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

IN RE: HOME HEALTH TECHNICAL ADVISORY COUNCIL

June 18, 2019
11:00 A.M.
Field Services Conference Room
Cabinet for Health and Family Services
275 East Main Street
Frankfort, Kentucky 40601

APPEARANCES

Rebecca Cartright
CHAIR

Billie Dyer
Missy Stober
Annlyn Purdon
TAC MEMBER PRESENT

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(Continued)

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Carol Steckel
Genevieve Brown
DEPARTMENT FOR MEDICAID
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Holly Owens
ANTHEM

Henry Spalding
PASSPORT

Cathy Stephens
Kelly Dockter Dean
HUMANA-CARESOURCE

Sammie Asher
Lisa Lucchese
Jennie Cahill
AETNA BETTER HEALTH

AGENDA

1. Call to Order

2. Welcome and Introductions

3. Approval of Minutes

4. Old Business
   * Telehealth reimbursement

5. New Business
   * Physical exam requirements for employees
   * MCO visit limitations
   * Supplies excluded from the Fee Schedule

6. Next Meeting - August 13, 2019

7. Adjournment

MS. CARTRIGHT: We will go ahead and call the Home Health TAC meeting to order.

(INTRODUCTIONS)

COMMISSIONER STECKEL: We have a new Chief of Staff at Medicaid. Genevieve Brown is an attorney and has done a lot of work on federal issues, a lot of work on home health CON issues. So, she knows a lot about the services that you all provide. She is from Lexington and we are thrilled to have her on board.

MS. CARTRIGHT: So, the next order of business is approval of minutes.

MR. REINHARDT: I don't think she sent the minutes.

MS. CARTRIGHT: I was going to say, I didn't see them but I thought I might have missed them.

MR. REINHARDT: The past two, I think, we will have to approve those at the next meeting.

MS. CARTRIGHT: Okay.

COMMISSIONER STECKEL: She has had the audacity to take some time off. So, I apologize but we'll get you the minutes.

MS. CARTRIGHT: That's fine.

And, then, under Old Business, I think we were discussing the telehealth reimbursement.

MR. REINHARDT: And we had sent some information over to you all just to have a look at some other states and their approaches. And I think at this point, we were just hoping to get some feedback and have a conversation about where you all were with thinking through telehealth and remote monitoring. The terminology gets kind of gray a little bit but we're interested in talking through that.

COMMISSIONER STECKEL: So, have you seen the new reg, the emergency reg that has come out? Has it come out yet or is it coming out?

MR. REINHARDT: I think it came out on Thursday. So, I need to ship that out.

COMMISSIONER STECKEL: Because it should address most of your concerns. Now, we've got some folks that are asking about certain codes that apparently were missing a provider home to school-based clinic services' connection.

So, if you all will look at the reg. One, we took the 85% reimbursement to 100.

So, that's the biggest, major change but I think we've addressed all the questions and the issues we've had from most of the providers.

If you all will look at it carefully and then get us your comments back, that would be very helpful because in any reg, there's always tweaks, but we need to get it out and get it implemented so that we can start paying for some and, then, we'll address the concerns that you all have.

Now, I would ask you all to look at the reg and keep in mind that we have basically made everything a potential telehealth service. We are already getting a lot of calls from out of state.

Our intent hopefully with the 85% was to avoid that for a little bit of time and then bump it up, but that being said, our desire is to have our Kentucky providers benefit from this reg rather than expand it to--I mean, expanding provider services is what we're all about, but you all understand, I think, I hope, what I'm trying to say.

So, we need you to look at the reg, make sure if you have any comments that they get to Jonathan because he does all of our regs,

and, then, be thinking about--so, this is about telehealth, expanding it, making it equal to an office visit as much as we can.

It's not about telemetry services. It's not about expanding scopes of services for providers. Now, all of those, we are looking into telemetry because we think that that's a good thing, and, so, we're looking at how we would do it, with what groups of patients we would do it with and we'll probably be reaching back out to you all asking your thoughts on that, but just keep in mind, look at it as a telehealth regulation and provide your comments based on that.

And, then, your expansive comments where you would like us to do more, we'd like those comments but in a different format.

MR. REINHARDT: And Missy probably has a little more to add to this, but in our space, the distinction is often--I mean, this isn't an encounter typically. It can be like in certain circumstances, but a lot of times, this is data that's coming in that's being monitored.

