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

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Via Videoconference
August 26, 2025
Commencing at 1 p.m.

Tiffany Felts, CVR
Certified Verbatim Reporter

APPEARANCES

BOARD MEMBERS:

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

MS. BICKERS: Hi, Russ, this is Erin with the department. I just wanted to let you know I'm also on. We're going to let Barb run everything, but I did want to let you know, as of now, you are the only TAC member I show logged in.

MR. RANALLO: I see that. That's interesting.

MS. BICKERS: They still have two minutes to get back from lunch.

MR. RANALLO: Okay.

MS. WASH: Okay, this is Barbara, and I -- it is 1 p.m., and I still have people that are joining us.

MR. RANALLO: Okay. We'll give them a couple minutes then.

MS. WASH: Okay, great. Thank you.

MR. RANALLO: Let's get the waiting room cleared would be fine.

MS. WASH: Okay.

MR. RANALLO: Hello, Elaine.

MS. YOUNCE: Hey, Russ.

MR. RANALLO: How are you?

MR. MCCLURG: Good afternoon.

MR. RANALLO: Chris, how are you?

MR. MCCLURG: I'm good. How are you?

MR. RANALLO: I'm good. Thank you.

MR. MCCLURG: Good.

MR. RANALLO: Well, I think we've got three out of five, so got a quorum at least. That's good.

MS. WASH: Okay, it is 1:01 and the waiting room has been cleared.

MR. RANALLO: Okay. Well, welcome, everybody. This is Russ Ranallo. I'm the TAC chair. I'm the CFO of Owensboro Health. We've got Chris McClurg and Elaine Younce, the other TAC members, so we have a quorum.

The minutes went out for the last meeting, the transcript. Anybody have any changes, or if not, can I have a motion for approval?

MS. YOUNCE: Russ, I'll make a motion to approve.

MR. RANALLO: Okay. Chris?

MR. MCCLURG: Second.

MR. RANALLO: Chris seconds. All right, all those in favor?

(Aye)

MR. RANALLO: That motion passes.

Okay, new business, the first under the A bullet point, we've got delivery and newborn issues, prior authorizations. This is an issue that has come up through, I think, the MCO meetings. We have one MCO that I'm aware of, maybe more, I've got some folks on the phone here -- or at the meeting here that can talk to it better, but as I understand it, is that if you have a baby, a newborn, in-house, and the baby stays for more than four days, they're -- the hospitals are being asked to get an authorization for that baby, which is contrary to the regulations, as I understand it, and contrary to some of the guidance I think we've gotten back from DMS. And this has kind of swirled around for a while, and I'm trying to understand if we can either level set on it, or if it's been resolved, or if it's not been resolved, how we can resolve it.

Anybody from the hospital group, Kim or anybody, that wants to chime in as well?

MS. ALEXANDER: Sure. Yeah, this is Kim Alexander. I gave Rich -- Rich? I'm

sorry, Russ, some information on the policies that we feel like are contradiction to the MCO policies.

MR. RANALLO: Kim, can you speak up a little bit? It's hard to hear you. I'm sorry.

MS. ALEXANDER: Sorry. Is that better?

MR. RANALLO: Yes, that's better.

MS. ALEXANDER: Okay, sorry. I think it's my mic. So the policies that the payers have put out are contradicting what the state -- the statutes are. Payers are requiring us to get auths when they are going to NICU or depending on the DRG, and sometimes you don't know that until after discharge. When we do have a sick baby, they are downcoding our DRGs to something other, and not paying what we're billing, saying that we're not justified in billing what we're billing. So there's lots of confusion, and we just need to get some clarity around what the payers are doing and what the state intended so we can all be in compliance and doing the correct thing and

getting paid the appropriate amount.

MR. RANALLO: So let's take -- let's take each one of those. So the first one, as I understand it, is that it's based on the number of days. So we've got an MCO that has a policy, as I understand it, that if you've got more than four days' stay, it requires a pre-auth. And we have babies that are being born that -- it may be a well-baby, it may be a neonatal, that may stay more than four days, and they're requiring that authorization. I know I've read the reg that says an authorization is not required for a newborn, but I think the MCO has taken that as their policy, either because the policy has been established, you know, the policy takes precedent.

MR. DEARINGER: Mr. Ranallo, do you know -- I'm sorry, this is Justin Dearinger with the Department for Medicaid Services. Do you know which MCO or MCOs have that policy?

MR. RANALLO: I believe Aetna Better Health is my understanding.

MR. DEARINGER: All right. Let us

have some time to kind of talk to them and look into it a little bit, if that's okay.

MR. RANALLO: Sure. I mean, and as I got it, it's a notification was required within 24 hours, and if it's on the weekend, I mean, there's -- it's just there's a -- it's just -- it's contradictory. And I know we've had some that have had well babies that have been denied because of it. All right, so that's the first one with the length of stay.

I think the second one is looking -- wanting an authorization when it's going to be a DRG that's outside of a normal newborn. And the challenge with that is, is that the clinicians aren't coders and coding happens after the fact, and they don't necessarily know what DRG is going to be assigned. You can have a baby in the normal nursery with diagnoses that drive it to a DRG that's outside of a normal newborn, whether it's a hearing, whether it's -- as I understand it. And what I'm getting at is we're getting -- because it has a DRG that's not a normal newborn, we're getting denials because we

didn't authorize that.

And then the third thing I heard was we're getting payers or MCOs, and I think it's more than one, that if there's not a NICU accommodation on the bill, they are regrouping the newborn DRGs to a normal newborn even though that's not where the baby should be grouped. And so they're regrouping it against the grouper, right? The grouper would not group it to a normal newborn. It would group it to a full-term neonate or one of the other neonatal DRGs, and you have payers, just because there's not a NICU accommodation, will deny that case. And that is -- it's highly inappropriate. If it's happening, there's no -- you know DRGs aren't attached to an accommodation. They're attached to a diagnosis and a procedure, and that's how they get grouped.

I can tell you I had -- we had one here and it was on the commercial side, but it's a similar type thing where we had to -- at discharge, the baby failed a car seat test. So you put the baby in a car seat,

you monitor their oxygen, the oxygen level dropped, we brought the baby back in. The baby wasn't necessarily NICU, but we had to figure out what was going on with that baby, but that payer denied that case because at the end of the day, that diagnosis that drove it to a different DRG because we didn't have the accommodation code. Still wasn't a safe discharge, still had something going on with the newborn, still had to provide care and resources to address it, and it's just -- and I'm going to let -- I've got others, I know hospitals on there, and please speak up if I'm mischaracterizing it in any way, but that's my understanding of what we're seeing across the board.

MR. DEARINGER: And Russ, when you say, "across the board," do you mean all -- with all MCOs?

MR. RANALLO: I'm saying with multiple hospitals. I know we saw the Passport and Anthem, particularly in this issue, where if you don't have a revenue code, a NICU revenue code in that accommodation, they were regrouping it to

the normal newborn DRG.

I'm gonna call on Rosmond. So Rosmond at KHA, I know she's been involved in these calls in a lot more detail than I have been with the MCOs and the hospitals. Is there anything on that -- on this piece that I'm missing?

MS. DOLEN: Well, I think when we're talking about the newborn specifically, or just downcoding and --

MR. RANALLO: The newborn specifically. The LIDs we'll -- we can get into --

MS. DOLEN: Okay.

MR. RANALLO: -- the line items we can get into the other items, but just for the one specifically.

MS. DOLEN: Yes, I think that actually Kim Alexander had some good examples of that, the downcoding on the newborns. Kim, was that correct? I know we've shared during the MCO meetings.

(No response)

MS. DOLEN: Let's see if Kim's with us.

MR. RANALLO: She was.

MS. WASH: She's just -- she's just coming on.

MS. DOLEN: Oh, got it.

MS. WASH: She's joined.

MS. DOLEN: Great, thanks. Kim, Russ just covered some of the DRG down coding with regard to newborns, and I know that you had some really good examples of that, and I thought you might be in a better position to kind of walk through what you see from a hospital's perspective.

DR. THERIOT: This is Dr. Theriot. While we're waiting on Kim, I was able to look at some of these examples, and what happened was the baby was born, normal newborn, but had another diagnosis. So was not a normal newborn, had a VSD, or had something, so it wasn't normal, or you couldn't use that code, but it was not in the NICU. So they had a code that was going to have trouble later on, maybe needed some tests or whatever, so it was not a normal newborn, but the only way to code it at one of those higher levels involved a NICU code,

and the baby wasn't in the NICU.

And so that's like a problem when you're following the rules of coding, you need to -- there needs to be a different code or it needs to be allowed to code it at a higher level, if that makes sense. And I know Kim can explain it better than I.

MR. RANALLO: And I appreciate that. Thank you, Dr. Theriot. And this is a new -- newer tactic by the MCOs. So, you know, NICU DRGs have -- I mean, have been around forever and that's been the normal process: You treat the patient for what they need to be treated for, and they may or may not, depending on the condition or the diagnosis, have an accommodation code of being in the NICU. But they group up to the DRG that is -- that is based on their diagnoses.

DR. THERIOT: Right. It was a normal newborn DRG, but the code was not a normal newborn code because it was a sick newborn, and so it -- like, it canceled itself out, if that makes sense.

MR. RANALLO: But the MCOs are doing

that through their own regrouping. If they would use the grouping -- the grouper the way it's intended to, it would group to a -- the sick baby DRG, it would pay out that way, but they're choosing -- they're choosing to use their own grouper based on information outside of what the grouper uses.

DR. THERIOT: Well, I think --

MS. ALEXANDER: I've got the examples pulled up.

DR. THERIOT: Oh, thanks.

MS. ALEXANDER: This is the one you're --

DR. THERIOT: Yeah, I think it's like a glitch in the system. Go ahead, Kim, I'm sorry.

MS. ALEXANDER: That's okay. So we billed DRG 783 -- 793, I'm sorry, which is a --

MR. RANALLO: Kim, can you speak up? I hate to ask you again, but --

MS. ALEXANDER: No, I think it's my headset sometimes.

MR. RANALLO: Okay.

MS. ALEXANDER: Can you hear me better now?

MR. RANALLO: Yes. Yes, I can.

MS. ALEXANDER: Okay. So this one had significant issues because it had an atrial septal defect. Now, it didn't require treatment at the moment, but this is a significant finding for this child for the rest of their life, and they will have to undergo, probably, treatment later on. But the point is, we discovered it, it's a new diagnosis, we have to report it. So they're trying to tell us that we're not treating it so we can't report it, and that's a fallacy in coding.

Same thing -- all three of these are we got paid basically $1,000 for the normal newborn delivery, and they'd ignored the coding, they denied the claims as no auth, which is not correct because we don't require an auth for these babies. But then there was no appeal, even though we submitted medical records and their coding based on the itemized statement.

MS. PARKER: This is --

MS. ALEXANDER: And it's from -- go ahead.

MS. PARKER: I'm sorry, Kim. This is Angie Parker with Medicaid.

MS. ALEXANDER: Hi, Angie.

MS. PARKER: Hey. So they've denied it for no auth, and because they didn't get an authorization, they paid you for the newborn only. So they did -- and Anthem's not on here I'm assuming, so --

MS. ALEXANDER: That's Anthem, yeah, right there at the top.

MS. PARKER: Yeah, so if they required authorization for a baby that was there for longer than four days, that's probably why -- if it was there for four days, that's probably why they denied it for no auth, and they went on and paid for the newborn because --

MS. ALEXANDER: But none of --

MS. PARKER: -- you cannot deny a delivery of a newborn.

MS. ALEXANDER: Right, but none of these were over four days. And I -- you know, for redaction purposes, I just

redacted the central --

MS. PARKER: Oh, okay.

MS. ALEXANDER: -- number.

MS. PARKER: All right.

MS. ALEXANDER: Yep.

MS. PARKER: Well, then I don't have an explanation. Because to Russ's point, if a well-baby has a diagnosis code that is not a -- that shows a defect, it should -- the DRG should be a higher DRG than the delivery.

MS. ALEXANDER: Right. And this one had tachypnea at birth, and they coded it -- let's see, this one's by Molina. That's the other one in there, okay. And so there were other codes that had significant problems, but, you know, we billed seven, contractually, we should've gotten nine, and we got a thou -- this is what the normal rate was going to be. Then this one, this is actually an OB patient, and it was denied for no auth, and OB patients shouldn't require an auth.

And then for Humana Healthy Horizon, this one is very interesting because they

gave a pre-cert for the admitting diagnosis, which was respiratory distress, right?

MS. PARKER: Mm-hmm.

MS. ALEXANDER: We coded it -- let's see, extreme immaturity, baby's premature, tachypnea -- transient tachypnea is what they coded it as, and then we fully coded it as respiratory distress after the coders reviewed the claim before billing.

MS. PARKER: Mm-hmm.

MS. ALEXANDER: And so they came back and downcoded saying we billed something other than the admitting diagnosis. The admitting diagnosis is only your final diagnosis on about 25 percent of the claims.

MS. PARKER: Right.

MS. ALEXANDER: And it's -- it's just a diagnosis to get it into the system.

MS. PARKER: The --

MS. ALEXANDER: So they didn't allow the claim based on what the coders had coded. And I've sent it to them saying, "You can't do this. This is -- you tried this 25 years ago. You can't go back and do this stuff again because that's not right."

MS. PARKER: The condition after study is the primary diagnosis.

MS. ALEXANDER: Yes, it should be, but it -- but they denied it.

MS. BASHAM: Kim, this is Nicole from Passport. Do we have these examples for the team to take a look at? Have you shared them I assume?

MS. ALEXANDER: Yes.

MS. NORRIS: Nicole, this is Meredith. I was going to speak up.

MS. BASHAM: Okay.

MS. NORRIS: We just got these on -- we got these during our KHA call through the rep, and we are reviewing these.

MS. ALEXANDER: Okay.

MS. NORRIS: So we do have these, we are reviewing these, and we will have a response to those.

MS. BASHAM: Thank you.

MR. DEARINGER: Yeah, let's have a little time to talk internally while you all send examples to the MCOs, and we'll kind of see what we can get figured out there first. And we'll look at some of these policies as

well on our side.

MR. RANALLO: I appreciate it.

MS. ALEXANDER: Yeah, I've listed the policies that I could find. Sometimes they're just not there, sometimes they're in the policy manual, but I can share this -- this spreadsheet with you if you -- if you want.

MR. DEARINGER: Yep, thank you.

MS. ALEXANDER: I put the newborns and the LIDs audits both on here.

MR. DEARINGER: Thank you.

MS. BICKERS: Kim, this is Erin with the Department of Medicaid.

MS. ALEXANDER: Uh-huh.

MS. BICKERS: If -- I'm going to drop my email in the chat --

MS. ALEXANDER: Okay.

MS. BICKERS: -- from where we're sharing on a live -- we need to put this on our website to be in compliance with open record meeting laws.

MS. ALEXANDER: Sure.

MS. BICKERS: Thank you. I will also share it with DMS staff.

MS. BICKERS: Okay.

MR. RANALLO: Thank you, Erin.

MS. ALEXANDER: Do you want me to go onto LIDs now, Russ?

MR. RANALLO: We can -- yeah, that's going to be another item, but yeah, we can talk about LIDs. Go ahead.

MS. ALEXANDER: Okay.

MR. DEARINGER: Real quick, were those -- the other items discussed, did they go through appeal processes?

MS. ALEXANDER: Oh, yes. Oh, yes.

MR. DEARINGER: Okay.

MS. ALEXANDER: And I've actually sent them to the payers trying to explain, you know -- the one I sent to Humana was a huge, long email to say, "You can't do this. You know, the UR nurses are not coders and that's where you're getting this initial diagnosis code from a list that they just pull up. It's not the final -- you know, this is just the initial presentation that this kid had respiratory issues, right? And he was critically ill." He/she, whatever it was. But you just can't put the admitting

diagnosis and expect that to be your final. That's -- that's erroneous coding, period. Doesn't happen.

Okay, so LIDs audits now. So the LIDs audits, so we've been experiencing LIDs audits in Kentucky for at least --

MR. RANALLO: So you want to tell them what "LIDs" stands for, please?

MS. ALEXANDER: Yes, I will. So these are line-item denials that we get from our payers, and it's all lines of business. Claim is billed, most payers in Kentucky now require an itemized bill to go with the claim if it's over a certain dollar threshold. And then those itemized bills are sent to their vendors, and it's Ceris, Equian, Optum. You know, everybody's getting in on the game because there's money to be made. So we have trouble getting the audit findings returned to us. Normally we do get the DRG payment upfront, and these are usually outliers because the itemized bills are requested for charges over, let's say, $50,000 for Anthem for an inpatient claim. So it's going to be working on the

outliers that we're billing.

So what happens is these auditors have algorithms in their system to deny charges. And they're denying the charges saying, "These should have been rolled into your room and bed." But then they're also discounting our total billed amount for the bed charges saying we billed too much. So you can't have it both ways. So we have fought these, tried to -- you know, back in my former world, I appealed these. There was nothing to be appealed because they're not looking at medical necessity. We hired a coder to review the coding to see if that could be fixed, nothing got overturned. They are denying with hidden algorithms that we're not privy to to say we're overcharging.

And Russ can address that content --

MR. RANALLO: So --

MS. ALEXANDER: -- if you want to go ahead and talk about that, Russ.

MR. RANALLO: Yeah, let me go -- so and they're -- they're attacking outliers here. And they're basically saying that

"you shouldn't be charging for this. It should be in the procedure or the room." But how the payment mechanism works is that once you reach a certain charge threshold that your charges get reduced to costs under Medicare, and most of our -- because it's -- the reg says "95 percent of Medicare," most people's contracts are Medicare-based. So Medicare takes those charges, and they reduce those to your cost, and once you reach a certain cost threshold, you get an additional payment on your DRG. So for an outlier case that's high cost, you get a portion of that cost back in additional payment.

The -- and so the payers are saying, "you shouldn't charge for this, it should be bundled into" -- CMS never tells you how to charge, they just say you have to charge consistently. So the -- some hospitals charge -- we have one hospital for an inpatient charges one charge. You have others that charge everything that's being used. So instead of the payers telling me they want me to charge it like a Big Mac for

the whole Big Mac, but if you use -- I'm charging for each component separately. It helps me determine the cost of the case, utilization, but also, if you didn't -- if you didn't get the pickle, or you didn't get the implant, or you didn't get the supply, you're not charged for it.

The problem that you have with these audits, or the problem I have with these audits is the way the payment system works is that it's a hospital-specific cost-to-charge ratio. So CMS takes the hospital charges and the hospital cost, that specific hospital, Owensboro Health Regional, Medical Center of Bowling Green, Ohio County Hospital, they take the cost report for each one of those hospitals and they take the hospital's costs and take their charges, and they come up with a hospital cost-to-charge ratio. That's what's being applied to your charges. So how a hospital charges, whether they bundle things, whether they group things, whether they charge each individual line item, is already accounted for in that cost-to-charge

ratio. It's not a statewide cost-to-charge ratio. It's not a national cost-to-charge ratio. It's not a regional cost-to-charge ratio. It's a hospital specific. It's the hospital-specific cost to the hospital-specific charges. How that hospital charges is already baked into that ratio. By stripping out charges on an outlier, you -- it is just a pure rate cut. And it's inappropriate based upon the payment methodology and how the payment mechanism works, period.

I've had -- I've had cardiac implants where the -- denied because of bundling when the patient came in to get a cardiac pacemaker. It's highly inappropriate. It's -- it does nothing -- I mean, they're not saying I didn't use the pacemaker. They're saying it should be in the cardiac cath line item. It has its own revenue code, it has its own billing code, but what they're saying to me is that "No, I'm not going to pay that." It's not right.

And this is en masse. All these issues that we've talked today, every

hospital is getting them. They have increased in intensity since the end of COVID, and it is a widespread issue for all of these items that we've talked about.

MS. DORSEY-CARDELL: Yeah, and Russ, I think we've been talking about the LIDs audits in our KHA meeting, probably since June, where we're trying to get additional clarification and assistance. So I just kind of want to point that out that this has been an item --

MR. RANALLO: So --

MS. DORSEY-CARDELL: -- we've been talking about.

MR. RANALLO: -- these LIDs audits have been going on for years.

MS. DORSEY-CARDELL: Mm-hmm.

MS. ALEXANDER: Twenty years at least.

MR. RANALLO: I can tell you probably six or seven years ago, I terminated my largest MCO because of this issue. Because of this exact issue. And so some people may have addressed it, but these have been around for a long time, but they have just

intensified greatly across the board with all the MCOs.

MS. ALEXANDER: And I've got some examples to show you because the appeals do not work. You know, everybody always says, "Oh, you can appeal them," but we don't -- there's nothing to appeal because there's an algorithm built by either Optum, Equian, Ceris, which is a CorVel company. They've built AI behind it that will just tell us that you can't -- this is not payable. You know, and we tried before here at CHI about seven years, we tried to work with one of the payers and sat down and said, "Let's go through this stuff," and, you know, we tried talking about it and nothing we said satisfied them. It's "No, that's not it, that's -- well, give us your nursing policies on how you staff." Well, what does that have to do with this? You know, it just didn't work.

So here's -- let me pull this example up for WellCare, and I've redacted the information. If it will pull up now. Well, just a second.

MS. DOLEN: Sometimes it won't open if you're actively in share mode, so maybe stop sharing --

MS. ALEXANDER: Okay.

MS. DOLEN: -- and then open it.

MS. ALEXANDER: All right. Thank you for the instruction, I appreciate that.

MS. WASH: Kim, I've made you a cohost.

MS. ALEXANDER: Okay, thank you.

MS. WASH: Mm-hmm.

MR. RANALLO: Thanks, Barbara.

MS. ALEXANDER: Well, they opened for me the other day when I created this, but I did drop these into another file, so let me quickly grab them. So --

MS. WASH: Kim, it says that you are starting to share, so we're looking for that.

MS. ALEXANDER: Okay. Yeah, I am, too, because it's still spinning. Sometimes my computer just doesn't like me.

MR. RANALLO: It does, it's opening.

MS. ALEXANDER: Okay. So this is a Ceris audit. So bill charges 500,000, they

disallowed 82,000, dropped our coverage down to 430. So this is the itemized -- this is how it comes to us from the auditors. So vent management is usual and customary and should be rolled into that charge, is what this tells me. They're not going to pay us for the vent. Airway management, they're not going to pay us for it. So this one was pretty quick and dirty, and I know Anthem's not a problem anymore, but, you know, they've been doing this for years. I mean, we could still -- if we could get things changed, fixed, modified, we could still probably go back and gather some money. But as you can see, they've lowered -- you know, routine supplies and routine services just disallowed totally.

Let me stop sharing because I gotta go pull the other one up. And the other thing I wanted to show you was -- sorry. I don't know why that won't -- let's see. So I'm pulling the WellCare example up.

MR. RANALLO: And while she's pulling it up, again, in her example, her cost-to-charge ratio accounts for how she

charges for the vent management, the airway management. So those charges are, overall, baked into her cost-to-charge ratio.

MS. ALEXANDER: But they also deny blood products, saying we should roll that into the bed charge because it's usually customary, meaning everybody gets that, and that -- it's not true.

MR. RANALLO: But it -- but again, that's built into your cost-to-charge ratio, so when they strip out those charges and they pay that outlier less but they're still applying the cost-to-charge ratio at the level that includes those charges, it -- again, it's an error.

MS. ALEXANDER: Yeah.

MR. RANALLO: That's not right.

MS. ALEXANDER: So this is an Optum. And so it's now the same thing. So you can see the bill charges here and what was used, treated.

MS. DOLEN: You're not sharing, we don't see it.

MR. RANALLO: We can't see your screen yet, Kim.

MS. ALEXANDER: Oh, sorry.

MR. RANALLO: It's all right.

MS. ALEXANDER: Oh, I clicked it, and then I didn't hit share.

MR. RANALLO: There you go, it's starting.

MS. ALEXANDER: Can you see it now?

MS. DOLEN: Yes.

MS. ALEXANDER: Okay. All right, so this is an Optum. And so, you know, they break it down by our average daily charges, and then here, the title is what they're denying, and how many bill charges, and what they're adjusting. And it's interesting to find that Tylenol is getting adjusted; aspirin gets adjusted; Bair Hugger blankets that are used to warm the patient; these are IV fluids; dressings; some kind of system, Hemopro, that's probably used in surgery; art. line; individual items that they just don't feel like we're entitled -- now here they're denying potassium labs, sodium labs, calcium labs, glucometer readings, blood glucoses, hemoglobin, lactic acid.

So let me get to the bottom because

this one's a very long one, as you can see. So unbundling -- they're calling it unbundling. Is that the last page? I think -- oh, here we go. So it was 215 in billed charges, removed 19,000, so there's the adjusted. We have had some of these accounts be adjusted down to where it didn't fit the outlier anymore, it didn't meet the criteria.

If I pull this screen over, can you see what I'm showing now?

MR. RANALLO: Yep.

MS. ALEXANDER: The Ceris page?

MR. RANALLO: Yep.

MS. ALEXANDER: All right, this is Ceris, one of the auditors, and this is on their homepage that anybody can go see. Right here's the salient part. So basically, they're telling the payers, "We're going to get your money back, you're not going to have to pay it." And it's not right. We're taking care of these patients, we're treating the patients, we're billing for our services rendered, and we're getting denied. DMS is not getting the money back.

Where's it going? It goes back into the payers' coffers.

MR. RANALLO: Well, some of it -- some of it's going to Ceris on the commission they earned for the denial.

MS. ALEXANDER: Gotcha. But, I mean, I would rather see a regular audit like we used to have: Did you bill right? Did you bill wrong? Did you bill too many? Or clinical -- I mean, well, you can't do clinical now, but, I mean, there's nothing medically necessary or clinically related about a LIDs audit. This is just line-item denials that they're doing across the country. These companies are making millions of dollars off of the care we're providing. And it's just not right.

MR. RANALLO: And Kim, they're not telling you that you didn't provide that service or that item. They're just telling you you can't charge for it.

MS. ALEXANDER: Right, right. And I do recall several cases about 20 years ago with these LIDs audits when Ceris started that there were a couple of burn patients,

and anybody in the clinical field knows that when you have a burn patient you put Silvadene cream on them, and it comes in tubes, right? And when you're treating that patient and dealing with, you know, large burn areas, you don't count the tubes. You just say "we applied it" in your nurse's notes. But because our nurses didn't say, "We used four tubes for the three wound care this morning," we had them denied because they couldn't prove it in the medical record. So that's what they used to do and then they got slicker and turned to this route. So it's evolved over time, but this is just not doable because there's nothing to appeal. There's, you know --

MR. RANALLO: Well, I --

MS. ALEXANDER: -- take it to Senate Bill 20, there's nothing to appeal. We can't get it overturned; we don't have any justification. And what were you going to say, Russ?

MR. RANALLO: No, you're right. I was going to say that the appeal rights aren't there.

MS. ALEXANDER: And you can see also --

MS. YOUNCE: You know, Russ, I understand what you were saying, too, if we don't charge for these things, then that artificially inflates our cost-to-charge ratio. And then we wouldn't be doing the right thing.

MR. RANALLO: Correct. And, I mean, that's right.

MS. ALEXANDER: So -- and you can see the --

MR. DEARINGER: I think we have some examples, so like I said, let us -- let us take it back, talk about it, look at it. We'll have to do some internal discussion, discuss with the rest of the MCOs.

You do have appeal rights. Now what you're appealing, I think, is the question, right? So if they say, "This should be bundled with something else," and you say, "No, it shouldn't," then that's, you know -- that's the --

MS. ALEXANDER: Exactly. It's the end of it.

MR. DEARINGER: Right. But --

MS. ALEXANDER: There's nothing -- that's why I say there's nothing to appeal because I've been doing appeals for 40 years. There's nothing on those audits that we can appeal. To tell me that blood products is usual and customary and should be rolled in the bed charge is not correct because not every patient gets it, so it's not a usual and customary charge to tie onto a bed. And we can't bill bed charges of $20,000 just for the MCOs just to cover these audits because that's not right either. We just want to get paid for the care we're giving and for the supplies we're using for your members.

You know, we are not committing fraud, waste, and abuse. We are against it. We are -- Foundation of CommonSpirit is against it. It's rigorous training and education and scanning what we're doing to make sure that we're doing the right thing. And if we're not doing the right thing, come to us and tell us. Don't hit us with these audits without any calls, and the effect is

we're just not getting our money.

MR. RANALLO: And again, that's why the payment mechanism is set up the way it is. It's hospital-specific for a reason, so that hospitals can't necessarily -- they can't game the system, right?

MS. ALEXANDER: And we don't want to.

MR. RANALLO: Because it's my -- it's my cost-to-charge ratio. So it's using my charge structure, how I charge, not how Kim charges, not how Elaine charges, how I charge to my costs. So it's not an average, it's not a statewide, it's not something that I can bump up my charges, or -- and game the system in a way.

MS. ALEXANDER: And then there's the time to -- you get your -- you get your base payment for the DRG, and then you start this audit process, and look at the times to final payment. That's just outside the bounds. You know, if this is going to be doing -- you know, if you're going to do this, then you have to follow the regulations, but you're not. We're not getting paid timely on any of these.

MR. RANALLO: Okay, I think they've got it.

MS. ALEXANDER: Okay.

MR. RANALLO: I appreciate it, Kim. You'll send that -- the stuff to --

MS. ALEXANDER: Yes.

MR. RANALLO: -- Erin and Barbara and that way we can get it on --

MS. ALEXANDER: Will do it.

MR. RANALLO: -- the website and then the cabinet can have it, and I appreciate that.

The 72-hour early delivery recoupments, is -- Rosmond, is that still an issue?

MS. DOLEN: So thanks to the clarification from DMS for providing support for early labor and delivery and the application of 72-hour -- the 72-hour rule. We appreciate that clarification very much. I do know that hospitals are checking because that's how they were alerted to the issue when there were recoupments that they saw related to this issue. But as of right now, we know that DMS has come out to

support hospitals in terms of this early delivery issue. So we've got the policy clarified, which we really appreciate, but I think we're waiting on hospitals to make sure that they don't have any of those recoupments.

The issue, at least as the hospitals have explained, is that they are searching for these recoupments rather than knowing that a sweep has been done and having that confirmation that there were no recoupments based on the 72-hour early delivery. Because it did sit out in -- it was outstanding for a while, and we know that this system was not addressed until DMS provided that clarification on the policy. So they're searching for those right now.

MR. RANALLO: Okay. I do appreciate DMS, and I know we had those conversations.

Okay, old business, the Passport, the EIR form, Rosmond, again, I know there have been conversations post our last meeting on this. Have we cleared this one up, or does it still need to be on the list?

MS. DOLEN: I believe you can take

that one off.

MR. RANALLO: Thank you, ma'am.

MR. ARMSTRONG-DEROSSITT: Yeah, this is -- hey, Russ. This is Jeremy Armstrong with the department, Division of Health Plan Oversight. So the passport EIR form has been updated, so if any of the hospitals still have any EITPRs requested through that plan in which an administrative denial was received, please be sure to go ahead and follow up with that plan, with Passport again on that request, because to my knowledge, all of those should have been corrected.

MR. RANALLO: Thank you, Jeremy. I appreciate that.

Okay, the AMA policy that Aetna Better Health had published in July, at the last meeting, DMS was going to further review it, and didn't know if there's any follow-up there.

MR. ARMSTRONG-DEROSSITT: And this is Jeremy again. I believe that policy has been rescinded by Aetna Better Health while that department is still in current review

of that -- of the Aetna policy.

MR. RANALLO: Okay. Thank you.

MR. ARMSTRONG-DEROSSITT: So any new -- of course, any policy changes that this MCO partner institutes into the provider networks, the requirement of contractual is to provide 30-day notice. So any new policy change will be notified to the providers.

MR. RANALLO: Thank you.

Behavioral health, Rosmond, I know I'm calling you again, but I know there was a meeting with the MCOs to discuss this, a series of those. Does this need to be on our -- did those get resolved, or do we need to keep these on?

MS. DOLEN: No, actually, I'm pleased that we had DMS support us in the behavioral health meetings, as well as our hospitals that were impacted around the prior authorization notices. So I think we can table this. We're going to get some additional clarification but really appreciate the MCO staff that participated alongside DMS and our hospitals to kind of bring this group together. Thank you.

MR. RANALLO: I don't know if we have anything on the SB 20 backlog. Just keeping it on there. I know that there is work going on, and --

MR. ARMSTRONG-DEROSSITT: Yes, sir. This is Jeremy again with the department. Just wanted to let the TAC members know as we have had a vacancy within a staffing that falls under this team called the Appeals and Complaints Branch, and so that is the role and position for the branch manager. But I do want to announce that we have an appointment that is in effect September 1st for Whitley Walker. And so Hospital Association members may be already familiar with Ms. Walker as she is currently under the Contract Monitoring Branch within Chelsea Agee's team. And so Whitley will be stepping into that role, coming in with a new fresh eyes -- set of eyes looking at the current processes and this backlog that has been lingering around for quite some years.

But understandably, know that the department is mitigating efforts with the vendor and entity as it relates to ensuring

that decisions per contractual expectation are rendered within 30 days in receipt of a complete and accurate appeal record from the department. And I say "complete and accurate appeal record" just with emphasis, as we are also taking steps of accountability with our managed-care partners to ensure that there is a complete and accurate appeal record received for each EITPR request. And so we have been working in collaboration also with our MCO partners to ensure that there is clear understanding of expectations, specifically down to the level of details of that document that we expect to receive in order for our vendor to review and make that decision timely.

So just wanted to share that update.

MR. RANALLO: Great. Thank you.

MR. ARMSTRONG-DEROSSITT: Mm-hmm.

MR. RANALLO: I know -- Jeremy, I know my own hospital is getting -- we've got some disconnect with some of the MCOs where we've got people that are requesting refunds from an MCO from one of their branches, but all of these cases are in appeals and

they've been there for a while.

MR. ARMSTRONG-DEROSSITT: Okay.

MR. RANALLO: And so I know that I've been trying to connect the two departments but not having a lot of luck. But not your issue, but I just know that those are -- I know we still have -- we still have a good chunk out there, but I appreciate the update, and --

MR. ARMSTRONG-DEROSSITT: Right.

MR. RANALLO: -- look forward to Ms. Walker in that role.

MR. ARMSTRONG-DEROSSITT: Yeah. Thank you, Russ.

MR. RANALLO: The ED downcoding, I think I was looking for a meeting, but I failed to pursue that outside of the TAC, but I will do that and report back.

Does DMS or the TAC members have any other items or general discussion?

(No response)

MR. RANALLO: Okay. Hearing none --

MS. DOLEN: Oh --

MR. RANALLO: Go ahead.

MS. DOLEN: Russ, I'm sorry --

MR. RANALLO: Yes, ma'am.

MS. DOLEN: -- just in terms of that ED downcoding --

MR. RANALLO: Yeah.

MS. DOLEN: -- we talk a lot about DRG downcoding. Do you think it would be helpful if the -- if there was a report of, you know, what is being downcoded?

MR. RANALLO: So I think so. I know we're seeing them en masse across, not only the hospital and the ED side with commercial Medicaid/Medicare, but also on the physician billing side and E&M side. I think I want to get my ducks in a row on the ask, Rosmond, and then make it a formal ask, but I want to put it together.

MS. DOLEN: Okay.

MR. ARMSTRONG-DEROSSITT: Rosmond and Russ, I know this is -- this is Jeremy again with DMS. This was something that was brought up during our last Hospital Association call as well, so the department is also kind of working on a report that we can kind of have a little bit of better oversight of these DRG downgrades that's

occurring and what that level set looks like. And so, Russ and Rosmond, if there is a chance and opportunity for us to collaborate on what you're specifically asking, collaborate with the department to ensure that we get a report.

MR. RANALLO: I think I'd like -- Jeremy, you know, the ED downcoding is a little different than the DRG, right?

MR. ARMSTRONG-DEROSSITT: Okay.

MR. RANALLO: The DRG goes through --

MR. ARMSTRONG-DEROSSITT: Yeah.

MR. RANALLO: -- you know, medical record review and they're looking at it, and you've got somebody from the clinical side --

MR. ARMSTRONG-DEROSSITT: Okay.

MR. RANALLO: -- either a coder on certain cases, but usually a physician on other cases, that they're saying that "This diagnosis that you reported isn't supported by the medical record, or we disagree with this diagnosis."

MR. ARMSTRONG-DEROSSITT: Gotcha, gotcha, gotcha.

MR. RANALLO: So there's a pretty -- there's a pretty good review --

MR. ARMSTRONG-DEROSSITT: Okay.

MR. RANALLO: -- that the ED downcoding, they're taking a level and it's going through an algorithm in a computer --

MR. ARMSTRONG-DEROSSITT: Yeah.

MR. RANALLO: -- and there's nobody -- there's nobody that's reviewing it. And they're saying -- and the algorithm, the AI, or the -- it's actually a more -- I think it's more in line of a virtual worker where it's a bot that says, "Okay, this is going from a level 4 to level 3, we're going to send it back."

MR. ARMSTRONG-DEROSSITT: Yeah.

MR. RANALLO: It goes back through on a remit, and -- a remittance advice, and it's not a letter. It's not a denial letter. There's no reason that they -- that we're given to say that this has gone from a four to a three. And so you have to identify that you've got this remark code on your remit, you've gotta understand, you know -- try to understand why they've

downcoded it, then you can try to appeal it. And I think the -- I think what Rosmond's getting to, and I think it's a good request, is how many, right?

MR. ARMSTRONG-DEROSSITT: Mm-hmm.

MR. RANALLO: How many ED claims are coming through, and how many have you -- how many have you downgraded --

MR. ARMSTRONG-DEROSSITT: Yeah.

MR. RANALLO: -- across -- you know, across each MCO? And just, you know, not to say, "Okay, what was clawed back, but what's the initial downgrade rate," right? Is it 50 percent? Is it -- out of, you know, 100,000 claims for St. Elizabeth, how many were downgraded? Or on a million claims across the state, how many were downgraded as a percentage from one level to another just to get the idea of the magnitude of what we're looking at?

MS. ALEXANDER: Well, and they're doing this en masse to everything. And, you know, what would be better for us if they would, you know, do sample -- do samples. You know, take the medical records and the

whole thing, and look at it. And then if you find issues -- because once again, we're being subjected to all of this fraud, waste, and abuse investigations, nothing else ever becomes -- you know, comes from it. We just get -- we then have to appeal. We have to provide the medical records. We have to do all of the administrative burdens to try to claw our money back when there's no -- there's no foundation for the suspected fraud, waste, and abuse that they're hitting us for.

MR. RANALLO: And as this -- as providers get more sophisticated with their own AI and their own virtual bots, it's going to be those that are built to appeal these, and then at the end of the day, the cabinet's going to get a mass influx, a wave of secondary and other appeals that they're going to have to deal with for complaints, right? So it's a -- again, it's a black box for most of the hospitals right now where there's no reason given, and there's not really a human looking at it. There's no one saying, "okay, that this" -- you know,

it's using an algorithm and the algorithm's not public, the algorithm's not shared with the providers.

MR. ARMSTRONG-DEROSSITT: I understand. Thank you.

MR. RANALLO: All right.

MS. WASH: Excuse me, there was a question that came in from Billie Hodge. "Are there ever upgrades when the provider under coded?"

MR. RANALLO: I've not seen any upgrades personally, but I can't answer that question --

MS. ALEXANDER: I've never seen one.

MR. RANALLO: -- across --

MS. ALEXANDER: I've never seen one.

MR. RANALLO: -- I mean, across the system. And that would be part of the data request. You know, how many have you downgraded, how many have you upgraded, you know, from a two to a three or from a one to a two? That's a good point. Thank you, Billie.

Okay, no other items. Recommendations, we don't have any

recommendations today for the MAC. The MAC meeting representation, I will be at the next MAC and report out. Our next meeting is set for October 28th, 2025.

And I appreciate everybody spending the time today. Appreciate DMS, appreciate all the hospital folks in helping us keep this committee moving. Thank you all, we'll talk again. We're adjourned.

MS. BICKERS: Take care.

MR. ARMSTRONG-DEROSSITT: Thank you.

MS. ALEXANDER: Thank you, Russ.

MS. YOUNCE: Thank you.

MR. MCCLURG: Thank you.

MS. DOLEN: Thanks, Russ.

MS. WASH: Thanks, everybody.

(Meeting adjourns at 1:57 p.m.)

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C E R T I F I C A T E

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

Dated this 1st day of September, 2025.

Tiffany Felts, CVR

Tiffany Felts, CVR