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

****

Via Videoconference
December 13, 2022
Commencing at 1:00 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Russ Ranallo, Chair

Elaine Younce

Stephen Oglesby

Theresa Fite

Danny Harris

MR. RANALLO: This is Russ Ranallo. I call to order the Hospital Technical Advisory Committee meeting. Go through some introductions. TAC members on the phone, if you could introduce yourself. Steve.

MR. OGLESBY: Do you want me to start?

MR. RANALLO: Yeah. Go ahead and start.

MR. OGLESBY: Oh, hi. It's Steve Oglesby, chief financial officer at Baptist.

MR. RANALLO: Danny.

MR. HARRIS: Danny Harris, CFO ARH.

MR. RANALLO: Elaine.

MS. YOUNCE: Elaine Younce, chief of payer administration at UK.

MR. RANALLO: And I'm Russ Ranallo, the CFO at Owensboro Health. On the -- who do we have from -- on the DMS side? I know I saw Angie.

MS. PARKER: Yeah. Angie Parker is here.

MS. DUDINSKIE: Jennifer Dudinskie with Program Integrity is here.

MR. BECHTEL: Steve Bechtel, chief

financial officer.

MR. RANALLO: Hi, Steve.

MR. BECHTEL: Hey.

MS. RICHARDSON: Amy Richardson, Division of Finance.

MR. RANALLO: Okay. Thank you very much. Establish a quorum. We've got a quorum. We've got four out of the five members here on the phone right now.

First up is the approval of the minutes. The last previous meeting was June 14th of 2022, and I think those minutes have been sent out. Any changes or edits? If not, may I have a motion to approve the minutes?

MR. OGLESBY: I'll motion.

MR. RANALLO: Is there a second?

MR. HARRIS: I'll second.

MR. RANALLO: Okay. Any -- all those in favor, aye.

(Aye.)

MR. RANALLO: Any opposed?

(No response.)

MR. RANALLO: Okay. The minutes are approved.

The third item on the old business we're

going to take off, the home health agencies. I thought I had sent an adjusted agenda, but that was removed.

The first item is the incarceration data. I think this is some follow-up of some previous discussions. I know there's been work on trying to get the data between the databases more in sync and more timely.

Providers have been having issues with when an inmate is discharged and the database not being updated properly. And even though they're not -- no longer an inmate and we bill claims, we're getting those denials saying they're incarcerated.

I know there's some on the front end, too, when you bring in -- we bring in -- have patients brought in, but they've not been charged. And their incarceration date is not -- is after the fact, and we've had some issues there.

I know the last time, we had -- at the last meeting, they said we could possibly have an update this meeting. Does DMS have an update on that?

MR. DEARINGER: Hello. This is

Justin Dearinger, Department for Medicaid Services.

MR. RANALLO: Hi, Justin.

MR. DEARINGER: How are you all? We've been working on this issue consistently. We were able to identify multiple issues in our system that we were able to correct, and I believe that will enhance the ability for our system to pick those things up faster.

We've also had conversations with some system users on uploading that data more efficiently and more productively so that it reads quicker. So I believe that we will see a lot less of these instances moving forward.

However, this will be a little bit more of a long-term project, to be able to make the systems talk to each other. They weren't designed -- we were able to find out they weren't designed quite the same way, and so we've got a team that's meeting, trying to get those two systems to match up.

There's a lot of, you know, programming-type stuff that I'm not sure I could explain well or understand well. But

the two systems don't talk well, I guess, is just how you'd say it. So we are working on that, and we will get that fixed. But it's a little bit longer term.

But in the short term, we were able to identify multiple issues with our system that we were able to improve that should cut down on the number of -- at least when someone is -- comes out of incarceration, that we'll be able to pick that up a lot quicker and help on the denial issues that the hospitals are having.

MR. RANALLO: Okay. Thank you for that update. Anybody from the TAC have questions?

MR. OGLESBY: No. That sounds good.