So, you're keeping track of blood pressure, O2, all of that, even as complex as like sleeping, how well you slept.

MS. STOBER: So, a physician or a provider visit is not covered under the home health regulation. You have to have a provider who is signing the plan of care. So, that may help us with something like making sure we have a face-to-face encounter for those places that we need it but not relevant to Medicaid.

However, the telemonitoring we were speaking of, it's not telehealth. It's telemonitoring. So, there's lots of data that I believe the Association sent that would be reimbursable for the unit and then the monitoring of that which does show a significant decrease in cost of rehospitalizations which could save Medicaid a lot of money.

COMMISSIONER STECKEL: Sure, sure and that's what we're looking at. That's why we're running through our numbers and looking at how would we operationalize that.

I actually did that in Alabama twenty years ago and it worked extraordinarily well, particularly in our rural areas.

So, I am very much on board with it, but we have to go through our process and how would we implement it, what codes, how would we

pay for it, where are we going to get the money to pay for it and that's where we have to do with our Finance Department, okay, if we do this and we avoid three hospitalizations, but even more so, if we avoid a catastrophic event that someone is not only a hospitalization but a rehospitalization.

You know better than I do all of the outcomes but that we are indeed looking at and would like to do something relatively quickly. Now, that's state government talk.

MS. DYER: When you did it in Alabama, did each individual agency own their own equipment - that's what we're accustomed to - or was it a state-driven program?

COMMISSIONER STECKEL: It was a state-driven. Back then, it was a pilot. So, it was done out of the University of South Alabama and they owned all the equipment and is sent out.

And, so, that's what we would need to think about and we would need your input on what's the best way to do that so that we can both save money and provide the services to the beneficiaries.

MS. STOBER: And I would say having telemonitoring units available as part of a

standard plan of care in home health these days is like the six-vital-sign kind of thing. So, having them available now is not an issue like it was twenty years ago where nobody had them at their disposal or usage.

COMMISSIONER STECKEL: Or you couldn't go to the drugstore and buy them off the shelf. You could, I guess, and spend a lot of money but now you can buy all of this stuff.

MS. STOBER: Well, this unit actually----

COMMISSIONER STECKEL: So you can monitor yourself, I guess I should say.

MS. STOBER: Well, the monitoring we're talking about actually, then, feeds data back and there's someone watching it.

COMMISSIONER STECKEL: Right. Right. If you have an irregular rhythm, it alarms.

MS. STOBER: Yes.

COMMISSIONER STECKEL: I'm very familiar with that.

MS. DYER: And you have doctor's orders for parameters and lots of times orders - you know this - if blood pressure is "x", then, you can administer or give orders for Lasix or

whatever.

COMMISSIONER STECKEL: Or you call the woman whose blood sugar has gone up to three or four hundred and she's had birthday cake that day, but the telemetry we are looking at but the reg is dealing with telehealth.

MR. REINHARDT: We'll get that out and definitely take a close look, but I think just conceptually we're looking for more the ability for an individual agency to look at that data to avoid the encounter as opposed to doing a video encounter.

COMMISSIONER STECKEL: Well, and it fits in with what the Cabinet and this administration is all about is how do we empower people to know more about their health, and a telemetry unit is a good way of doing that. You can do so much education. They're taking part in making a decision about when data goes or when it does. It's a win/win. It's just we have to go through how do we do it, how can we afford it and make all the math work, and your information has been very helpful. So, thank you.

MR. REINHARDT: And that's the part about the equipment and the complexity now.

It's just amazing. It can all be Bluetoothed in different parts at home, feed into a central unit and, then, that gets uploaded. Obviously, in a more rural area with less connectivity, you might need a different setup but there are so many different options out there. It sounds like we're on the same page.

COMMISSIONER STECKEL: Absolutely. I smiled about Bluetooth. The Secretary is a young man and the Deputy Secretary is young and everybody around us are young, and, so, I'm learning a lot about technology. I thought I was technologically advanced. No. They're teasing me because they tell me I should have a--what is that phone they advertise on TV for the elderly people with the big numbers on it?

MS. ASHER: A Jitterbug.

COMMISSIONER STECKEL: A Jitterbug. The Secretary said I should have a Jitterbug and he's probably not too terribly far off, but you're exactly right. Now it's so much easier and it gives people control and that's what is so exciting about it.

So, we're on board. We just have to figure out how to do it.

MR. REINHARDT: Anything else you need from us, we're happy to help. And, again, it's already in Indiana. It's in Colorado. It's in a couple of other states.

MS. CARTRIGHT: South Carolina.

COMMISSIONER STECKEL: We got your information, so, that was helpful. We had a National Association of Medicaid Directors' meeting last week, two weeks ago, and Stephanie was asking a couple of folks about it. So, give us some time. Stay on us but give us some time and we will work it out.

MR. REINHARDT: Sounds good.

MS. CARTRIGHT: Thank you. So, under New Business, I think we had some questions about the physical requirements for home health employees.

We would like to get this regulation removed actually. It is burdensome and costly. We were cited on an OIG visit because they did not think that we did appropriate medical health screenings on our employees which, in turn, turned into a physical for employees.

It's a lot of money for the

agency to put out for these full physicals when, generally speaking, in the past, we have never had any issues with our form. We talk about TB, flu, all those things, but they said this was a requirement.

COMMISSIONER STECKEL: What regulation? Do you have the cite?

MS. STOBER: It's in the home health reg.

MS. CARTRIGHT: It's in the home health regs. I can get that for you.

COMMISSIONER STECKEL: Jonathan probably knows it right off the top of his head.

MS. STOBER: I've been here in the state a long time, too, and for probably, of the thirty years I've been doing this, twenty-two to twenty-five of them we did the same process with the screening and did the TB testing but we did a screening for TB and other issues and, then, it could be signed off by a nurse.

And, then, one day a different surveyor came in and all of a sudden got cited as well - not all the areas that we have in the state - and, then, we had to move to go in to do everybody

had to have a physical. So, we had to go to an op med place and have a physician do it. So, it's costly.

COMMISSIONER STECKEL: So, what does a physical get you that a TB and flu screening----

MS. STOBER: We have no idea. It's fit to work. I guess if you were like in a hospital where you're doing a lot of other--I mean, you're in a facility but we're not. We're in folks' homes. I'm not sure.

MS. BROWN: So, is it about workers' comp? Is it lifting?

MS. STOBER: Well, our workers' comp----

MS. CARTRIGHT: We have workers' comp. She basically said that I needed to know that my employees didn't have diseases. And I said, well, I mean, you know, we do these screenings. In Baptist's world, everybody gets a flu shot - that's a requirement - and everybody gets screened for TB and all kinds of other questionnaires, a wellness thing that you do every year and we have employee health.

And the interesting thing was

my office in Madisonville didn't get cited but my office in Paducah, Lexington and Louisville and Breckinridge did.

MS. STOBER: It hasn't been consistent. It was like some of them did and then some did not.

COMMISSIONER STECKEL: One surveyor versus another surveyor.

MS. STOBER: Yes, and then it started to spread.

MS. DYER: We weren't cited on it actually. I don't know why but we weren't. We do have like blood pressure, pulse, assessment, heart rate, you know, more than screening.

COMMISSIONER STECKEL: This is just my ignorance, so, I apologize, but what I would be worried about is my beneficiaries being exposed to something. So, if you've tested for TB, I guess, does your physical----

MS. CARTRIGHT: Hepatitis and all that.

COMMISSIONER STECKEL: You've tested for Hepatitis A and C, you do TB, all the things that we hear about in the newspaper. So, what does a physical do that would help me protect

my beneficiary?

MS. CARTRIGHT: Nothing that we know of.

MS. STOBER: The word physical is in the reg, and I think people--the word physical. So, it moved from having surveyors who had been there and done it and then someone interpreted that as being it had to be by a physician.

MS. CARTRIGHT: Full blown.

MS. STOBER: Yes. It's very costly.

COMMISSIONER STECKEL: Let me look into that with Jonathan and see because our goal is to protect our beneficiaries. Let me look into that and see what we can find out.

It's so much that you want the reg done away with. You want the word physical removed.

MS. STOBER: Screening would be better.

MS. CARTRIGHT: Screening would be a better word.

MS. STOBER: Because we all had a screening process.

COMMISSIONER STECKEL: Great. This is helpful. Let me look into it.

MS. CARTRIGHT: Okay. Thank you.

And, then, Evan, I wasn't sure about the MCO visit limitations.

MR. REINHARDT: So, we brought that up at the last meeting and the topic was basically it's administratively burdensome to only have a limited number of visits authorized and then you max those out really quick and you've got to go right back for a PA.

So, the thought process was if we can demonstrate medical necessity, why can't we have a little bit more room to breathe and let more visits be authorized and then the agency doesn't have to come back literally. And I don't know what the turnaround is but it sounded like it was within weeks.

MS. CARTRIGHT: It is.

MS. DYER: It can be very quick.

MS. CARTRIGHT: It can very quick and then you're waiting and waiting to see if they're going to be authorized because if you send

somebody out in good faith, you run the risk of not getting paid.

MS. BROWN: It's not done by the CPT code?

COMMISSIONER STECKEL: But the agency wouldn't have anything to do with this. It would be the MCOs.

MR. REINHARDT: So, the MCO is saying you get - I'm just throwing numbers out - you get five visits. Well, you're going to use five visits, depending on the person, within the first week or two. Then you've got to go back and do another PA, and not only are you doing the administrative burden of applying for the PA, but now you've got to wait and it could take----

MS. CARTRIGHT: We've got patients and they're like what do we do.

MS. DYER: It can take up to two weeks.

MS. CARTRIGHT: We haven't heard back. They need wound care.

COMMISSIONER STECKEL: What do our MCOs say about this?

MS. OWEN: Is it a particular MCO? Speaking for Anthem, I'm the lead for the

department that actually does the prior authorizations. You all give us your care plan. It's typically sixty days and you ask for whatever you think you will need in those sixty days and, then, we either approve it or deny it based on medical necessity.

So, if you tell us we need ten skilled nursing visits for this time span, that's what gets reviewed. We don't have a max, speaking from Anthem.

MS. ASHER: We review based on what's requested - this is from Aetna - what's requested and then we'll determine whether or not that's an appropriate amount based on----

COMMISSIONER STECKEL: So, you would approve whatever is medically necessary according to your guidelines.

MS. ASHER: Right. Yes. We would use InterQual guidelines and determine based on what the findings are and what the plan of care states whether or not it's an excessive amount or if it's an appropriate amount or what it may be.

MS. STEPHENS: We do the same process except with Milliman.

MR. SPALDING: I'll take it

back and find out but I believe it's the same process as well. It's whatever the provider requests.

MS. STOBER: But my understanding is that InterQual does have visit limits on it. So, I could have a hip or a knee replacement patient and we may look at six weeks' worth of care, but Interqual would only up front tell them you need four weeks of care.

So, it's different because InterQual is trying to set some minimum standards because if an MCO is an organization who also does Medicare replacement, they're getting pots of money. They get a monthly amount and they're trying to cut it off and, then, hopefully incrementally add.

We see that when you have a Medicare replacement plan on a regular basis. So, they use the same process for their Medicare replacement plans as they do - the InterQual - as they do with Medicaid, and the difference is is that Medicaid doesn't have visit limits and it's a burden on the agency to have to do that.

COMMISSIONER STECKEL: But it has to be medically necessary. So, if InterQual, which is the group we use, all of us use, says that

it's six weeks or four weeks, and even though you all have said six weeks----

MS. STOBER: They use the minimum standard. And, then, what will happen is we will go back and say, yes, they do need the other two weeks and we'll usually get it approved but we have to stop and do that.

COMMISSIONER STECKEL: So, here is what we would need from you guys is data that shows that exact point. Of 100 requests that we've made beyond the date, you've approved 99% of them. Then, that gives the MCOs more information to work on, but this is a decision that the MCOs would have to make.

MS. STOBER: I think the difference is, too, is InterQual is looking at the total population and a Medicaid population by demographics is way, way, way different than your Medicare replacement plan patients, not all of them but there is some overlap.

COMMISSIONER STECKEL: Sure, sure.

MS. CARTRIGHT: I was going to say, InterQual does not take into consideration the social----

MS. STOBER: Right.

COMMISSIONER STECKEL: But it's my understanding, though, and I could be really wrong on this, so, correct me if I am, that if the MCOs determine medical necessity in a way that's different than InterQual, you could do that. Correct?

