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

IN RE: HOME HEALTH TECHNICAL ADVISORY COUNCIL

February 19, 2019
11:00 A.M.
Conference Room A
Public Health Building
275 East Main Street
Frankfort, Kentucky 40601

APPEARANCES

Rebecca Cartright
CHAIR

Susan Stewart
Annlyn Purdon
Billie Dyer
Missy Stober
TAC MEMBERS

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Sharley Hughes
David Gray
DEPARTMENT FOR MEDICAID
SERVICES

Kathleen Ryan
Holly Owens
ANTHEM

Henry Spalding
PASSPORT HEALTH PLAN

Cathy Stephens
Kelly Dockter Dean
HUMANA-CARESOURCE

Sammie Asher
Lisa Lucchese
AETNA BETTER HEALTH

AGENDA

1. Call to Order

2. Welcome and Introductions

3. Approval of Minutes

4. Old Business

5. New Business
   * Copays
     (a) Is it possible to get a list, by provider type, of both those included and excluded from copays
     (b) Can clarification be provided as to whether laboratory services provided as a part of Home Health services would be subject to copays?
   * General discussion on Commissioner letter regarding guidelines to TACs
   * Passport has recently not been paying providers and concerns have been raised about whether it is solvent or not. Can any further information be provided on Passport and Passport payments?
   * Aetna Better Health has been denying all our auth requests for patients for personal care only stating there is "no medical necessity." We did appeal and win with appeal but this is a very long process and the chance we take on providing the services without possible payment. We have been told by them that if a patient does not have a skilled need, they will not cover personal care.
   * Humana-CareSource - Humana is saying that if a patient has Medicare and Humana-CareSource MCO, we are required to bill Medicare first and get an EOB denial before we can even get auth for services. We do not have a skill for Medicare on these patients and we do have a MAP-34 as required by Medicaid but they would not take that from us. We have submitted an appeal on this but have gotten no response yet.
   * Other

AGENDA
(Continued)

6. Next Meeting - April 9, 2019

7. Adjournment

MS. CARTRIGHT: This meeting is officially called to order and we'll go around and do introductions.

(INTRODUCTIONS)

MS. CARTRIGHT: I was going to do approval of minutes but I'm not sure that we have those. So, we will defer until next time.

And there's no Old Business. So, under New Business----

MS. HUGHES: I'm sorry. I meant to say this right at the beginning. The Commissioner had planned to be here today. The legislators are keeping Medicaid hopping this Legislative Session.

So, she has meetings at LRC all day long today. I think she had them there all day long yesterday. So, we wanted to extend her condolences for not being here. She had every intention of being here.

She wants to start coming to all of them. She believes it is important for you all to get information from her. So, just to let you know she hopefully will be here by the next one because I believe your next one, the Legislative Session will be adjourned.

MS. STEWART: With that said, Sharley, so, there is no one here besides you from the Department for Medicaid.

MS. HUGHES: Correct.

MS. STEWART: Is that intentional?

MS. HUGHES: Today, yes, because there are lots of meetings going on. So, we're spread kind of thin. I think probably most of the things on the agenda I can probably--well, I think the last three, based upon emails I have received from the MCOs, I think have kind of been resolved or at least they've made contact with folks.

And they can certainly make additional comments. I'm not going to comment on behalf of them; but I think with the other stuff, if I don't know, I can always take it and get back with you.

MS. STEWART: Do we expect them to be at our future meetings?

MS. HUGHES: At least the Commissioner or one of the Deputies will be at future meetings, yes.

MS. CARTRIGHT: Okay. So, I

think under New Business, we had some questions about the Medicaid copays.

MS. STEWART: I'm sorry. I just want to make sure I understand.

So, we're not going to get opportunities to meet with the OIG, Provider Relations and things of that nature if the Commissioner and the Deputies are the only ones that attend TACs?

MS. HUGHES: Correct. They will have answers for you if there's problems with provider enrollment and so forth. OIG is not--let's switch directions here because you've got general discussion on the Commissioner's letter.

MS. STEWART: Yes. So, let's start with that one.

MS. HUGHES: Let's start with that one, if you don't mind, Madam Chairman.

MS. CARTRIGHT: I just do as I'm instructed.

MS. STEWART: Well, it's the elephant in the room.

MS. HUGHES: It is, and, so, let's just go ahead and get it addressed at this point in time. And I know Susan was at the MAC

meeting when the Chair of the MAC actually asked why anyone from DMS felt the need to be at any of the TAC meetings.

So, today is not representative of her comment. That's not our plan. Our plan is that we will be here. What the statute says as far as the TACs is that you all are an advisory committee to the MAC. You're to advise on policies and so forth that you think how we can better serve our Medicaid members.

The Commissioner does not feel this is the forum for you all to bring claim issues like the three here because I did contact Evan and it appeared that at least the Aetna and Humana were maybe one or two claims had happened. It was not a systematic error that we were seeing that we needed to go to the MCO and say, what are you all doing? What is happening that every one of these claims are being denied?

And one of the main reasons, a good example, at the Behavioral Health TAC meeting in January, one of the TAC members said she had gotten a call from a member the day before and, so, she wanted to talk about the issue at that TAC meeting.

So, she did and I said, but, on the flip side of that, you could have gotten that same call tomorrow, and if you wanted to wait until the TAC meeting came around again, you would have to wait two months to talk to us about it.

So, we are compiling a list of contact information that the MCOs have provided us that will be distributed to each of the TACs and the MAC for you all to be able to call them to get issues resolved.

There are procedures in place if there's a denied claim for you all to appeal it to the MCO; and if that doesn't get you satisfied, and, trust me, that whole appeal process I'm not that familiar with, but----

MS. STEWART: We are.

MS. HUGHES: ----once it is denied, then, you can come to DMS at that point in time.

So, if you're having claims' issues, we don't want you to wait two months to bring it to a TAC. You should be bringing it to our attention or the MCOs' attention at that time.

So, she is trying to get it back to you all advising the MAC on how you all

think we could better serve our members with home health benefits instead of us spending a lot of time on claims' issues and that type of thing.

MS. STEWART: And I would say because I served on the TAC prior to MCOs that that's how the TACs functioned, but the MCOs came in and really diverted and highjacked TAC meetings because it became MCO issues.

MS. HUGHES: Are you saying that the MCOs came in and said we need to kind of take over your meetings?

MS. STEWART: No. I'm saying we got inundated with process problems because they didn't follow Medicaid regs - why one, supply only, things of that nature. So, our whole TAC function and focus because MCO problems.