MR. RANALLO: Okay. Thank you, Justin. We'll inform the membership and see if we can -- we can observe those improvements. I appreciate the update. Thank you.

The second follow-up item, DMS expedited review. I know we had this at the last meeting. We had a member hospital that asked

if we could consider looking at expedited review. Right now, the process, if we -- for medical necessity is a long, drawn-out, back-end process rather than something that is real-time. And there may not be an update on that. I know that was just something I wanted to keep on the agenda.

MS. PARKER: Can you be more specific on expedited review, on what specifically you're talking about?

MR. RANALLO: So there's -- so on the Medicare side, if you have somebody that doesn't meet medical necessity, there's an expedited review process.

MS. PARKER: Okay.

MR. RANALLO: And on Medicaid side, right now, we have a -- you know, we have to take it through the MCO's appeal process. Then it has to go to the IPRO, and it's a back-end process. There's not an expedited, closer to real time, review process for Medicaid.

MS. PARKER: Okay.

MR. RANALLO: And we can -- we can follow up offline. I don't think there was

going to be an update on this. It was something that we had a couple of members bring up and some of the frustrations with it going through.

MS. PARKER: I mean, if something is denied, that you can't do a peer-to-peer, if that's what you're talking about.

MR. RANALLO: Is the peer-to-peer real-time?

MS. PARKER: Yes.

MR. RANALLO: Okay. Let me bring it back, Angie. Let me go back and review it.

MS. PARKER: Okay.

MR. RANALLO: Okay. New business, Molina policies. I know there's been -- there's been some communication from Molina on policies with -- with the ED. I know there's been discussion with the KHA, and I know I've seen some of this.

So in their -- they've announced a pre-pay review policy for the emergency department. Is that my understanding, is the Cabinet has approved that; is that correct?

MS. BASHAM: This is --

MS. PARKER: Correct.

MS. BASHAM: -- Nicole Basham from Molina. Yes. The Cabinet approved all of our requests for pre- and post-pay. The update that I can give you, though, however, is we have the pre-pay on hold as we're working through some -- review of some records with several of the payors so that we can make sure that we are targeting and refining the query that would then be integrated into a prepaid review. So we haven't moved forward on the pre-pay at this moment.

MR. RANALLO: Okay. So on the pre-pay, it'll be select? Would it be select accounts or records or all records?

MS. BASHAM: No. It would not be all records. It would be any records that came in that hit the set of criteria set to review to determine whether it was emergent or nonemergent. And then the pre-pay -- the future state of pre-pay would be around leveling, and so we're working through the logic around that. We're not ready to release that.

MR. RANALLO: Okay. So we don't have the criteria. We don't know logic yet?

MS. BASHAM: No. I have the criteria. There's a ton of exceptions that we certainly can share with you all as it relates to this project. What I mean by "we haven't released that," we have not released pre-pay to be implemented yet at this time.

MR. RANALLO: Okay.

MS. BASHAM: But I -- we can share some of the criteria. We have numerous exceptions around this so that we do not target anything that would be emergent in our review. We want to only target things that appear to be nonemergent and then send them through the required review for, you know, a prudent layperson. And then additionally, when we implement the leveling piece, there will be additional criteria around that.

MR. RANALLO: So what is -- can you explain to me the leveling piece, what that means?

MS. BASHAM: So from a leveling perspective, it would be: Did you bill it at a Level 4 but the criteria then meets a

Level 3? Those type of things.

Again, that's -- it's really early in the discovery of the logic around that. We do have it published, the criteria around that, as do other MCOs. But for right now, we are on hold with any pre-pay activities.

So more to come. We certainly can come back once we're ready to have further discussions around that and provide some detail, as needed, to the group.

MR. RANALLO: Okay.

MS. BASHAM: But we're having individual meetings, Russ, with each of the facilities to also walk through it. So, again, we want to make sure that we're being collaborative and hearing feedback, and we've heard certainly your feedback and concerns over the post-pay review. And so we're taking that into consideration and reviewing that internally for next steps.

