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

****

Via Videoconference
October 22, 2024
Commencing at 1:02 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Russ Ranallo, Chair

Lori Ritchey-Baldwin (not present)

Elaine Younce

Michele Lawless (not present)

Chris McClurg (not present)

P R O C E E D I N G S

CHAIRMAN RANALLO: Welcome, everybody. This is Russ Ranallo. I'm the chair of the TAC and the CFO at Owensboro Health. It's October 22nd, 2024. It's the Hospital Technical Advisory Committee meeting.

We do not have a quorum today. I have Elaine Younce there as the other TAC member. The other three were not able to attend today, so we will not be able to do the approval for the minutes. We will hold that until next time. And we're going to review some of the old business items and just go through the agenda.

Okay. The first old business is the NDC issues. Were we able to -- I know last time we talked, we wanted to see if anybody could join us from the pharmacy side. I don't know if that was able to happen or not.

DR. ALI: Yes. Hi. This is Fatima. I'm on with the DMS pharmacy team. So if I understand correctly -- and I haven't been on these calls recently.

CHAIRMAN RANALLO: Sure.

DR. ALI: But if I understand correctly, you know, I know the hospitals had concerns with, you know, how they're submitting their claims to the respective MCOs and how the MCOs are handling it from that end. My understanding is that perhaps there were some rejections received from the MCOs that, you know, aren't getting resolved in a timely fashion or if at all.

So with that being said, you know, our primary concern with what our MCO health plans submit is eligibility for rebate invoicing so ensuring that we have a proper HCPCS NDC combination, a valid NDC in and of itself, amongst, you know, other things that we look at to ensure that we can invoice for rebates.

So what we're doing, in collaboration with our health plans, is developing a process to appropriately invoice for rebates for those claims that are coming in from the health plans.

So, you know, we're working on it. We'll have some follow-up meetings with our health plans and kind of go from there. But

I do want to stress and emphasize the fact that, you know, the respective billing departments from clinics and hospitals should be working with the health plans to ensure proper billing.

You know, there are a couple of sources of truth that we're using on our end to ensure that, you know, we're receiving valid combinations from our health plans. However, it's not an all-encompassing list, so we're creating supplemental files with our health plans to, you know, kind of create and get to that comprehensive list. But, again, you know, the hospitals and health systems should be working with the managed care plans to ensure appropriate billing.

CHAIRMAN RANALLO: So I appreciate that. So when you say there's a couple of sources of truth, I think that's one of the pressure points. Because I've got health systems that we have what we believe are valid NDCs and are receiving rejections, being told it's not on the NDC list, or it's not on the source of truth. And we're trying to make sure that we have -- we understand

what the source of truth is that the MCOs are using.

DR. ALI: So we've communicated the quote, unquote, foundational source of truth which are the CMS Medicare Part B file as well as the Palmetto file which are both public documents. You know, whatever is not on there -- I understand that there are combinations not on those respective files that, you know, may still be eligible for rebate invoicing.

That's where we're working with our health plan partners to, you know, kind of create a more comprehensive list that's maintained and developed over time, you know, to ensure that any valid combinations that you all are submitting are being processed by the health plans.

So, you know, that's what we're working on. However, you know, if there's a combination you believe is valid, it should be run up by the MCO. Those two sources of truth are not, again, all-encompassing. You know, there are other sources out there that the health plan could be using to say, you

know, whether it's valid or not. However, you know, the two that we're using are those CMS and Palmetto files.

And like I said, we're working on creating a supplemental file for any combinations that the health plan deems valid so that we can, you know, create that collective list, if you will.

CHAIRMAN RANALLO: Can -- can the supplemental list or that additional list be sent to the TAC so that we can distribute it, at least what you have now?

DR. ALI: So that's what's in the works right now with our pharmacy benefit manager who also handles rebate invoicing. Those supplemental files will be coming over on a quarterly basis to our health plans. So it's going to be an evolving process and something that just keeps going on and on. But when we --

CHAIRMAN RANALLO: Can you share it with -- I know you said the health plans, but can you share it with the hospitals? Because, you know, we have the CMS file, and we have the Palmetto file, or access to it.