And it's improved fairly well. I mean, we still have a lot of recurring issues; but like they said at the MAC meeting, we have to have a venue to meet with them to discuss the issues that are global because 90% of the ones we bring up, like, Billie brings everything from all public health - she meets with them and brings up their issues and we all pretty much have the same issue across the board. So, it's not onesies and twosies.

MS. STOBER: I do have a question related to that because I understand your point of a billing issue is a by the ones and could happen at anytime. So, I'm just trying to understand.

But, for instance, this issue about the denying without there is no medical necessity and they had to go through the appeal process.

While that billing process happens and everyone knows what it is and we can do that, what would be the venue when the Medicaid benefit says that you can put that on your claim and it should be paid - and I'm not picking on Aetna - I'm just using this as an example - but if, for instance, this did happen, it was supposed to be paid, then, the agency is getting denied and has to spend the money to go through the appeal process when they followed all the rules and regulations.

And, then, the MCO is holding onto the dollars waiting another sixty, ninety, a hundred and twenty, six months, a year - I'm just using this as an example - I'm not saying Aetna did this - then, the agency is going to end up not being able to service patients because of cost.

So, to me, you're going to end up with a member issue because of lack of being able to have agencies to care for the patient.

Where would those issues go if they don't come here is my question?

MS. HUGHES: Your first contact should always be with the MCO that's giving you the problems.

I will say that when I contacted the MCOs on the examples that Evan gave me on the Aetna and the Humana issue, it appeared to me, based upon their response, that it had been--one of them, I think, and please, Aetna and Humana, if I'm saying this wrong, tell me - I think I got an email back that said something had been sent out by mistake, that they went back to the person that had faxed something to let them know I think with Medicare, you did not have to check some box or something.

I'm not a coder, so, this is all Greek to me.

MS. STOBER: Right. I'm assuming that whoever this agency was - it wasn't me - tried to resolve this with the MCO and then had to go through the appeal process.

MS. HUGHES: And if they can't get----

MS. STOBER: So, now they've spent all these dollars. Is the MCO, if it turns out they followed the process, should they have to be liable for those dollars or how do we keep that from happening in the future?

MS. HUGHES: If you call the MCO and don't get the answer that you expect to get, and based upon the regulation, they're telling you something is incorrect, then, you can at that point in time contact either Angela Parker who is the Director over the Managed Care unit or Corey Kennedy. She is one of the Branch Managers over MCO Oversight.

So, either one of those can help you. All you've got to do is email them. I'm going to have to write their emails down. If I just tell you it's angela.parker@ky.gov, it's probably got an initial in there and, then, it won't get to anybody.

MR. REINHARDT: Well, we will correspond after this meeting.

MS. HUGHES: Right. I can send the emails out, and they get in touch with the

MCOs to find out what's going on.

MS. STEPHENS: And, then, they have the provider complaint form out, too, that you can fill out.

MS. HUGHES: Yes. There is a provider complaint form out on our website also.

MS. DYER: Sharley, if I may. I think that when Susan was speaking and really what Missy is getting to is that most of the interference with providing care, and I think on both sides of this room, people would agree that it is issues with preauthorization or the billing. Is that what we're saying really?

MS. STOBER: Yes.

MS. DYER: So, that interferes, whether the provider says forget it, I can't do this anymore, or it's such a burden that people have such an administrative cost to do it. So, I think that's why for me and knowing the people on the TAC and what we've been through with different things - and you guys know it, too, and we've had lots of help from many of the representatives from the MCOs - but sometimes they go away and then they just come back around.

So, I think we're worried that

we won't have a venue--I don't know if we really know what the definition is of a problem that across the state would interfere with recipients getting services.

MS. HUGHES: And what we have offered to each of the other TACs and the Hospital and Nursing Home - I know those two TACs have been doing this for some time - is that we can offer you, after this meeting, we can extend the time that you have this meeting where, if you all are having one-on-one claims' issues that you can talk to the MCOs about.

The Hospital and Nursing Home TAC, they have monthly calls, I think, with the MCOs. If you all want to do that and be able to talk one-on-one to the MCOs at that point, we will get up and walk out. The TAC meeting will be adjourned and will no longer be an open meeting.

It will be just you all talking to your business partners about claims' issues because another thing with claims' issues, we can't sit here and disclose PHI to be able to even know, for the MCOs to even know how to even respond to you in an open forum like this because it's all open records.

MS. STEWART: Right, and we don't discuss patient name level stuff, but I think that we're missing a piece of the puzzle and I think it will come out when the MAC - we're working on our response to her letter - is it would serve the Cabinet to their benefit to hear what our issues are with the MCOs. They wouldn't be our partners if it wasn't for DMS.

MS. HUGHES: Well, this is true, but I'm sure that our MCOs are not the only insurance companies you all do business with. So, they all require PA's and so forth. So, it's not something new.

Her intent is not to take away from you all your ability to have situations that you are experiencing in your office or you're experiencing all over the State of Kentucky to not be heard. That is not what we're saying here at all.

We're actually hearing them. We're hearing them through members calling us and saying, hey, I can't get my home health service paid for or I can't get it approved by my MCO or we're hearing it at legislative hearings and we're hearing it from home health providers that are calling us

every day.

So, it's not that we're not hearing what you all are saying and it's not that we don't want to hear. That has never been her intent. It's just that this committee is an advisory committee.

And I understand. I went through the switch-over to MCOs. I understand. Anytime you go through something new, it's scary, it's challenging, all of those things. So, we understand that, but we've now been four years, five years on MCOs.

MS. STEWART: And we still have MCOs denying for home health status and that's not a requirement. That's our point.

MS. HUGHES: Right. Right. And if you're having those issues, that's why I've given your Angela's - and I'm pointing to you because she was the one----

MS. STOBER: Corey. I wrote it down. Angela and Corey.

MS. HUGHES: I pointed to you because you were the one that asked the question. That's why we're giving you Angela's and Corey's email address and so forth so that if you all having

issues with the MCOs, they're the ones that oversee all of the MCOs. And, trust me, I get complaints from our Constituent Services' offices at both LRC and the Governor's Office and I send them straight to Angela and Corey and, then, they contact each of the MCOs and get me responses back.

So, we're not saying we don't want to hear it. We just think that as far as the TAC meeting itself, it should be more towards helping develop policy and procedures that will better serve our needs.

And, yes, there's a fine line of if all of the MCOs are denying something or even if one MCO is denying something every time you try to get it approved and you know it shouldn't be denied, that's a problem that we need to hear about.