MR. RANALLO: So -- okay. I'm going to -- I'll get my head around the pre-pay. So from the Cabinet side, the pre-pay would be -- the clean claim would be subject to the KRS with interest; correct?

They would have 30 days to pay the clean claim and then they would be subject to interest if they don't?

MS. BASHAM: Russ, that was a question to the Cabinet; correct?

MR. RANALLO: Correct.

MS. BASHAM: Okay. I just want to make sure.

MS. PARKER: Yes. Clean claims are to be paid within 30 days.

MR. RANALLO: So, I mean, if, I guess -- and I guess from my viewpoint, when I read the clean claim definition, what I -- my billing would be a clean claim. If they come back 25 days after and ask for a medical record and an itemized bill for a claim, would it no longer be a clean claim?

MS. PARKER: Well, you ask a very good question. I would have to go back and look at the regulation on that.

MR. RANALLO: Okay. Because -- well -- and so here's my concern, right, is that -- that's happened in the commercial world, and I can see it happening here.

The additional concern is, is that I

don't -- depending on -- you know, they're about -- you know, Molina is about 20 percent of the business. And if the other ones start to do this, you've got about 1.9 million or so ED claims for Medicaid. And 20 percent is, like, 400,000, right, claims.

The resources to look at itemized, depending on how many they pull out, how many -- the resources to look at itemized bills and medical records to make a determination are going to be significant, and not -- nobody has resources right now.

And I know when we've seen this and fought back on this or pushed back on this on the commercial side, is that, you know, these things can't sit there for 60 days, 75 days before we get -- we get an answer back. And I just want to make sure that, you know, once it passes the 30 days, that there's going to be a clock ticking on the regulation from an interest perspective.

And I guess the other piece is -- I mean, like, on credentialing, credentialing. You know, when I talk about resources, credentialing, we're so far in arrears with

most of the MCOs on credentialing because they don't have staff to process it. And you're adding -- going to add extra staff to do this. I just don't see it's going -- I know what's going to happen.

So I'd like an answer -- an answer to that, you know, if it meets clean claim. Because from my view, it still would.

MS. BASHAM: So, Russ, our intent is certainly not to add additional burden to you or your staff. And so that's why we're working individually with each of the facilities on, you know, how best to execute this so that we're all -- all aligned. And so there will be some additional meetings coming soon to make sure that we're doing that.

Again, I think the initial way that this was rolled out was not a way any of us would have expected it to roll out, and so we are taking a step back and kind of regrouping on the approach to this, whether it be pre- and post-pay audits or whether it be some type of contractual way to address it.

But, again, it's not our intent to add

additional burden, and we certainly want to make sure we're aligned with what is required, you know, by the State. So we're set up to pay interest on clean claims.

So I know that that was part of your concern, but I'm sure it's bigger than that. And we're happy to have individual conversations around that.

MR. RANALLO: It is. I mean, just as an aside, you know, this issue came up shortly after we went into managed care with one of the MCOs. And what we found at our own facility was that we were getting -- we're providing service. But what we found was, is that the majority of the things that were getting denied were kids and were after-hours and that the MCO didn't have any Urgent Cares or only had one Urgent Care in the area to -- and no pediatrics offices in the after-hours.

So you had parents coming home from work. Their kid is having a hard time breathing, and there's no other option but the ED. But they bring them into the ED and then we're getting denied because they're

saying, no, that's not emergent. They should have went to the doctor's office.

And so there's got to be some kind of -- as we go through this, at least in my area, I'm going to hold -- you know, that's the kind of conversations we're going to have. What kind of responsibility does the MCO have for case management and utilization access for these members that aren't just coming to the ED because they have nowhere else to go?

MS. BASHAM: Yeah. And so the situation you just described would not hit any of our outliers. We are screening out, you know, children under the age of two, pregnant women, people with comorbidities, people with cancer, how they arrive.

So there's a number of different ways that things are getting screened out. Because we want to look at things like there's an ingrown toenail, those types of things.