But not having access to the supplemental list that's already built is kind of, you know, one hand behind our back. If we can see that, that would be helpful for us when it's ready.

DR. ALI: Right. So those will be passed on to the health plans, and the health plans can go ahead and kind of share that with the TACs and with the provider community because it's going to be something that comes over quarterly. I mean, we can share it on a quarterly basis, but that upkeep and maintenance of it is, you know, the challenging part in all of this.

So right now, our processes have the files going out to the health plans. And, again, the health plans are responsible for communicating with the provider community and handling those billing issues.

MR. IRBY: Dr. Ali, this is Greg from UnitedHealthcare. Do you mind if I ask one clarifying question?

DR. ALI: Sure.

MR. IRBY: How will the fee-for-service program be communicating with

the providers?

DR. ALI: Well, I mean, those -- so, you know, we have the Gainwell provider help desk that assists with the fee-for-service billing side of things.

MR. IRBY: Right.

DR. ALI: And then there's the physician-administered drug list as a reference point. So, you know, any of those fee-for-service claims are handled by Gainwell.

MR. IRBY: I guess my question is: For providers who may be out of network for all MCOs but still serving Medicaid through the fee-for-service population, what is the plan for educating them on this list?

DR. ALI: So it's going to really be the same for fee-for-service. You know, the volume of claims that we get on the fee-for-service side of things is significantly fewer than the MCO side. So it's going to follow the same process. We haven't seen a bulk of issues on that front.

And, again, there is that Gainwell help desk, you know, that's assisting with any

fee-for-service issues as well as the physician-administered drug list. You know, I'm sure there are combinations outside of the physician-administered drug list that come in to -- come in to Gainwell, and they help reconcile it from that end.

MR. IRBY: Okay. So there will be no proactive education to fee-for-service-only providers for the list? Instead, it will be handled more responsively as providers email; is that correct?

DR. ALI: For fee-for-service; right?

MR. IRBY: Yes.

DR. ALI: Yeah. Correct. It'll still follow the same process that they're doing right now.

MR. IRBY: Okay. And then other question for clarity is: Do we have an idea of timeline of when this will be communicated to the MCOs?

DR. ALI: We're hoping to set up a meeting hopefully by next month. Some of this is really dependent on MedImpact helping us develop that supplemental file. But we

have been working very diligently on developing this process and getting the word out to our MCO plans.

MR. IRBY: Okay.

CHAIRMAN RANALLO: From the Hospital TAC side, I would request that DMS at least send that quarterly list to the hospital association, so it can be distributed to the hospitals. I don't know why that can't occur.

DR. ALI: So, again, you know, it's really about the maintenance and upkeep of it. You know, right now, we have the process. And, you know, we'll certainly take this back and look into it a bit further.

But, you know, from an initial perspective, you know, this is a process that goes back and forth between the MCO health plans and, you know, we don't want to communicate the incorrect information. I think the flow of communication with our health plans is, you know, what we would like to use because the health plans communicate directly with the providers.

CHAIRMAN RANALLO: They are not

great about communicating with providers. I'm just going to tell you that right now because we --

DR. ALI: Understood.

CHAIRMAN RANALLO: The issues that we've had with these NDCs are the NDCs using their -- or the MCOs using their own list, or at least what we perceive as their own list for some of these denials. And so there's inconsistencies among the MCOs on the NDCs. I mean, I know that from my own billing shop.

DR. ALI: Yeah. So, again, once the -- once the supplemental file is developed and shared with the MCOs, the expectation will be that the MCOs work in collaboration with the provider community. I mean, that's what their contracts are set out to do, you know. So we would -- we would expect that the health plans really be at the forefront of working with the provider community. Again, if there are issues with specific health plans or combinations that you're not able to get through, certainly bring those up to us. But the first line of communication lies with the health plan.

CHAIRMAN RANALLO: I still -- and I don't mean to be difficult. But I still have a problem with the NDC list being a black box that the providers can't access and set up their own billing codes and be able to evaluate it and establish their own -- the billing properly if it's -- it should be a public list. And it shouldn't have to go through -- we shouldn't have to get it through one of the MCOs.

I mean, that's my request, I guess. And if the answer is no, then we can bring it back next month and, I guess, make a recommendation. But I don't understand why it can't be -- I mean, it should be a public list that the providers should be able to see.