And there's a fine line between, okay, we need to hear about it over here to Angela and Corey or I want to make sure the Commissioner is aware of it.

MS. STEWART: I fear that the relationships that we've built with people in the Department, we're not going to have that venue anymore if all we ever see is the Commissioner and a Deputy. That's my fear.

MR. REINHARDT: And I think we felt - and everybody feel free to speak up - but the way that things were going, it was productive. We were getting answers. We were getting response. We felt comfortable with the oversight because Medicaid was in the room and got questions answered on their end.

That's the concern is both from a big change in terms of people in the room but also that we thought it was working and now it's going to be changed and there's that concern that----

MS. HUGHES: It probably was working for what you all were needing at that point in time or even still needing today. And, so, that's why we're offering that, yes, we will still allow you all time to meet that's not a part of the TAC meeting.

MS. STEWART: And I think that's the part that scares us is because at least if you're in the room with us, that we feel like that Big Brother at least hears what our concern is with them.

MS. PURDON: The issue is on the record officially.

MS. HUGHES: But officially on the record, the Commissioner at this point in time has made her statement that she does not want claims' issues really brought up and discussed.

And, like I said, when I checked on the three that are on the agenda for today, they did not appear to be widespread.

Trust me, I'm not a provider but I worked for an insurance company for twenty-two years. I worked in the Personnel Cabinet and handled the state employees' health insurance. I've been doing health insurance and health care a lot longer than what I'd like to think about and I know how that providers are busy.

And, so, we're not taking away from that. And based upon statute, we're interpreting what the statute says is that you all are to be an advisory group to advise the MAC on policy. And, so, getting into the weeds over claims' issues is not being in an advisory role.

MS. STEWART: I'll have to agree to disagree.

MS. HUGHES: And I feel probably that several different TAC members disagree, not just from you all.

MS. STEWART: Correct. And even from the MAC's standpoint, we disagree.

MS. HUGHES: Right.

MS. STEWART: And I think his name is Chris. I think his comment was, that's her interpretation. Our interpretation may be different.

We had a period of dysfunction and I think we were getting on the right track and I felt confident where we were headed. Now I guess I'm guarded because I see no supervision and the MCOs not really being--and I know they're governed by my contract with them, but they're governed by DMS and I don't think DMS is ever going to get the list of issues if they're not in the room and hear them. That's my opinion.

MR. REINHARDT: And hopefully you can understand that it's important for us. We've sort of heard that position and heard you out, and respectfully we want to offer our thoughts on how we thought where things were headed and all of that piece that we thought was productive might be missing and, then, that turns this meeting into just a check the box.

The agency's goal is to hit

the target, whatever the target might be and that's what this meeting was about was narrowing in on the target and, then, we can all walk away hopefully agreeing that that's what we were going to do in the future.

MS. DYER: And there could have been a misunderstanding that individual claims or people were discussed. That's never been the case. I've been on the TAC a long time. We would bring to you guys samples and hand them over.

MS. HUGHES: Some of the TACS are very guilty of this.

MS. STEWART: We are not.

MS. HUGHES: So, you all all got the same letter that went out to the ones that are very guilty as to the ones that are not as guilty.

MS. DYER: We're not. We might be guilty of other things but not that; but I think what we did find and what we collectively have said in the past even is that when we see an issue, it may arise for one or two agencies and, then, it is more across the state.

Like, this issue that you have to have a Medicare denial and then submit. Well,

that's just where it's rearing its head again. So, it becomes a global issue when it first appears as a small thing. Would you all agree with that? I think they even know.

MS. ASHER: I agree. It usually does become global because you're all the same as far as Aetna is concerned. We all have you set up the same. So, if it affects one, it's going to affect the other eventually. It may not today but we'll see it.

MS. STEWART: It depends on my volume with you. If I don't have a large Aetna population, then, my pressure point is going to be smaller.

MR. REINHARDT: And the provider agreement is going to look very similar. Despite it being a one-to-one contractual relationship, those contracts look almost identical.

MS. STEWART: I mean, the reg is the reg no matter what the MCO is. The reg is the reg.

MS. HUGHES: And I'm sorry. I think I do not have the response. I do. We're not even sure if this is the case because we did not have actual I think member number. We had a case

number. So, I don't want to give really a lot, but when it talked about Medicare, the employee was mistaken regarding the process for a member who has Medicare as primary for this type of service. So, whoever got that, whichever home health agency----

MS. DYER: They go to Evan now and just me cc'd on them actually instead of me just getting them all but they still cc me on them so if I need to help explain from the public home health group.

MS. HUGHES: So, there's going to be mistakes made. We get calls on our own Member Services' folks and they say, well, they told me the wrong thing, and we go back and listen; and if they truly told somebody the incorrect thing, then, they go back and re-teach that employee.

And I know each of the MCOs do the same thing and I know they have the ability to go back and listen because I've actually had them go back and listen to calls regarding constituent complaints that I've received. And, so, that does monitor.

Truly, if you all are seeing that this is a huge problem across the state or even if it's a region or an MCO, we want to hear that.

And I was using these three as an example because it appeared--well, the two, it appeared that the two from when I contacted Evan back to get information, it did not appear to be a big global issue.

MS. DYER: Not yet.

MS. HUGHES: Not yet, right.

MR. REINHARDT: And that's part of this, too. We want to head off those issues before it becomes widespread. So, sometimes it is going to be on a smaller scale.

I do want to say thank you for immediately, as soon as I sent the information, we started exchanging emails and we got to a place where I think the provider at least felt satisfied that it was being worked through. So, in that respect, yes, we want to offer thanks.

MS. HUGHES: And I think that might be actually a better avenue. If there's something that you all are seeing, if you want to cut it off, because it's the same thing. If you get these issues tomorrow, you have to wait two months to bring them back, whereas, even if you just send me an email and say, Sharley----

MS. DYER: We'll let Evan look at it.

MS. HUGHES: Or send it to Evan or whatever and can get me----

MS. REINHARDT: But these that you are seeing, we wanted to go on the record and say this was our perspective. These are our concerns. We want to move with our best foot forward but this is a lot of change and it's making us concerned about what direction we're headed in.

MS. STEWART: I work for a big corporation, but if you're a small home health agency that doesn't have access to lawyers and advocates and lobbyists, that's what we as an organization do for smaller members that don't have that.

Billie represents all public home health agencies and she works for a small corporation or a small home health agency. So, we're their voice and it matters.

MS. HUGHES: And I want to assure you because you've mentioned it a couple of times that you're afraid that we're not going to do an oversight on these MCOs.

