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

IN RE: HOME HEALTH TECHNICAL ADVISORY COUNCIL

April 9, 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

Susan Stewart
TAC MEMBER PRESENT

CAPITAL CITY COURT REPORTING
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APPEARANCES
(Continued)

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Carol Steckel
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DEPARTMENT FOR MEDICAID
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Holly Owens
ANTHEM

Henry Spalding
PASSPORT

Kelly Dockter Dean
Cathy Stephens
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
   * Followup on the PluerX drain discussion
   * Followup on the non-published edits on supplies
   * Discuss MAC recommendations regarding TAC functions

5. New Business
   * Confirm "aide only" visits are covered. WellCare recently indicated they were not
   * Update on plans for Kentucky HEALTH
   * Since DMS is attending our TAC, do we need formal recommendations to the MAC

6. Next Meeting - June 18, 2019

7. Adjournment

MS. CARTRIGHT: We will go around and introduce ourselves.

(INTRODUCTIONS)

MS. CARTRIGHT: Since we don't have a quorum, I guess we can't approve the minutes, correct?

MS. HUGHES: That's correct.

MS. CARTRIGHT: Under Old Business, there was going to be some followup on the PluerX drain discussion.

MS. HUGHES: Yes. I sent each of the MCOs questions on that and the edits on supplies.

MS. STEWART: Yes, ma'am.

MS. HUGHES: So, just so you all know exactly what I asked when I got the answers, at the last Home Health TAC meeting, a question was brought up about the PluerX drain for home health.

Apparently, the drain is inserted in the hospital but there are supplies needed at home. The Home Health TAC states that no MCO will prior authorize the drain for the home health services.

The way they explained it to

me was it was like a drainage bag. Could you please check with the MCOs to see if they do not issue PA's.

And, then, on the other one, I just said, on supplies for things such as wound care, the TAC members gave an example of a patient needing 4x4 bandages. Apparently, every MCO has a different quantity amount they will approve but they will not tell the home health agencies what those amounts are.

So, if they send in a claim, the MCO will deny it for being over the limit but doesn't tell them what the limit is.

MS. STEWART: Correct.

MS. HUGHES: So, those were my questions.

MS. STEWART: You did a good job.

MS. HUGHES: So, for the answers from Humana, DME's such as the PluerX drain and wound supplies follow the Humana-CareSource rules for prior authorization. Basically, for the PluerX drains, a PA is not required unless it's over $750.

MS. STEWART: Okay. A box of

them is over $750.

MS. CARTRIGHT: I was going to say about $1,000.

MS. HUGHES: Okay, but they do cover them. It's just you would have to get the PA on them. For a non-participating provider - I'm assuming many of you all are all participating - the PA will be required regardless of the dollar amount, but for a non-par provider, it's just if it's above $750. So, you should be able to get a PA, and this is basically the answer I got from all of them on that.

COMMISSIONER STECKEL: I don't understand. If you're a participating provider, you have to do a PA but if you're a non----

MS. OWENS: That's backwards.

COMMISSIONER STECKEL: Okay.

MS. HUGHES: No. If you're a non-par, you have to do it regardless of the dollar amount.

COMMISSIONER STECKEL: That makes sense now. Okay.

MS. HUGHES: WellCare, it says the kits are approved above the benefit and there is technically no limit to them. A doctor will order

what is medically necessary for member and that is what will be approved.

The drain mentioned - this is Aetna - ProPat indicates no PA required unless it is an Inpt. That's inpatient, correct?

MS. STEWART: Yes.

MS. HUGHES: For home health, I do not see any reason why there would be reason home health could not care for this item, especially since the POS would not be inpatient. So, that's from Aetna.

Anthem does not require a PA for the drain. Home health is paid for on a per diem basis based on the revenue codes. The providers do not get paid separately for the drain.

MS. STEWART: Who was that?

MS. HUGHES: Anthem. And Passport, in response to the PluerX drain and 4x4 supplies, the provider will only need Passport to review if the home health provider is out of network or if the billable line item is greater than $500. So, you just need to get a PA.