We are not looking to make -- you know, we're not looking to impede anybody's treatment, especially when a parent doesn't have another option other than ER. If they

are in significant distress, they -- we encourage them to use the resources that are necessary, and that's what we're looking at.

So, again, this is not an attempt to -- in the situation that you described where they had no other option, this is not that approach.

MR. RANALLO: Okay. Well, then, the criteria sharing would be great. Because I know I asked here, and I told -- I was told, like, a fact sheet would be coming out.

MS. BASHAM: Yep.

MR. RANALLO: And I went and pulled the policy, and I didn't -- you know, I don't -- there was some general exclusions like expired in the ED, admitted inpatient, things that, you know, went to outpatient surgery, you know, those type things that made sense; right? They're essentially bedded, or they passed away. But that additional criteria would be very helpful for me.

So on the post-pay, what's the status in the post-pay reviews?

MS. BASHAM: So the status of the

post-pay reviews is we've started with two facilities that we're pulling just 50 records. Again, we do not want to inundate or have an administrative burden, you know, on anyone, you or us. Again, there's no sense in us looking at things that are clearly emergent, which is why the criteria is really important. And so we're looking through those 50. We have access to the EMRs so that our team is actually pulling the 50, so it eliminates the need for the facility to do so.

And then once we've done our review, we're going to connect with the facility and walk through it. Like, what are we seeing? What are we doing? You know, is there opportunity? Is there something else we need to do different?

And so the results are to be determined. But at this moment, it is about reviewing what's going to be in front of us and doing that in conjunction with the facility itself.

MR. RANALLO: Okay.

MS. BASHAM: And so the intent is to make sure that you all are in lockstep

with us as we progress through this process. I don't expect any of you to be surprised that something happened, or there should never be a surprise on your radar around this.

MR. RANALLO: Okay. I appreciate that. And the concern -- the reason I'm asking that question was, you know, when we had the short stay letters that came out, right, they were a surprise. And they had just a reason. Well, it doesn't meet inpatient. We don't think it meets inpatient criteria. And there was nothing -- there was nothing else after it. And so when you get a list of patients and that's it, you can understand what --

MS. BASHAM: Yeah. The short stay project is on hold right now. We need to make sure we've got everything properly documented, having further conversations again.

You know, no excuses, but as a new health plan converted over, we've got some missteps that are occurring, so we're trying to clean them up. We've got some pretty

experienced folks here at the plan who cringe sometimes when things happen, but we're committed to get it cleaned up and make sure that we are partnering with you. I don't want you to ever be surprised by anything that's occurring.

Again, sometimes we have to have hard conversations, and we will continue to do that. But I'd prefer you not to be surprised. We want to make sure we're documented and everything is above board and that, you know, we're following all the regulations. And so that's our objective right now.

So as it relates to short stays, that is on hold. There's no activity on hold -- on short stays at this moment.

MR. RANALLO: Yeah. And I knew that, and I apologize. I was kind of referencing the letter that I got back that had -- you know, that had a denial but had a reason, just a generic reason; right?

MS. BASHAM: Generic reason, yep. Yep. So we're addressing those items.

MR. RANALLO: And I don't want to

be the only one talking if my other TAC members want -- have questions or want to weigh in on this.

MR. OGLESBY: You covered our concerns, Russ.

MS. BASHAM: And we're happy to meet with anybody else individually that we've not yet scheduled time for. My information is certainly available to have those conversations. We are -- we truly do mean to be a partner and not to be a burden.

And so we're here to serve the members of -- you know, our membership in Kentucky, and we want to do that in the best way possible. Again, sometimes there's hard decisions that have to be made, and I'd appreciate if we could make those together in how we move forward.

MR. OGLESBY: Thank you for that partnership.

MR. RANALLO: Yep. Absolutely. Thank you, Nicole. I appreciate you attending and weighing in.

MS. BASHAM: You're welcome.

MR. RANALLO: Danny or Elaine, you

guys okay?

MS. YOUNCE: You covered our questions, Russ. Thank you.

MR. RANALLO: Okay. Good.

All right. Next item, COB Medicaid patient compliance issues. So this came out of the meeting in October with, I think, the hospitals and the MCOs and DMS -- I was not on that -- where there was concerns about COB and when a patient is not updating the data that they need.

And I know that's rare for us. We have more the -- more the issue is the delay between the state systems and the MCO systems on COB, where the State says it's -- the state database we can see says it's plan XYZ, and then that plan doesn't recognize that patient as a member. And I know that's been an ongoing -- ongoing concern because we get -- we have to battle through those -- those denials quite a bit.

From the TAC side, I don't know if any of you -- the other TAC members heard the patient compliance issue concern, but I don't see that as an issue. I think it's more of

the delay between when the state system is updated and the MCO systems are updated.

(No response.)

MR. RANALLO: No. Okay. And, Angie, I can probably bring you some -- I know I've got multiple examples. If that was the true discussion and the issue about COB with Medicaid, I can definitely bring some examples of where we're finding disconnects between the two systems, and maybe we can have somebody look and see why.

MS. PARKER: That would always be helpful.

MR. RANALLO: Okay.

MS. PARKER: And I want to clarify something on the earlier question regarding expedited review process. Were you talking about, like, inpatient and a day is denied, or were you talking about an external, independent third-party review?

MR. RANALLO: I'll have to go -- let me go back and clarify and make sure I've got it right.

MS. PARKER: Okay. Because those are two different things.

MR. RANALLO: It is. I want to make sure I've got the right one.

MS. PARKER: Okay.

MR. RANALLO: I think -- yeah. I think what -- the way I got it, if the patient meets the criteria from the hospital side and the MCO denies it, I think the viewpoint was the only recourse was to take it through the MCO process, then the IPRO.

MS. PARKER: Well, if they're in an inpatient and the day is denied, the MCO should be able to offer a peer-to-peer, or the hospital can request a peer-to-peer.

MR. RANALLO: Okay. All right.

MS. PARKER: While they're still in the hospital.

MR. RANALLO: Okay. All right.

MS. PARKER: Okay.

MR. RANALLO: I'll get you examples on COB.

Outpatient HRIP update. Steve, any --

MR. BECHTEL: Yeah. I'm trying to unmute my phone here, unmute my computer. You'd think after two years, you'd get used to it; right? But I guess not. Can't teach

an old dog new tricks evidently.

The -- on the HRIP side, on adding outpatient to it, to the HRIP program, we have submitted that to CMS, and we're in the process of going back and forth with the different questions, rounds of questions that they have for us. So we are in that process.

We submitted it to CMS on October the 4th. We received first-round questions sometime around middle of November, and we got our responses to those questions submitted back to CMS November 30th. We have not heard back from them since.

They normally will follow up with, like, a round two of questions in which we will follow up -- try to follow up as quickly as we can with our responses. So we are in -- we're in the process of getting it approved through CMS.

Now, that's only one step of this whole process. The next is to get the legislative approval as well as budgetary approval, which we have been working with Jon Copley of KHA as well as Carl Herde to work with their contacts through the legislative session

that's coming up to get that expedited and try to get that through the session as quickly as possible. He may have more to say on that. I'm not sure. But that's -- that's where we're at.

You know, once I get CMS approval, I still need the legislative approval as well as the budgetary approval to make these things work. So it's just one of those cogwheels, you know, of a whole thing that you have to get moving.

So we've went ahead and started our process so that we can be ahead of the game when legislators come back into town, that once they hopefully vote it through with no issues, that hopefully we will have the CMS approval and be able to run forward with that.

Now, I will just say this. It's beginning 1/1 of '23; right? So your first quarter, even if we don't have the approval before February or January, it doesn't mean anything because, you know, we have until -- normally, we won't process that payment until sometime in May, maybe sometime end of May,

maybe first of June for quarter-ending March. So we do have some time.

We just didn't want to take any risks. We wanted to make sure that we got in front of it and got the preprint. Because the preprint is the longest process of getting the approval so...

MR. RANALLO: Well, I -- we really appreciate the Cabinet's efforts in trying to help us and help the hospitals with this. I can tell you that. The inpatient HRIP has been so valuable with --

MR. COPLEY: Hey, Russ. It's Jon Copley. I can add in here if that's okay.

MR. RANALLO: Yeah. Go ahead, please.

MR. COPLEY: So on the legislation, Steve, I do expect that to be filed the first possible day, which is Wednesday, January 4th. I do expect it to be filed with an emergency clause which would, you know, retro it to the January 1, as needed, that you referenced.

As you know, the first week, that four-day week is the quote, unquote,

organizing session and then they come back in February. So I expect it to be filed on the 4th. Then I expect it to move in the house quickly when they return in February. That's my understanding as of today from our folks.

MR. BECHTEL: Thank you.

MR. RANALLO: Thanks, everybody, for their efforts, DMS, KHA, everybody. I mean, the HRIP on the inpatient side has been very valuable and very important to the hospitals that are dealing with --

MR. OGLESBY: Yeah. Absolutely.

MR. RANALLO: -- supply chain, with labor issues, just extreme amounts of expense increases in this environment. And our rates unfortunately don't mimic that, right, don't mimic that change for a while. They're very slow to change, and so it's been very important for us.

MR. BECHTEL: So just to give you a little -- numbers to go with that, inpatient was about 1.2 billion, and this is aggregate across the state. I don't want everybody thinking that every hospital is getting 1.2 billion. But it's 1.2 billion across the

state for inpatient, and it's another 1.5 for adding in outpatient. So it's approximately 2.7, is what this will be in total funds.

MR. RANALLO: And I think the -- if I looked at it right, Steve, I think the outpatient will impact the rural side.

MR. BECHTEL: Yeah. It was more of a -- it's like a -- on the inpatient, it was, like, a 60/40 split, so to speak, 60 percent for the urban areas, 40 for rural. It's kind of flipped on the outpatient side. It's more 40 percent on the urban side and 60 percent to the rural areas.

MR. RANALLO: Yep. Yep. That would be awesome. Any other questions from the TAC members?

MR. OGLESBY: No. No. That sounds extremely positive. And, again, I just reiterate Russ' thank you to you, Steve, and everybody else who's done a tremendous amount of work on our behalf. It means the world to us to be able to continue to do what we do, so thank you.

MR. BECHTEL: Well, I can't take all the credit. I've got a great team, and

we worked together with KHA as well as our consultants, Myers & Stauffer, and Milliman, who is our actuary, to make sure that we're making sure everything is in the rates correctly and addressed it -- addressed through the MCO rates.

So we just -- we can't speak enough about the collaboration that we've been able to do as a team, and it took a team approach on this. And so that's why it's so successful, in my opinion, so...

MR. OGLESBY: Yeah. Agreed. Thank you.

MR. BECHTEL: Thank you.

MR. RANALLO: Okay. Any other items from the TAC members that they want to bring up?

MR. OGLESBY: None here.

MR. RANALLO: Okay. I don't think we have any recommendations today.

I will be at the MAC meeting to represent and give a summary of the meeting for the MAC.

Our next meeting is February 28th. We are continuing to be on Zoom. I think we've

got the meetings scheduled. They should be on your calendars for next year.

So barring anything else, may I have a motion to adjourn?

MS. FITE: Hey, Russ. Just real quick. This is Theresa Fite. My apologies. I did get on late, but I am on.

MR. RANALLO: Hi, Theresa. Okay. We will note in the minutes that we had a full TAC. Thank you so much for letting me know.

Okay. Motion to adjourn?

MR. HARRIS: So moved.

MR. RANALLO: Second?

MS. YOUNCE: Second.

MR. RANALLO: All right. Everybody, have a wonderful Christmas and New Year's holiday. Thank you so much, guys.

(Meeting concluded at 1:35 p.m.)

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C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime 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 16th day of December, 2022.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR