duty nursing regulation is very small, as I recall. We can do as home health agencies private duty.

So, it's not really--so, I mean, we can do the private duty, but we are licensed, credentialed. Many of us are Joint Commission-accredited. You don't have to be but we do have to follow the Conditions of Participation from the federal level, a very strict State regulation that Licensure does look at but that the State requires to be a Medicaid provider.

MS. HUGHES: But wouldn't these same providers that are out here that are PDN, wouldn't these PDN providers still have to meet----

MS. STEWART: Not under this change.

MS. DYER: Not under this change because they don't have to meet it now. They don't have to meet that.

DR. THERIOT: So, what do they have to meet?

MR. REINHARDT: They just have to employ a licensed nurse.

MS. DYER: The PDN regulation is very small. And if you're a PDN provider - I think this is what you can probably say way better than me - if you're a PDN provider, you don't have to follow - this is what we're all saying - you don't have to follow nearly the strict regulation that provides safety to the public.

MR. REINHARDT: And that's our concern. In particular, the language almost gets even more vague because it goes from licensed registered nurse and licensed L.P.N. to skilled nursing. So, it gets even more broad in terms of the definition for the service that gets provided.

DR. THERIOT: So, do the home health agencies provide PDN?

MS. CARTRIGHT: Some do.

DR. THERIOT: So, is it a problem in the state? Like, if I lived out in the middle of nowhere, could I get PDN through a home health agency?

MS. STEWART: No, you probably couldn't because we can barely find R.N.'s to do intermittent skilled need, much less stay with someone eight hours a day. We feel like the PDN companies are going to have the same issue.

But, again, our overall concern is about safety of the patient and allowing some company to just start up and go out and do skilled care without any supervision we have a concern about.

It's not a population that my company is going to lose because we don't do it now. So, it's not about fair trade. It's about, for us, really about safety of the patient because I don't do it.

MR. REINHARDT: And one of the key questions we have is what population is going unserved right now? So, can we get a better handle on that? We've exchanged some questions with the Cabinet on that. We will talk to the OIG about that. So, what does that population look like? How

can we serve them in the current environment without mean to make a change that could have some negative impacts on the patients related to lack of oversight for the agencies?

But to your point, that comment gets raised from time to time about home health agencies don't want to lose business. There are a lot more high-level concerns about workforce and nursing shortages, that the business piece is just not even a part of this because if the workforce and the nurses were out there to do this, we probably wouldn't be talking about someone that went unserved for private duty or otherwise in a particular area.

So, I think that's backing up from--you know, it's not a fundamental dollars' thing. It's just we live in a world where a certain--reasonable people can disagree about certain regulations, but there's a minimum standard that I think we all think needs to happen within patient care, and this change would not only go below that but would just eliminate sort of a standard altogether.

So, that's the concern is the care delivery should be at a high level or at least

an agreeable level and this change could potentially not have that kind of oversight.

MS. HUGHES: So, I'm wondering because, like I said, I've not seen the reg but I'm wondering if OIG is opening this up to allow for some of the areas that don't have anybody there to provide private duty nursing.

I don't think the PDN - I've not seen claims data, so, I don't even know how much PDN is used in Medicaid - but if there's a shortage of providers, especially in rural counties or even any place that they can't get the service, then, I'm thinking OIG must be opening that up to allow.

DR. THERIOT: And existing home health companies do not offer the service.

MS. HUGHES: Right.

DR. THERIOT: And some may but many don't.

MS. HUGHES: And the R.N. and the L.P.N. would still have to----

DR. THERIOT: Have standards.

MS. HUGHES: Yes.

MS. STEWART: They have to follow their scope of practice but it doesn't mean that the company that employs them has to have a

high level of----

DR. THERIOT: But it doesn't mean it doesn't. I mean, this is all based on an assumption that they're not as good as the credentialing done at the home health company and that is a big assumption.

MR. REINHARDT: I mean, you also have to--I understand the point you're making, but we live in this world over here and you're saying, all right, we're going to allow people to come in to your world without the same standards that we have to meet. That sort of scenario in any other situation, I mean, you wouldn't let someone open a hospital without having to meet certain standards.

DR. THERIOT: Right. But if it's an access-to-care issue, if the care is not being delivered----

MS. STEWART: So, you lower the standards so care will be delivered?

DR. THERIOT: No, or you guys can provide it, you know, and I don't think it's--I mean, you're assuming it's lowering the standards. That's a big assumption. I guess if we had some of these companies in here, they would argue with you.

I just don't know enough about it.

MS. STEWART: No. We've talked to some of them. We are peers with some of them.

DR. THERIOT: Well, who are some companies that do PDN in the state? Do you know?