MS. STEWART: So, can we have documentation of those answers because we've got a crap pile of denials we will send back in with those

things attached?

MS. HUGHES: I would suggest that you contact your MCO provider rep.

COMMISSIONER STECKEL: Well, why don't we do this because they're responded officially back to us. Let's give these copies to the TAC and, then, the TAC will have that information.

MS. HUGHES: Okay. I can email these to you so you will have them.

MS. STEWART: Because if we go back to that meeting, there was discussion with them all around the room confirming, going she is right, we don't pay for that.

MS. HUGHES: Do you all deal with the home health side of it, I'm assuming?

(MCO representatives nod affirmatively)

MS. HUGHES: So, do you all agree with what has been said?

(MCO representatives nod affirmatively)

MS. HUGHES: Okay.

COMMISSIONER STECKEL: So, we will provide you this in writing so that you will have it when you go back, and that's a good double check, not that we don't trust but we also verify

that they're not just telling us one thing and then doing another thing.

MS. HUGHES: And it was basically almost the same type of responses for things such as bandages on the quantity limit.

As far as wound care - this is WellCare - that are requested above the allowed monthly amount, the allowed amount is included in the writeup and it would be up to the Medical Director if there is medical necessity to go above the amount.

So, they're just saying if you go above the amounts normally needed for a month, the Medical Director would have to approve that.

MS. OWENS: And for Anthem, if you're unsure what that monthly limit is, you can call our UM Department and I can give you the phone number and our direct extension and we can tell you exactly what that is with each code.

MS. CARTRIGHT: They're about a hundred and fifty to a hundred and eighty----

MS. STEWART: Cost, what we pay for them and they normally get changed every three days. We had a patient from WellCare that comes to mind of late that we had $10,000 in just

one supply alone over the course of a month and that was denied.

MS. HUGHES: If you want me to, I can either read you their answers or I can just email them to you.

MS. STEWART: Just emailing them is sufficient. Thank you.

MS. HUGHES: And if you're getting something different than what is said, then, I would maybe ask for each--after the meeting, ask for each of these folks' phone numbers.

MS. DEAN: Can I give an additional clarification for Humana-CareSource that just came from one of our UM gals. She said it's $749 per month per line. No PA required if you're par. So, to your point, if you've got that big amount, you should be okay with us if it's a line item type of billing. Like, today, you took this much out. Next week, you took this much out. It should be fine so long as one day doesn't exceed the $749, but if you have a question ahead of time, you might want to double check with a nurse.

MS. STEWART: So, make sure it's not lumped-line billing.

MS. DEAN: Yes. I think that

will kind of shoot you possibly in the foot because the system is probably hard-coded. Then it says anything $750 and over per month per line requires an auth. So, it kind of goes back to you. That's an unusual scenario maybe. And, then, she also said if we're secondary, we don't require a prior auth but you would need to submit the EOB with the claim. Sometimes that comes up, too.

MS. STEWART: Okay. What about the non-published edits, Sharley?

MS. HUGHES: That was on the supplies, wasn't it?

MS. STEWART: It would be two different--there were two separate questions.

MS. HUGHES: Then, I didn't get the second part of that question.

MS. STEWART: No. You read them. The questions you asked were the right questions.

MS. HUGHES: Oh, okay. So, you want me to read the rest of the responses to that one?

MS. STEWART: Just give us a highlight. Just pick one and tell us.

MS. HUGHES: Basically both of

them are saying the same--the same thing on both that they will cover them up to the----

MS. STEWART: No, not the----

MS. HUGHES: The supplies and the PluerX.

MS. STEWART: Not just PluerX drains. The non-published edits.

COMMISSIONER STECKEL The second question.

MS. HUGHES: Right, and that was my second question. As far as wound care supplies that are requested above the allowed monthly amount - that was the WEllCare one that I read - the allowed amount is included in the writeup and it would be up to the Medical Director if there was medical necessity to go above this amount.

MS. STEWART: They misunderstood the question. We want to know what the limit is.