DR. ALI: Well, I think there are a few complexities there with how evolving and rapidly changing, you know, NDCs and those combinations are. You know, again, like I said, I will take that back to our internal teams and see how we can best assist our providers.

But, you know, again, a lot of this

frontline communication falls with the MCOs who will have those lists. But, again, you know, those lists are not a hundred percent -- I don't want to say accurate all the time. But, you know, the fact that NDCs and things change all the time -- you know, NDCs get terminated on a daily basis. New NDCs come in, so on and so forth.

So, you know, there might be some instances where there needs to be some research done for a combination that a provider is submitting to the health plan and -- you know, to determine if it's deemed valid or not. So, you know, this is not a hundred percent full-proof system, and the reason for that is just the way that the industry works.

CHAIRMAN RANALLO: But it's not going to be a real-time list. You said it was going to be published quarterly; right? So it would never be real-time.

DR. ALI: Exactly.

CHAIRMAN RANALLO: So it's always -- I mean, it's always going to be as good as the last list that was published on

the quarter.

DR. ALI: Really -- yeah. And, really, it's going to be the date that the list is given to the MCOs, you know, because things change every day. However, we can't maintain and update the list on a daily basis, if that makes sense.

CHAIRMAN RANALLO: It does.

MR. DEARINGER: Russ, this is Justin Dearinger. I think we can definitely take it back and talk about it here at DMS and see if maybe there's a way we can have a provider-facing part when we get that completed, if that would be okay.

CHAIRMAN RANALLO: I mean -- I appreciate that, Justin. I mean, I don't think what I'm asking for is unreasonable. I mean, we've got the public list for the CMS and the Palmetto file. If there's a quarterly list that's generated to the MCOs, putting that out there for the providers to be able to see shouldn't be difficult. I mean, it should be the same list that everybody gets. That way, everybody is on the same playing field.

I mean, we're here because the MCOs have created this -- what it seems, to me, to be their own billing and coding issues with these NDCs to delay or not pay the providers. And so I don't -- without having the same information, again, I'm trying to win a fight or win payment for things that we've provided with one hand behind my back.

MS. YOUNCE: Russ, I'm going to add, too, from UK's perspective, it would help us prepare our systems to bill them correctly as well. So just having a heads-up beforehand would be very helpful.

MR. DEARINGER: Yeah. I think this is good knowledge for us to be able to take back and discuss, and maybe if you could leave this on topic for the next meeting.

CHAIRMAN RANALLO: Okay.

MR. DEARINGER: Or if we come to some resolution before then, we'll reach out.

CHAIRMAN RANALLO: Okay. I think the other issue I heard is about compound drugs that don't have NDCs that are being denied through the MCOs, that there are no NDCs for and they're being denied for no NDC.

As I understand it, there is no NDC for the compound drugs, so that's another -- another piece that I'd like to discuss either now or in a future meeting.

And then I think, just from the fee-for-service perspective, I've always had this opinion. You know, if Medicaid is paying 95 percent of costs, there should be no rebate that they're going after or getting because they're already paying less than cost. And if our cost is the -- for a 340B hospital at least, they already discounted the price.

I have some questions on that, I think, I'd like to have maybe a separate meeting to kind of dive into because it doesn't make a lot of sense to me.

DR. ALI: So without opening up a can of worms there on the 340B piece of it, you know, that sentiment is correct, that, you know, the discount is applied for providers using -- or billing 340B claims. However, for 340B claims, you know, with the modifiers and tools that we have to identify those claims, those are automatically

excluded from collecting the rebate.

CHAIRMAN RANALLO: So if you have a 340B hospital that is getting a denial for no NDC and you can't claim the rebate for it because of the way they bill it, should they be getting a denial for no NDC? Because you're using an -- I mean, you're requiring an NDC to get the rebate.

DR. ALI: Right.

CHAIRMAN RANALLO: And if you have a hospital that is a 340B hospital that's billing and the payment is coming in at less than their cost anyway, should there be any -- I mean, should there be a need to have the NDC for that hospital? Should that be a reason to deny a claim, I guess?