MR. REINHARDT: Bright Star and Maxim are two of them. There's only ten agencies that are private duty nursing agencies in Indiana.

MS. HUGHES: And for these agencies, they don't have to do anything to start up? They don't have to go through any kind of credentialing? They don't have to go through--I mean, they've got to do credentialing through us. In Medicaid, they've got to be credentialed and meet the standards in order to become Medicaid members.

MS. PURDON: There's no licensure standard.

MR. REINHARDT: CMS doesn't come in and license a private duty agency. All the oversight exists on the home health side. So, they just have to meet whatever standards you guys have.

MS. STEWART: So, if you say

hours on the door, name of the agency, hours on the door or hours of operation Monday through Friday and that's what you required and I have a door that does that, then, we're checked off.

There's not anything that comes in that verifies Susan's license, that she's not on any type of watch list and that she's not had a criminal past and she's not had this and she's not had that.

MS. HUGHES: I mean, honestly, guys, that sounds like that it's an OIG issue on how this business is getting started because once they get their license to do whatever, they still have to be credentialed through Medicaid.

If I'm understanding this correctly, just them going to OIG to be licensed to do that does not mean they are Medicaid eligible. They've got to still be credentialed through Medicaid and become Medicaid participating providers.

The issues that you're having I think more OIG. You're welcome to write it up. Judy has got obviously more authority than I do, but I think the ones you need to have this conversation with are probably not in the room.

MR. REINHARDT: Sure.

MS. HUGHES: I mean, we can go back and forth all day on it. So, I think it would be better if we just had you all write up what your concerns are, send them to me. I will get them to the Commissioner and Stephanie and so forth and we will see what we need to do.

MR. REINHARDT: And the takeaway is, I mean, we're happy to do that - we will do that - we as a group think your group should be concerned about, just like you hold these entities around the table to a certain standard - the same for private duty agencies, we would advocate for you to hold them to a higher standard as they provide care to your Medicaid members. That's sort of the takeaway here.

We can get into the nuts and bolts of the decision with the OIG, but the fundamental piece here is these agencies could be out there within a short period of time providing care that might not be the same standard as home health.

MS. HUGHES: But it seems like the only thing they're changing is the four hours. Is that correct?

MR. REINHARDT: Correct.

MS. HUGHES: So, they've been being credentialed basically----

MR. REINHARDT: There's a few other slight changes but fundamentally yes.

MS. HUGHES: ----kind of through the same process; but as I said, Rebecca, if you could write me up something and make your TAC comments known, I will make sure I get that to the Commissioner and so forth. And if there's a need that we need to address with OIG, we will. I think you all definitely need to express your concerns through OIG.

If every one of you want to send a comment regarding the reg, you don't have to do that as a group. You can all--now, they will be bundled up if they all are the same comments. In the Statement of Consideration, they all bundle them and say so and so and so and so and so and so and so make this comment but you could go that route.

If you get me the information on what your concerns are as far as for Medicaid beneficiaries, then, I will get t hem to the Commissioner and Stephanie and we'll see if we need to get with OIG.

MR. REINHARDT: Sounds good.

MR. GRAY: To clarify, private duty nursing, they're licensed in the State of Kentucky, correct?

MR. REINHARDT: Yes.

MR. GRAY: I thought somebody said they weren't.

MR. REINHARDT: Licensure and accreditation or two different things.

MR. GRAY: Right, right, yeah, but they are licensed and they have to then enroll in Medicaid.

DR. THERIOT: And go through that whole credentialing process.

MS. STEWART: But when you're credentialing, you're credentialing a company.

MR. GRAY: So, you have to have a license. If you have a license, then, you can apply to be enrolled in Medicaid. Once you're enrolled in Medicaid, then, you can apply for Medicaid purposes, and I'm speaking for Medicaid and Medicaid only. Then, you're credentialed by an MCO. That's our language.

MS. STEWART: But it's a company.

MR. GRAY: Yes. The company is, yes.

MS. STEWART: And how that company chooses to--their policies and procedures that they establish and the safeguards they put in place, there's no oversight on that after it's licensed.

MS. DYER: And I think the change in the reg totally addressed that, that it was pretty vague of how the policies and procedures of that company even had to be in place. Isn't that correct when we looked at it?

MR. REINHARDT: Yes.

MS. STEWART: Think of it this way, Sharley. Think of it as if you have an elderly parent that you have to care for and you hire someone from the church that you pay $10 an hour, you expect some level of consistency. You hired them from church and they're taking care of your family member.

But if the State is paying someone to do that, you expect a higher level of care for that person coming in to your home. That's the difference to me.