MS. HUGHES: They're saying it's in there. It's generally included in the writeup. The allowed amount is included in the writeup. I mean, they're here.

MS. STEWART: Which ones?

COMMISSIONER STECKEL:

WellCare is not here.

MS. STEWART: So, pick somebody that's here and let them answer.

COMMISSIONER STECKEL: Well, let's just ask. Where is it in your documentation so they can find the limits?

MS. DEAN: I would have to get that for you because I didn't do the original research on that.

MS. HUGHES: You're Humana?

MS. DEAN: I'm Humana-CareSource.

COMMISSIONER STECKEL: And Anthem?

MS. OWENS: I would have to do the same but I can give you our phone number for our UM line and we can tell you on the phone. I can definitely do that and you can call and say I've got this code and what is the monthly limit.

MS. STEWART: You are correct on the things that have a published edit on them but there are supplies that don't have a published edit. That's the ones we want to know about.

MS. OWENS: Do you have those codes, like what those would be?

MS. ASHER: Or an example of the supply?

MS. STEWART: I don't have one off the top of my head but I think 4x4's was an example. There's a box of fifty and one edit is forty-seven. Somebody else's edit is potentially thirty-five but they come in a box of fifty.

So, there are a series of supplies that aren't listed anywhere for Medicaid or the MCO because Medicaid doesn't have a published quantity. The MCOs don't have one either and that's their stance is Medicaid doesn't give us a----

COMMISSIONER STECKEL: Well, we've told MCOs time and time and time and time and time again that their systems should not be built off of Medicaid's system, not our rate schedule, not anything.

So, if they're doing that, it's because they choose not to publish those edits, not because Medicaid has told them not to publish those edits. Do I make myself clear? Thank you.

MS. STEWART: So, on this topic, do we need to bring back specific examples?

COMMISSIONER STECKEL: Yes. The more specific you can be, the easier it is for

both Medicaid and the MCOs.

MS. HUGHES: You can just email me some of that and I can get Angie to send it out to the MCOs to get a response back.

MS. STEWART: I'm pretty sure it's 4x4's.

MS. CARTRIGHT: That's the only thing I can remember from the last meeting.

MS. STEWART: That's what is sticking out in my head but I'll go back and ask my revenue cycle and we'll poll some other home health agencies.

MS. HUGHES: Because looking at their responses, it's pretty much the same thing. No prior authorization required on $750.

COMMISSIONER STECKEL: And we'll share this with you so you'll have it.

MS. STEWART: All right. Thank you.

MS. CARTRIGHT: The MAC recommendations regarding TAC functions.

COMMISSIONER STECKEL: We're meeting with our lawyers. So, we will have an answer after that meeting.

MS. CARTRIGHT: Okay. Thank you.

COMMISSIONER STECKEL: I will reiterate my desire for TACs, whether I win this battle or not, that this should be policy discussions and that's what we would like to use the TACs for, understanding that things like claims and all of that become a big issue, but we would prefer to have these meetings be policy meetings and I have been consistent on that. I may not win it and we may just have TAC meetings that are of no value to the Medicaid agency but that's okay.

MS. CARTRIGHT: Okay. Thank you.

So, under New Business, we have confirm "aide only."

MS. HUGHES: I sent an email to Charles. I just checked and I haven't gotten a response back yet. Before the meeting is over, in case my phone is not working, I'll go back to my desk and make sure if I've got an answer for you.

I just wasn't sure and I honestly didn't pay that close attention to it until this morning and I was like, wonder what that means? I had gotten all the other information, some updates

for you but I missed that one somehow.

MS. STEWART: Commissioner, the State doesn't require that--aides can stand alone in a home. It doesn't require an RN or a PT to be there. And evidently we have some agencies that WellCare is saying that that's not----

MR. REINHARDT: And there was some back and forth between----

COMMISSIONER STECKEL: Is it only WellCare?

MR. REINHARDT: That was the only example we got so far and the agency sort of said this happens all over the state and it was a new thing that previously had gotten these sorts of cases approved and now they were not approved.

COMMISSIONER STECKEL: So, what happened when you all reached out to WellCare?

MR. REINHARDT: They were adamant that this - and I think I sent Sharley the summary of--you know, the correspondence from the agency.

MS. HUGHES: Was that on the agenda?

COMMISSIONER STECKEL: From us?

MR. REINHARDT: In the feedback that I sent. So, on the agenda, I think I included the summary. And if I didn't, I will get it to you.

MS. HUGHES: Okay.

MR. REINHARDT: But they've said they had asked WellCare several times and WellCare said, no, aide-only visits are not covered.

COMMISSIONER STECKEL: Okay. Again, this would be helpful if we had who specifically at WellCare. And, then, did that agency take it to their provider rep at WellCare? And is it only one agency? This is my----

MS. STEWART: No.

COMMISSIONER STECKEL: ---- frustration with these meetings.

MS. STEWART: I will go out on a limb and say typically what we find in our meetings is that it happens to all of us. We typically are a cross-section of public health, for-profit, not-for-profit home health agencies across the state, and when you get us together, we normally meet beforehand and it's all of us.

From my company's standpoint, we are meeting with MCOs monthly. And to say that

those meetings are beneficial, I would have to tell you that more than likely they are not. It's a run-around.

I know this isn't the forum you want but you don't really get anywhere when you meet one-on-one with them either. It's the give me example. Oh, well, we're still working on it. That's typically the response we get.

I have been working with one specifically for about probably five months now and really haven't gotten anywhere, and they're denying a - I'm being specific - they're denying a claim and the logic behind it is not homebound. I've sent them the regulation that says homebound is not a reason to deny and I still get an appeal, denial for homebound.

So, what is our recourse when that----

MS. HUGHES: If you can send that to me, then, I will----

MS. STEWART: I threatened them. I told them, I said, you either get me an answer by the TAC meeting today or that's what I'm going to do. And I met with them yesterday and I still don't have an answer.

MS. HUGHES: If you get me that information, the Medicaid member and so forth and the dates of service you're talking about, then, I will get Angie to go back to whichever MCO it is and we'll get you some kind of a response.

COMMISSIONER STECKEL: Is it one of the MCOs that are in this room?

MS. STEWART: Yes, ma'am.

MS. ASHER: Is it Aetna?

MS. STEWART: I'd rather not.

COMMISSIONER STECKEL: Call them out. No. You're down this road. Who is it?

MS. STEWART: Well, I mean, I talked with Cathy at the MAC meeting about it.

MS. STEPHENS: And we are working. I know they've gone through eighty-five of the claims and they're continuing, I think, to work on the rest or it might be thirty-seven.

MS. STEWART: There are two different batches. We have thirty-seven claims, we have seventy-five claims and, then, we have the denial for homebound status but it's not a requirement. The reg is the reg.

MS. STEPHENS: There was a coding issue, too.

COMMISSIONER STECKEL: So, why has it taken five months to resolve this issue?

MS. STEPHENS: There has been some coding issues, if I'm correct, that needed to be corrected and resubmitted.

MS. STEWART: It's been going on for about eighteen months with my revenue cycle person and it just bubbled up probably in the past five months that I'm causing stress to her because we have outstanding AR of about probably $50,000 with Humana-CareSource and that's when, okay, I'll start having these meetings because, you know, Cathy has been great. We had a call. We had a no show. No one from Humana shows up.

MS. STEPHENS: I've been working with----

MS. STEWART: She has. She has.

MS. STEPHENS: About three times a week now, I get summaries and I'm on calls with them to make sure we're making some headway here.

MS. HUGHES: Are they making headway?

COMMISSIONER STECKEL: Not if

it's been five months and it's still unresolved.

MS. STEWART: It bubbled up at the MAC meeting because I pulled Cathy aside at the MAC meeting and I said something is going to give or I'm going to report. And by the time I got back to Hazard, I had a phone call that day.

COMMISSIONER STECKEL: You all are not making our jobs any easier. The Legislature doesn't want us to have managed care. The providers don't want us to have managed care. We're fighting the battle and you all are making it difficult.