DR. ALI: So, you know, again, the claim needs to follow a certain list of requirements, and maybe, Greg, you can speak to this if you've seen some of those compound claims come in. But, you know, an NDC is a requirement there. I guess it depends on what part of the compound is coming in, whether it's, like, a bulk powder or one of those sweetening agents or, you know, any

piece of the compound that's being billed to Medicaid. You know, some of those are part of exclusion lists.

Again, without an example, it's a little difficult to speak to it. But maybe if one of the MCOs want to chime in, or we can take it back if someone wants to send it via email.

CHAIRMAN RANALLO: We will -- we'll bring some examples. I know we have some. I know KHA has some that they've logged, so we'll bring back some examples on that particular issue; okay?

MR. IRBY: The only thing I would add -- I can't speak to the complex drugs. I can't speak to all of that. But what I will say is that our process is dictated by our encounter rules, meaning anything that's submitted to us as a claim will end up going to DMS as an encounter, and we are required to strictly adhere to rules there.

And so we use a proprietary list. We use RJ Health. I think a few others do. And so their list we've found to be more comprehensive than others, and so we are

using their list as a primary source. If there's a dispute about that, we're checking other files, and we're not seeing that our file is less inclusive than others.

And so I just want to make sure that if there are providers who have potential issues with NDC issues with UnitedHealthcare, I want you to know that we are very open to that. We want to help solve this problem. We have discussions with DMS frequently about this. I know that DMS wants to solve this problem, too.

So, Russ, to your point, I am advocating for a more public and transparent list that's universal. I think that would be helpful. And I know that there's nuances that make that difficult to do. And so I just -- I want to make sure that everybody on this call knows that you can absolutely come to us if there's an issue, and we will help to solve that issue.

CHAIRMAN RANALLO: Thanks, Greg. I appreciate that.

Okay. Elaine, anything else on this before we move on? Anything that -- okay.

MS. YOUNCE: No. It's been on the list since I can remember, so it's longstanding.

CHAIRMAN RANALLO: Thank you for the input and the discussion. I do appreciate it.

Okay. Retro authorizations. I know we had the two letters that were sent out on the retro authorization and the altering of the medical records from us. I don't think we have anything else there.

Elaine, anything that you have from your list?

MS. YOUNCE: No.

CHAIRMAN RANALLO: I know we'll get down to the changing medical records on the post-discharge later.

On the soft denial issue, I know we -- we talked about this being, you know, a prepayment review last month. I don't know if we have any follow-up on anything here.

We'd also talked about the ED downcoding, again, being pre-payment review and looking at sending it through an algorithm or a claim -- a claim-by-claim

review.

And the third one was denials without -- you know, when we do get those downgrades either on an E/M or an ED, there's no reason that's given to us. There's no letter that's coming back to us.

Is there any follow-up from DMS side, or is there things that I need to -- that weren't given that we need to go back and secure?

MR. DEARINGER: Hi. This is Justin Dearinger. So I think we had talked with each of the MCOs in accordance with what you all had sent. And the two things that we stressed to them were that any denial needs to have a sufficient reason behind it and that they need to let you all know that. So if you all are still getting denials that have no reasoning or rationale behind it, you need to let us know.

The other thing is that any denial or downcoding that you all receive, that they make sure that you all are given the same appeal rights and options that you would have with any other denial because that's what it

is. It's a denial so -- to make sure that you all have access to that whole process. So I think we've had those discussions.

CHAIRMAN RANALLO: Okay.

MR. DEARINGER: And then on the vendor request for medical records, we have talked to multiple MCOs and partners about making sure that those medical requests -- the medical records requests are given sufficient time and that you all are given -- if there's time -- extra time needed to supply those, that you all are able to request extensions for those.

So we've had discussions on each of those three topics. Was there more that you all wanted us to chime in or the MCOs or...

CHAIRMAN RANALLO: No. I think -- I think we'll go back and review what we're getting back now after you've had those discussions, and I'll leave it on here. And we'll report back the next TAC meeting.

MR. DEARINGER: Sounds good.

CHAIRMAN RANALLO: Thank you, Justin.

All right. D. I'm going to table D.

