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

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Via Videoconference
August 12th, 2025
Commencing at 11 a.m.

Tiffany Felts, CVR
Certified Verbatim Reporter

APPEARANCES

TAC MEMBERS:

Susan Stewart
Janet Marlene Reynolds
Annlyn Purdon, TAC Chair
Teudis Perez (not present)
Evan Reinhardt

MS. BICKERS: Good afternoon. This is Erin with the Department of Medicaid, and by "Good afternoon," I mean, good morning. It's almost 11 o'clock and we're still clearing the waiting room, so we'll give it just a moment before we get started.

MR. REINHARDT: Thanks, Erin. I think Annlyn was trying to log in --

MS. BICKERS: Okay.

MR. REINHARDT: -- so she may need --

MS. BICKERS: Okay.

MR. REINHARDT: -- another minute or two.

MS. BICKERS: I see a couple people pending in the joining area, so --

MR. REINHARDT: Thank you so much.

MS. BICKERS: You're welcome. A little off my game. We had a fire alarm about 45 minutes ago, and it just kind of threw me off, so.

MR. REINHARDT: Well, that'll throw your day off for sure.

MS. BICKERS: Yeah.

I think Annlyn's coming in under "set up." It still just says it's joining and

pending.

MR. REINHARDT: Sounds good, thank you.

MS. BICKERS: Yeah, we'll give her a moment longer.

Okay, it does look like the waiting room is clear. I think Annlyn is on the set up and maybe is trying to get her camera on. I see they keep coming on and off mute.

MR. REINHARDT: Annlyn, can you hear us?

MS. PURDON: Oh.

MR. REINHARDT: If it doesn't work, she's --

MS. PURDON: I hear you. Can you hear me?

MR. REINHARDT: Oh, there we go. All right. Yeah, we can hear you.

MS. BICKERS: Okay --

MS. PURDON: I'm still trying to get my video to work. It's supposed to be on, but, oh, man, this computer.

MS. BICKERS: Are you on a laptop?

MS. PURDON: Yes.

MS. BICKERS: So I discovered there's

a little, I'm going to call it a toggle switch just left and right that I didn't know existed. So sometimes, I accidentally slide that, and it locks my camera. So that might be a quick try.

MS. PURDON: Or I just find that it's all spinning. Like, it takes forever after I get it to come on. Like it's changing, I don't know.

MS. BICKERS: But you do -- it does look a little blurry on our side, but it didn't look that way a moment ago, so maybe it's trying. We do have Evan, Susan, and Marlene on camera. That does give us a quorum to vote if you can't get your camera working.

MS. PURDON: Okay.

MS. BICKERS: So the waiting room is clear, so if you guys want to go ahead and hop in, we can, or if we want to give it a moment longer to see if anybody else joins us, we can also do that.

MS. PURDON: I'm fine with starting.

MS. BICKERS: Okay.

MS. PURDON: Can -- am I allowed to

do the talking if --

MS. BICKERS: Yes, since we have --

MS. PURDON: -- if I can't get the video --

MS. BICKERS: -- three voting members on camera.

MS. PURDON: Okay.

MS. BICKERS: Yeah, we're good.

MS. PURDON: Okay. Alrighty, then we'll get started. We'll start with -- oh, darn, I thought my camera was getting ready to come on. Introductions, I'm Annlyn Purdon with Hayswood Home Health.

MS. REYNOLDS: Good morning. I am Janet Marlene Reynolds with Alexi Group.

MS. STEWART: Susan Stuart, Appalachian Regional Healthcare.

MR. REINHARDT: Good morning, everyone. This is Evan Reinhardt with the Kentucky Home Care Association.

I think Annlyn might've gotten kicked out, so we'll -- while she's trying to figure that out, we'll go ahead and jump in. I think we have -- you said we have a quorum, right, Erin, with our three?

MS. BICKERS: Yes.

MR. REINHARDT: So we're good to go there. Approval of the minutes, any changes from the TAC members?

MS. STEWART: I'll make a motion. Susan Stewart.

MS. REYNOLDS: Second. Marlene Reynolds.

MR. REINHARDT: All right, it's been moved and seconded. All those in favor, say "aye."

(Aye)

MR. REINHARDT: Any opposed?

(No response)

MR. REINHARDT: All right. We will jump into old business. So we're going to touch on the supplies quantities here again. Any updates there? I mean, I know we've been working with DMS. We're trying to get some claims examples together, but any updates from either DMS or the MCO side of things?

MS. HANCOCK: Evan, I don't see Justin or Jeremy on. I believe they were taking this, and yes, they were waiting for

some more examples.

MR. REINHARDT: Okay.

MR. DEARINGER: Hi, I'm --

MR. REINHARDT: Hey, Justin, I see you there.