MS. STEPHENS: Not our intention. We are working on it.

COMMISSIONER STECKEL: Well, but I don't care what your intention is. It's what your results are.

MS. STEPHENS: I agree. I'm not disagreeing.

MS. STEWART: That's our frustration, and I don't mean to pick on Humana-CareSource. I mean, my people is meeting with WellCare today. It could be any one of them.

COMMISSIONER STECKEL: We pick on you but it's everybody. It's WellCare who isn't even here but it's just getting to be frustrating

that I can't have a TAC meeting that I want to have because I've got experts here that could help me with policy because they have legitimate concerns that you all should be dealing with, not me. So, that's my frustration.

MS. STEWART: Agree. So, Cathy knows that we're working on it and we had another two-week deadline on our call yesterday and hopefully we'll have an answer in two weeks. If not, then, especially the homebound things.

What we've experienced, and Rebecca can chime in, and not just with Humana-CareSource - I'll say blanket across all MCOs is they have such a turnover in their staff that you work with somebody and they don't have the information or the knowledge, and by the time they get it, they're not the person there anymore.

And, then, you're starting all over and they don't know and you try to educate them. And, then, by the time you get to the end to a possible result, it's past timely and that person is not there anymore and they can't hold that person accountable and then you're screwed.

COMMISSIONER STECKEL: Well, the MCOs have this responsibility. So, we will

start looking at this.

MS. HUGHES: If you don't see some good improvement by the time of your next call in two weeks, send them to me.

MS. STEWART: Okay.

MR. REINHARDT: So, the WellCare issue - and I'll send you this information - but they were speaking with a nurse reviewer independently and they also contacted their field rep and had heard nothing, but the nurse reviewer was adamant that an aide-only case was not acceptable. And even after being shown in the Medicaid manual that this is a regular thing, they still denied. So, I'll send you the information.

COMMISSIONER STECKEL: Okay. That would be helpful and then we'll deal with WellCare.

MS. STEWART: That's why we're so protective of the way the meetings because if we don't have this venue, then, we don't have a recourse.

COMMISSIONER STECKEL: I totally understand it. I get it now. I get it.

MR. REINHARDT: And we understand your perspective. You want this meeting

to be productive, and the flip side of that is that's why we felt this meeting was productive was this is the first place we could sort of make progress on these things.

COMMISSIONER STECKEL: Sure, which we all should not be having to deal with it anyway. I think I've made my point.

MS. STEWART: You have.

COMMISSIONER STECKEL: Okay.

MS. CARTRIGHT: Okay. So, the update on plans for Kentucky HEALTH.

COMMISSIONER STECKEL: Kentucky HEALTH. As you all know, the Judge remanded the Kentucky HEALTH 1115 Waiver back to the Secretary of HHS.

We are meeting with the Department of Justice lawyers, our lawyers about the appeals process. We are going to appeal it.

It goes through the Circuit Court and I don't know what number Circuit Court, whether it's the 9th or the 6th. It goes through a Circuit Court.

And, then, if we prevail there, then, we prevail but we're not anticipating that. We're anticipating a Supreme Court decision

on this which means that we're basically in a legal process until September if we win in the Circuit Court and June of 2020 if we go all the way to the Supreme Court. It's frustrating.

MS. CARTRIGHT: Definitely.

COMMISSIONER STECKEL: Now, the odd thing about it is the SUD component of the 1115 is moving forward. So, that was not stayed. Even in the first Order it was not stayed. So, we are moving forward with our 1115 on SUD services. Any questions?

MS. CARTRIGHT: Thank you.

COMMISSIONER STECKEL: Thank you all.

MS. CARTRIGHT: Okay. Susan, did we already ask this?

MS. STEWART: I asked Sharley this before we started.

MS. CARTRIGHT: So, we got that answer, Sharley. Thank you.

MS. STEWART: It wasn't more about--I knew a formal recommendation had to be at the MAC but I didn't know if our minutes automatically flowed up because I have an email reminder to send stuff to Sharley; and if I don't

have to try to remember to do that, I wanted to remove that.

MS. HUGHES: Right. Terri sends me all the minutes and, then, I'll send them all out to you all and to the MAC.

COMMISSIONER STECKEL: And it really is our intent to work with all providers, whether they're TAC members or not or MAC members. They're too important to us to go without saying, but I'm new and I may have gotten off on the wrong foot with some folks; but my efforts are sincere in that the TAC idea to me is beneficial because I have the experts all gathered into one place.

The thing I get frustrated with CMS, I tease them or complain to them that they sit in their ivory tower and they don't have a clue what it's like to work in the state and I don't want not be accused of that.

So, I try hard to not. And I've been here since September and it's time for me to get out of my office which I'm hoping to be able to do. I've got some staffing hiring and all of that, but having you all here is part of how I answer that question is I'm not relying on me or my staff. We're talking to people who are actually on

the ground, hands on our residents, our beneficiaries and actually doing the work. It helps us be better. So, that's my goal.

MS. STEWART: I have been a TAC member for a very long time; and in my history, we've never had a Commissioner come to a TAC meeting.

COMMISSIONER STECKEL: I've heard that more times than not.

MS. STEWART: So, that is a plus that we get an hour to an hour and a half of your time to discuss our issues, whether it be with an MCO or things we would like changed. I think there can be a happy mix between the two.

COMMISSIONER STECKEL: I think you're right.

MS. STEWART: Our stance has always been we didn't ask for MCOs. We never thought there would be a day where we would have been thankful to go back to traditional Medicaid because we thought they were bad but MCOs just compounded our problem and it's been a difficult road.

And we think we get it fixed and, then, they have a system upgrade and then we're

right back to where we started when the MCOs first came in to the state. So, not having this venue to be able to discuss issues I think would be detrimental to our group.

MS. CARTRIGHT: I agree.

MS. DEAN: May I ask a question? And I don't want to derail anything. I'm from Humana-CareSource. I just wanted to clarify with Susan.

Was there a call separate from the one with Thomas Brown and Keesha Finn?

MS. STEWART: We have had, as of yesterday, four calls.

MS. DEAN: I believe April Lovin missed a call previously who is the rep, but Thomas and Keesha are in the management role and they wanted to know if there was another call.

MS. STEWART: No, no, no. It's just we had a call. None of Humana-CareSource - and that's my complaint I went to Cathy about at the MAC is they were a complete no show.

MS. DEAN: And that was yesterday.

MS. STEWART: No. That was a couple of weeks ago.

MS. STEPHENS: That's when I got involved.

MS. STEWART: That was a couple of weeks ago. I had no more got back to Hazard and Cathy had already addressed my issue and had Keesha calling me; but on our call yesterday, it was still not giving me the resolution I expect when we have in faith provided services, tried to reach out to our reps along the way, done what we were supposed to do and still we're getting denied.

MS. DEAN: I absolutely understand.

MS. STEWART: That's my issue.

MS. DEAN: I understand.

MS. STEWART: And the homebound issue. I shouldn't have to fight that homebound issue.

MS. DEAN: Oh, I understand.

MS. STEWART: Page 4 something of the reg says homebound not required - boom - pay me.

COMMISSIONER STECKEL: And I should say that we recognize that sometimes the MCOs are going to be right and that we have to tell the providers, yes, you want this but here's why and

here's the regulation.

So, I'm not saying they're always right, you're always wrong, but there's a median there, but what frustrates me is the seemingly lack of response and action. I have been in your chairs but I still don't understand it.

MR. REINHARDT: Our goal is to find whatever the target is. So, if we're wrong, we want to hit the target.

MS. STEWART: And in fairness, there are some things that we did wrong with our claims that we are not going to get paid for. Shame on us. But the ones that we did right, I want my money.

COMMISSIONER STECKEL: Understandable. Okay.

MS. HUGHES: I think, and I may have the TACs confused, I think at the last TAC meeting, Missy talked about possibly you all doing a recommendation on some telemonitoring. It wasn't telehealth. It was like a telemonitor type thing.

MS. CARTRIGHT: Remote patient monitoring.

MS. HUGHES: Patient monitoring and I think there was a survey. A couple

of states had done a survey that had proven----

MR. REINHARDT: Yes. We haven't gotten that together yet but we will get that information to you because we wanted to gather information on their requirements because Indiana pays for it but has certain requirements. I think Colorado pays for it and, then, there's a couple of other states that have gone ahead and----

MS. CARTRIGHT: South Carolina.

MS. STEWART: And I think that's the partnership that you are wanting.

COMMISSIONER STECKEL: Yes. Exactly. That's what I would say. That would be a great discussion point for an agenda item for this meeting.

And, then, we can bring our folks that are experts or that manage the program around telehealth, telemonitoring, tele whatever and we can actually--instead of it going to the MAC and, then, us talking and, then, making a recommendation back to the MAC which doesn't even have you all as part of it, things like that, yes, that's exactly what I'm looking at.

If you guys have an idea and

you think it could improve care to our beneficiaries and save us money or at least not cost any more money than we're currently spending, then, let's talk about it in this environment, and I'll bring in my policy folks, you all bring in your policy folks and let's hash it out.

MS. STEWART: Well, I think there is one thing that we can all agree on and that is the home is the cheaper place to pay for anything.

COMMISSIONER STECKEL: Absolutely.

MS. CARTRIGHT: And where people want to be.

MS. HUGHES: If I understand it correctly, remember it correctly, it was actually a monitor of some sort and it saves some re-admissions.

COMMISSIONER STECKEL: I'm familiar with all of those.

MS. CARTRIGHT: And there's new technology out there all the time. We're getting ready to do a pilot. It looks like the thing I put on my arm when I run and I think the patients will like that a little bit better than

having to plug in stuff.

MR. REINHARDT: And the specific information you wanted was re-admissions data.

MS. HUGHES: Yes, just the survey. I think it was Indiana and South Carolina had both done surveys to prove that it saved money on re-admissions to the hospitals.

MS. CARTRIGHT: South Carolina had done a grant. I was in South Carolina and I was part of that grant that Medicaid gave to agencies. You submitted your proposal and, then, after so many years - and I had to move back to Kentucky before it was finished - but when they got the results, they do pay for it now.

COMMISSIONER STECKEL: Anything that you can show us, what are other states doing, any data about the effectiveness of the program, and particularly you all are right. The home is a better place, both safety, quality of care and getting someone out of the hospital.

Any of that data that you can either provide to us or tell us where it is and we'll go get it. For instance, if I need to reach out to the South Carolina Medicaid Director, I can

do that, but that's the kind of information and, then, let's schedule an agenda item to really talk about it, to flesh it out to see what are our questions, what are your questions, how would it work specifically in Kentucky. That's exactly the kind of ideas and things that I think would benefit us greatly.

MS. STEWART: Telemonitoring is something that--you know, there's always it seems like a telehealth bill that never makes it very far. In our organization, there's a difference between telehealth, telemonitoring, remote patient monitoring. Theoretically, it's the same but it all serves different purposes.

I think remote patient monitoring in our state could prove beneficial, especially in remote areas.

COMMISSIONER STECKEL: I've seen it work, so, I'm a believer. It's just making all the numbers work and how we follow the rules, but this is one area where I have seen it work well and would be very supportive of it.

MR. REINHARDT: We'll have that information back to you and definitely put it on the agenda for next time.

COMMISSIONER STECKEL: Okay. Perfect. That will be fun.

MS. HUGHES: I was pretty sure it was you guys but, then, I was thinking, wait. Was it the Therapy TAC? I didn't think it was the Therapy TAC.

MS. CARTRIGHT: No. We had discussed that at the last meeting.

MS. HUGHES: I'm going to go back to my desk real quick because I don't think my phone is updating my email just to see if Charles has given me anything on that aide only.

MS. CARTRIGHT: And our next meeting is June 18th.

COMMISSIONER STECKEL: So, what else is on your all's minds now that we've got a few minutes?

MS. CARTRIGHT: I was just thinking back to your thing on policy. There are some home health regs that we have looked at in the past.

MS. HUGHES: I have not gotten a response.

MS. STEWART: Which ones?

MS. CARTRIGHT: Like the

(inaudible) for anybody that has to have this physical. That was something that we looked at and thought that we would be able to get past that because every organization has different requirements and it's very costly.

COMMISSIONER STECKEL: Especially things that aren't benefitting the beneficiary that are costly, we need to address. I can't promise anything but that is exactly what we would be willing to talk about to address.

And in that case, I would have Jonathan Scott, our legislative regulatory person, attend the meeting along with the policy folks so that he can hear the discussion as we're talking about issues in the regs.

MS. HUGHES: And, Evan, on the patient monitoring, if you could get that to me a couple of weeks before the next meeting and I can get it out to our policy folks for them to review before the meeting.

MR. REINHARDT: I'll get it to you before the end of the week.

COMMISSIONER STECKEL: Perfect. That would be great.

MS. HUGHES: It just gives

them time to read over it and develop questions before they come in to a meeting.

MS. CARTRIGHT: That's always good to have.

MR. REINHARDT: And I will say, what we would like to avoid, Indiana sort of made the reimbursement almost impossible to get. It was great that they were paying for remote monitoring but you had to have a diagnosis of COPD, CHF or I think something related to kidneys. Diabetes was in there, too.

So, you had to have one of those diagnoses and, then, you also had to have an emergency room visit within the last six months related to the diagnosis.

So, to hit that target. I mean, the whole idea is preventative. You want to avoid any of those kinds of things happening.

So, to make that bar so high that only certain patients could get remote monitoring and the idea is that we want to prevent everybody from deteriorating to a point where they need an inpatient stay or to go to an emergency department.

So, that's one comment I would

make based on our experience is if and when we can go forward, you want it to be something that's reachable for each member, not that everybody is going to be getting remote monitoring but it's something that proves beneficial.

And I think there's a behavioral health component to it as well. We heard anecdotes of individuals out there that artificially, just the way the system was set up, cued a nurse to have to call them. And the real reason they want a call is they wanted to just talk to somebody and usually in a remote area on their own and really just needed conversation.

And, so, those kinds of things, I think it's a holistic, sort of bio, psycho, social and it's not just home health. We're identifying other issues that we can have an intervention on and prevent something even more serious happening.

So, I think all of those are the benefits of looking at it, but just to make it reachable for providers and not add so many criteria that it's just impossible to find someone to fit into that little ground hole.

COMMISSIONER STECKEL: It

would be interesting to know why - and we may have to call them and find out - but why Indiana did it that way. The way I tell my folks is come in with an idea but don't put boundaries on yourself. We can do that in the meeting.

So, it may be that we think through this and we do a pilot, that we do COPD and these are the rules and, then, we kind of see how that works. I don't know because, again, I'm a big believer in this.

So, I think it is an effective program, but we'll think through alternatives and we'll think through it together.

MR. REINHARDT: Sure, and that dialogue is what's important.

COMMISSIONER STECKEL: Exactly.

MR. REINHARDT: We passed legislation to pay for it and the rule just got sort of produced that added the constraints on the back end.

COMMISSIONER STECKEL: Now I know exactly why they did it.

MR. REINHARDT: Previous administration, well, previous Medicaid Director in

Indiana anyway, so, not the same group of people but they will be able to give you an idea.

COMMISSIONER STECKEL: I know exactly why they did it that way.

MS. STEWART: You probably can't answer this question but I'll ask it. Is the Medicaid expansion in jeopardy while we wait for all of this?

COMMISSIONER STECKEL: I can't answer that question. You know what the Governor has said. You know what the Secretary has said.

We've not been given any instructions to make any changes or even to prepare for any changes.

Anything else?

MS. CARTRIGHT: I don't think so.

MR. REINHARDT: I think we'll have telehealth and at least the physical exam and maybe something else on the agenda to start talking about. So, it will be good to spend some time on those.

MS. CARTRIGHT: I guess we can adjourn.

MEETING ADJOURNED