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

****

Via Videoconference
April 21, 2026
Commencing at 1 p.m.

Tiffany Felts, CVR
Certified Verbatim Reporter

APPEARANCES

BOARD MEMBERS:

Russ Ranallo, TAC Chair
Lori Ritchey-Baldwin
Chris McClurg
Michele Lawless
Elaine Younce
Kyle White (not present)
Nina Eisner

MS. DAVIS: Good afternoon. The time is now 12:58. We are still clearing the waiting room, and as of now, we just have yourself, Mr. Ranallo.

MR. RANALLO: Thanks, Danni. How are you?

MS. DAVIS: I'm good. How are you?

MR. RANALLO: I'm good, good day.

MS. DAVIS: That's good to hear.

MS. RITCHEY-BALDWIN: Good afternoon.

MR. RANALLO: Hi, Lori.

MS. RITCHEY-BALDWIN: How are you doing?

MR. RANALLO: I'm doing great. How are you?

MS. RITCHEY-BALDWIN: Doing well.

MR. RANALLO: Hi, Lisa. How are you?

COMM. LEE: Doing good. How are you doing, Russ?

MR. RANALLO: I'm doing good. I'm good. Beautiful day on the west side of the state here today.

COMM. LEE: Yeah, it's been sunny and nice. I think it's going to be -- is the weather -- I haven't been outside. Is it

warm out?

MR. RANALLO: It was a little chilly this morning. Here it's at least going to be around 70 today so it's coming back a little bit, but --

COMM. LEE: Yeah.

MS. RITCHEY-BALDWIN: It's warm on the north side, too.

MR. RANALLO: Good stuff.

COMM. LEE: I haven't been out. I have been in here since 7:30 this morning.

MR. RANALLO: I hear you. I got a window, so I'm at least happy about that.

COMM. LEE: I have no window.

MS. EISNER: Lisa, you need to be home on your porch.

COMM. LEE: I know, I do, Nina. I really do need to be home on my porch. I love sitting on my porch.

MS. EISNER: I agree. I wouldn't go anywhere else if I had that view.

COMM. LEE: I love it. I used to have a bed on my porch a little, like, a futon thing on the side, I have a wraparound porch. And so I used to sleep out on my

porch at night.

MS. EISNER: I don't blame you.

COMM. LEE: I love it.

MS. YOUNCE: Hello, everybody.

MR. RANALLO: Hi, Elaine.

COMM. LEE: Hi, Elaine.

MS. RITCHEY-BALDWIN: Hi.

MS. DAVIS: It is now 1 p.m. We're still clearing the waiting room, but so far for the committee, we're just missing Michelle Lawless and Kyle White.

MR. RANALLO: Okay. I see Chris. We got a quorum.

MS. DAVIS: Yes.

MR. RANALLO: I'll let you clear the waiting room. We can wait until you clear the waiting room. Just let me know when it looks like it's cleared out.

MS. DAVIS: Alrighty. I'll probably give it another minute or two.

MR. RANALLO: Okay.

MS. DAVIS: All right. You also have Michele Lawless now here, and the waiting room seems about clear.

MR. RANALLO: Okay. Well, welcome,

everybody. We've got -- looks like we've got a full TAC membership on, so we do have a quorum. This is Russ Ranallo, the chair of the TAC. Can we -- for the TAC members, I know the minutes were sent out earlier, can we have approval for the minutes, or a motion?

MS. RITCHEY-BALDWIN: This is Lori. I'll move.

MR. RANALLO: Okay. Second?

MR. MCCLURG: Second.

MR. RANALLO: All right. All those in favor?

(Aye)

MR. RANALLO: All right, motion passes.

Okay, new business: the Medicaid budget. Steve Bechtel, does he happen to be on?

COMM. LEE: No, Steve is not on today. He is in another mandatory meeting this afternoon.

MR. RANALLO: Okay.

COMM. LEE: So I am no Steve Bechtel, but, you know, he knows everything budget,

but at this time, we really don't have anything to advise related to the budget.

We do start a new fiscal year July 1st. You know, we'll be in our 2027 fiscal year. Our budget was not fully funded, so as we start looking at decisions that we have to make and things that we have to look at we will definitely keep you all updated and be in touch with anything hospital related.

MR. RANALLO: So Lisa, I think that was my question more than anything. You know, we started off --

COMM. LEE: Mm-hmm.

MR. RANALLO: -- you know, I had heard from the administration, I heard from legislators, and there were a lot of different numbers, right?

COMM. LEE: Yeah.

MR. RANALLO: It started out a couple billion dollars, and then it went to 700, and then I heard 400. Do we know -- from the cabinet's or from your standpoint, do we have a number that we think it's short for the two years or the each year?

COMM. LEE: Yeah, we're still looking at that number --

MR. RANALLO: Okay.

COMM. LEE: -- and just trying to determine as best we can, so I don't know if we have a definitive number. I'm like you, Russ, I've heard a couple here, there and yonder, so just waiting to see if we can get that final number.

MR. RANALLO: Okay. All right, maybe we'll bring it back to the next TAC --

COMM. LEE: Yeah.

MR. RANALLO: -- because I'm just trying to figure out, you know, I mean, if it's, you know, 200 million or 500 million are two different numbers completely, right?

COMM. LEE: Yes, they are. Right.

MR. RANALLO: And so --

COMM. LEE: And what we're short in '27 you know will have an effect in '28, too --

MR. RANALLO: Sure.

COMM. LEE: -- so kind of trying to evaluate both of those years there.

MR. RANALLO: Okay. All right.

Well, I appreciate that.

COMM. LEE: Mm-hmm.

MR. RANALLO: Okay. The second one was NDC issues. I know we -- in our prep meeting, I think Dr. Lee was there. I don't know if he's on the phone.

MR. RADCLIFF: Yeah, good morning, everyone. My name's Quinlan Radcliff. I'm the Medicaid specialist with the Pharmacy Policy team here at the Commonwealth.

MR. RANALLO: Great.

MR. RADCLIFF: Yeah, so I understand that there's been some concerns with the invalid HCPCs and NDC process that, you know, many providers are having to go through, in particular, 340B providers. So I know there were concerns with the billing process where providers are kind of required to submit with valid NDC when the provider's going to be excluded anyway. So what we did is we started a conversation with Med Impact, our pharmacy benefit manager, on why that's needed, and they let us know that it is federal guidance to do so. So we understand that, yes, it can be cumbersome

for you all, so they are looking into a way to possibly exclude you all in their system to kind of make it easier on you all's end. So, you know, for the time being, those NDCs are still going to be required with the claims that you guys submit.

So we're also focusing on getting, you know, as many rejections down as we can at this point. So with our next invoicing cycle with Med Impact, that should really help tremendously because they're implementing a new status system on their side, so this will kind of accurately match a lot of the NDCs and HCPCs that you all are submitting.

MR. RANALLO: So okay, so that -- let me unpack. So for the TAC group, I asked the question at a pre, like, agenda review meeting, you know, with hospitals that are DSH -- 340B DSH eligible, you know, the question was -- that I had is that I don't see the value, you know, that the state can't get a rebate necessarily from our claims if they're -- you know, depending on how we bill and, you know, the cost that

they are -- they're paying us 95 percent of our costs, right? So the question -- you know, we've had this question before about, you know, is there a path that those hospitals can have from these denials that they're seeing and not getting paid for these drugs? And so they're looking into that.

The source of truth, I think, is another question that I think the hospitals have. I know, you know, we can bill -- at least from my shop, I can bill the same drug administered the same way billed with what we think is a valid NDC, and then we get different adjudication outcomes depending on the MCO. So same drug, same NDC can get paid from one MCO, get rejected by another MCO, and not having that source of truth is problem-some. I liken it to having, you know, CPT codes that are required for us to bill, but we can't have the CPT code list, right? It's a hidden list. And I understand that Med Impact list that the cabinet's using as the source of truth is proprietary. I think the question I have is

can I purchase it, right? I mean, is it possible for me to -- if you can't give it to me, can I acquire that same list from Med Impact, so I know what the source of truth is so that I'm working at least from some transparency on my side?

So that's one question I think we have, Quinlan. I don't know, you may not know the answer to that, but I'd like to have, you know, at least researched or asked so that we can figure that out because I've got hundreds of thousands of denials and so does a lot of the other larger systems, and if I could have that, that may help me, and may help me if I have issues on my end.

MR. RADCLIFF: Right. Right. So our source of truth is the Palmetto file and the CMS file. Those are both publicly available. The only thing that's proprietary is we have a supplemental file that is kind of rejected claims that Med Impact researches and kind of adds to their own thing each month. So that's the only thing that is not publicly accessible, so your --

MR. RANALLO: Okay.

MR. RADCLIFF: -- main source of truth is always going to be that Palmetto file and that CMS file, which I can send those over to the whole group as well.

MR. RANALLO: They were sent to us, and I sent it out to the TAC members.

MR. RADCLIFF: Okay.

MR. RANALLO: I also sent it to KHA, my KHA contact, so she will send that out. So we have those links, I appreciate that. And those are the ones that -- so that's what the MCOs should be working off of.

MR. RADCLIFF: Right.

MR. RANALLO: And I guess this -- you know, and why this has become an issue is that we're seeing these, you know, each time that we have a denial we have to -- you know, we have to manually go through and investigate, rebill, appeal preparation, there's no automated way for us to do this, and -- because we have to submit the drug labeling, the administration records, the manufacturer documentation. And when we get that rejection, it's -- you know, it takes

time for each one of those, so we're trying to minimize these as much as we can. It's we're seeing MCOs that, you know, vial versus package, right?

MR. RADCLIFF: Right.

MR. RANALLO: When we get down to it, you know, it's a vial versus package issue, when we bill the vial, and they've got package in their systems. When we run into these things where we think we're right, and we can't resolve it with the MCO, what's the process for the hospitals to either escalate it or try to get it resolved? Because what I can tell you is that we're routinely instructed to rebill using alternate NDCs that we don't believe correspond to actually what was administered, right? Vial and package, right?

MR. RADCLIFF: Right.

MR. RANALLO: And from a compliance standpoint, we've got concerns on what we're being told by some of the MCOs on "You need to bill this NDC," and we don't agree that it's necessarily right.

And so from a compliance perspective,

I got my compliance folks going -- and me saying, "You can't -- we're not doing that." So if we get to that point where we've -- you know, I've got some of these issues. What's the process for our members to try to resolve it, or how do we -- I mean, am I filing the appeal and it goes through the IPRO? Do I have to file a complaint? How do we -- you know, how do we take this further when we think it's X and the MCO is telling us it's Y?

MR. RADCLIFF: Yeah. I can definitely take that back and get, you know, a more formal process in place for you guys that I can probably send over. I will say, if you guys are seeing the same claims over and over, it's the same thing, same drugs, same NDC and everything, and it's just a problem month after month after month, claim after claim, go ahead and send that over to me personally and I can look at that. I'm only one person --

MR. RANALLO: Yeah.

MR. RADCLIFF: -- so I can only, you know, escalate so many things. And I know

you guys are in the same boat with thousands of claims getting denied --

MR. RANALLO: Sure.

MR. RADCLIFF: -- but if it's something pretty common that needs to be going through, you know, please escalate that directly to me and I will get that taken care of.

MR. RANALLO: Okay. And, you know, going back to the first piece, you know, if there is a way to not have denials for those folks that you can't get rebates for, right --

MR. RADCLIFF: Mm-hmm.

MR. RANALLO: -- you know how complicated the NDC process is with the -- you know, you can't have a really compendium of it, right? It's just a --

MR. RADCLIFF: Exactly.

MR. RANALLO: But if we can get passes on that, that, I think, eliminates a lot of administrative burden from both sides, right?

MR. RADCLIFF: Mm-hmm.

MR. RANALLO: From all sides, right?

From your side, from the provider side, and from the MCO side, you know, because it's -- again, if it's not bringing value or it's not rebatable, then maybe that's a way we alleviate some of this noise.

MR. RADCLIFF: Yes, definitely.

MR. RANALLO: Okay. Anybody else from the TAC got questions that they want to ask Quinlan on this?

COMM. LEE: Russ, I don't -- I just have a question for you.

MR. RANALLO: Okay.

COMM. LEE: I want to make sure I heard you right that the MCOs are instructing hospitals to change the NDC number for 340?

MR. RANALLO: Well, I don't think they're doing it out of malicious intent. What they're telling us is that -- they're instructing us to rebill using an NDC that doesn't necessarily correspond to what we believe was actually administered. So it goes into this, you know, vial or syringe versus package, right? It may be the same manufacturer, it may be a different -- you

know, they've got a package NDC and we can't get them to understand that they've got a different NDC there for the package versus the vial that we administered.

COMM. LEE: Okay.

MR. RANALLO: And so -- but what they're saying is this is what they have in their system or this is how it would get processed, and that's what they're advising us that is the correct NDC for what we gave, and we don't necessarily agree with that.

So again, I don't think it's a -- I don't like it's anything like malicious intent. I don't I want to -- I want to make sure that you understand.

COMM. LEE: Mm-hmm.

MR. RANALLO: It's just that I think there's a disconnect in what they're seeing in their, again, source of truth versus what we think is what's right, and then they -- but it won't process. And so then we don't get paid for that drug on the outpatient side, and then there's a whole host of issues with that, right? I've got, I mean, the financial and operational strain of it,

and the disruption is -- you know, especially with some of these drugs that can be very pricey becomes difficult.

I know there's also occasions where I've had members say that there is not an NDC for this particular thing, like water, and they're being told by the MCO that there is an NDC, and they should be having an NDC for it. And so there's components there that I've heard from others on the hospital side that said, you know, "We can't resolve those as well either." So it's there's a lot of -- there's a lot of churn and noise around it, and it's been like this for a little bit and we're just trying to see how we can make it better. Like I said, every time at least one of my folks touch this, it takes around five minutes on average to go through this and kind of go through, and we've got a lot, and it's a manual process for us to do these.

COMM. LEE: Okay, thank you for that.

MR. RANALLO: Anyone else from the TAC have any questions at this point?

(No response)

MR. RANALLO: On this one, there was -- I know there was a global issue with WellCare. I don't know if WellCare folks on the phone.

Quinlan, thank you so much for attending and the input. I appreciate it very much.

MR. RADCLIFF: Yep.

MR. RANALLO: There was a WellCare global issue, as I understand it. I know that was they were working through where their system was dropping off, I think, two digits of some of these NDCs, and when there were -- there were spikes. Is there an update on the rework of those?

COMM. LEE: I'm sorry, I --

MS. BROWN: Hi, I'm -- sorry.

COMM. LEE: Go ahead, I'm sorry.

MS. BROWN: I'm Brittany. I'm here because Kathy can't be here. We have our provider summits going on right now. Is this in relation to KEYTRUDA?

MR. RANALLO: I can't -- I don't know if it was a specific drug. What the issue that was brought to me was that there were

spikes in NDC denials because the WellCare system was dropping off a couple digits of the NDC, and so they couldn't get matches and it was denying that, and that they were doing a rework --

MS. BROWN: Yes.

MR. RANALLO: -- on projects to --

MS. BROWN: We are doing a rework. There was a change, but it caused a subset of NDC codes to incorrectly appear as termed --

MR. RANALLO: Okay.

MS. BROWN: -- resulting in claims being denied for invalid or expired NDC codes. The operating system migration was initiated on January 23rd, 2026, and the issue was identified and corrected on February 13th, 2026, at which time the IT team handling the migration updated the FDB table load process and corrected the dates in the FDB table. We conducted an impact analysis to identify the impacted claims and initiate a reprocessing project. The first batch of claims were reprocessed on April 4th, 2026, and the second batch of

claims are currently in process and slated for completion by May 8th, 2026.

MR. RANALLO: Okay. And then will that clear out -- there's not a third batch? Is there third batch, or is the second batch it?

MS. BROWN: No, just two separate projects.

MR. RANALLO: Okay. So everything should -- by May 8th should be cleared off the deck?

MS. BROWN: Correct.

MR. RANALLO: Okay, thank you.

MS. BROWN: You're welcome.

MR. RANALLO: All right, anybody else have any questions or input on the NDC issue?

(No response)

MR. RANALLO: Okay, we'll move on.

Old business: the HRIP. And Lisa, this was something that, you know, I brought up with Steve the last meeting. We talked about, you know, the way I understood the HRIP, you know, was this year, we couldn't go over. You know, in prior years, we've

gone -- based on volume, we have kind of gone over our target, right? And CMS had historically approved those, but this year, the target was not going to be able to be breached, right? We couldn't go above it.

COMM. LEE: Yeah, right. Yeah, the managed care final rule states that the HRIP payments will be required to transition from their current status as a separate payment. It's going to be fully incorporated into the managed care capitation rates, and so the change isn't scheduled to go into effect until '28, calendar year 2028, so January 2028. So we'll get some additional details on how all HRIP's going to be administered once those decisions have been fully evaluated. And so right now, our focus is definitely on finalizing the '27 program and submitting the associated preprint by the end of May 2026.

MR. RANALLO: Okay, so the '26 -- so what I -- I may have understood it wrong.

COMM. LEE: Yeah.

MR. RANALLO: I kind of understood that the Big, Beautiful Bill kind of froze

--

COMM. LEE: Yes.

MR. RANALLO: -- so whenever you got like your budget was --

COMM. LEE: Mm-hmm.

MR. RANALLO: -- for the '26, that was kind of your upper limit, right?

COMM. LEE: That is correct.

MR. RANALLO: And so if we go through three quarters this year and we're running hot through those three quarters, are -- what I asked him was, you know, are we going to get communication about kind of where we're at to the budget because we can see our payment, but we don't know overall -- you know, if it's 700 million a quarter, right --

COMM. LEE: Mm-hmm.

MR. RANALLO: -- we don't know if it was 800 million the first quarter or 900 million --

COMM. LEE: Right.

MR. RANALLO: -- to kind of understand from a forecasting perspective, you know, what we think the last quarter is

going to be.

COMM. LEE: Yeah.

MR. RANALLO: You know, 20 percent, 50 percent, so that we don't, you know, accrue something or expect something that doesn't happen. Does that make sense?

COMM. LEE: Yeah. So yeah, it makes perfect sense. So let me make sure that I understand the question, and it may be something that we can send an email so you don't have to wait for the next TAC. What you're asking is if since House Resolution 1 froze the provider payments or the amount that you all can receive, what happens if you all are spending -- if your expenditures exceed the amount of HRIP funds you would receive back?

MR. RANALLO: That's right.

COMM. LEE: That you're anticipating, and how will you all be able to plan for that and how can we help with any kind of communications of tracking?

MR. RANALLO: Yeah, that's correct because --

COMM. LEE: Okay.

MR. RANALLO: Yeah, because, you know, we've been -- like I said, the last two years as I looked at it, we've been over, and like I said, CMS kind of approved it on the back side, but they're not going to do that again as I --

COMM. LEE: Mm-hmm.

MR. RANALLO: -- understood. So --

COMM. LEE: Yeah, so if your spending is in excess of what you would receive in HRIP funds based on this new rule --

MR. RANALLO: Yeah.

COMM. LEE: -- how can we work together so that you all can plan a little bit? Not just at the back end, you know, you need a little bit of a heads up. Mm-hmm.

MR. RANALLO: Yes, ma'am, because -- yeah, I don't want to get to -- I don't want my folks to get to the fourth quarter, and all of a sudden, they get, like, a 50 percent payment of what the first three was --

COMM. LEE: Got it.

MR. RANALLO: -- and everybody freak

out, right? Because they've been planning on that fourth payment to be the same, and it's not going to be, right? And that way we can reserve and make sure that everybody understands what cash they're going to get and what payments --

COMM. LEE: Yeah.

MR. RANALLO: -- they need to book, those type of things.

COMM. LEE: Yeah.

MR. RANALLO: That would be so helpful, and we would be very appreciative.

COMM. LEE: Okay. I will pass that along to our CFO, and I'm sure his little brain will get to work on some sort of a plan for you there.

MR. RANALLO: Appreciate that.

MS. RITCHEY-BALDWIN: Russ, I have a question, and I'm sorry, I couldn't quickly find the "raise my hand" button on Zoom.

MR. RANALLO: Okay, sure.

MS. RITCHEY-BALDWIN: So I thought also the question we asked was assuming we can't go over the cap, was there also going to be sort of maybe a hold back for the --

so let's say we're going along and one subset of hospitals is running hot and more than what they normally get, and another set of hospitals is running less than normal because they're -- they really pick up at the end of the year, but we run out of money after the third quarter so there's nothing left, so those healthcare systems whose cycle's a little bit different, if they are hotter in the second half than the first half are going to get proportionately less whether their -- or are we just going to pay it as it goes and then we'll figure out what's left in fourth quarter?

MR. RANALLO: Yeah. And just to add onto that, there's been in the history we've had where an MCO has had an issue, right, where they've had a system change or system conversion, or an issue where their payments were impacted. And so, for example, WellCare is the biggest one in my region, right --

COMM. LEE: Mm-hmm.

MR. RANALLO: -- but it's not necessarily for Lori or for Chris, right?

Passport or another one may be the biggest. So if WellCare has an issue, it may impact me disproportionately than it impacts other folks, and if they can't pay claims for whatever reason for a period of time depending on the timing of that issue and when it gets resolved, to Lori's point, it could impact some providers differently.

COMM. LEE: Yeah.

MR. RANALLO: And so that was -- yeah, that was another discussion we had with Steve, and he was going to think on it and try to come back with us.

COMM. LEE: Yeah. That definitely makes sense to me, and we'll make sure -- and it sounds like -- and while we could probably put something in writing to you all, this sounds like it needs to be more of an in-person discussion so that we don't lose any nuances or any interpretation. So let us take that back and see what we can pull together for you and when we can have that next conversation.

MR. RANALLO: Yeah, that'd be great. We would definitely be up to participate in

that.

COMM. LEE: Mm-hmm.

MR. RANALLO: And I know my TAC folks would, too.

COMM. LEE: Yeah.

MR. HAY: Commissioner, this is John Hay. If I can just add to the conversation a little bit to ease Russ and Lori's minds.

This is -- these are all very valid concerns. We've been working with Myers on this. We've been working with KHA on this. And -- but at this point, we still don't have a final plan, but we understand the concerns and we are discussing.

MR. RANALLO: Thank you, John.

MS. RITCHEY-BALDWIN: Thank you.

MR. RANALLO: Okay. Anybody else, anything else on this one?

(No response)

MR. RANALLO: Okay.

All right. The next old business was the delivery of newborn issues. I think the -- in the prior-auth for -- there were a couple of things here, but I know we had the progeny issue that I think was being worked

through. I think one of the bigger concerns here was that, you know, we were having deliveries and we were getting denials for no pre-authorization, right, across this. And I know -- I know Justin, last time we had -- that there was a workgroup, and he was -- that they were going through this issue in particular and was going to come back with a report.

MS. BOHANNON: Hi, Russ. This is Jennifer Bohannon. I work for Healthcare Policy under Justin Dearinger.

MR. RANALLO: Yep.

MS. BOHANNON: He sent out a policy clarification today to the MCOs --

MR. RANALLO: Okay.

MS. BOHANNON: -- and I think mainly focusing on there cannot be -- there shall not be a zero payment for newborn delivery ever, and that was shared with the MCOs. I think he also mentioned -- let me pull up -- I think there was denials mentioned in this letter, too. Okay, the policy clarification states that "A payment for a Medicaid-eligible newborn should never be

zero, and no payment is to be recouped or paid zero due to a provider requesting an appeal." And internally, we are still reviewing the situations where we have a sick newborn but not necessarily sick enough to go to the NICU.

MR. RANALLO: Yep.

MS. BOHANNON: DMS is still with the workgroup, we're still working on that and we'll communicate --

MR. RANALLO: Okay.

MS. BOHANNON: -- updates to you as we work through those.

MR. RANALLO: Okay. All right. I appreciate that.

MS. BOHANNON: Mm-hmm.

MR. RANALLO: Okay. Any questions from the TAC members on that?

(No response)

MR. RANALLO: Okay. Thank you, Jennifer. I appreciate the update.

MS. RITCHEY-BALDWIN: Looks like there was something in the chat requesting that we get a copy of that as well.

MR. RANALLO: Is that possible,

Jennifer, to get a copy of that?

MS. BOHANNON: The policy clarification is not a public document, it's between DMS and the MCO contractors.

MR. RANALLO: Okay.

MS. BOHANNON: So it's not something we could share.

MR. RANALLO: Okay. All right. What is that -- does it have an effective date; can you tell me that?

MS. BOHANNON: Today.

MR. RANALLO: Today, okay.

MR. ARMSTRONG-DEROSSITT: And Russ and Jennifer, this is Jeremy with the Health Plan Oversight team. That communication Jennifer was describing is in the pipeline to be received by MCOs by end of today.

MR. RANALLO: Okay, thank you.

MS. BOHANNON: Thank you, Jeremy.

MR. RANALLO: Okay, COB issues, I know we asked for the hospitals to send some examples. I think you only had one as of last week, and I will continue -- I'm going to put this in the parking lot until we can get more examples to you guys that we can

work from.

So all right, prepayment reviews. I think at the last meeting, I think we had requested WellCare to kind of report at the next meeting on this. I don't know if they're here and ready to.

MS. BROWN: I am here for Kathy, but I was not told anything about this. I was just speaking on the NDC issues.

MR. RANALLO: Okay. Just to kind of refresh, there was -- DMS said they had no updates last time from WellCare. From the provider views, we're getting prepayment reviews outside of what we believe the guidelines are from DMS, and it was -- what it appeared to be was targeting processes for specific providers, not across like a network and across all providers. And we were -- we had requested WellCare to come and kind of talk about this and their programs and what it entails. So we'll put it off to the next meeting. If there's clarification, if it's needed, we can work on doing that, too.

MS. BROWN: Okay.

MR. RANALLO: All right. I think the behavioral health, I think there was an update on the IMD; is that correct?

MS. GRAHAM: Hi, my --

MS. EISNER: This is Nina.

MS. GRAHAM: Oh, hi, Nina.

MS. BOHANNON: Hi.

MS. GRAHAM: Go ahead.

MS. EISNER: We were waiting -- when we met on February 25th, we were waiting for clarification about the update that was out about the IMD, and also about ASAM.

MS. GRAHAM: My name's Heather Graham for the Department of Medicaid Services. I'm a behavioral health specialist, and we have the policy guidance that is with leadership for approval as far as the IMD partial hospitalization ask. There's been several changes in different flexibilities and extensions of telehealth services after COVID, and, you know, we're going to follow the federal policy, which changed again in February about, you know, different avenues of behavioral health services being allowed to be provided. So, you know, intensive

outpatient services, partial hospitalization services are allowable when they're clinically indicated, and pursuant to any of the requirements in the 907 Kentucky Administrative Regulation Chapter 3:170, which covers our telehealth service coverage and reimbursements.

So that letter is with -- it looks like the date on the letter is April the 2nd, so we have requested and followed back up again this week, too, so hopefully, we'll hear something back soon about what avenue we can get to get that published and out to you guys as soon as possible. And --

MS. EISNER: Thank you, Heather.

MS. GRAHAM: Absolutely. And the ACM --

MS. EISNER: Mm-hmm.

MS. GRAHAM: -- I do know is also still in the works to get that clarification out provided to you. I know we've had several discussions and have some drafts and language prepared, I think we're just waiting for a couple of impact pieces and then moving it forward from there.

COMM. LEE: And Nina --

MS. EISNER: Thank you.

COMM. LEE: And Nina, this is Lisa.

MS. EISNER: Yes. Hey.

COMM. LEE: I did look at the -- I looked at the IOP and PHP today as far as telehealth, and you should be getting that pretty soon now.

MS. EISNER: Great.

COMM. LEE: All right.

MS. EISNER: And then, there was a separate issue of ASAM. I'm sorry, a separate issue of IMD. So there was the telehealth issue, but there was also the issue about the change that we were notified on where it was not limited to 15 days within a hospital, it could be up to 60 as long as the state average stayed at 60 or less. And we were waiting still on policy clarification about that.

MS. GRAHAM: Do --

COMM. LEE: Okay. Heather, yeah. You can go ahead with that one, Heather.

MS. GRAHAM: Yeah, absolutely. Do you have a specific part of that you were

waiting for? Nina, I just want to make sure that I address the right concern as far as you're -- I'm -- no, you're discussing the serious mental illness, SMI 1115 Waiver?

MS. EISNER: Yes, uh-huh.

MS. GRAHAM: Yeah, and so that was enabled or enacted, went live, all of those words, on January the 15th of this year --

MS. EISNER: Right.

MS. GRAHAM: -- which did change from the voluntary 15-day in lieu of service criteria and then made it as if it was a state plan service, which offered medically necessary stays up to 60 days as long as we maintain the average length of stay. And so is -- what specifically --

MS. EISNER: There were questions at our meeting on February 25th about billing and just any more information. Rosmond, are you on?

(No response)

MS. EISNER: I thought she might have more information.

MR. RANALLO: Yeah, she's --

MS. EISNER: So it was -- I'm sorry.

MR. RANALLO: She's on, Nina. I don't know if we can't hear her, or --

MS. DOLEN: Sorry, Nina. I'm on. It took me a minute to get off mute. What can I help you with?

MS. EISNER: We're talking about the IMD --

MS. DOLEN: Mm-hmm.

MS. EISNER: -- and there was a communication that effective 1/15, the SMI, IMD, SMI 1115, allowed for up to 60 days of care as long as the average was 60 or less statewide. And I think the question was, and correct me if I'm wrong, I think what people wanted to know was how will we know what the statewide average is and whether or not days of care that are paid for will be reduced? Do you remember anything else from that issue?

MS. DOLEN: No, I don't. I do know that several hospitals had outstanding questions about the 15-day issue and what if it exceeded 15 days and the payments on that. But I think that you've summarized the initial questions correctly.

MS. EISNER: Any further clarification on that matter, Heather?

MS. GRAHAM: So it sounds like you're specifically wanting to know about the -- how you guys will know the average length of stay and how we're monitoring those pieces.

MS. EISNER: Yes.

MS. GRAHAM: We are monitoring those internally with our team. As far as 1115 demonstration, there is an entire team of people that we meet weekly, daily, on most different aspects of that --

MS. EISNER: Sure.

MS. GRAHAM: -- to make sure that we're in alignment with CMS policy and guidance. And so there are certain reporting requirements that CMS asks of us, and so we have to keep those monitored consistently throughout the demonstration. We do our yearly updates and reporting, and then from there, we also will do every couple of years we have, like, a midterm assessment, and then we have a final assessment of different processes and procedures in different demonstrations.

So at this time, since we just started this in January, we don't have any consistent data to be able to report what that is at the moment. We are monitoring it and looking at what CMS is requiring us to pull for that data to be able to give an accurate representation. And the average length of stay, if there is anything that we're coming up close on it, or anything that there's any concerns whatsoever, we will bring that up to you guys and let you know. I will say that the actual average length of stay reporting period is not till the end of '27, the beginning of '28 --

MS. EISNER: Okay.

MS. GRAHAM: -- so they're giving us time to figure out, right, and address and look at those things. And we meet quarterly to be able to address some of those concerns with CMS so that if we come up with anything, we can start addressing those sooner rather than later.

MS. EISNER: I appreciate that. Thank you, Heather.

MS. GRAHAM: Absolutely.

UNKNOWN: So Heather, can you --

MR. RANALLO: So Heather and Nina, is the average length of stay based on paid days or submitted days? Because what I understood when that communication came out, if the service extended past 60 days, the whole claim could be denied, right? Not just days over 60, but the whole thing, so if the whole claim is denied, is that thrown out of the average because there is not a paid day with it, and then you would never get over the 60, to my point, right? If it was just on paid days and you can only -- you're only paying claims up to 60 days, you'd never breach that average of over 60.

MS. GRAHAM: So we have, with our MCOs as well, they will let us know, they keep track of any stay that's over 60 days that was submitted to them, and so anything that has been submitted is being tracked in that way. It will be paid claims is the average length of stay because the entire stay can be up to 60 days, but the average length of stay for the state must remain under 30 days.

MR. RANALLO: Under 30 days.

MS. EISNER: Oh, okay.

MS. GRAHAM: Yes.

MR. RANALLO: Okay, that -- I didn't understand that.

MS. GRAHAM: That's okay.

MR. RANALLO: I got you. That makes sense. All right, I got you.

MS. GRAHAM: Yeah.

MS. EISNER: And if that stay -- yeah, I'm still trying to figure out how a provider would know that they have exceeded the 30-day state average if that's not coming out in a report.

MS. GRAHAM: They -- so we are going -- it's based on cumulative periods of time.

MS. EISNER: Okay.

MS. GRAHAM: So it's not going to be based on, you know, per month, or per -- you know, it's based on a series of time that CMS has given us guidelines for --

MS. EISNER: Uh-huh.

MS. GRAHAM: -- and so if we get anywhere close to that average length of stay, we will notify you beforehand.

And also, when we start reporting, like I said, we report every quarter with CMS, so when we start tracking those numbers that they've asked us to track for, we will be able to know what our average length of stay is. So consistently, so far, I mean, we're only in the first quarter, so -- right? We've not had enough claims data in --

MS. EISNER: Sure.

MS. GRAHAM: -- to be able to accurately represent. But in history, in state hospitals as well, I think maybe 15, 16 --

MS. EISNER: Yes.

MS. GRAHAM: -- you know, days average length of stay for the overall, so we've not come close to it yet, so we don't anticipate that being an issue.

And CMS did give us some guidelines on if we get close to that time period, or we get close to those time limits or restraints, that there are other steps we can take to be able to work with them to ensure that we get back to meeting our

average length of stay.

MS. EISNER: But if a hospital does go beyond 60 days, the paid days can be clawed back to zero payment, right?

MS. GRAHAM: Any claims cannot be paid anything over 60 days.

MS. EISNER: Okay, thank you. And we'll look forward to more information as you accumulate that length of stay information. Thank you very much.

MS. GRAHAM: Absolutely.

MR. RANALLO: Thanks, Heather. Thanks, Nina.

MS. EISNER: Mm-hmm.

MR. RANALLO: Okay. Next item: denials. I know Jennifer talked about the one piece with some of the DRG downgrading, especially within the newborn and the neonatal DRGs. And we talked to -- I think, you know, this with the E&M, at the last TAC meeting, what DMS had said is that they were working on guidance for the MCOs, that they were to provide clear and specific reasoning and are giving rights and ability to appeal. So for example, like on an E&M down coding,

some of those with some of the MCOs are coming through a remit and there is no real notice of "We've downgraded this from a Level 3 to a -- or a Level 4 to a Level 3 and this is why." And DMS, again, was working on guidance for the MCOs that would give us, the provider, a reason and notice of our rights and ability to appeal. Do we know where that is, Jennifer?

MS. BOHANNON: Russ, it's Jennifer again. So this is actually outlined in the policy letter that talks about the newborn issues as well.

MR. RANALLO: Okay.

MS. BOHANNON: And it was outlined that the MCOs are to provide specific reasons, whether it be a denial, a line-item denial, E&M down code, or DRG downgrade. They have to provide specific reasons for the denial along with details that will allow the providers the opportunity to research and appeal, you know, if they need to appeal those decisions. So he has also added that to the newborn letter, too.

MR. RANALLO: Great. That's great

news. I appreciate that, thank you.

MS. BOHANNON: No problem.

MR. RANALLO: Thank you for that input and that guidance. I appreciate you guys hearing us. Anybody from the TAC, questions on that?

(No response)

MR. RANALLO: Okay. Any other items for discussion from the TAC members?

MS. LAWLESS: I don't have any, Russ.

MR. RANALLO: Lori, anything?

MS. RITCHEY-BALDWIN: Mm-mm. Appreciate the update.

MR. RANALLO: Okay. No recommendations this time. I'll be at the MAC meeting. Our next meeting is June 23rd, 2026. Jennifer, Lisa, everyone from your side up, I appreciate you guys. Thank you for spending time --

MR. ARMSTRONG-DEROSSITT: Hey.

MS. DAVIS: We do have a hand. I'm sorry for interrupting.

MR. ARMSTRONG-DEROSSITT: Yeah.

MR. RANALLO: Oh, I am sorry.

MS. DAVIS: We do have I raised hand

for Jeremy Derossitt.

MR. ARMSTRONG-DEROSSITT: Hey.

MR. RANALLO: Thank you, Danni, appreciate that.

MR. ARMSTRONG-DEROSSITT: Yes. Hey, Russ, this is Jeremy with DMS Health Plan Oversight again.

MR. RANALLO: Uh-huh.

MR. ARMSTRONG-DEROSSITT: I believe my team had -- Chelsea, I believe you had an update to prepare for the prepayment review topic --

MR. RANALLO: Oh, that's great.

MR. ARMSTRONG-DEROSSITT: -- so I just didn't want it to close out with any additional information there.

MR. RANALLO: Okay, great. Sorry about that. That'd be great.

MR. ARMSTRONG-DEROSSITT: Yeah.

MS. AGEE: Yeah, we just -- I think this was more related to some notifications that were received from Optum for Passport by Molina where some of the notices had the word "prepayment" in the notice. So we are working with Passport to have their vendor

correct the terminology that they're using in those letters because it is not a prepayment review that is tied to FWA, which is the context in which an MCO would have to request prepayment review from DMS first. The reviews that are happening with Optum are just coding reviews, claim reviews, just ensuring that claims were coded properly: medical necessity, you know, is there and all that. So they're not the fraud, waste, abuse focused prepayment reviews, which are, you know, outlined in the MCO contract in sections, I think it's 34.2.

So it's a separate process, and so we're working with the MCOs. I know we, you know, also worked with WellCare in this space because they had a similar messaging in some of their letters that were going out, so they, too, are, you know, working to correct that, kind of change that terminology in their letters so that it doesn't cause that confusion. So I can provide an update once we get confirmation that that's all completed.

MR. RANALLO: Okay. I'd appreciate

that. I think --

MS. AGEE: Yep.

MR. RANALLO: -- that was a big chunk of it. I think the other piece was some of these ones that were going through the EOB process, right?

MS. AGEE: Mm-hmm.

MR. RANALLO: The ones that were going through an algorithm, right, or a black box, or, you know, "I'm going to send all claims through this," and it's spitting out downgrades, right, on E&Ms and certain things, you know, the ability for the -- you know, with no reason, right?

MS. AGEE: Right.

MR. RANALLO: And no notification, so I think, you know, I viewed that as a prepayment review as well, and we questioned that, but with the clarification I think Jennifer gave on the policy -- or the clarifications going out with the MCOs, I think that'll help us, right, help providers --

MS. AGEE: Yes.

MR. RANALLO: -- with that type of

review. I appreciate you guys looking at that because, you know, the prepayment reviews are very targeted, very specific on an issue, right?

MS. AGEE: Mm-hmm. Yep.

MR. RANALLO: You say, "Okay, this provider had an issue or suspected to have an issue, we're going to do this for a certain period of time, here are the results, here's what we found, where we need to do education or let it go." And so when we started seeing these things with prepayment reviews without those guardrails in it, they were being called prepayment reviews and brought up all kinds of concerns.

MS. AGEE: Yep. Absolutely, yeah, and we definitely understand that and how that can cause confusion, so working with them to make sure that gets corrected.

MR. RANALLO: Okay. Anybody from the TAC, any questions?

(No response)

MR. RANALLO: Thank you. Appreciate that. Appreciate that update.

MS. AGEE: Yep, no problem.

MR. RANALLO: Okay, anything else?

(No response)

MR. RANALLO: Lisa, thank you for attending and working through these things. If we want to talk about -- like, if we do need to have, I mean, you know, face-to-face would be great on the HRIP and the cap process. You understand. I know you guys are aware of it, but, you know, just, you know, people are nervous a little bit, right? Because they just don't know how it's going to go, that's all.

COMM. LEE: We definitely have some challenging times coming up ahead of us. And just --

MR. RANALLO: Yes, ma'am. Yes, ma'am.

COMM. LEE: -- hope we can identify some opportunities within those challenges, and I think it's just more important than ever that we work close together to make sure that we're building the best healthcare system we can, not only for the Medicaid population, but all of those individuals

across the Commonwealth.

MR. RANALLO: I agree 100 percent, and, you know, you've got some folks on this TAC that have been around a long time and care deeply for the patients that we serve, so anything -- anytime we can be of service, just please let us know.

COMM. LEE: Appreciate that, Russ. Thank you all so much.

MR. RANALLO: All right. We stand adjourned. I appreciate everybody. Have a good day.

MS. RITCHEY-BALDWIN: Thanks, everybody.

(Meeting adjourns at 1:51 p.m.)

* * * * * * * * * * *

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 28th day of April, 2026.

Tiffany Felts, CVR

Tiffany Felts, CVR