MS. HUGHES: Now, to me, this

is me as an individual, not me as a Medicaid employee, I'm looking at it from the qualifications of who is performing the job, not necessarily the--I mean, I want the agency to be a reputable agency obviously, but if I'm expecting it to be a licensed registered nurse or an R.N., that's where I'm going to look. Is that person that's coming in and taking care of my mother an R.N. and is she qualified to take care of my mother?

And the R.N. and the L.P.N. have certain standards that they have to meet in order to maintain their R.N. and L.P.N. license. They can go through continuing ed and all that.

And I'm thinking - again, this is my guess because I don't get into licensing and stuff with OIG - you all are performing, as a home health agency, are performing a lot more detailed and more I guess critical services than a PDN agency.

So, would that be the reason that you're having to be accredited and go through more?

MS. STEWART: But now they can do the same thing without doing that.

MS. HUGHES: A PDN agency

could only provide PDN services, correct?

MS. STEWART: But by hiring an R.N., their scope of practice says they can do wound care, they can administer IV's, they can do ABCDE. So, there is no difference from what they can do than what we can do. If they have an order from a physician, they will be able to do the very same thing that we do under PDN. Does that make sense?

MS. HUGHES: Rebecca, write up the concerns of the members and send it to us.

MR. REINHARDT: So, that sort of shaped your perspective on why we had potentially two different scenarios here, but our point is the exact same patient could float between----

MS. HUGHES: And I understand that. I understand the patient care. I'm thinking that through the credentialing for Medicaid and probably through the MCO credentialing, there's got to be some patient care and safety lined up in there somewhere.

MS. STEWART: And that's our concern is it's not there.

MS. HUGHES: And that's OIG. That's where you get the license. I'm talking about for them to become Medicaid eligible participating

providers, I would think there's some stuff in there about patient safety but I don't know that. I'm not the one that can address those concerns for you all. So, if you will get me that in writing, I will gladly try to get you all an answer back on what we need to do.

MS. CARTRIGHT: Thank you, Sharley.

MS. HUGHES: And you said you had two New Business items.

MR. REINHARDT: The only other one and we just touched on this briefly last time is EVV, electronic visit verification.

We're not aware of any sort of developments or changes that might have occurred and I'm sure you will announce them when they do, but the window has opened for the State to request a delay in implementation.

That was our question last time. Given kind of where we stand without having started a pilot or started down the path that we're even having announced a vendor being selected, that hitting 1/1 of '20 will be very difficult at this stage since we're already to August.

I know other states, they're

intending to request delays. Indiana, who is already in the midst of a pilot, will be pushing for a delay in Indiana.

So, we just wanted to see what the lay of the land was and if there's any information for us to get in terms of the EVV and the go live of 1/1/20.

MS. HUGHES: The last that I had any updates on for the EVV was that there was an RFP being released and so forth. It could be because of procurement laws that nothing else is really being said to anybody. So, I can ask.

MR. REINHARDT: So, that's our last update. We're already mid-August here.

MS. HUGHES: I think Community Alternatives for the waiver program is the one that's been working on that but I can check with them. I know she is at a meeting this morning. So, as soon as I can get with her, I will ask her and get back with you.

MR. REINHARDT: That would be great. We would appreciate it.

MS. DYER: Because it's going to be hard. We'd have to make some major changes because it doesn't just affect, for your information

or anybody else's, it's personal care under any license that's given, home health or whatever it is, waiver, too, but also home health.

MR. REINHARDT: Home health would be included under the personal care definition which that's the other thing. Getting agencies familiar with how this is going to work because, in certain circumstances, they will have to potentially clock in and out during shifts on the system, all those kinds of things.

Everyone needs to be familiar with the claims payment, the communication between whomever the vendor is and if agencies already have a system up and running, all that stuff, you know, we'd like to have plenty of lead time just to be able to make sure that we don't have unintended consequences.

MS. DYER: Because if you don't have that in place, it's going to be really hard with four months to get it. We use Telephony. All they do is dial in and select what they've done. So, that doesn't facilitate a time and date stamp which EVV does require that.

So, we'll have to totally change, for us, for instance, to a computer or a

mobile device that will communicate, our software vendor will be able to communicate with the State. Not knowing what that is, it's a little hard to even wrap your head around doing that in four months but we're small. So, people who are bigger it's going to be even harder.

MR. GRAY: That RFP has not gone out yet. I don't the when. I just know the what.

MS. DYER: As long as there's not an RFP, we can't do it, right?

MR. GRAY: There is not an RFP out yet.

MS. STEPHENS: And the MCOs are in the same predicament as far as the 1/1/20 date.

MS. CARTRIGHT: All right. Anything else? Do I have a motion to adjourn?

MS. STEWART: So move.

MEETING ADJOURNED