And trust me when I tell you, there is extreme oversight on these MCOs. It may not appear to the public.

MS. STEWART: That's one fear. The other fear is I'm going to lose the relationships I have with people at DMS. That's my second fear.

MS. HUGHES: And I know you've addressed the issue of them not answering your emails, and I did send an email after the MAC. I will send another one in the morning. I have thirty minutes between this TAC and the next one.

So, it will be in the morning but I will send another email out to Lee Guice and Charles Douglass and so forth just to say, guys, make sure your employees understand that they need to respond to those folks.

Just because I've taken over as being the liaison doesn't mean they should not be responding to actual benefits or coverage questions for you all. And if you continue to get more problems, then, you can let me know.

MS. STEWART: So, in addition to your list of contacts for MCOs and the MCO oversight two people, can you give us a list of who the primary contacts are at each division?

MS. HUGHES: At DMS?

MS. STEWART: Yes.

MS. HUGHES: Yes, that's going to be part of the contact list.

MS. STEWART: Okay. I'll feel a little bit more comfortable when I get that.

MS. HUGHES: Lee Guice is our Director over Policy and Operations and Angela is our Director over the MCO Division, and I think those probably are the ones you're going to need more than anything but we'll also give you like the Branch Managers----

MS. STEWART: Because I had a contact at DMS, I was able to work out a licensure issue because I knew who Kate Hackett is.

MS. HUGHES: Right. That's what I was going to say. I will also break it down all the way to the Manager level over each of the various little sections within the Division, like, for instance, Kate for Provider Enrollment.

So, you will have all of those contact names and so forth. You're not going to lose that. You will still be able to contact them. They're aware.

MS. STOBER: So, just going back, like, for instance, this one where someone made an error and this patient who should have

received care but they sent a denial because they had Medicare and it wasn't a Medicare skill, this provider, whoever it is, had to submit an appeal but it's still unresolved according to the agenda. Now, it might have been since the agenda.

Will this Angela Parker and Corey Kennedy, do they have the authority to fix the problem? In other words, are they going to be able to go back to Humana and say, yes, you must pay this bill because the cost of an appeal and the time of the claim being not paid is, for a mom and a pop, it's a really big deal but even if you're a big company, it's a big deal?

MS. HUGHES: Right. And when I say we're going to give you these contacts, your contact numbers will be for you to probably be able to use to resolve without having to go to file an appeal.

MS. STOBER: That was my question. Okay. Great. Thank you.

MS. HUGHES: In particular, in that instance, I think that if someone had gotten a hold of the I don't want to say proper person because the person that probably answered it was proper. She just made a mistake. But if we get you

in touch with folks that we know you should be, that it will prevent you from having to file appeals.

MS. STOBER: That would be helpful.

MS. STEPHENS: And if it was denied correctly, then, that's where you go and do the appeals process.

MS. HUGHES: Yes. If they come back to you and say, sorry, but according to the reg, this is how we have to do it, then, you can file an appeal at that point in time. We're trying to keep you from having to do that appeal.

MS. STEWART: And I'll say from my standpoint, since the MAC meeting, I have started having calls and meetings with the MCOs on specific claim issues. I'm not seeing much benefit to that yet.

I'm kind of getting the runaround a little bit but I'm working the process. And if it doesn't work, then, you will hear about it.

MS. PURDON: I spend my two months between TACs doing the process. And when it doesn't work, it comes to the TAC.

MS. HUGHES: Right, and that's

fine. And I think when we get you these contacts - I actually have the list compiled. I'm letting the Commissioner look at them to make sure she is okay with what I've got put together because we don't want to send something official out if she doesn't like the way it looks or what-have-you.

The MCOs are who provided with me the contacts, so, there's no change in those.

MS. STEWART: So, if we're from an advisory standpoint to Medicaid, our focus should be what exactly?

MS. HUGHES: To help us to develop home health policies and procedures. And, again, if they're systematic problems that you're witnessing, then, to let us know about those.

So, I don't really think you're going to see a lot of change in what you're doing other than if it's just like claims' issues, routing those to other folks or contacting the MCOs and so forth first and trying to get it taken care of, and if you can't, then, come in to DMS, but coming to DMS before you come to a TAC meeting.

And I only say that because if you have a concern tomorrow, you don't want to wait until that.

MS. STEWART: So, if we are working the process with an MCO and we're not getting what we need, what is the time frame that you say allowing them time to work through the process - thirty days, sixty days before we bring something to Angela and Corey?

MS. HUGHES: Now, I don't want to answer that. I can get back with you because I'm just not that involved in that process. The MCOs may want to answer.

MS. ASHER: It would really depend. If we have to reconfigure something, obviously you're probably looking at over thirty days. If it's something simple that can be fixed quickly, not that long.

So, it really would depend on the size of the issue and the issue itself. Is it a technical issue? Did we have you all set up incorrectly in the beginning like we did six months ago? That has taken some time.

So, I would say, as far as what my experience, it would be the size and what it's involving.

MS. STEPHENS: There's not a cookie-cutter answer.

MS. DYER: But I think to take the problem, if you're AR is aging significantly because you don't have resolved payments, then, internally, you have to decide, in sixty days, I should have already had a payment and I'm seeing all the--I mean, that's an internal decision to me.

I don't think the MCOs - I love you guys - but I don't think that they can tell us how long to wait before we take a problem on.

MS. HUGHES: Right. And I think sixty days is getting entirely too long.

MS. DYER: I think so, too.

MR. REINHARDT: Particularly from this group. Everybody wants to get paid obviously, but for home health in particular, ninety days, you're way, way out there. Thirty days is even, to Missy's point, like, you've already spent a lot of time that you didn't have in the first place. So, you're running into the red really, really quick.

So, again, to tie it back to that's why we felt this was productive and we were addressing those kinds of things. And for this group in particular, it has its own unique set of needs to keep the doors open and stay in business.

MS. HUGHES: Oh, it's not just unique to you all. We hear that from every TAC.

MR. REINHARDT: Everybody is going to say it, but I think this group, it's something that if you saw the folks, you would understand that it's legitimate. That handful of claims can be the difference between being in business next month or six months down the road.

MS. HUGHES: As I said, I don't want to give a time because I'm not that involved in that. Personally speaking, sixty days is too long.

MS. DYER: Because it just gets worse sometimes. That's what we've found.

MS. STEWART: As a home health agency, you have to decide, okay, I've got $20,000 over here in AR a hundred and eighty days and older with "x" company. The next referral that comes in, am I going to take it or not? And the answer is probably not. So, then, it does become a member issue.