Incarceration issues. We had a meeting set up, but there were some -- I think some confusion, and we need to -- we're working to reschedule that meeting to talk about the FAQ list. I appreciate the scheduling of that and then we'll report back the next time.

On the SNF coverage, Emily Hardin sent us an email following up on this from the last meeting that said if you have someone from the MCO that's moving into a SNF, the first 30 days, that Medicaid indemnity would cover their room and board, but the remainder of services would be covered by the MCO. And that was the follow-up that we were given.

And I just want to put that -- thank you, Emily, for sending that. And then we're going to take that back to the hospital group and see if there's any further issues, but that was the guidance that we were given based on our question last time.

I think we got our question answered on the notification of payment rate updates.

The split authorization guidance, that was sent out in August clarifying new coverage. I think we're okay there. We can

take that off.

The partial hospital guidance. I know the last time, we said that it was being reviewed internally, DMS. I don't know that that -- is there anything there that we need to review, or we need to just leave it here until there's follow-up?

MS. EISNER: Russ, can I speak on that? This is Nina Eisner.

CHAIRMAN RANALLO: Okay.

MS. EISNER: We have gotten communication, you know, verbally from Commissioner Lee -- and, Justin, you were on the call -- where we again talked about this on October 2nd, that telehealth via PHP -- or PHP and IOP via telehealth is approved and that CMS -- she sought CMS guidance, and there was support for that.

I think what we're still lacking -- and we very much appreciate the Cabinet's significant review of this topic. But we still don't have anything out to the provider community that says that the communication, Justin, from -- I think it was October 16th of '23 is no longer in effect and that, in

fact, PHP and IOP can be delivered via telehealth.

We still had some questions, too, about whether or not there was any change in billing practices from the time that these services were billed under the Public Health Emergency. And Commissioner Lee said no, there shouldn't be any new billing guidance required.

And so, Justin, we're still asking for a communication to come out from the Cabinet, from you or whomever at DMS, advising the hospital provider community that this service is now available to be rendered and billed and paid.

MR. DEARINGER: Yeah. So we have that -- we've talked about that. We've communicated with CMS, and so we're kind of going over the final pieces of that internally before we send out provider guidance. So that's been drafted, and it's going through its reviews and will come out at some point.

MS. EISNER: Any --

MR. DEARINGER: And I know -- I

know y'all are waiting on that. I don't have an ETA right now. I have -- we have a lot of different provider guidances. And so they're just -- they go through a process of approvals and reviews, and it is in that process.

MS. EISNER: Okay. So you don't know if it'll be a week or a month or --

MR. DEARINGER: No, I don't.

MS. EISNER: I've been dealing with this for a year already.

MR. DEARINGER: I understand. That is correct.

MS. EISNER: All right. So the word back to the provider community is that provider guidance will be sent out. But it is not yet finalized, and there is no ETA.

MR. DEARINGER: That's correct. Hopefully, it won't be -- hopefully, it won't be a month. I mean, I think that's a stretch.

MS. EISNER: Cool. That would be great. All right. Thanks, Justin.

CHAIRMAN RANALLO: Thanks, Nina. We've leave it on the old business for the

next TAC meeting just to follow up and close the loop.

MS. EISNER: Yes. Thank you.

CHAIRMAN RANALLO: Okay. Next item, MCO vendor requests to change medical records post discharge. I know we got guidance on this that that shouldn't occur.

We're still getting reports from providers as of last week that we've got -- we've got one MCO that when they have a DRG change, is requiring -- and if a provider doesn't dispute -- so they're coming back and saying, we don't believe that records support to this diagnosis.

If a provider either loses that appeal or agrees with that, they -- the MCO is requesting the removal of that diagnosis on the billing which would -- you know, would not match up the billing to a medical record. And instead of just -- and hospitals are getting no payment, then, if the hospital doesn't do that versus getting the DRG change payment that the MCO says it should be.

So this is still -- there is still noise around this issue.

MR. DEARINGER: So I think there's a way to have -- you know, to make that change without removing anything from the medical record. I think it's important that -- you know, the letter that we sent was accurate, and I think it's important that we maintain that. I also think there's a way to be able to add additional information after review to that medical record without removing anything.

So that may be something that we need to take offline off this meeting and meet with the individual MCO and see if we can come up with a solution that -- because, you know, we can't take anything off of the medical record, but we can certainly add if something has been decided or changed in after tense to make something different than was previously put on there.

CHAIRMAN RANALLO: And I appreciate that. I'd like to follow up on that because, I mean, you could have -- I mean, I know we've had situations where we disagree, but the reviewers agreed with the MCO. And even though we disagree and our physician

disagrees -- you know, from our perspective, that diagnosis should still be there. And if, you know, we realize that we may have lost appeal for whatever reason and, you know, we don't want to change that bill. We feel like it's out of form.

And so -- but understanding that we shouldn't get zero payment. We should get the payment that the new or the adjusted DRG that the MCO has said that they would pay, that's what they should pay. But they're putting in this step because they know we won't do it and in order to pay nothing rather than pay the changed DRG, from my viewpoint.

MR. DEARINGER: Yeah. We definitely need to meet about this specific issue, you know, in a separate meeting. I think it's something that we can do. I think it's doable.

CHAIRMAN RANALLO: Okay.

MR. DEARINGER: I think it's going to be an easy fix, but it's some technical billing stuff. We need to have the proper people and kind of maybe have a workgroup

type meeting where we work through the solution.

CHAIRMAN RANALLO: Okay. I'm more than happy to attend that, or I'll have other members from the TAC attend that if you want us there.

MR. DEARINGER: Yeah. Absolutely. I'll have that set up.

CHAIRMAN RANALLO: Okay.

MR. DEARINGER: All right.

CHAIRMAN RANALLO: Thank you.

Nina, this one came from you from the last MAC meeting, the new business, burden of increased number of medical necessity audits. I don't know if you want to speak to that.

MS. EISNER: Actually, that was coming mostly from Debra Anderson with Baptist. So I don't know if anybody is on with Baptist about that. I don't really have anything to weigh in on with that.

CHAIRMAN RANALLO: Okay. Well, we'll -- if she is -- if there's no representative from Baptist here, we'll follow up with them and get that information and have them here at the next time.

MS. EISNER: What I recall was that there were a number of records being requested all at once, like, I want to say, hundreds and that the burden -- the administrative burden of being able to turn around those audits was significant.

And I think DMS had weighed in on that, that it should be possible just to, you know, send a part of a medical record. So, yeah, let's leave that on unless DMS has anything else to add.

CHAIRMAN RANALLO: Okay. And I'll follow up with Debra.

MS. EISNER: Okay. Appreciate it. Thank you.

CHAIRMAN RANALLO: Thank you.

All right. And then the last one, Erin, I think you set this. The newborns -- that DMS wanted to talk about newborns with invalid Medicaid IDs.

MS. BICKERS: Yes. I was asked to put that on the agenda. I believe Justin wanted to speak on that.

CHAIRMAN RANALLO: Okay. Justin?

MS. BICKERS: You're on mute,

Justin.

MR. DEARINGER: Oh, sorry. I think we had somebody maybe from eligibility that was going to talk about that today. Is that correct or -- I might be wrong.

MS. GRIFFIN: Sorry. Can you hear me?

MR. DEARINGER: Yep.

CHAIRMAN RANALLO: Yes.

MS. GRIFFIN: Okay.

MR. DEARINGER: Awesome. Thank you.

MS. GRIFFIN: Yeah. So it was brought to our attention by the Department for Community Based Services that they'd been receiving a lot of the MAP-221 forms, the newborn add forms.

And they just wanted us to mention that in the Kentucky child system, when a provider is entering a birth record for a newborn, we have added a field for the mother's Medicaid ID number. And that Medicaid ID number is what links that child to their mother's Medicaid case and can automatically add the child to the case and issue the correct

benefits.

And I think someone had mentioned that providers were entering dummy Medicaid ID numbers into that system when the newborn record is being added, and they just wanted us to stress the importance of making sure that you look up the mother's eligibility, look at the mother's MAID number, and ensure that that MAID number being entered is not just a random dummy number. That makes sure that our system links the newborn to the mother's case appropriately and relieves the need for the MAP-221 forms to be submitted.

I think that was -- that was all I remember the conversation being. They just wanted us to mention that.

MR. DEARINGER: That's correct. Thank you, Jiordan.

MS. GRIFFIN: Absolutely.

CHAIRMAN RANALLO: Yeah. Thank you, Jiordan. We will -- I'll bring that back to the hospital association. We'll have that communicated out to all the providers so that they're aware of that and try to -- try to help with making that

better.

MS. GRIFFIN: Sure. Thank you so much.

CHAIRMAN RANALLO: Yep. I appreciate that. I appreciate that input. Thank you.

DR. THERIOT: That's kind of a big deal, that a hospital professional would just put in a dummy number like that.

CHAIRMAN RANALLO: I think they -- I think they're probably thinking that it is the baby's number, and there's not a baby number.

DR. THERIOT: Right.

CHAIRMAN RANALLO: And they can't get past it, and so they're putting in a -- that would be my guess. But they're putting in a dummy number because there is no number for the baby yet. And in order to get it through -- and that's the only thing that I can think of what they're doing. They don't realize it's the mom's number. They think it's for the baby.

DR. THERIOT: Should we change, you know, the identification on the form somehow,

Jiordan?

CHAIRMAN RANALLO: I don't know. I'm going to go back to my folks and have them walk me through it and see what it looks like; right? To see if that is confusing or if it's pretty --

MS. GRIFFIN: Yeah. I'm not sure what it looks like from the provider side in the Kentucky child system because I don't have access to see what that looks like. But yeah, if there's anything that seems confusing or could be further clarified, we're happy to take that back. Just let us know.

And I think there was one other mention, is when providers are putting in a record into the Kentucky child system using G baby or B baby as the name, that -- when that does appropriately link to the mother's case, it causes issues because then we have to go back and correct the name and get verification of what that child's actual name is.

Again, I don't know what the process is for the providers, if they're able to go back in and edit that information once that record

is entered. I'm not sure. But they just wanted me to bring that up as well, as an issue they've seen.

CHAIRMAN RANALLO: I'll -- I know I'll personally go through our hospital and see how they do it and see what it looks like. But we'll also send out the communication to all the other providers and ask for feedback.

DR. THERIOT: Thank you.

CHAIRMAN RANALLO: Good. Thank you, guys.

All right. Any other items or discussion? Elaine, anything?

MS. EISNER: This is Nina Eisner. I just went back and pulled my notes from our MAC meeting on that authorization issue in terms of increased audit requests and the burden of the number of requests.

The other thing, in addition to the burden, was that the turnaround time was too short and that if there wasn't going to be a change in the request for so many records, the turnaround time needed to be more reasonable. So I just wanted to add that.

CHAIRMAN RANALLO: Okay. Did your notes show, was it one particular MCO or multiple MCOs? I'm not aware of that type of request.

MS. EISNER: Let's see. It's a good thing I'm still paper driven; right? No. It did not say a particular MCO.

CHAIRMAN RANALLO: Okay.

MS. EISNER: I think it was -- for the behavioral health community at least, and Debra was talking about that, it was pretty much across the board.

CHAIRMAN RANALLO: Gotcha. Okay. All right.

MS. EISNER: Okay. And we'll take it back to next week -- or next time. Thank you.

CHAIRMAN RANALLO: Yes, ma'am.

All right. Elaine, anything on your end?

MS. YOUNCE: Nothing I can think of, Russ. Thank you.

CHAIRMAN RANALLO: Okay. No recommendations. I'll be the MAC meeting representative to report. Our next meeting

is December 10th. We're having it early because of the holidays and Christmas.

Erin, if you could look at it and make sure everybody is still okay with that date.

MS. BICKERS: Absolutely.

CHAIRMAN RANALLO: That's a little change from our normal cadence.

MS. BICKERS: I'll send out an email after the meeting. And, also, I'll let you know I am working on the 2025 dates. I should have those out in the next week or so for approval.

CHAIRMAN RANALLO: That would be wonderful. I appreciate that.

Okay. All right. Thank you, everybody. I appreciate everybody's time, and we'll stand adjourned. Thank you.

MS. BICKERS: Have a wonderful day.

CHAIRMAN RANALLO: You, too.

(Meeting concluded at 1:43 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 8th day of November, 2024.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR