CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
HOME HEALTH
TECHNICAL ADVISORY COMMITTEE MEETING

****

Via Videoconference
June 20, 2023
Commencing at 11 a.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Annlyn Purdon, TAC Chair

Susan Stewart

Marlene Falconberry (Not present.)

Teudis Perez (Not present.)

Evan Reinhardt

MS. SHEETS: Okay. I have 11 o'clock. I don't believe we have a quorum just yet. It looks like the TAC members that I have on is Annlyn, Susan, and Evan. Are there any others that I may be missing?

(No response.)

MS. SHEETS: Okay. We need one more to have a quorum, so if you want to give it another minute or two, that's fine, or you can go ahead and start and maybe come back to the minutes later. It's however you want to do it.

MR. REINHARDT: Yeah. If you want to give us another minute, I'll try to round up a couple folks.

MS. SHEETS: Okay, perfect. Thank you.

MR. REINHARDT: Thank you.

All right. I haven't heard anything yet. So, Annlyn, Susan, I don't know if you all wanted to go ahead and just get started, and then we can come back to the action items, hopefully, once someone else jumps on.

MS. STEWART: That's fine with me, Evan.

MR. REINHARDT: All right. Annlyn, I'll let you take it away.

MS. PURDON: (Inaudible.)

MR. REINHARDT: We can't hear you, Annlyn. I don't know if you're on mute or.

MS. PURDON: (Inaudible.)

MR. REINHARDT: Yeah. It's not working now for some reason, Annlyn. I don't know if you -- can you select a different microphone option with the little arrow to see if it's on the one you need?

(No response.)

MR. REINHARDT: You want me to go ahead and jump in, Annlyn? Does that work while you're working on that?

(No audible response.)

MR. REINHARDT: Okay. All right. Well, we'll go ahead and get started with old business, which is really kind of a group of recommendations we had made previously related to home health reimbursement rates, which, I think, are now, at this point, 15-plus years haven't

been changed. So we had recommended an increase to home health reimbursement rates. Likewise, for supply reimbursement rates, and a sort of policy consideration change to add supply-only to DME services, as well as a publication of limits for MCOs and standardizing supply quantity limits.

So those were all recommendations that were made previously. So just checking in with DMS to see if we have any feedback on any of those recommendations.

MS. SMITH: Evan, I do not have any feedback. Sorry. I think we're having some -- can you all hear me? I know I hear some, like, background -- kind of some screeching or some noise in the back --

MR. REINHARDT: Yep.

MS. SMITH: But we're --

MR. REINHARDT: Yeah, we can.

MS. SMITH: -- still looking at those. I will add the -- there was, prior to -- oh, thank you, Susan. The PleurX drains, yes. We are -- the intention is to add that, the coverage for that. I need to do the change order.

Some of the supply-only -- so there was a change order. Before home health moved to our division last year, there had been a change order done. That was only, though, for individuals under the age of 21, so it was for children. So in looking at just in general the whole supply-only, or just supplies in general and what makes sense to be on home health fee schedule versus what makes sense to be on DME.

Would also probably like to open that up to talk to you all about -- in the future, I don't know, maybe we might do a survey, or do, like, a webinar to have some discussions about supplies just in general, and what makes the most sense for what you all think, too, since you all are the ones out there doing it.

So -- and then we are still looking at the rates. So, Evan, sorry. I don't really have an update other than we haven't forgot it. We are looking at it, and I will be doing a change request on the PleurX drains. We've decided that that is -- we do want to cover that and add that to home

health, so we will be doing the change request with the MMIS to get that done.

MR. REINHARDT: Great. That's good news on PleurX. How can we, I mean, can we work directly with you, Pam, to follow up on any of that, or --

MS. SMITH: Yeah, you can.

MR. REINHARDT: Okay.

MS. SMITH: Yeah, you can just follow up with me.

MR. REINHARDT: Perfect. All right. We'll stay on top of that. So no other updates otherwise, Pam?

MS. SMITH: Not on that.

MR. REINHARDT: Or --

MS. SMITH: I think we're going to talk about the big thing in the new business. So I'll wait 'till we get down there.

MR. REINHARDT: Okay. Sounds good. All right. That's it for old business. Susan, anything else for the moment, or Annlyn?

MS. PURDON: No, that's all I had.

MR. REINHARDT: Oh, perfect. Do you

want to take over, Annlyn, or do you want me to keep going?

MS. PURDON: Oh, you just keep going; you've done so well.

MR. REINHARDT: All right. All right. New business: Home health CON changes. You know, we wanted to make the group aware of the proposed change for the certificate of need program in in-home health that's been, I think, at this point, sort of just recommended or proposed for the state health plan. And that change would allow hospitals, nursing homes, and one other group that I'm forgetting just at the moment, and I'll find that here in a second, but would allow them to have non-sub -- or non-substantive review for any CON that they put forward for home health.

The issue, as we've been sort of explained on this particular topic, is that for hospitals, they've run into some difficulties here and there for discharging patients in particular situations. This is something that, you know, we're very keen to try and address, and we've submitted some

comments to, you know, to really try to push back on the notion a little bit that home health agencies are out there not accepting patients because, you know, particularly our group is very interested in going above and beyond to try to admit as many folks that are appropriate for home health services as possible.

So we have submitted some comments to the OIG on that topic, as well as a number of other groups to try to address that, but I think the biggest upshot here is if a change like this were to be made to give hospitals in particular, you know, somewhat unfettered access to the home health arena, you know, without having the traditional certificate of need process, that really puts some downward pressure on agencies. With hospitals, the way that they can function, and, you know, operate, and have programs, and funding that home health doesn't have access to that facilitates them, you know, as well as having the size and scale that traditional home health doesn't have. You know, this could

potentially be some serious and ultimately really kind of devastating competition that would be put out there.

So really have some great concerns with that proposal that's been put forward. We've been talking with the Office of Inspector General to make sure, you know, we've been transparent in all of those discussions about where we stand. And we've also offered an alternative because, as it stands right now, a hospital can already provide care for an individual patient in that same circumstance so long as they provide the OIG with documentation and evidence that they have attempted to, you know, place that person in a home health agency.

So really, you know, it's already something that they can do. This change would, you know, make it at a scale that, you know, really hasn't been seen before in terms of allowing hospitals and nursing homes to provide services really, you know, as they see fit. Because while you still have to have a hearing under non-sub review,

you know, you're in a situation where none of the traditional requirements for CON exist.

So with that, I don't know, Susan, Annlyn, if you have any additional comments, but really that was just -- we wanted to make the group aware of that proposed change. And comments were due right at the tail end of May, so, you know, I think the OIG is processing those comments, and, you know, putting them under consideration, and may, hopefully, look to make some changes in the proposed language in the state health plan.

So that's where things stand now, but we just wanted to make the group aware of that and have any appropriate discussion that we might need to have. So, Susan, Annlyn, I'll let you all -- if you have any additional thoughts or comments.

MS. STEWART: Well, my comment is I am part of a hospital system. So I, you know, have a unique perspective on that. From -- one, I'm associated with, and it has opportunity for me, but it also has concern

for me to think that other people could come into our space. We -- the hospital systems have the same problems that we do. It's not about us not being able to take care of them. They can't find staff to staff a hospital, either.

So, you know, I would just caution that it's not a true fix for the problem, and adding more people to the mix does not mean more patients are going to -- more patients with multiple payers, including Medicaid, will be taken care of.

And that's my politically correct answer.

MR. REINHARDT: Annlyn, anything else to add there, or just leave it at that?

MS. PURDON: Nope. I think Susan covered it.

MR. REINHARDT: All right. Any other comments from the group?

(No response.)

MR. REINHARDT: All right. We'll move on to the EVV update. So really, I'm curious to know, Pam, you've indicated to us that we've got a contractor selected. So

really wanted to just see where things stand as far as that goes. Any additional launch details, and, you know, I think our group really just wants to reiterate our concern about readiness for moving forward.

You know, I think folks are doing their best to kind of stay up-to-date, but, you know, really want to make sure we're really ready to go once that program's ready to launch. So I'll turn it over to you, Pam, for further discussion on that.

MS. SMITH: So Therap is our -- is the selected vendor. They have been doing EVV for many years. They're in many other states. We actually have some providers that are using Therap.

We had a kickoff -- well, our second in-person meeting with them yesterday. And coming out of that, we are going to begin the, you know, reaching out to -- there'll be communications going out to providers about expected timeline, training. I think there probably will be some -- potentially a survey that goes out to kind of capture preferred methods of training, some

preferred, you know, just some knowledge barriers.

The system, from what I -- what we saw yesterday, the demo, very user-friendly, very intuitive to use. I think that things are going to move quickly because, obviously, they have to. We have a 1/1/24 deadline that's looming out there. Therap is the name of the provider. It's T-h-e-r-a-p.

So news: So look for, you know, in the coming -- you know, in the coming couple of weeks information coming out about how we're going to approach training, just general information about them. Really excited, too, after we met with them yesterday and saw, you know, additional demos of the product. I think that they are going to be a good fit for Kentucky, and like I said, they are in use in Kentucky by some providers already. I don't know if it's more on the personal-care side, or I think we do have, maybe, a home health agency that is using them today. But they're going to be -- they are up for the

challenge. They've done this quickly in other states, so I think that we will, you know, things will start happening soon.

We're working with the different MCOs because, of course, this is a different component with this than PCS is that we have, you know, the MCO piece of that, as well. As far as the MCOs go, there'll be, you know, there's an option whether the MCO wants to use Therap as their, you know, as their EVV solution, or allow individuals to have third parties. But Therap will be the aggregator for everything, meaning all of the data will come from -- everybody ultimately will end up in Therap for us to do reporting.

But -- so change is to start happening quickly, information to start coming out quickly, but very excited to welcome Therap on board, and to get started.

MR. REINHARDT: Thanks, Pam, and --

MS. STEWART: Would -- I have a question.

MR. REINHARDT: Go ahead.

MS. STEWART: Would it be beneficial

to have Therap come to, maybe, our next meeting, or schedule a one-off meeting with them, so that -- as a provider, you know, I'm not sure what I should be doing from a system standpoint.

MS. SMITH: I think there'll be a larger webinar, Susan, versus bringing it to the TAC where we're not reaching everyone. So I think there'll be larger -- a larger webinar where, you know, any home health agency is encouraged -- which I know they can attend, you know, they can attend the TAC, as well, but where we will cover, specifically, just EVV, and where it will be, you know, encouraged.

And then, we will also record it, so that anybody that's not able to attend -- but, yeah. We're absolutely planning on doing that sooner versus later so that there's more information --

MS. STEWART: Can you make sure that Evan gets those training dates so he can send it out to the membership?

MS. SMITH: I will. Yes, I will do that.

MS. STEWART: Thank you.

MS. SMITH: Mm-hmm.

MR. REINHARDT: And they're going to be at the conference, Susan, so that will be another touch point. They're going to do a separate session and have some folks at our conference in August, so that will be a good touch point for them.

MS. SMITH: And we also talked to them yesterday about -- and we couldn't do this with PCS because, you know, it hit right during Covid, but also doing some in-person sessions, so doing some town hall-type sessions across the state, as well, so.

MR. REINHARDT: Great.

MS. PURDON: This is Annlyn. Can you hear me?

MR. REINHARDT: Yep.

MS. PURDON: Okay. Did you say that the MCOs can select a different vendor?

MS. SMITH: They can. Yes.

MS. PURDON: Okay. I just -- I have lots of fears about this. Well, like, I've never even heard of that, and everything

I've talked about with my software vendor, is it all going to one place? And, of course --

MS. SMITH: Well, and it does. It's the aggregator. So Therap is the aggregator, but we, as Kentucky, chose an open model, which means that we provide a vendor for free, which is Therap. Or agencies, and we have several agencies that already had been using EVV --

(Frozen.)

MS. PURDON: Am I the only one that has to --

MS. SMITH: -- they -- third parties have to send that to the -- have to send that to the aggregator, but they can continue to use their third party vendor. So if they've hired -- if they have purchased a different software, for example, ClearCare is a big one. Then they can continue to use that. That data just has to be sent to the aggregator, which in this case is Therap.

MS. STEWART: So, can I -- I have a question. So if you are a home health

agency, and you have the MCOs pick different vendors, so we would have to potentially contract with five different vendors to be able to submit our information depending on what vendor the MCO chooses?

MS. SMITH: That would --

MS. STEWART: -- and is there a financial -- is there a financial aspect related to being with each vendor for the provider?

MS. SMITH: Not if you choose the vendor that is offered. So, for example, if you chose to use Therap, then there is not a cost to you as an agency for that. The cost would come if you decided to purchase your own software. So if you decided to purchase your own software and have your own EVV vendor, that cost would be on your agency. But if you choose to use what is offered by the state, then, no, there is no cost to that agency.

MS. STEWART: So if the -- if I don't know, I'll just use WellCare. If WellCare chooses that other vendor you suggested, that's their choice. We still use Therap.

MS. SMITH: So --

MS. STEWART: I guess I just don't understand.

MS. SMITH: And to be honest, Susan, we kicked off yesterday, and so we have not had the MCO kick-off. So I really cannot answer -- I don't want -- to be fair, I don't want to answer those questions yet just because I don't want to give wrong information.

So I think we need to still have that conversation with the MCOs. That is coming -- that meeting is coming up, and then we will share. Obviously, we know time is critical, and we need to share that information with you all, but I don't want to share incorrect information.

MS. STEWART: Well, and the reason I ask is because immediately after I got -- I was notified that Therap was the chosen vendor, I reached out to my EMR and said, "This is the vendor for Kentucky." And we -- they already work with Therap, that should be good to go. But if the MCOs have -- require us to do something different,

then I would have concern. And I guess I just -- more to come because I just don't understand it.

MS. SMITH: Right, I think we just don't have the answers -- I don't have answers to that right -- I -- we do not -- the intent is not to make it difficult and burdensome on the providers. I just have not had the opportunity -- now that we've chosen Therap, everything's been signed. To be able to have that, we have not had that kickoff meeting with the MCOs yet. That is coming very soon, so I don't want to give incorrect information right now.

MR. REINHARDT: Just to clarify, Pam, though, so each of the MCOs can choose their own aggregator that would then --

MS. SMITH: No, no.

MR. REINHARDT: -- have to communicate with Therap, or --

MS. SMITH: No. The aggregator is Therap for everyone.

MR. REINHARDT: Right, but you're saying that each MCO can choose their own individual --

MS. SMITH: Some of them already --

MR. REINHARDT: -- EVV provider.

MS. SMITH: Some of the MCOs already have EVV vendors. They already -- in the initial survey that we did with them, some of the MCOs are already using EVV. So they already have a vendor and have been using that -- that's been in place. They still will require -- be required to send that data to us.

Now, if they are going -- I don't know what choices they're going to make. If they -- it may be possible that they change with, you know, with Therap being our provided solution, I don't know. I can't answer those questions yet, Evan.

MR. REINHARDT: But just a -- I mean, from an individual provider perspective, you know, they get to still select their own EVV provider, and then, if an MCO has a different one, they would just have to connect, you know, and have those two communicate, you know? That's --

MS. SMITH: It has to come --

MR. REINHARDT: -- that's the step.

MS. SMITH: -- it would have to come to Therap. Yes, that's part of -- as the aggregator.

MR. REINHARDT: Okay.

MS. SMITH: Yes.

MR. REINHARDT: And, Susan, most of the time, the individual EVV providers or EMRs, you know, they generally spread that cost across all of their customers, or, you know, take it on themselves to connect and be able to communicate with any of the other ones that they're not already hooked up with. So we can help navigate that one, though.

MS. STEWART: Thank you.

MR. REINHARDT: All right. Anything else on EVV? Thanks, Pam, for the update.

MS. SMITH: No, just more to come.

MR. REINHARDT: Yeah.

MS. SMITH: And it will come quickly.

MR. REINHARDT: Yeah, lots to do before 1/1.

All right. Next topic is claim modifier requirements for each MCO. So this one came out of, I think -- particular -- in

particular, started with Aetna, where there was not necessarily a requirement to do modifiers for therapy billing, but a preference for adding those modifiers.

And so, I think there's been some discussion about whether these are going to be required in the future or not. So I'm throwing that out there, both for the plans and Aetna specifically, but just in general as a question, you know, will modifiers be something that we see has a requirement in the future? And does anyone currently, you know, think -- have a requirement on their end?

MR. OWEN: This is Stewart Owen with WellCare. We do not have anything other than what DMS uses, you know, the standard coding guidelines and DMS guidelines. I checked with our staff, and we don't have any unique requirements for modifiers.

MR. ELLIS: Yeah, and this is Herb with Humana. We also default to the standard that the state uses. I will say there are -- but we do follow also the NCCI edits on -- only when it's an accurate edit

that's required, and the state is silent on. Other than that, we default to the state's billing requirements.

MS. PAGE: Hi, this is Anna from Passport. And we follow the same as the other MCOs.

MS. LEWIS: Hi --

MR. COLLINS: And this is Shaun Collins from Anthem. We follow the same as the rest of the MCOs, as well. Thank you.

MS. LEWIS: Hi, this is Suzanne from United Healthcare. I believe we follow the same. I don't believe there are any specific modifiers, but I would need to confirm that with my team. So I'll have to get back to you to confirm.

MR. REINHARDT: Thanks, Suzanne. I'll put my e-mail in the chat, so if you want to get back to us on that.

MS. LEWIS: Yes. Thank you.

MS. RISNER: And this is Krystal with Aetna Better Health. Can you all hear me?

MS. PURDON: Yes.

MR. REINHARDT: Yes.

MS. RISNER: Okay. Aetna does have

the modifier policy that became effective, I believe it was 6/15 of '23, and that notice was sent out to all providers.

However, I've been speaking with Annlyn, actually, about the requirement, and I do think that it plays into home health a little differently than it would with our standard PT OT ST therapy services. Because you all do use revenue codes to bill those, and it's set up in our system, you know, to look at those revenue codes, details, etc.

So those modifier requirements is to identify, like the PTA, or whatever that may be. That's billing, but it's more so for those 900 codes and so forth. But if anyone has any questions about those, you can always reach out to me, and we can walk through those.

MS. PURDON: So, Krystal, in the end -- this is Annlyn. Do we need to put the modifiers on there or not? Because I think in our last e-mail it was to use different G codes for PTA, as compared to PT and OT and OTA to differentiate those.

MS. RISNER: Yeah, because home

health is, like I said, it's a little different with the billing where that it's revenue code based, and not specifically those 900 codes or so forth.

I would suggest using the appropriate G code for the PTA versus the PT. But I do think, you know, it bases the payment, and everything is driven off that revenue code. And because that rate is, like, a standard fee, the modifiers is kind of -- they distinguish which payment applies for other provider types. So a PT may receive a higher reimbursement than a PTA does.

MR. REINHARDT: Is that something, Krystal, that's possible for us to kind of collaborate on and get something in writing that we can send out to the membership? I know you guys sent out --

MS. RISNER: I --

MR. REINHARDT: -- the notice, so if we can start there, that'd be awesome.

MS. RISNER: Mm-hmm.

MR. REINHARDT: And then --

MS. RISNER: We have notice. It's posted on our website. We also sent that

out to anyone that signed up for our network notices that goes out.

MR. REINHARDT: Okay.

MS. RISNER: So that was, I believe, on 5/15 is when that notice was sent out because it didn't actually go into effect until 6/15. But I'll be more than happy to get that over to whoever needs it. I can put my e-mail in the chat.

MR. REINHARDT: Perfect. Thank you. All right. Anything additionally on that, Annlyn?

MS. PURDON: No, I don't think so. I just -- I just think it's something that the MCOs should look at. Since I do a lot of the billing or train the billers, I get all the time from the MCOs, "Oh, we do it just exactly like Medicaid." And that is never true.

And then, they don't want to tell you how they want it done. They want to just say, "Well, you should do it like Medicaid." Well, when I bill like I do Medicaid, you know, Medicaid doesn't use G codes. Medicaid is a three-two-one type of bill.

Not another MCO accepts a three-two-one type of bill.

MR. REINHARDT: Mm-hmm.

MS. PURDON: So I just really wish that they would tell the truth on what their billing rules are, and the same with modifiers. We don't bill any modifier to Medicaid --

MR. REINHARDT: Yeah.

MS. PURDON: -- and WellCare requires modifiers on their supplies, you know, and then, whenever you talk to them about it, it's like, well, this is what you do for Medicaid. And, no, it's not what we do for Medicaid. And then they say, well, you know, we can't tell you how to bill.

MR. REINHARDT: Right.

MS. PURDON: That's your responsibility. And I'm like, well, you're just making me guess.

So I just really wish they would all come up with a real and true guideline of how they want things billed. Because what they do is come back on audit, and I spend countless hours changing, rebilling, fixing,

you know, for stuff that we should have been told how they wanted it billed in the first place.

Anyway, that's my rant for the day.

MS. STEWART: And, Evan, that falls right in line with our supply issues. Not knowing the billing quantities, you know, it's the same principle there.

MR. ELLIS: So this is Herb with Humana. Maybe it would be good to take Aetna's modifier policy and just have all of the MCOs take a look at it, and be very specific to that particular modifier requirements and see if that's something that would impact the other MCOs. I --

MS. STEWART: Well, why don't we get MCOs to follow Medicaid's policies?

MR. ELLIS: Oh, we -- well --

MS. HARRISON: This is Samantha with Humana Healthy Horizons --

MS. PURDON: You were getting ready to say that you follow Medicaid.

MS. HARRISON: Well, we do follow Medicaid policy. So as you've been talking, the lady from Hayswood Home Health, I'm

sorry, I don't know your name.

MS. PURDON: Annlyn.

MS. HARRISON: Hi. We can certainly go back and see if there's a challenge with like you said, the type of bill, how we're set up. Because we basically take the Medicaid billing instructions and provider-level manuals, and we built our system based on that. But if you're experiencing a challenge, we would love to have some examples so that we can take a look and do an investigation to see what's different. What maybe isn't set up the way the billing guidelines require for home health. Happy to do that if you're willing to provide some examples.

MS. PURDON: Oh, sure. And I'm sorry. I didn't catch which MCO you were with.

MR. ELLIS: Humana.

MS. HARRISON: Yeah. Humana Healthy Horizons.

MS. PURDON: Yep. Do you want me to send them to my provider rep -- the examples?

MS. HARRISON: I would ask that -- I'm going to put the e-mail address here. It's our compliance e-mail that utilizes -- gets all the information for TACs, so I'll put that in the chat. Okay?

MS. PURDON: Okay. Yeah, it would be nice if everybody went by the true Medicaid billing guidelines, or I don't even care what the rules are. Just somebody tell me what they are and how they want it done, and then that's how I'll do it. Just so long as I don't have to guess and get a denial, and guess again, or get an audit, and then fix everything, and try it all again.

MS. HARRISON: So it's in the chat, the e-mail address. So, please, you know, send that information to HumanaKYMedicaid@Humana.com, and we'll start researching those examples.

MS. PURDON: Okay.

MS. HARRISON: Thank you.

MS. PURDON: I will get them sent.

MS. SHEETS: And this is Kelli. I will send everything in the chat out to the TAC members, so you don't have to worry

about taking extremely detailed notes.

MR. REINHARDT: Awesome, thank you.

MS. PURDON: Thank you.

MR. REINHARDT: I think our next topic is along those same lines, right, Susan? About the billing of supplies, revisiting that discussion, and what are the current policies for each MCO, and, you know, what do providers need to know to bill supplies?

MR. OWEN: This is Stuart with WellCare again. And, you know, I met with our claims configuration team with home health, and they said we follow DMS's requirements. We don't have anything unique for supplies.

MR. REINHARDT: Thanks, Stuart.

MS. STEWART: But I think, you know, did you say you were with WellCare? Well --

MR. OWEN: Yes, yes.

MS. STEWART: -- on your side, you might not have any unique issues, but on our side, I'm pretty sure we do have issues with billing quantities and limits with WellCare. My revenue cycle manager is off on FMLA, so

I can't give you a specific example right now, but that was -- WellCare is what started this entire conversation multiple years ago.

MR. OWEN: Billing requirements -- I mean, limits to me is different than billing requirements. I know we do have some CMS proprietary edits that we don't publish -- limits that we don't publish.

MS. STEWART: That's what we're after is what you don't publish because --

MR. OWEN: Oh, okay. Well, I thought it was billing requirements, and we're the same for that. But, yeah, and we actually checked with CMS, the medically unlikely edits, MUEs, and it is proprietary. And we actually checked with CMS, and they're not allowed to be published, so we do not publish those. We do not publish those limits on our home health fee schedule.

MR. REINHARDT: How do we square that circle, Stuart?

MS. STEWART: Can we --

MR. REINHARDT: Yeah, in terms of the provider not playing a guessing game with,

you know, what the supplies limits are? Is that --

MR. OWEN: Yeah.

MR. REINHARDT: -- something you can communicate to each individual provider rather than, you know, publishing, or how can that --

MR. OWEN: Well --

MR. REINHARDT: -- best be understood?

MR. OWEN: -- I mean, the limits are published, like I said, except for the ones -- the proprietary. And the reason why CMS does not publish them is because it's a fraud, waste, abuse concern that if they publish those -- and it's a higher -- I think if it's anything over four, I believe it is, but if they publish it then the concern is the providers will just happen to bill that amount where the limit is instead of what, you know, the plan of care -- the unique plan of care that's member-centric. But otherwise, I mean, we do publish what the limits are. But we can -- I mean, we checked with CMS, and they said no, you

cannot publish these.

MS. STEWART: So, Stuart, can you tell us the difference between -- so give us an example of what is a nonpublished supply and what is a published, and explain why one is one way, and one is another?

MR. OWEN: Well, according to CMS's website -- and again, you know, we publish ours. But I believe it's anything over four; where the limit is anything over four, CMS does not publish it.

MS. STEWART: And what do you mean by anything over four?

MR. OWEN: The units. They're called medically unlikely edits, MUEs, and they've got a website, a CMS website addressing it.

MS. STEWART: And if I'm not mistaken, four by fours are one of those items.

MR. OWEN: That are CMS MUEs?

MS. STEWART: I think so. And, Annlyn, correct me if I'm wrong, and that might just be the example that I've always had in my head. I don't know, but I mean, it's just an unnecessary administrative

burden, and, I mean, you bill, rebill, bill, rebill. Trying to know -- I mean, you deny the whole line. Why can't you just pay up to what the limit is instead of denying the entire line?

MR. OWEN: Well, I mean, that I don't know. If you could send me a couple of examples, I'll have that vetted with the team and look into that.

MR. ELLIS: Yeah, and if you have examples for, I think, Humana, we'd be interested in knowing that, as well, if you're seeing that on our side.

MR. COLLINS: Same with Anthem. Feel free to drop me an e-mail; this is Shaun Collins. I'll put it in the chat again.

MR. OWEN: Yeah, I'll put mine in there, too.

MS. SHEETS: This is Kelli. If you all just want to send me those, I'll get them to the MCOs. I'll drop my e-mail in the chat.

MR. OWEN: And we'll just have to make sure we don't get each other's -- because of HIPPA -- each other's

information.

MS. THERIOT: So, hi, Stuart. This is Dr. Theriot. So, like, if I was going to do a wound or dressing changes, and I had to do them twice a day, then I would, you know, guesstimate how many, you know, four by fours I was going to need, and then order that amount versus --

MR. OWEN: Right.

MS. THERIOT: -- saying give me the max. Is that what you're --

MR. OWEN: Yeah. I mean, the concept is you develop a plan of care, you know? You assess the member's needs and develop a plan of care based on that, and then request that authorization based on that.

MS. THERIOT: That makes sense.

MS. PURDON: So you do know, Stuart, that WellCare does not require authorization. So --

MR. OWEN: Well, there you go.

MS. PURDON: -- we come up with the plan of care, and the nurse guesstimates what the patient needs. There is no authorization. If you were to call WellCare

and try to get an authorization for supplies, you're going got be told that it does not require authorization.

MR. OWEN: Okay.

MS. PURDON: So then we provide the supplies, bill it at the end of the month, and then just don't get paid. That's truly how that works.

MR. OWEN: Okay. If you can send me some examples, I will definitely, you know, huddle with the team to look at them and research that.

MS. PURDON: And then also, just so you know, where your team said that you all didn't have any special billing requirements, you all do require modifiers on your supplies. On all of your logical supplies and all Loom Care supplies. That is --

MR. OWEN: Okay.

MS. PURDON: -- not what we bill to Medicaid -- how we bill Medicaid -- traditional Medicaid. So, yeah, they have come up with their own little modifier structure, and it's different than how I

bill modifiers to Humana, also. So I just learned by trial and error how WellCare likes it.

MS. STEWART: And just so you guys have an understanding on our side, from my seat. My business office and my clinicians are in two separate places. So the clinicians do create a plan of care and give supplies based on said plan of care. And then, the business office bills based on what is distributed, and, I mean, the clinicians have no idea really if it gets paid or not.

So, I mean, your mindset's kind of off there in that -- when it comes to fraud and abuse. Maybe for scrupulous agencies, so I always suggest, you know, you punish them instead of the good guys. And I consider myself a good guy.

MR. OWEN: Yeah, I mean, CMS controls the MUEs, the medically unlikely edits, and what's not published.

MS. STEWART: But you could --

MS. PURDON: But then, how does -- how does CMS and Medicaid publish the DME

fee schedules? I look at them. They have limits on them. I mean, it's not like they don't publish theirs. Medicaid publishes one.

MR. OWEN: Yeah, and I mean, I don't know. I mean, this is literally from the CMS home health website regarding this, and it may, you know, vary with DME. I mean, I know there's spillover -- there's crossover with DME. But there are, you know, certain ones where CMS -- it's proprietary, and they will not publish it. And it's on their website. And --

MS. SMITH: We also have to --

MR. OWEN: -- the patients --

MS. SMITH: -- we also is Medicaid. We have to follow those MUEs, as well, and so we don't -- they are different than the limits that are on the DME fee schedule. And so, I mean, as Stuart is speaking, we don't publish those either. We can't. CMS does not allow it, but we do also follow those same edits.

MS. STEWART: And, Stuart, our frustration is not at you.

MR. OWEN: Thank you. I appreciate you saying that.

MR. REINHARDT: We'll start with that one next time.

(Laughter.)

MR. REINHARDT: No, but we appreciate the dialogue, but this is, Susan, this has been three years, I think, that we're, you know, trying to really chase this down and --

MS. STEWART: It's been three years with you, Evan. It was a long time before that, as well.

MS. PURDON: It's been ever since I've been on the TAC.

MR. REINHARDT: Yeah. So that's why there's a little bit of frustration. I mean, it's a long pattern of, you know, we don't know what the target is, and we're -- that's all we're trying to do is just hit the target.

So any help you can provide us as we're trying to narrow this stuff down, we appreciate it, and we'll definitely follow up, you know, both within the TAC and

within, you know, our separate discussions with the MCOs to try to get some progress made on this.

MR. OWEN: Yeah and --

MS. STEWART: And maybe I need to manage my staff to the point where we don't distribute supplies like we do, but we really do do what's needed for the patient, and we don't worry about that. But we would like to get billed for everything that possibly could be billed for and collected on.

MR. OWEN: I understand. And again, we definitely appreciate examples because anytime I talk to them about an issue, they'll say give me examples. Give me examples so we can research so we always need those.

MR. REINHARDT: Right.

MS. PURDON: And, Stuart, just so you know, in the five years we've been doing this, examples have been given before.

MR. OWEN: Okay.

MS. PURDON: I mean, you might be new to this one, but we've done this many times

over. And I'm just more confused as we talk because I'm looking at the Kentucky Medicaid home health fee schedule, and I'm looking at ostomy patches, the 60 per calendar month. Some of them are 31 per calendar month, you know? Diapers: It says they get 192 per month. Chux or underpads: They get 150 per month. So they tell things that go over for.

MR. OWEN: Yeah, and, you know, I mean, the MUE edits, I presume it doesn't apply to that, so that's probably not a broad policy or whatever, but I just know on the website they talked about that, the MUEs. I'm sure there are some things that are not subject to the CMS MUE edits/limits.

MR. ELLIS: Yeah, I mean, they're unlikely, right? They're unlikely units for that item in question.

MR. REINHARDT: All right. Any other discussion on the supplies? Susan, Annlyn, we're good on that for the moment?

MS. PURDON: Yeah, we've beat it to death for today.

MR. REINHARDT: Well, we'll revive it

and bring it back per the next TAC and do some follow-up in the interim.

All right. General discussion: So first topic, we'll go updates from any MCO -- any -- from all of the MCOs related to common billing issues, common PA issues, or any other home health-specific issues you have to share.

Stuart, since you're in the hot seat, we'll come right back to you.

MR. OWEN: Yeah. Keep it rolling. So when I talked -- the only thing that the staff told me is that regarding stuff that's more of, I guess, would be a DME supply that home health can bill, sometimes providers don't include the manufacturers to invoice. That's the only thing that they said is an issue that they're aware of. I don't know, I mean --

MR. REINHARDT: That's for GME across the board to include the risk factors?

MR. OWEN: Yeah. I mean, the context was home health, and, I mean, I guess there are some. I don't know, maybe not. Some home health that you can bill, or maybe not,

but they -- when I asked them, they said that was the only thing that they were aware of. So I know that's DNE.

MS. PURDON: That's DNE.

MR. OWEN: Okay. It's just solely DNE? Okay. All right. Then we got nothing else then.

MR. REINHARDT: All right. Thank you.

MS. PAGE: Hi, this is Anna from Passport. I don't have anything to share. I wanted to know if anybody has anything for me for Passport.

MR. REINHARDT: Thank you.

MS. PAGE: Thank you.

MR. REINHARDT: Hearing nothing, we'll go on to the next one.

MS. OWENS: Hi, this is Holly with Anthem. And we also have none to report at this time.

MR. ELLIS: This is Herb with Humana; same. Though I will say I am definitely interested in going back to that prior conversation. Anything that you're seeing issue-wise for claims for Humana, we

definitely want to know about them and maybe do something, working with you all to improve the quality of those edits in our front door so that we'll see immediately if something was done wrong under claims.

MR. REINHARDT: Thanks, Herbert. We'll be happy to provide you some examples. We're going to get -- huddle internally and get back with you all for sure.

MR. ELLIS: Thank you.

MS. LEWIS: Hi, it's Suzanne from United Healthcare. The only issue that we had, and this isn't, like, super recent, but -- and you all kind of touched on this earlier. The only issues we've had have been with some of our more rural counties, finding home health staff. Hearing that, you know, again, it's just been a challenge that home health agencies have with staffing right now.

And I know we had, I want to say a couple months ago, you know, some difficulty with some of those harder-to-reach areas, but nothing, like, recent comes to mind within the last 30 days or so. And I know

that -- excuse me, sorry. I know that staffing is still an issue, just based on what I've heard in this discussion today.

I don't know of any billing issues that we have or any trends or anything, but I can certainly take that back to my team and ensure -- I haven't heard anything on the PA side either, but if you have any -- anything for United, you guys, I put my e-mail address in the chat, and you can please feel free to reach out to me, and let me know examples. As everybody has said, if you have specific examples of anything that you want to send our way and we can look into, I'm happy to do that and bring it back to you.

MR. REINHARDT: Thanks, Suzanne. And I think that just leaves Aetna.

MS. RISNER: Hi, this is Krystal with Aetna. We don't have any known billing issues. I've not really heard of any kind of trends from our PA department, but as always, you know, if there's any issues that come up or anyone sees something that they have questions about, please reach out, and

we will take a look at those and see what we can do to assist.

MR. REINHARDT: Thanks, Krystal. All right. I think we're onto any updates from DMS. Anything additional to share?

MS. SMITH: I don't think we have anything additional to share that we haven't already talked about.

MR. REINHARDT: Thanks, Pam. Anything direct from Commissioner Lee?

MS. SMITH: No. I do not have any updates from the commissioner.

MR. REINHARDT: Okay. Recommendations: I don't think we have any recommendations for today's meeting.

MS. PURDON: No.

MR. REINHARDT: And on the MAC meeting side, Susan will be at our -- be our representative at the next MAC meeting. And our next meeting is August 15th. And I think that's all we have for today.

MS. SHEETS: Hi, again. This is Kelli again. I just wanted to remind you that because we didn't have a quorum on this time, that you will need to approve the

minutes at the next meeting in August.

MR. REINHARDT: Good.

MS. PURDON: Okay.

MR. REINHARDT: Yeah, thanks for the reminder.

MS. SHEETS: Sure.

MR. REINHARDT: All right. Unless anyone has anything else for the good of the order, I think we can go ahead and adjourn.

(Meeting adjourned at 11:56 a.m.)

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CERTIFICATE

I, Tiffany Felts, CVR, Certified Verbatim Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 9th day of July, 2023.

Tiffany Felts, CVR

Tiffany Felts, CVR