MS. REINHARDT: And a network issue for you guys.

MS. STOBER: Especially if you're in a county where there's only one or two

providers.

MS. HUGHES: When you're talking about your AR list, that's pretty much what the Hospital Association does in their one-on-one meetings with the MCOs is that they bring their accounts receivables and shows it and says this claim hasn't been paid, this hasn't and this hasn't.

That's my understanding - I've not attended them - but it's my understanding that's pretty much what the hospitals do is that they come in and it's like this claim has been there sixty days.

MS. STEWART: That's what I'm doing right now with some of the MCOs is claim-by-claim issues.

MS. HUGHES: And you know it because when the Hospital TAC comes in, he's been bringing charts in to show which MCO has claims sixty days and ninety days old, which one doesn't and shows his little charts to the MAC meetings.

So, that's kind of the opportunity for you all if you want to extend this room to be able to really hammer them out. Now, I asked the last TAC not to beat them up too bad. They wanted to beat them but I said, please don't.

MS. STEWART: We're always cordial.

MS. DYER: Well, the one-on-one meetings have proven to be the most effective. And whether we're a small public home health or some big large corporation, it doesn't matter. It's about keeping it all going because we're all needed.

So, the farther we let things go for whatever reasons, individual employees with our agencies or whatever, the worse it becomes for all of us, it seems like. So, that has proven the most effective for us and our individual agency.

MS. STEPHENS: I will say the KHA meetings, Angie Parker or Corey Kennedy attend the KHA meetings.

MS. HUGHES: Do they?

MS. STEPHENS: Yes. So, if we set something up like that, I just want to make sure you have all the right people there.

MS. STEWART: So, is that something that they could come to our extended session?

MS. HUGHES: I would have to ask that. I will have to ask that. I'm not over them, so, I can't say they have to come.

MS. STEWART: But that would be a request from us.

MS. HUGHES: All right.

MS. DYER: A request because I think even though one-on-one meetings work, it's still relating back to what Susan and Missy or Evan, all of us have said, that it is getting on record what the issues collectively mount up to be and how that interferes with everything, mainly service to the patient.

MS. STEPHENS: And KHA also meets with each MCO individually. They take a whole day and we just come right after the other and, then, Angie and them stay the whole day, not the whole day but a good part of the day. It's six hours and we come in for an hour of that and, then, the next MCO comes and then the next.

MS. HUGHES: Don't they do that plus have a monthly with all of you?

MS. STEPHENS: No, I mean, not with all of us in the room. They have a Hospital TAC but, no, it's just once a month, we come for our hour and then we leave and the next MCO goes in and we leave.

MS. DYER: So, it's the same

thing as what we're talking about, really a one-on-one.

MS. STEWART: We wouldn't need all day. I think an hour after our meeting would be sufficient.

MS. STEPHENS: So, you wouldn't want to meet with each MCO individually?

MS. STEWART: I'm doing that already.

MS. DYER: We do that agency specific.

MS. STEWART: I'm not having much luck but I am meeting.

MS. STOBER: So, when you say advisory to the MAC, are you looking for ways to better serve the members?

MS. HUGHES: Yes.

MS. STOBER: When you say better serve, are you looking for ideas of what Medicaid might be able to cover in the home to eliminate hospitalizations or improve quality of life?

MS. HUGHES: Yes. Anything that you all feel that can be done. Now, keep in mind, we have a budget. Now, obviously if it's

something that could possibly help us save money, then, it's going to be real serious, but we have to operate within the budget we're given.

MS. STOBER: A couple of things, and I've been around home health for a long time now and Kentucky Medicaid used to pay for prefilling medication planners, right, and they don't provide that service anymore. It's not considered a skill any longer.

However, the number one reason that a patient goes back into the hospital is for not taking their medications properly.

I would say looking at either a once every other week prefill medi planner or medication management for patients who are Medicaid who are at least high risk for going back in the hospital, have had two or three hospitalizations in whatever, to do that on a long-term basis could probably save the State a whole lot of money.

The other thing would be telehealth. In the episodic payment world, I believe most home health agencies put telemonitors into the home to be able to decrease the number of visits that they have to do because the telemonitor, one can keep the patient data on a daily basis first

thing in the morning, the same time, after they get up, go to the bathroom, and can definitely decrease hospitalizations.

The data says that if you have a weight gain in a couple of days, a certain poundage, that there has to be medical intervention or the patient is going to, even before they're symptomatic. And, so, the research has proven to drastically decrease hospitalization rates.

Most of us will do that in an episode to decrease the total number of visits and improve quality care and increase the star ratings.

On the Medicaid patients, because they're per visit, we either may do that because we want to keep our hospitalizations down and pay for which it costs somewhere around $3,500 a month to do with no reimbursement.

So, from a global, can the Medicaid system decrease total costs if you paid for telehealth monitoring for patients? Then, the data is so supportive of the decrease cost of care and the improved quality of life.

MS. HUGHES: Yes, those are the kind of recommendations we're looking at from a TAC standpoint for you all to make that we can try

to look at to implement.

I will tell you, and I know really very little about telehealth, but I only know this because of the fact that at the TAC meeting last week, Stephanie Bates told them that there is a telehealth regulation----

MS. STOBER: House Bill 144 was put in a couple of years ago.

MS. HUGHES: Do you know very much about that regulation? I know we've been meeting on it.

MR. GRAY: There are a lot of changes that are going on in telehealth.

MS. STOBER: Telemonitoring and telehealth are very different. Telehealth would be someone could call you on their phone and Facetime and get a doctor's visit. I'm talking about telemonitoring, patient monitoring.

There was House Bill 144 a couple of three years ago that was doing a pilot. I don't know where it is right now, and the MCOs would know that because they have the Medicare products, too. They could save a lot of money if they would pay for it; but because all of it is per visit, their membership and your membership in Medicaid

don’t get the benefit of that service because we don’t get reimbursed for it.

MS. HUGHES: Yes, those are the types of recommendations that we would like to see coming out of the Home Health TAC.

MS. STOBER: And I simply can’t afford $150 in a sixty-day episode when I’m already losing money on a Medicaid managed care patient anyway.

MS. STEWART: And I’d like to go on record as saying a hospitalization compared to a few home health visits, we are the cheaper venue than nursing home, skilled nursing facilities, rehab facilities.

MS. HUGHES: Those are perfect examples because, obviously, if you all are out there and know it and are witnessing it every day that this is something that could help Medicaid beneficiaries, yes, tell us.

MS. CARTRIGHT: South Carolina Medicaid did a study when I was there and I was part of that and they now cover remote patient monitoring in the home.

MR. REINHARDT: Indiana did as well.

MS. HUGHES: Do you have access to that study?

MS. CARTRIGHT: I probably could get it.

MR. REINHARDT: We have information on hospital system readmissions and this is a particular population for CHF and COPD patients which are among the most likely to be rehospitalized. It went from one in five rehospitalizations to one in twenty which is huge. Just that in and of itself pays for all remote monitoring.

MS. HUGHES: Obviously, if you make the recommendation and you can provide us some good data sets as what you're talking about, that would certainly help us and those would be something we would very much like to see, good recommendations like that coming out of this TAC, and we look at every one. We seriously do.

We may not respond back to the way some of the TACs may want us to respond but we seriously do look at every one of the recommendations.

MS. STEWART: We haven't had very many. Like I said, that was our period of

dysfunction. We've had one of late and it ended up going our way but I don't think we really had much influence with it.

MS. DYER: It was resolved before it got to the MAC.

MS. STEWART: It got resolved before the MAC recommendation got there but we'll take credit for it.

MS. HUGHES: Hey, I believe in taking credit for where I can take credit.

MS. STEWART: Well, I guess as we trudge into this new territory, we'll all go in with open minds.

MR. REINHARDT: And we appreciate the opportunity to provide feedback. You have been more than receptive and you hopefully can understand why we're saying what we're saying.

MS. HUGHES: Right.

MS. STEWART: Okay. Now let's go to the agenda.

MS. HUGHES: We got off track there but we needed to address that anyway.

MS. CARTRIGHT: Yes. I was going to say, so, we kind of skipped around. So, I think you talked about the Humana-CareSource issue.

So, do we want to go back up to copays?

MS. STEWART: Yes. At our last meeting, I think it was him, you got a text or a call at our last meeting that we were excluded from copays.

MR. GRAY: For the home health visit.

MS. STEWART: Yes.

MS. HUGHES: You don't know who this gentleman is.

MS. STEWART: Yes. We met with him a couple of times.

MR. GRAY: I'm sorry. David Gray with the Cabinet for Health and Family Services.

MS. STEWART: But I think we asked for something that--none of the literature that comes out really says home health is excluded.

MS. HUGHES: Didn't I send you all--I sent it to I thought all the TAC and MAC members the copay document that goes down to the code levels.

MS. STEWART: Right, but if you're not a biller, you don't know what code number

it is. Do you follow me?

MS. HUGHES: Okay.

MS. STEWART: And there's nothing in that literature that says home health PT, OT, ST is excluded.

MS. HUGHES: I had to stop and think for a minute because you said all three together really quick.

MS. PURDON: I think we're looking for something at the provider level, like 3442.

MS. ASHER: I have a provider type list that came from the State actually.

MR. GRAY: And I think we're really having to depend upon that document because I think what happens is we have to be careful about how the question is asked. And then we respond and then sometimes people expand how that response is.

So, that's why we've been very careful about saying yes/no and referring truly back to the document that is more coder-based, yes, but that really gets at that level because that's really where it happens at because, again, we run the risk of people asking a certain question and then expanding that to other things.

And it does get into, okay, no, there isn't a copay here but, then, somebody doesn't tell us they had three other types of visits that day.

Also, again, people ask the question in such a way so they can get a certain answer that they want to get. So, that's, again, why we have to be specific and really depend upon that document that I know that we've sent out to various persons for the copays.

MS. STEWART: So, there isn't a provider document that says home health is excluded? The document exists but we can't have it?

MS. HUGHES: No, no, no. The document that we sent----

MR. GRAY: No, no, no. The document that we sent out that has all the billing codes is the document.

MS. STEWART: Is that the same thing that the MCOs got?

MR. GRAY: Yes.

MS. HUGHES: Yes. It was done for the MCOs to use as well as DMS.

MR. GRAY: It's about four pages.

MS. HUGHES: Seven.

MS. STEWART: Hold that up there. Is that what we have, Evan?

MR. REINHARDT: Yes. It was the one you sent.

MS. DYER: I think that's the same one you're talking about.

MR. REINHARDT: The one that I forwarded to you. You had gotten it at the MAC meeting, too, I think.

MR. GRAY: Now, if there are clarifications we need to make to that, those are the type things we would need to----

MS. STEWART: Well, I guess on the thing - hold that up, Sharley.

MS. HUGHES: I'm going to take it out and let you see it.

MR. REINHARDT: See, it does have this part right here.

MS. HUGHES: See, I don't even know what your provider type number is.

MS. STEWART: Then, all right. I stand corrected.

MR. REINHARDT: But we did have the clarification on the laboratory services

provided underneath of home health. That's a separate question. So, we had this question about can we get a firm decision on whether it applies to home health or not. I think that satisfies that question, but if lab services are provided under home health, that's a separate question. Do they get a copay attached to it?

MS. HUGHES: There's a laboratory section.

MS. STEWART: But we don't bill lab. So, we don't know any of that stuff.

MS. STOBER: In home health, there is a skilled nursing, a visit for a nurse to go out and do the home. It clearly says there a nursing visit or Provider Type 34 does not have a copay.

When we go out, though, it may be a congestive heart failure patient who needs some sort of lab to monitor their levels. And, so, we draw the lab and we send it to the lab. Then, that lab, the question is, would the processing of the lab be subjected to the copay?

MR. GRAY: And I would have to respond by saying based upon our document that we provided to the MCOs, have you had any indication

from the MCOs----

MS. STEWART: We would never know.

MS. STOBER: We don't know. We don't get paid for the lab. The lab processing fees say Lab Corp but we need to let our patients know in full disclosure if we're going to draw a CBC or whatever it is that you're going to be getting charged a 20% copay for doing lab because many times our patients can't afford that or say don't do the lab service and, then, we've got to coordinate with the physician which could be detrimental to their well being.

MR. GRAY: Right. I would have to defer to the MCOs whether or not you guys would view that as----

MS. ASHER: For basic lab service, I would ask them to expect a copay. There are the exclusion of our members, but just a normal person that's getting a regular lab service, I would just advise, yes, you probably need to expect that $3, $4 copay.

MS. STOBER: No different as if they were getting it in the physician's office.

MS. ASHER: Right. Same

thing. The lab would consider it the same.

MR. GRAY: And in that case, that bill is going to be like from Lab Corps or somebody like that?

MS. STOBER: Yes.

MS. DYER: Or a hospital, you're dropping off at the hospital or a freestanding lab or whatever.

MS. ASHER: And that provider type is not excluded.

MR. GRAY: If it's drawn in a home setting, it's not excluded.

MS. ASHER: Well, the home health drawing it, but, then, they're delivering it to the lab.

MS. STOBER: Right, yes. It's not excluded.

MS. CARTRIGHT: Thank you. Any more on that?

So, we've already talked about the Commissioner's letter.

Passport, I think this has been resolved from the Baptist standpoint that was my issue.

And, then, Aetna Better

Health. Sharley, do you have anything on that one? You said those last two----

MS. LUCCHESE: I can say from an Aetna standpoint, this has been an education for the staff. So, we have provided education with our staff and with the Medical Directors as well, too. So, this should not be an issue moving forward.

MR. GRAY: And I would say and this is not necessarily home health but I have had some other provider types where and I've had discussions from all the MCOs. Not all of the MCOs are taking the same approach on the copays which, as you can imagine, causes that provider type to be a bit confused with regard to two MCOs are requiring a copay under these set of circumstances. These three MCOs are not requiring and it involves multiple visits on the same day over in the behavioral health world and you can have a lot of different types of visits.

So, I think as much as the MCOs, when there's one approach, but if you find out that three MCOs are kind of doing it one way and two MCOs are doing it a different way, those are the kind of things we need to have surfaced, that you get some clarification on what is the right approach

on copays because we're only seven weeks into copays. So, we're still all collectively learning.

MS. STEWART: I know this is a home health meeting but we had an issue where an MCO was charging a copay for DME on every line item for the day and that's contradictory to the document. So, we're working to get that fixed and on an heightened alert with all copay issues.

MS. HUGHES: As he said, we're seven weeks in and about seven or eight weeks until it changes and, then, they kind of do away with copays because if they pay premiums, they won't have copays.

MR. GRAY: They don't go away. It just depends on who they apply to.

MS. HUGHES: Right. Right.

MS. STEPHENS: But the traditional side will still have the copays. If you're not Kentucky HEALTH, you will still have the copays.

MS. HUGHES: Right, correct. That's what I meant. If you're paying premiums which would be Kentucky HEALTH.

MS. STEWART: Sharley, in our current new format, is it appropriate to ask for

Cabinet representatives to come and talk to us about updates on 1115 and all those types of things? Those are still legitimate agenda items?

MS. HUGHES: Yes. And I do have some information. Did you all get a chance to look at the presentation that was made at the stakeholder forum? I think I sent it to you guys. You all are just ignoring my emails, or, I should say, Susan, are you ignoring my emails?

MS. STEWART: Well, it could be in one of the 500 I have right now. I try to pay very close attention to yours.

MS. HUGHES: Of course, the go live is still expected to be 4/1. There will not be any premiums or copays for the month of April just to get everybody accustomed to it.

The medically frail status, I think the MCOs have been told to start sending those out around the first part of March, around maybe the first week or so of March.

MS. DYER: Is that notification that they meet medically frail or fragile conditions?

MS. HUGHES: Yes. If they meet that medically frail status, yes. So, those

are some dates that are coming up.

The premium billings for May will come out probably about mid-April.

MR. GRAY: The community engagement requirement will be July 1.

MS. HUGHES: Yes. Community engagement, July 1 is when it actually starts and it starts on a regional basis.

MR. GRAY: And I think that's still yet to be determined.

MS. HUGHES: Okay, but the Medicaid beneficiaries will receive a notice thirty days in advance of that, that they have to start meeting the community engagement if they're supposed to.

There's a Notice of Eligibility form that will go out sometime I think about mid-March, if I remember correctly, that basically is going to let every one of the beneficiaries know you're in Kentucky HEALTH, you have to start paying premiums April 1. I don't know that the community engagement date probably won't be on it but it's just to let them know that Kentucky HEALTH will officially start April 1 and this is what is going to be going on.

MS. STEPHENS: I think My Rewards is 5/1, right?

MS. HUGHES: Yes. Well, now, I had not heard My Rewards was 5/1.

MS. STEPHENS: I thought that's what I understood. I might be wrong. I can go back and check.

MS. DYER: Could you send that to Evan again to send out again?

MS. HUGHES: The presentation?

MS. DYER: Yes.

MS. HUGHES: Yes. There was in the presentation something about that beneficiaries have already accumulated like $70 million into My Rewards' accounts. They've done that by doing their well visits.

We've automatically gone back to January 1 of 2018 to give them My Rewards' dollars for any wellness visit they've taken themselves or their children to.

There's been courses put up since July 1 of last year. We didn't take them down so people could continue to be doing them.

MR. GRAY: They're good utilizers of not utilizing the Emergency Department.

MS. HUGHES: Yes, not utilizing the emergency room last year. We went ahead and awarded everyone for last year even though Kentucky HEALTH hadn't even started. We put that reward money into their My Rewards' accounts.

So, a lot of the beneficiaries, there's $70 million out there in My Rewards, fake dollars for right now.

MS. STEWART: So, is there still concern that it will be delayed or halted again?

MS. HUGHES: I'm going to plead the 5th.

MR. GRAY: It is in the Washington court.

MS. HUGHES: So, it will be up to them.

MS. ASHER: It could be stopped the Friday evening before it goes live Monday.

MS. HUGHES: But that's just to give you a little bit of an update on Kentucky HEALTH.

MR. GRAY: Which always puts expansion at risk, though. Always keep that in

mind. Not getting approval for Kentucky HEALTH puts the expansion at risk which is 450,000 participants in Medicaid.

MS. CARTRIGHT: Thank you. We talked about Humana-CareSource. That was the one earlier.

MS. STEWART: That's resolved.

MS. CARTRIGHT: That was resolved.

So, then, is there anything else?

MS. PURDON: I only have one thing.

MS. STEWART: I had one thing, too, but go ahead. You can go first.

MS. PURDON: Is this our website that you were talking about?

MS. HUGHES: Yes, ma'am.

MS. PURDON: Who updates it because these are wrong?

MS. HUGHES: Oh, yes, I need to do that.

MS. PURDON: And, then, just a question. Where does that phone number go, the contact information?

MS. HUGHES: That contact information puts you to I think that's Lee Guice's division for Policy and Operations.

MS. PURDON: I just wondered if I call that number for information who I would get.

MS. HUGHES: We actually considered putting the email address of the Chair out there on it but we changed our mind because we know that people get on a website, and if they find an email address, they will send that no matter what it is to that email address. So, we didn't want our TAC Chairs to get a bunch of stuff that really wasn't related.

MS. STEWART: And I don't know if this other topic is appropriate or not and I'd rather rely on my peers because I might screw it up. It's a patient issue where the patient - I'm not going to tell you any details - but it's a black hole for every home health provider.

The patient had a need for wound care supplies. There isn't a fee schedule for that supply. Let's just say it's 4x4's. I'll make that up. So, the MCO doesn't have to provide a quantity schedule for that supply and we don't know

what to bill by. Let's just say it could be a box of 4x4's that comes fifty to a box. "X" MCOs wants you to bill it at forty-seven, but they don't have to tell us that has to be on at forty-seven because there's no Medicare fee schedule and there's no DMS fee schedule. So, it can be a black hole for them for us to try to have to figure out. Am I articulating that correct?

MS. PURDON: Are you talking about where they're putting limits on them that we don't know about?

MS. STEWART: Yes.

MS. PURDON: We get that, too.

MS. DYER: Yes. And it's not really under DMS. It's really under home health in this state which has been, for your historical information, has been a very hard task for you guys as MCOs in the past historically to understand that.

It comes under home health in Kentucky and that was a huge hurdle that we got past and we hope we don't have to hurdle that again because it was huge, but that's exactly right, that you don't know the limits. You just have to keep----

MS. STEWART: Billing and

rebilling until you get the magic number.

MS. DYER: Sometimes you know it but not always.

MS. STEWART: And on the denial, it doesn't tell you. It just says denied for excessive supplies or something like that.

MS. PURDON: Exceeds limits.

MS. DYER: So, we don't know what the limits are. That's what we're saying.

MS. STOBER: Annlyn, you're saying each MCO has a different limit number?

MS. STEWART: They can because it's not governed by Medicaid or Medicare.

MS. STOBER: So, if one says forty-seven, you bill forty-seven. The next MCO----

MS. STEWART: It could be forty-six.

MS. STOBER: And you could exceed again and you have to do the same thing.

MS. STEWART: Yes.

MS. HUGHES: Do you all know if you have limits?

MS. STEWART: When I met with the MCO, they told me they were under no obligation to tell me what their limits were because there was

no fee schedule associated with that.

MS. HUGHES: I will take this back and try to get you a response.

MS. STEWART: One more question. It's patient specific related to MCOs and Medicaid is Medicaid will pay for a patient to have a surgical procedure, to have a PleurX drain inserted into the patient in the hospital but there is no coverage for the PleurX drains. No MCO will prior auth the drain.

MS. STOBER: They're expensive.

MS. STEWART: Very expensive.

MS. HUGHES: For you all to remove it or for you to replace it?

MS. STEWART: No, to supply it.

MS. STOBER: So, if you think about a drainage bag, like, if you have a catheter and you have a catheter drainage bag and it got full, you would have to take it off and put a new bag on. That's what a PleurX drain is. Like, you can't empty it and just put the same one back on. It's an actual drain that you have to change regularly.

MS. HUGHES: And how do you spell that?

MS. STEWART: P-l-e-u-r-X.

MS. PURDON: You can get them cheaper on Amazon.

MS. STEWART: But that's an issue.

MS. DYER: And it's a lot cheaper than being in the hospital with it. They're chest tubes. That's what it is.

MS. HUGHES: But they'll pay for them in the hospital but they won't pay for them at home.

MS. STEWART: They'll pay for them to have the surgery to have it put in but they won't pay for the supply once they get discharged. They pay for the surgical procedure to have it inserted. They won't pay for the supply post-discharge.

MS. RYAN: Susan, do you know the code?

MS. STEWART: I do not off the top of my head.

MS. DYER: And there are other brands, too. There's like the Denver drain.

There's other brands of it but basically it's a chest tube that somebody ambulating can have with a drain bag attached that does have to be changed. It's not like a Foley catheter in that you can teach them how to empty it three times a day. It comes out the side and it's a big deal and it keeps people at home.

MS. STEWART: And there is a big push in that right now and there's a lot of salesmen going around to physicians, hey, use my product. And that's fine and dandy when they're in the hospital but there's nowhere for them to come out to because nobody will prior auth the supply.

MS. HUGHES: So, it's not just this brand. It's that we just won't cover any of the brands for those.

MS. DYER: It's the supply, period.

MS. STEWART: It's that supply.

MS. HUGHES: All right. I will see if I can get you all some kind of response on both of those.

MS. DYER: You can tell we're not coders. Some of us might be clinical but some

of us are billing, or all of us are billing.

MS. HUGHES: I will see if I can get you answers on both of those questions.

MS. STEWART: Thank you. I don't have anything else.

MS. CARTRIGHT: Anybody else? Okay. So, it looks like the next meeting is April 9th.

MS. STEWART: And hopefully we'll be back in the cafeteria.

MS. HUGHES: Hopefully we'll be back in the cafeteria. I'm going to give it until about mid-March and if it's still not open try to find another room.

MS. STEWART: And you will be the one sending us our minutes going forward.

MS. HUGHES: Yes. Your last meeting would have been December. I probably have the minutes.

COURT REPORTER: I will send them to you, Sharley.

MS. HUGHES: But, yes, I will get those minutes and send them out to all of you and then you can just approve both months at the next meeting.

MS. CARTRIGHT: All right. Then I guess that's it. We're adjourned.

MS. STEWART: Do we have any issues for the MCOs outside of what was on our agenda? Did anybody bring anything?

MR. REINHARDT: The ones that were on the agenda were the only ones sent to me.

MS. DYER: And I will say that we got it resolved quickly. I forget which one.

MS. ASHER: Medical necessity?

MS. DYER: Yes. That was you and, then, we got it resolved quickly but that is starting up for more than one agency. I don't know where that is coming from. So, that would be the only thing. I don't know how many of us across the state do personal care only in Medicaid but several of us do it at times. It goes up and down.

So, I guess what I would say is a revisit of the regulation for that because it's pretty clear that it can be done.

So, that might be something if Angela Parker comes next time to bring with her the clarity in the regulation for personal care only for home health patients. Would that be helpful for everybody or do you all feel like that's resolved?

MS. LUCCHESE: I think we're okay now. I think part of the issue was InterQual. When you get to a certain point in InterQual, if you don't have a skilled needed will say doesn't recommend but we need to move past that so it's providing education for our Medical Directors. I think we're okay on that front.

MS. DYER: Oh, there's been a change in the Medical Director.

MS. LUCCHESE: I think we're okay. They're all going to be educated across the board generally just so that everyone is on the same page again but I think we're okay on that end.

MS. CARTRIGHT: All right. We stand adjourned.

MEETING ADJOURNED