MR. DEARINGER: -- Justin Dearinger, with Department --

MS. HANCOCK: Oh, there he is.

MR. DEARINGER: -- of Healthcare Policy. So yeah, I think we're just waiting for some examples right now to see what that looks like. So as soon as we get those in, we'll take a look at those. We are looking at some of our overall policies, though, on supplies quantities, make sure those match up with medical necessity limits. And then also making sure that anything that bounces off that medical necessity limit wall, that we have prior authorization process in place to be able to request additional supplies should those hit those medical necessity limits. And then, of course, if it is for a child and not for an adult, we can always go through EPSDT special services to kind of bypass those supplies and quantities, as

long as it's medically necessary.

But overall, we're still just kind of waiting for those examples so that we can kind of deep dive into those and see if -- if and where we can help with that.

MS. STEWART: I have a question related to supplies. Do we have an answer to the fundamental question of whether it's proprietary or not and whether that information should be shared with us?

MR. DEARINGER: On the -- on the amount of the supplies?

MS. STEWART: Well, on the billable limits.

MR. DEARINGER: On the -- on the -- yeah, you absolutely should be able to have what the limits are, although I think the issue is, you know, each case is different. So that's kind of the problem, I think. So we would have to kind of see exactly on a case-by-case basis what you're asking about specifically, if that makes sense. Again, those are bounced off of medical necessity criteria. So somebody that has -- just say, you know, gloves, for example, it would

depend on what that individual's diagnosis was, what stage of that diagnosis, what setting, all those different things kind of feed into that medical necessity criteria. And that pops back on -- depending on whether -- which set of criteria they're using, what the proper amount is that that pops back. Does that make sense?

MR. REINHARDT: I guess our bigger question, I think Susan is leaning towards is, I mean, does DMS have a position -- and we don't -- we're not asking you to speak on behalf of the department, but it sounds like it should be published public information. Is that correct? Is that a correct statement?

MR. DEARINGER: We do have our supply limits published for certain things, that's correct. Again, for some things, it's on kind of a case-by-case, so I'd have to see exactly what we were --

MS. BICKERS: Justin, a little background on the TAC's behalf. So the TAC has requested, and through DMS several times, for these supply limits. Part of the

issue is some of the MCOs don't want to provide that information saying that it's proprietary per CMS. This has been an ongoing discussion since I took over these TACs, and it's just they're trying to figure out if they have a member in, can they bill 20 pairs of gloves? Can they bill 19? They're just -- we had gathered information from the MCOs at one point. Not being the subject expert, you know, I sent those over to the TAC, and a lot of those fields were just empty. So it's been an -- it's been an ongoing discussion/struggle from my point of view trying to provide this to the TAC.

MR. DEARINGER: Okay.

MS. BICKERS: Does that help some?

MR. DEARINGER: It does.

MS. BICKERS: Okay.

MR. DEARINGER: Yeah, I'm just trying to catch up.

MS. BICKERS: No, I totally get it.

MS. STEWART: So --

MR. DEARINGER: Let me -- let me dig in a little bit and see exactly, you know, what -- what you all have sent, what we've

worked on previous. But I do know that those limits can change as far as the medical necessity criteria for certain diagnoses, certain places of service, certain stages of that diagnosis, those type things. But to give, like, an overall in general, we do have some limitations on our fee schedules, and those type things we can put together and send out a list of those, so.

MS. STEWART: Well, our stance is that it is not proprietary, and it should be shared with us, because right now, we're playing Whac-A-Mole, and it's been going on for six years now, and, you know, we're not getting anywhere.

MR. DEARINGER: So real quick, so when you -- when you say -- just so I can understand completely. If you submit -- or is it, like, the same number, a same limit to -- for every individual, or is it on a case-by-case basis that they're determining limitation?

MS. STEWART: It's every MCO's billing limits are different. Like, a 4 by

4, the quantity might be 48 for this one, it might be 32 for this one, and we don't know what it is, and when we submit a claim, the whole line gets denied for excessive supplies.

MR. DEARINGER: Chelsea, you have your hand up?

MS. BICKERS: Yep. Thanks, Justin.

MS. AGEE: Yeah, so I just want to just to provide a little context for Justin as well. I think one of the concerns was the Business Associate Agreement that MCOs have with InterQual, and part of that agreement is a licensure agreement that the information is confidential and proprietary and is licensed exclusively for use by the MCO. And that's where I think the MCOs were a little concerned with sharing that because they have that BAA with InterQual. And I think part of DMS's solution or offered solution was that the MCO could share that information with DMS, we would review to determine if that was in alignment with, you know, regulations, etc., and then we could provide a response to the TAC with our

findings.

MR. REINHARDT: So is that -- I mean, is that under review currently? I mean, we're just trying to figure out -- to Susan's point, I mean, this has been a long time in the making, and we keep kind of running into dead ends. So is that ongoing?

MS. AGEE: Yeah, and I wasn't -- I knew there was one MCO that was -- that this issue had stemmed from, and that I didn't -- I wasn't aware that the other responses -- that there was gaps in the responses, so that is new information, and we'll definitely take that back to determine, you know, where those gaps are. But yeah, so I think that was kind -- that's just a little bit of context around the concern with sharing the criteria. But again, you know, our -- DMS's offered solution was to review, and then provide the TAC with the findings, which those looks like would still be in review at this time.

MR. DEARINGER: Yeah, let me get a little bit more caught up, but, I mean, just off the top of my head, I think that's --

that's the issue, is that it's probably -- I mean, I think what you all are looking for is here's the supply, here's the limit.

MR. REINHARDT: Right.

MR. DEARINGER: But I think the -- it's deeper because when we run that into that system through whichever medical necessity group they're looking at, InterQual, Milliman, whatever group they're going through, that MCO is going through, when they put that claim in there, it's going to read the diagnosis code, it's going to read the stage of that diagnosis, the place of service, the provider type, and it puts all that into a formula and it kicks back what that is based on those things. Age of the individual, all those things are factored in to what limit of that supply can be.

And so I think that's where it gets difficult is, you know, those are -- it's not proprietary for the MCO, but it's proprietary for whatever data set they've signed on to use for medical necessity, so InterQual, Milliman, those companies. So

there's some things we need to look at, but we'll -- I understand the issue, so we'll try to -- we'll see what we can do, and we'll look at that listing and try to go through that a little better. And we'll work with Chelsea and Carmen to get you all something. I understand it's been a long time, and so we'll see by next meeting if we can have something much better. I apologize it's been so long.

(Mr. Reinhardt speaking with no audio)

MS. STEWART: Evan, if you're talking, we can't hear you.

MR. REINHARDT: Can you hear me now?

MS. STEWART: Yeah.

MR. REINHARDT: Perfect. Sorry about that. Justin and Chelsea, is that something we can follow up with both of you on? You're the point people on that?

MR. DEARINGER: Yeah, it's, you know -- since it's supplies and quantities, just I can take point on that, Chelsea. Chelsea or I, either one.

MR. REINHARDT: Okay.

MR. DEARINGER: We'll work together

on this pretty tight, so.

MR. REINHARDT: Yeah, we'll --

MS. HANCOCK: Yeah, that's fine, Justin.

MR. REINHARDT: We'll follow up here, and, I mean, just a little more context, like, the first answer we were given was that, you know, supplies limits were public information, and they were the same as, you know, the DME fee schedule, I think was the original answer. And then the confidentiality piece was something that came up later, but, you know, you can imagine our frustration is, you know, that's great that they have an algorithm, and, you know, they can dial it into a diagnosis and demographics, but that just means the providers gotta play a guessing game for how many supplies to bill. And, you know, Susan and Annlyn can attest, this isn't a big hospital that has resources that -- you know, these are home health agencies or home health divisions that don't have the administrative, you know, overhead to be able to take that sort of a task on.

So yeah, Chelsea and Justin, if we can follow up directly, you know, after this, that'd be great.

MS. STEWART: Well, I mean, another fix would be on the line item, don't deny the whole line, pay what's -- what the limit is, and then move on. But right now, the whole line's getting denied.

MR. ELLIS: That's a great point. Okay. That I was not -- this is Herb with Humana, sorry about that. I was under the impression that they were paying up to whatever the allowed amount was, or allowed units, and then --

MR. REINHARDT: No, they --

MR. ELLIS: -- just denying the remainders past. They're denying the whole thing.

MS. STEWART: Yeah --

MR. REINHARDT: Yeah, everybody's denying the whole claim, yes.

MS. STEWART: Yes.

MR. ELLIS: Okay. Okay. Justin, I know you're going to work on the review. I will pull this into the Friday discussions

with the all MCOs plan association meetings on Friday, and we'll research that possibility. I can't promise anything because all of us are different, but I can at least pull that into our Friday discussion and get back with you.

MS. STEWART: And that's our point exactly, is every one of the -- every one of them are different, so, you know --

MR. ELLIS: Yeah.

MS. STEWART: -- it's --

MR. ELLIS: Yeah, we'll -- yeah, we'll almost never get symmetry on, like, vendors that we use for editing, and I don't think anybody would expect that, right? Every hospital uses their own vendors for whatever stuff, but I think we can -- we can maybe align on next steps as to what's considered -- expected from a claims payment perspective. So let us take that back and we'll get back to you all.

MR. REINHARDT: Herbert, do you have a sense of, I mean, just for your MCO --

MR. ELLIS: Mm-hmm.

MR. REINHARDT: -- you know, if we

took that shorter solution of paying the limit instead of what was submitted, I mean, any --

MR. ELLIS: Uh-huh.

MR. REINHARDT: -- I'm not going to hold you to it, but any idea on how long that would take? I mean, is that something we could look at weeks? I mean, what kind of a lead time do you need to make that change?

MR. ELLIS: I don't really know what all would require to make the change, so I really couldn't put that out there. I know that typically, at least for Humana, when we have built special edits such as this, it's not been weeks, it's usually been at least a month just because we're having to build -- and not from a short-term perspective, from a long-term, obviously, that would be an IT fix, but from a short-term, a lot of times, we can build certain edits that says if certain codes are billed that we know are triggering --

MR. REINHARDT: Sure.

MR. ELLIS: -- then allow up to a

certain whatever -- you know, allow up to whatever the allowed unit number is. I just don't understand -- I don't really know the complexity of how that logic would work to really give you a good answer. But --

MR. REINHARDT: Okay.

MR. ELLIS: -- I will say typically, it's not been months, but it has been a month or two usually to build special edits and put those in play.

MR. REINHARDT: Okay. Well, we'll follow up with you. You said that meeting's Friday; is that right?

MR. ELLIS: I hold it every Friday except for the third Friday, so I think the next -- so the next meeting is actually not this Friday, it's the following, so it will be on the 22nd. But I'll still put it in an email, and -- for the MCOs to review prior to that discussion, so that way we come back together on the 22nd, we can be ready to talk about it.

MR. REINHARDT: Okay. Yeah, well, we'll try to touch base with you pretty regularly just to see where things stand.

MR. ELLIS: Yeah. I think for all of us, all the MCOs, that's definitely not a Whac-A-Mole game, right? That's not what we're in the business for. Obviously, you know, we're just trying to manage limited resources with expectations, right? So does it make sense that you're going to bill 1,000 gloves for an injection? Probably not, right? But does it make sense that, you know, when you go to do home health, should you only be allowed one glove? Nope, that's probably not right either. So there's somewhere in between where we have to -- that's where the edits come into play to help us get to right aligning the resources necessary for the service.

MR. REINHARDT: Well, I appreciate the dialogue there, but yeah, I mean, I think we can find a solution one way or another, even if it's a short-term --

MR. ELLIS: Yep, agreed.

MR. REINHARDT: -- you know, approve the limit, that would be ideal.

MR. ELLIS: Okay.

MR. REINHARDT: Anything else, Susan,

on that one?

(Ms. Stewart shakes head "no")

MR. REINHARDT: Okay. All right, Justin and Chelsea, I'll follow up with you as well, so appreciate the dialogue, and hopefully we can make some progress here.

All right, next item is EVV denials, which I think that was Annlyn's, which I don't know if she's been able to jump back in here. I think her computer had a bit of an issue, so she had to do a reset. So if she can't make it in before the end of the meeting, we'll follow up with DMS on that issue.

MS. BICKERS: I don't see her, Evan.

MR. REINHARDT: Okay. Thanks, Erin.

MS. BICKERS: But I do see Carmen came off mute. She might have something.

MS. HANCOCK: No, I don't. I was just making sure that you didn't have the name wrong, Evan, because I get called Cameron a lot, so.

MR. ELLIS: I just think of Carmen Sandiego, that's how I'll never forget.

MS. HANCOCK: Yes.

MR. REINHARDT: Yeah, so we'll -- hopefully Annlyn can get back in here, but if not, we will -- we'll go to the next one. And then I saw, Janet, did you have something, and wanted to jump in?

MS. REYNOLDS: I do. In regards to the EVV, for my billing department, they're saying that visits are being rejected by Therap. Other states that they work with allow for the provider or vendor to update the items and resend it, but Therap requires a new visit number for the same visit, and that requires that we have to look at the original visit, void it on the back end and resend. And, you know, that's just such a cumbersome process, and it doesn't allow for true visibility on our interoperability report. So may not be something that can be changed, but, you know, we're not experiencing that in other areas. We can't update the service, the payer, or the old code.

MS. STEWART: And Evan, from an ARH standpoint, which is maybe on the other side of the state from Marlene, is service is

a -- lack of service continues to be an issue from our standpoint. And then the labor involved in getting those manually input is a burden.

MS. BICKERS: Is that a MCO subcontractor? Is that a Medicaid --

MS. STEWART: It's --

MS. BICKERS: -- I'm sorry, I'm not sure who would speak on that. I'm not familiar with that program.

MS. STEWART: It's a --

MS. AGEE: I would --

MS. BICKERS: Oh.

MS. AGEE: Oh, sorry.

MS. STEWART: Go ahead.

MS. AGEE: I would say Jade Bolin --

MS. BICKERS: Okay.

MS. AGEE: -- would have more information. I'm not sure if she's on the call or not --

MS. BICKERS: Okay.

MS. AGEE: -- but she probably would be the SME for that.

MS. BICKERS: Okay. Thank you, Chelsea.

MS. AGEE: You're welcome.

MS. STEWART: And I would call them a department partner.

MS. BICKERS: Thank you.

MS. STEWART: Medicaid partnered with Therap to be their EVV provider, and as a provider -- and as a home health provider in the state, we did not really have a choice in who we partnered with to meet this mandate. So Therap was the vendor you all chose, and now we're forced to work with them, and it doesn't really work.

MS. BICKERS: Okay. Marlene, do you mind to type just the issue you're having into an email to me, and I can get that over to the appropriate contact to follow up?

MS. REYNOLDS: Yes, I'll be more than happy, and, you know, that's outside my scope of practice. It's from our billing department, so --

MS. BICKERS: Oh, okay.

MS. REYNOLDS: -- I will forward her email and contact information as well.

MS. BICKERS: Perfect. And I'll see if -- I know EVV's been a big issue, so it's

probably something they're already working on, but I'll just make sure to -- that they have that contact, so thank you.

MS. REYNOLDS: Thank you.

MR. REINHARDT: Anything else on EVV?

(No response)

MR. REINHARDT: All right, we'll go down to home health aide utilization, still an ongoing one for us with DMS and the MCOs just to understand where we are, and what we need to change in terms of policy to right the course for MCO utilization trending. So if DMS has anything on that, love to hear it.

MS. HANCOCK: Evan, it's Carmen again. I took this last time thinking that it fell under my purview here in Long-Term Services and Supports because we do have home health aides in some of our, like, programs. But as I dug in, and I just heard you say what I thought you were going to say, and that is that this is home health aide utilization connected with an MCO.

MR. REINHARDT: Well, it's all of the above. It's fee-for-service as well.

MS. HANCOCK: Yep.

MR. REINHARDT: I mean, the utilization across the board's gone down, and -- on both a fee-for-service and managed care setting.

MS. HANCOCK: Yeah, so if it's through an MCO, then I hit a wall on that. I will continue to dig because I know that there has been research done on this. I haven't been able to track it down, but it is on the radar, and we -- excuse me -- I am still trying to pin it down. It may be something that I have to hand over to one of my other counterparts here in DMS, especially as it relates to MCOs.

MR. REINHARDT: Looks like --

MS. BICKERS: Suzanne --

MR. REINHARDT: -- Suzanne from UHC has her hand up.

MS. LEWIS: Yeah, hi, Evan. This is Suzanne. I had done a little bit of research around this from the -- from our perspective and reached out to some of our national partners and a few different states in UHC to find out if I could pull together

some information. I just have a couple of slides if you'd like to see them. I'm happy to report out what I found and the information in Kentucky that I was able to gather if that would be of interest.

MR. REINHARDT: Yeah.

MS. LEWIS: Okay.

MR. REINHARDT: We'd love to see it, yep.

MS. LEWIS: Okay. Let me share.

MS. BICKERS: You should be a cohost, Suzanne.

MS. LEWIS: Okay. Let's try that. Can you see my screen?

MR. REINHARDT: Yep.

MS. LEWIS: Okay. So I got -- I think you sent me some information about the claims over the last, like, you know, 10 plus years or what -- or I guess longer than that.

MR. REINHARDT: Yeah.

MS. LEWIS: Went back to 2006, and it looks like the significant shift happened from 2009 to 2010, and then we saw a drop of claims below 10,000 right around between

2016 and 2017. And then I broke it down a little bit further about the volume of claims year-over-year with, obviously, Kentucky -- here, let me make this bigger. Fee-for-service, of course, was the highest contributor, and then WellCare was number 2, and I think Aetna. So you guys can see, obviously, kind of this laid out so we can see who the MCOs -- you know, their volume year-over-year and what that looks like.

And then, as for the reasons -- oops, let me make this one smaller -- behind what I could find, just talking to some of our -- like I said, some of my counterparts from a national perspective, we know that Medicaid and Medicare reimbursement trend nationally made some changes in reimbursement models during some of the -- this time frame. Like, the nurse -- prioritizing, like, the skilled services for nursing services and therapies, we know that we still had agencies that were struggling to hire and retain staff. The nursing -- or the workforce shortage was listed as, like, the top reason for not being able to staff for

home health aides. A lot of that was due to low wages, limited benefits, and high turnover rates creating inconsistent services. There were also some training and educational requirements that changed in there. I don't have the date on there, I apologize.

And then, there was a Medicaid policy shift. There were about 32 states from my research -- this could be higher or lower, but based on what I could find, in 2016, there were 32 states, including Kentucky, that applied utilization controls to Medicaid home health benefits, such as visit limits and prior-auth. So we -- you know, again, looking at this from a -- more of a global standpoint, not one -- any one thing in particular contributed to this, but a combination of factors across time and policy shifts and reimbursement trends looks like that had influence, you know, at different parts of the last, you know, 15 years or so, that as that happened, we saw those things impact the home health aide utilization.

So that's what my research came up with. You know, I worked with -- like I said, I worked with some of the different states to talk about this, and tried to gather some information and research, and this is what I found. Hopefully that was helpful.

(Mr. Reinhardt speaking with no audio)

MS. STEWART: Evan, we can't hear you again.

MS. BICKERS: Suzanne, this is Erin with DMS. Can you make sure to send me a copy of this so I can share it with the TAC, please?

MS. STEWART: While Evan's coming back, I'll make a couple of comments on this. I mean, we have not had a -- can we go back to the slide?

MS. LEWIS: Oh, yes.

MS. STEWART: The CON rules really haven't changed, so I don't know relative to CON that that's been -- been a real factor related to that. And my question to -- while there are trends from a Medicare standpoint, that direction, it -- you know,

from a Medicaid standpoint, it's been fee-for-service and prior authorization. So what happened in -- from a provider standpoint, what happened in the industry is that you couldn't get a PA, therefore, you couldn't have an aide. When they can't meet productivity and you don't have enough volume to hire them, then it becomes, you know, cart before the horse kind of a deal. There's not enough volume for them to have, so because of no prior-auth, you kind of whittled away the whole discipline. And I don't know if that was the intent, but that's logistically what happened.

MR. REINHARDT: Yeah, I think I would just add to that -- can you all hear me now? Sorry about that.

MS. LEWIS: Yes.

MR. REINHARDT: Perfect. Just a couple things, appreciate you putting that together, Suzanne. The -- to Susan's point, I mean, we're just -- like, we're not seeing the auths, that's the story from our side. We understand the policy landscape and that sort of thing has changed over time, but,

you know, when it doesn't get approved, and that's sort of the big limitation from our side. And then, you know, I would say just from, you know, happening to be on the Kentucky side, as well as the Indiana side, Indiana has a pretty robust home health aide utilization. You know, it tends to be the -- almost the focal point of the home health program in Indiana, particularly for the aging side of the equation. So, I mean, I think that's where we're scratching our heads that while we get it, you know, and you've done a great job of kind of pointing out that trend, it's just, you know, our question is to the MCOs and to DMS: Why isn't -- why can't it -- why isn't it being authorized, you know, in terms of the home health aide services within a PA submission? So that question, I think, still lingers out there.

MS. STEWART: And from a provider standpoint, you know, you get to the point where you don't -- you can't have the staff because there's -- you can't get a PA, so you quit asking for the PA. So, you know,

it is what I would call a key-valued service in our world that's been completely eradicated because of the prior-auth -- implementation of prior-auth.

MR. REINHARDT: So just in terms of feedback, Suzanne, and for DMS as well, I mean, I think that's our question, is policy-wise, you know -- so if Susan submits a PA for home health aide that includes home health aide, you know, what prevents that from being approved? And, you know, how can we work on that from a policy perspective?

MS. BICKERS: Evan, this is Erin. Would you be able to maybe share some of the Ohio information and send it to me, and I can send it out? You know, just -- I know the policy folks do like looking at other states when there are successful programs. Is that something you could share?

MR. REINHARDT: Sure. For Indiana you mean, yeah.

MS. BICKERS: Or Indiana. I'm sorry, I said Ohio.

MR. REINHARDT: Yeah.

MS. BICKERS: Wrong touching state.

MR. REINHARDT: Yeah, I'd be happy to. I mean, we're in the same -- like, there's managed-care up here, you know, some very similar plans, but I think a very different philosophical approach, and, you know, a policy approach, so that's one thing, and it sort of leaves us scratching our heads because, I mean, I think Susan touched on it a little bit, but this is in a very, you know, cost -- low-cost program, very efficient program, this is the low-cost, you know, staff to send out. So while, you know, I think Suzanne's slides point out how skilled nursing got prioritized, I mean, that can make sense in certain circumstances, but just from a programmatic perspective, you know, home health aides need to be and kind of are a key component and need to be more of a focal point, you know, policy-wise in our view. So happy to share some information from our side, for sure.

MS. STEWART: And I think that's -- Evan hit spot on: It's a philosophy approach to this where the state of

Kentucky's philosophy on this has changed from -- and the MCOs have changed from aides being an integral part of the plan of care to being a nonexistent part of the plan of care.

MS. LEWIS: And then just one note, I don't know the history here, but I do know that in Indiana, there is an aged and disabled waiver that does include personal care, so that might be the difference. That waiver could be, again, what kind of makes the difference between Kentucky and Indiana.

MR. REINHARDT: Yeah, I mean, that's definitely influential, but I was referencing specifically the home health program, which falls -- used to fall under state plan services, but now, at least partially falls under the Pathways for Aging Managed-Care Program. So that's the side I'm referencing is for skilled services, because the waiver, at least in Indiana, is for nonmedical services, so there's some nursing in there, there's some respite nursing, but primarily, it's attendant care, which, you know, has its own separate, you

know -- it's -- it has some pretty significant utilization, but the home health aide service within home health specifically in Indiana sees a lot more utilization than it does in Kentucky comparatively. So definitely, you know, understand your point there, Suzanne, but I definitely think there's some potential lessons to be gleaned from the Indiana approach just globally.

Now, again, very different programs, so we've got to kind of translate that a little bit, a little bit of apples and oranges, but I think from the home health aide perspective, there's still a lot to be learned, and Kentucky, you know, inasmuch as it kind of looks like Medicare a little bit from just the program design, even Medicare, you know, uses home health aides more than Kentucky Medicaid does, so -- depending on the circumstances, and, you know, needs of the patient, and all of that kind of thing. But yeah, I think from a Medicaid perspective, you know, that's where we're coming at this is that policy is something we support and would like to see, you know,

more utilization to help support the folks remain in their homes.

So happy to chat further on that, and Erin, I'll try to pull some data together so you can have a look.

MS. BICKERS: Thank you, that'd be helpful.

MR. REINHARDT: You're welcome. All right, anything else on home health aide utilization?

(No response)

MR. REINHARDT: So we'll close that out.

New business, I think the only thing we had, Janet, was the one topic you had about the Therap issue. So we already touched on that with EVV, so I don't think we have any other topics for new business.

So we'll jump down to the general discussion. Any updates from the MCOs?

(No response)

MR. REINHARDT: Suzanne, do you want to start for United just because I happen to see your name still here up at the top?

MS. LEWIS: Oh, wait a minute.

Sorry, I couldn't figure out the mute button for some reason that time. I don't have any -- any updates from our side. I know I have a team member on the phone. Noel, do you have anything?

(No response)

MS. LEWIS: I don't think he does. He's not -- he hasn't been answering --

MR. HARILSON: No, I don't.

MS. LEWIS: Okay.

MR. HARILSON: Sorry, I was navigating my mute button. No, I don't.

MS. LEWIS: Okay, thank you. Nothing from us.

MR. REINHARDT: All right. Anybody else want to jump in?

MS. SLATTERY: This is Theresa from Molina. And I don't have any updates, but I do have a question. Regarding the home health aide utilization, what type of a time span from the MCOs are you all looking for for data collection? Because I just did a one-year look-back from June to June, and we had 100 percent approval rate, but the volume was quite low.

MR. REINHARDT: Yeah.

MS. SLATTERY: So we only had, like, 121 auths in that one-year period, but they were all approved, so I don't know if that is reflective of a staffing availability issue. I don't know, but those requests that we have gotten in the last year have all been approved. So I don't know if that's helpful information or not, or if you need a deeper dive data on that, then I can try to do that before the next meeting.

MR. REINHARDT: Yeah, I think it would help to put any data you have together, and my reaction, I know Susan probably has some thoughts on this as well, it's a bit of a chicken or the egg thing.

MS. STEWART: Mm-hmm.

MR. REINHARDT: I mean, when the auths start getting -- and she sort of mentioned this earlier. When the auths start getting denied --

MS. SLATTERY: Right.

MR. REINHARDT: -- a lot of times, there's not enough work to actually keep a home health aide on staff, and so that's

where we are is, you know, to your point, that -- those organizations might've had one home health aide or two home health aides on staff, and so they submitted and those were approved, but no one can keep a person full-time, you know, potentially. So that's part of the reason why I think we're seeing what we're seeing in terms of the low utilization is, you know, that chicken or the egg, is the auth going to be approved? Do we have enough work for that person? Can we keep them around? You know, and then that's just a circular issue internally.

MS. SLATTERY: Yes, sir. So is DMS actually looking at claims data from all of the MCOs to see what their utilization rate is?

MS. BICKERS: Yes, I pulled the data from our DMS data request.

MS. SLATTERY: Okay. And we all -- are you going to be publishing that at the next meeting? I just wanted to make sure that from our perspective, that we were giving you all the information that you needed. Is there anything further from an

assignment perspective that you want us to, as the MCOs, to complete prior to the next meeting?

MR. REINHARDT: From our side, if there's anything policy-wise internally that --

MS. SLATTERY: Okay.

MR. REINHARDT: -- you can speak to. I mean, the data sort of speaks for itself. There's just not utilization, so --

MS. SLATTERY: Mm-hmm.

MR. REINHARDT: -- is there a policy issue within each MCO that we could, you know, sort of discuss and lay out? Or, you know, if your side's approving everything, like, we -- that's important information to know. So I think that's our question is, you know, what is your MCO policy on home health aide utilization --

MS. SLATTERY: Okay.

MR. REINHARDT: -- from a home health perspective.

MS. SLATTERY: Okay, thank you.

MS. BICKERS: Evan, this is Erin. I think we already asked all the MCOs to

provide their home health aide policy. Now, I could be mis -- I could be wrong. There are a lot of you TACs and I could be confusing you with something else, but I think we had already made that ask of the MCOs when we started doing the data pull. If I go back through my records and find that I'm wrong, I will send that out to the MCOs and ask for their policy.

MR. REINHARDT: That would be great. Thanks, Erin.

MS. SLATTERY: One other quick follow-up, could somebody please put the email in the chat of where we would send any of that information, who that should be submitted it to?

MS. BICKERS: Sure, I'll drop my email in there.

MS. SLATTERY: Thanks, Erin.

MS. BICKERS: You're welcome.

MR. REINHARDT: Any other MCOs on for updates/issues?

MS. ALLEN: Hi, this is Aaron Allen with WellCare, and we don't have any issues that I'm aware of.

MR. ELLIS: This is with Humana. No issues that I'm aware of as well.

MS. BICKERS: Anybody on -- I think Aetna may be the only one we didn't hear from.

(No response)

MS. BICKERS: Okay.

MR. REINHARDT: All right. Krystal put it in the chat, so no issues. Mic issues as well. Zoom appears to be giving everybody headaches today.

So let's go to updates from DMS and/or Commissioner Lee.

MS. BICKERS: I don't think the Commissioner is on today. I can give you just a quick, brief update for your new MAC/TAC liaison. She is not on today. She had a family issue to deal with, but her name is Barbara Wash. She's very kind. I told her you guys would be very nice to her. And she has already been told that she has big shoes to fill, so I think she's going to just catch on great. Good thing is, is I'm not going anywhere, I'm still part of team Medicaid. I will be a branch manager in

Long-Term Services and Supports, so I'm sure that makes a few of you very happy. So I'll also get to work with you guys. You have -- my contact information will all be the same. Of course, I'm always here to help, just let me know what you need, as always.

And we are -- just a quick MAC/BAC update. They have officially appointed all of the new MAC members that didn't roll over. We have new BAC members appointed, and so they are working with communication on trying to establish some new meeting cadences. And as soon as all of those meeting dates are put together and out, we will get them out to all of the TACs as well for the representatives who come to the meetings. If TACs are making recommendations, we are taking those and just kind of holding them until our next MAC meeting, we're hoping to be around the end of September-ish.

MR. REINHARDT: All right, thanks. Thanks for that information, Erin. Thanks for all of your help, and we look forward to hopefully being able to continue to work

with you over on the LTSS side.

MS. BICKERS: Same.

MS. STEWART: Erin, will the MAC meetings still remain virtual?

MS. BICKERS: As far as I know, that is the plan. That might be something that they ask. My assumption is they'll send out some sort of Monkey Survey: dates, times, virtual, in-person, to kind of get a feel which -- what works best. The MAC now has 31 members, so that's a lot of schedule coordinating and things. So as I have more information, you'll start to see things coming likely from Barbara or myself, and I will be on all TAC meetings, and so if you need, you know -- I will be there to help and support, so.

MR. REINHARDT: Awesome, thanks. Thanks, Erin. That wraps up item 6. Item 7, recommendations, I don't think we have anything for today, but may have things for next time. And Susan is our MAC representative, and our next meeting is October 14th. So with that, we can go ahead and adjourn, unless anybody has anything

else for the group.

(No response)

MR. REINHARDT: Okay.

MS. STEWART: Do you need a motion?

MR. REINHARDT: Sure, I'll take one.

MS. STEWART: I'll make it. Susan makes a motion to adjourn.

MR. REINHARDT: Okay. I will second, and we will go ahead and adjourn for today. Appreciate everyone jumping on, and we'll be talking to you all soon.

MS. BICKERS: Thank you, everybody. Have a wonderful afternoon.

(Meeting adjourned at 11:55 a.m.)

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C E R T I F I C A T E

I, TIFFANY FELTS, Certified Verbatim Reporter, herby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 15th day of August, 2025.

Tiffany Felts, CVR

Tiffany Felts, CVR