MS. ASHER: What we do, speaking Aetna-wise, the way we review, we don't necessarily go by the timelines that InterQual recommends because InterQual is very stringent. A lot of the requests, InterQual will only approve two weeks. We go by the visits.

So, if InterQual says six visits over two weeks, if you're requesting six visits over six weeks, if it meets medical necessity, then, we go by the visit. We don't go by the timeline.

COMMISSIONER STECKEL: But if you need twelve visits over six weeks, how would you make that determination?

MS. ASHER: That would have to go to the Medical Director and the Medical Director would determine at that point----

MS. STOBER: Which takes a

long time.

MS. ASHER: ----because it's outside of the scope of the nurse, what the nurse can approve.

COMMISSIONER STECKEL: Got you.

MS. PURDON: Speaking strictly for Hayswood, I don't think we mind as much requesting it but you have to wait up to like two days before. On our Medicare replacements, we can call and get an answer that day. On Medicaid, we're waiting a very long time. And we're one of those that send it out in good faith and sometimes don't end up with our money.

MS. STOBER: I think the word stringent that she uses was a good term.

MS. PURDON: If we could just get a quicker turnaround on it, we would be thrilled.

MS. DYER: I think that is a big part of it because we have the order to go. And it's my understanding if we have the order to go, we have to follow the plan of care; but if we don't have preauth, we have to--and in EPSDT Special--it happens across all the services that we provide, not

just skilled, but in EPSDT Special Services, if we have the order to go or the orders to see the patient, then, we have to say we don't have preauth and have to offer private pay to somebody who cannot do it. And they're going to turn that down and then they don't get the service.

And in skilled, they might not get a service that is more immediately needed because of the delay, and it can be forty-eight hours to two weeks. That doesn't sound like very long, but if it's a new hip, it's a long time. Even if it's two days, you need to get on out there possibly, or wound care, you've got to get on out for wound care.

So, I think Annlyn brings up a good point and this is not new. We've talked about this a lot of times. It kind of varies between MCOs. It's inconsistently consistent. It goes from one kind to another. It seems like it really depends on who is looking at it, whoever it is, but, again, back to Missy's point, if it's straight Medicaid, we don't really run into that, I don't think, as nearly as much. We don't have the gaps.

MS. STOBER: And in either case, the reimbursement that we get is not so

lucrative that we're trying to excessively utilize visits. I would go on the other end.

COMMISSIONER STECKEL: Well, unfortunately, the good people get caught up because there are bad people out there and we have to set rules based on them, not on you, unfortunately, but I hear what you're saying.

We have a Managed Care Medical Directors' meeting this week, I believe. So, I'd like to put this on that agenda; and if you all will take it back with the idea of how do we turn these things around quicker, then, that would be helpful.

MS. STOBER: There's no way on nights or weekends. If you've got to start a care on a Friday afternoon, the turnaround time, the MCOs shut down all of their authorization processes.

So, even if you have an organization or a place where you have authorization and eligibility that can run and you have a way to do that, it becomes immaterial because there's no one working anything nights, weekends or holidays. So, you're risking patient care because of the lack of turnaround.

COMMISSIONER STECKEL: So, what would be helpful, I think, for both the MCOs

and for us is if you all can quantify the number of approvals that you get versus disapprovals. It says something different to me if 90% are being approved versus 20%.

The other thing, too, that would be interesting is of the folks that you don't get the approvals for in time, how many of them end up back in the hospital?

MS. DYER: And how long it takes to get the approval. Would you like that in there?

COMMISSIONER STECKEL: Yes, please.

MS. DYER: And a breakdown of who does what per MCO, per Medicaid?

COMMISSIONER STECKEL: That would be helpful, yes, because then we can go directly to the MCO. That would be helpful.

MS. OWEN: Speaking from Anthem again, our turnaround time is a strict two days. We're pretty strict. It has to be in and out the door from the time that you all fax it or call it in and we send back your decision. It should always be a two-business day thing. It should never go beyond that.

MS. CARTRIGHT: I think the issue, though, is, like she said, on Friday, you can't get an approval. You have an IV.

MS. PURDON: Or if it gets to a Medical Director.

MS. OWEN: With Anthem, even if it has to go to the Medical Director, it should be two business days.

MR. REINHARDT: But assuming the best-case scenario, so, you guys turn it around in two days, the nurse isn't just sitting there waiting to go and do the visit. They're going to get out there as soon as they can, but you're going to have up to kind of a three- or four-day gap there and, then, who knows what's happened if it's a COPD, CHF and they've had four cans of soup for dinner one night.

So, all those kinds of things. Even if there's some way where we can create some sort of an exception to allow that service to happen quicker and still align with your processes, but to get that nurse out there for the visit so that we can prevent any sort of deterioration in the condition.

MS. STOBER: The majority of

our patients come out on Thursday, Friday and Saturday, at least from the large group of providers that I'm representing.

MS. DYER: That's true of the small ones, too.

MS. STOBER: I thought so. I'm just saying I thought that was everybody but I can't speak for you all.

MS. CARTRIGHT: They work nights, weekends and holidays. In one of my offices, we have six nurses working every weekend because that's just how busy we are.

MS. STOBER: Friday is huge.

COMMISSIONER STECKEL: So, we will raise it at the Medical Directors' meeting and if you all could take it back, that would be great because I know we've got a couple of MCOs that aren't here today. So, we'll talk about it at the Medical Directors' meeting.

MS. BROWN: When is that, Commissioner?

COMMISSIONER STECKEL: Good question. I know what I'm doing today only because I have this. It's this week.

MS. DYER: So, would you like

data over like a month's period of time? How much data would you like?

COMMISSIONER STECKEL: I think a month would give us a taste of what it's going to be.

What else do we have on the agenda?

MS. CARTRIGHT: Talking about the supplies that are excluded from the Fee Schedule is the last topic I think we have.

MR. REINHARDT: Susan who couldn't be here today but she had sent over a list of supplies to Sharley to have a look at. So, we were just looking for feedback on that.

COMMISSIONER STECKEL: I don't know the answer to the question. I'd have to get with Sharley and she is with her camera on some beach in Florida. So, supplies that aren't on the Fee Schedule.

MS. CARTRIGHT: Yes. We sent a list over for Sharley to review.

COMMISSIONER STECKEL: Okay.

MS. CARTRIGHT: Is there anything else? I don't have anything on the agenda.

MR. REINHARDT: We have one

other thing. I know you guys are in the middle of things with EVV but just in terms of the timeline, there's been some discussion my counterparts around the country about 1/1/20 implementation, and I didn't know if you could speak to that at all.

COMMISSIONER STECKEL: No. I know we're looking--EVV is one of our modules in our MMIS. So, we're looking at that. Other than that, everything else would be guessing. So, I don't know. I don't think we're in a position to implement it any sooner.

MR. REINHARDT: No. Other states are asking for--they're at this point----

COMMISSIONER STECKEL: Asking for an extension?

MR. REINHARDT: Yes. They've not gone into the process of implementation. So, they're asking for CMS to give them an extension. So, I didn't know if that was something that was potentially on the radar just being that we're approaching July 1 here pretty quick and would only have six months to kind of gear things up.

And just based on the experience in Indiana, I know a lot goes into that. There's a lot of work there. So, I just wanted to

throw that out there.

COMMISSIONER STECKEL: I'll look into it. It hasn't come to my desk yet. A lot of times, it helps that other states are doing it and we can stand down and take the benefit of an extension.

MR. REINHARDT: Well, even some states that theoretically were way ahead of everyone else, Ohio in particular, has been doing a lot and they're going to ask for a waiver, I believe. They've just had some technical issues because with having to get so many systems to try to communicate to a central repository, there's just a lot of logistics and they've run into some hiccups, it sounds like.

COMMISSIONER STECKEL: And this will be something that will hit Program Integrity.

MS. DYER: Is that mainly in personal care?

MR. REINHARDT: The definition of personal care includes home health in it.

MS. DYER: And then other home health 2023?

MR. REINHARDT: Yes. So, if

you're only doing kind of a select bit of services, that's 1/1/23, but we're basically telling everybody you're carved into the definition. So, 2020 is the date.

COMMISSIONER STECKEL: We'll get to you all on that.

MS. CARTRIGHT: Okay. Thank you.

Okay. Our next meeting is August 13th, and if no one else has anything, I guess we're adjourned.

MEETING ADJOURNED