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DEPARTMENT OF MEDICAID SERVICES
HOSPITAL CARE
TECHNICAL ADVISORY COMMITTEE

Via Videoconference
February 24, 2026
1:01 - 2:29 p.m.

Theresa Prokop
Certified Voicewriter

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A P P E A R A N C E S

TAC COMMITTEE MEMBERS:

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

1 MS. WASH: Russ, just to get
2 started, I want to introduce to you all, we
3 have Danielle Davis, who will be the BAC, MAC,
4 and TAC Coordinator. And Danni might want to
5 say a few words.

6 MR. RANALLO: Great. Welcome,
7 Danni.

8 MS. DAVIS: Hi. It's nice to meet
9 you all. I definitely look forward to working
10 with you, and please feel free to reach out to
11 me as a resource moving forward.

12 MR. RANALLO: All right. Thank you.

13 MS. WASH: Okay.

14 MR. RANALLO: All right. We're
15 going to go ahead and get started. We do not
16 have a quorum, then we cannot approve the
17 minutes from the last two meetings. So get
18 into new business.

19 The first item is HRIP. So we've
20 gotten notice of our 2026 approval and the
21 rates.

22 I appreciate the DMS and all the
23 effort they put behind it. It was good news
24 that we got updated rates for the 2026
25 calendar year.

1 The question I think that we have,
2 some hospitals have, is that so, in the past,
3 we set a target for the HRIP amount. So, in
4 2025 it was, I think, 2.4 billion, but I think
5 we ran higher than that all year to the point
6 where it was going to be, I think the
7 projection was 2.7 billion maybe at the end of
8 2025.

9 My understanding is that in prior
10 years DMS has gone and asked for approval for
11 the overage from CMS and that's been given.

12 What I also understand is that in
13 this current year, 2026, that that can't
14 happen again. That won't happen again. And I
15 just need to confirm that. That is one of the
16 questions.

17 I think if that is accurate, then
18 the question is, if we have a budget of
19 2.8 billion for 2026, what is the process to
20 keep us from going over it, or how are the
21 payments going to work, or are we going to pay
22 payments out until we reach the cap and then
23 be done, or are we going to split it up by
24 quarter. There is a lot of unknowns about how
25 this would work in the 2026 year.

1 I don't know if Steve is on, but I
2 know that's a question that I have heard from
3 multiple hospitals over the past couple weeks
4 since we have gotten the approval.

5 MS. WASH: So, I did not see Steve
6 on here. I'm looking. Oh, he is. Okay.

7 MR. WILSON: This is Jacob Wilson.
8 Steve is having trouble getting on to the Zoom
9 call. So we might have to push this topic
10 maybe down.

11 MR. RANALLO: Okay. We can do that.

12 MR. WILSON: Until he gets on.

13 MR. RANALLO: Yep. Thanks, Jacob.

14 Okay, so we'll put that on hold to
15 see if Steve can get on.

16 Under old business, we've got
17 delivery and newborn issues. The prior
18 authorizations. So, we had issues with
19 Progeny Health level of care audits. I know
20 Becky Harris may be on to talk about this.

21 What this issue is, is that we had
22 an MCO that was using Progeny Health. If the
23 level of care for the newborn didn't match the
24 authorization exactly, they were getting paid
25 zero for newborn claims.

1 And I know we brought this up with
2 DMS that all newborns should be retro eligible
3 and it shouldn't require prior auth, and there
4 shouldn't be a denial for authorization where
5 there is a zero payment. And I know, so
6 Becky, are you on? I saw you on there.

7 MS. HARRIS: Yes, I am.

8 MR. RANALLO: Do you want to give us
9 an update at least where you are at with them?

10 MS. HARRIS: Sure. I kind of break
11 these down into three issues to your point
12 about the retro and no auth denials where
13 technically an authorization should not be
14 required.

15 Secondly, we have Progeny, who is
16 issuing authorizations by day for level of
17 care. Keeping in mind some of the babies at
18 UK healthcare are here for hundreds of days.
19 And when the billing for those levels of care
20 do not match exactly to the authorized levels
21 paying zero.

22 And then third would be Progeny and
23 the DRG downgrades. We do consider this
24 global. This is not UK Healthcare alone, but
25 our current status, we have had some progress

1 in getting some of our claims paid.

2 However, just to provide some
3 context, we have a team at UK currently
4 working 56 accounts worth about \$2 million net
5 to us, and some of these accounts include
6 babies who have been here nearly 200 days. So
7 that is exclusive of those that we have
8 resolved. So lots of issues around the
9 babies. Lots of issues.

10 (Ms. Harris speaks on mute)

11 MR. RANALLO: Are you on mute there,
12 Becky? You went to mute. Sorry.

13 MS. HARRIS: Oh, I'm so sorry.

14 MR. RANALLO: It's okay.

15 MS. HARRIS: What was the last part
16 you heard? Did you hear the stats I was able
17 to provide?

18 MR. RANALLO: You said lots of
19 issues with the babies after like a couple
20 hundred days.

21 MS. HARRIS: Yes. So we've put some
22 stats around the issue. Over all we have the
23 team at UK where we are currently working 56
24 accounts which is worth about \$2 million net.

25 Some of those babies have been here

1 in the neighborhood of 200 days. So it is a
2 lot of our level 3 and 4 babies tied up in
3 these figures as well. We have made some
4 progress in getting some babies paid, but
5 those figures are exclusive of anything
6 resolved today. So some progress. Definitely
7 not resolved at all.

8 MS. TRIGILIO: Hi, Russ and Becky,
9 this is Pam Trigilio, I'm the Associate
10 Director for Humana Healthy Horizons, and I
11 would like to provide you all with just some
12 actions that we have taken regarding this
13 issue, if that's okay.

14 MR. RANALLO: Okay.

15 MS. TRIGILIO: So, as of 1/16 of
16 this year, we did reprocess 184 claims. Of
17 those, 118 were repriced based on that
18 authorized level of care. The remaining
19 claims were denied just based on other edits
20 within our system.

21 So, for instance, it could have been
22 COB, could have been duplicate, so forth.

23 As of 2/16, we did complete a second
24 claims impact analysis to address the more
25 recent claim submissions with that same

1 denial. We did submit another IPAR request
2 for 107 claims.

3 And then our system was also updated
4 on 2/23 so that that does not continue to
5 happen. So we will actually be submitting a
6 third IPAR for claims that were missed within
7 that second IPAR.

8 Going forward, we are reviewing some
9 of our provider educational materials for
10 potential revision. That's so that we can
11 better inform our provider partners regarding
12 the process. So once we get those revisions
13 figured out, we will submit those for approval
14 and we will provide re-education to our
15 providers.

16 So I hope that helps some, Becky. I
17 believe that we shared with you all too the
18 claims that have already been reprocessed.
19 Our PR reps did. I don't know if you get a
20 chance to look at those yet.

21 MS. HARRIS: You have. and the
22 figures that I provide are amongst two
23 different MCOs and those that have not
24 processed to date.

25 MS. TRIGILIO: Okay.

1 MR. RANALLO: So, Becky, who is the
2 other MCO?

3 MS. HARRIS: Passport Molina.

4 MR. RANALLO: So, Pam, is the prior
5 auth denial for zero stopped? Is that what I
6 hear you say?

7 MS. TRIGILIO: As of 2/23.

8 MR. RANALLO: Got it. Anybody from
9 Passport or from DMS? I know the message we
10 got at our last meeting from Dr. Theriot and
11 Justin was that they had an internal
12 discussion in their group that they were
13 working on it and we were awaiting a response
14 to.

15 MR. DEARINGER: Yes, sir. This is
16 Justin Dearing with Department for Medicaid
17 Services. We are working, reviewing these
18 issues with Humana and Passport. And so I
19 think they are working on those issues as
20 well. So, hopefully, we will have those
21 issues resolved. I know they are both -- both
22 managed care organizations are working on the
23 issues that they had, and we're working on
24 creating some information for those managed
25 care organizations to make sure that they

1 comply with those things. Because it's just a
2 couple of MCOs with specific issues, there
3 probably won't be a provider letter, but we
4 are working with those two MCOs to make sure
5 that the issues of zero payment.

6 And then there was another issue of
7 making sure that we had -- and I think that's
8 a little bit farther down, but making sure
9 that any type of denial or downgrade, that
10 there is clear, specific reasoning why, and
11 that you all are given opportunities for
12 appeals through those, any type of downgrade
13 or denial. So those are the two specific
14 issues that we are going to be working with
15 our managed care organization partners on for
16 this specific issue.

17 And then there's another whole
18 different kind of work group that's going on
19 that has to do with neonatal newborns, and
20 that's a little more complicated, and we're
21 still working on that.

22 Dr. Theriot is heavily involved with
23 that. She's been out for little bit, so as
24 she gets back, we'll resume those meetings and
25 we'll have something on that specific part of

1 this later on.

2 MR. RANALLO: Okay. Anybody from
3 Passport with an update or Humana?

4 MS. WASH: So, Russ, I have not seen
5 anybody on from Passport. Oh, there might be
6 someone. Is that Lori? I don't see anybody
7 there.

8 MR. RANALLO: I've got a quorum now.
9 That's great.

10 MS. WASH: Yay.

11 MS. RITCHEY-BALDWIN: Sorry for my
12 delay.

13 MR. RANALLO: That's all right.
14 It's all good.

15 All right. Any questions on this
16 item with the delivery newborn prior auth
17 issue?

18 MS. CARDELL: Yeah, Pam, you
19 mentioned a report you shared with U of K. If
20 we still need a report, can we reach out to
21 you for our claim here at UofL?

22 MS. TRIGILIO: Absolutely. Yes.
23 Please do, Crystal. Thank you.

24 MR. RANALLO: All right. So we'll
25 go back to the top. Establish a quorum. I

1 know we've got the minutes from the old
2 meeting that were sent out, the prior
3 meetings. Can I have a motion to approve
4 those?

5 MS. YOUNCE: I'll make a motion to
6 approve them, Russ. It's Elaine.

7 MR. RANALLO: All right.

8 MS. RITCHEY-BALDWIN: Lori. I'll
9 second.

10 MR. RANALLO: Okay. All in favor is
11 aye. So those are approved. All right.

12 We'll continue onto old business
13 before we go back to the new business item.

14 The COB issues, I know there was --
15 I got some correspondence or an e-mail from
16 the Cabinet. We sent the response.

17 We've got reports of takebacks
18 because there's another coverage, but the MCOs
19 are not giving us the information on the
20 third-party payor. Gainwell, the info gets
21 sent out to the MCO's. We can't get it from
22 DMS.

23 There's a lot of examples where we
24 don't even know who the primary payor is and
25 there's no way to reconcile the COB issue. I

1 know we had a discussion. I know that e-mail
2 was sent with, and then we had a discussion
3 last week.

4 Is there any update from -- And I
5 know we were looking at examples. Rosmond, do
6 you know if those examples to the Cabinet?

7 MS. DOLEN: Hi, Russ. I don't have
8 that confirmation because we wouldn't be able
9 to see those examples for HIPAA reasons. But
10 we do have several hospitals on the line that
11 may have sent examples.

12 MS. WASH: And Russ, we do have
13 Chris Turner on from DMS. Sorry, Chris.

14 MR. RANALLO: Hi, Chris.

15 MS. TURNER: That's okay, Barbara.
16 Hi. Hi, Russ. Yes, so Teresa couldn't be
17 here today. She's actually our TPL
18 [Inaudible] but I did speak with her prior to
19 this, and to date we haven't seen any examples
20 yet from the hospital.

21 She and I did meet and we did kind
22 of draft up a little template that I'm going
23 to drop into the chat of exactly what it is
24 that we need from the hospitals as far as
25 detailed examples. Where you can send that.

1 And we are actually asking if you
2 all can get those examples back to us in about
3 two weeks. We are asking for it by maybe
4 about March 13th. That way we can get a good
5 sampling submitted to us. We can kind of look
6 through those, review, and start addressing
7 some of those issues that you all have brought
8 up.

9 MR. RANALLO: Okay.

10 MS. DOLEN: Appreciate that, Chris.
11 Thank you. And this has been a long-standing
12 issue for hospitals. It's been kind of on our
13 radar that we have shared with DMS for over a
14 year. And I do know that we have at least one
15 hospital that might have the ability to kind
16 of provide an overview just for this meeting,
17 and that might help provide a little context
18 when those examples come in.

19 MS. TURNER: Okay. And I did drop
20 that information in the chat. And I also
21 spoke with Jeremy and Chelsea, and I believe
22 they're going to try to get out a detailed
23 e-mail possibly to you all in case you want to
24 send this out to the KHA so that all the
25 different providers have it if they want to

1 submit additional information as well.

2 MS. DOLEN: Sure. I'd be happy to.
3 Thank you.

4 MR. RANALLO: Rosmond, who do we
5 have on that could -- could provide
6 information for the record?

7 MR. WILSON: This is Chris Wilson
8 from Norton Healthcare.

9 MR. RANALLO: Hi, Chris.

10 MR. WILSON: Hi. Yes, I was asked
11 to provide some examples. I did try to submit
12 at least one of those examples today, and it
13 was sent back by DMS because we attempted to
14 encrypt it so that the PHI wasn't captured.
15 So, I will be following up. I will resubmit
16 that without the encryption included so the
17 DMS gets those examples.

18 However, I wanted to just kind of
19 provide some insight into the issue that we've
20 been discussing on the KHA, and this really
21 started for us back about the 2022 and 2023
22 years.

23 Passport by Molina had brought in a
24 third-party entity conduit to assist them in
25 identifying primary coverages to the Medicaid

1 line of business.

2 And what happened in hindsight is
3 that a lot of times that vendor identified
4 previous coverages that had termed, but
5 Passport went ahead and loaded those files as
6 if it was open-ended coverage that had not
7 expired, and then they began to recover
8 previous primary payments from us even though
9 after researching it we found that Passport
10 was still the primary coverage because the
11 commercial coverage or any other coverages had
12 already been termed. So those were just
13 automatically loaded. The recoveries took
14 place.

15 The issue that we encountered with
16 those is, the way that they were recovered was
17 a full recoupment of the previous claim.

18 What then subsequently happened is,
19 when they recovered at the claim level, they
20 then gave us a TPL offset in the check section
21 of the remittance to basically balance out the
22 offset that they had taken. But it doesn't
23 contain any claim information.

24 So from our standpoint as the
25 provider, Passport recovered the entirety of

1 that claim. And because the check level
2 information is basically normally reserved for
3 stuff like interest that doesn't go back to
4 patient claims, then we had an undistributed
5 balance that we had no ability to tie back to
6 a particular claim.

7 So they gave us the money back, but
8 we don't know of the 100 or so claims that
9 were adjudicated and that remit which ones
10 were taken back and offset by this TPL
11 adjustment.

12 The other concern that we had in
13 this is, where Anthem was involved as the
14 supposed primary coverage, a lot of times
15 Passport just went to Anthem and recovered the
16 money that was paid as primary so that when we
17 found out what had happened, when we attempted
18 to go and submit a claim to Anthem as the
19 primary coverage, Anthem's response was this
20 was already a paid claim, because they paid
21 Passport, they didn't pay us.

22 So there are some concerns there
23 because we do have contracted rates with other
24 payors for which we would be entitled to that,
25 but Passport is preventing us from being able

1 to bill those, because they received their
2 payment from the third-party coverage,
3 commercial coverage. And so that prevents us
4 from being able to do the proper coordination
5 of benefits orders that we would want to do.
6 We want to bill our primary coverage and then
7 bill Medicaid as the secondary, just like we
8 would in a normal situation if we identified
9 it upfront.

10 So it's causing some issues in
11 reconciling, but it's also causing us issues
12 in getting the reimbursement that we would
13 expect to receive for those services when it's
14 valid.

15 But the bigger concern we had is the
16 loading of information that was in contrast to
17 what DMS has loaded in the KYMMIS system.

18 A lot of times, we were able to find
19 out that, yes, DMS did have record of that
20 coverage that had termed and it was correctly
21 loaded in the KYMMIS system.

22 But Passport wasn't relying on that.
23 They were relying on their third-party
24 information to support that.

25 And what we would ask is the state

1 would have -- exercise some -- maybe some
2 oversight into ensuring that there is a single
3 source of truth when it comes to coordination
4 of benefits information.

5 Ideally, the state would probably
6 want the MCOs to communicate with them when
7 they find coverage so that everything stays
8 synchronized, but that is not the case today
9 is KYMMIS has a piece of information, the MCOs
10 have a piece of information, and they don't
11 reconcile with one another.

12 MS. TURNER: Okay, Chris. And I
13 know that's a -- I believe Teresa has
14 mentioned to me that that is something that
15 has come up in the past. I believe kind of
16 that exact example.

17 I am going to have to defer to her a
18 little bit to kind of walk that back and work
19 our way through that. So as you send over
20 those examples, we will take a look at that
21 and we will meet internally and try to get a
22 response back to you on that.

23 MR. WILSON: Okay. And then I would
24 have one other ask of this process. The
25 situation I described where the MCO is

1 receiving payment from the commercial coverage
2 directly in lieu of us being able to do that.
3 What we were told by Passport is they were
4 using the subrogation rule that is in the
5 state contract.

6 But typically, subrogation is in
7 regards to any insurance company having an
8 interest in some sort of liability coverage in
9 being a party to recovering the cost of that
10 care. So it's typically auto, workers comp,
11 home owners or commercial liability where
12 there's an accident or injury involved, but we
13 don't believe that it's correctly interpreted
14 for commercial medical coverage to be part of
15 the definition of subrogation.

16 MR. RANALLO: So, Chris, how are you
17 getting your commercial rate? Your contracted
18 rate?

19 MR. WILSON: We're not. We have to
20 settle for the Medicaid reimbursement because
21 Passport has paid us and adjudicated and kept
22 any ability for us to go back and get our
23 commercial rates from that primary coverage.

24 MR. RANALLO: So is Passport making
25 money on the claim?

1 MR. WILSON: I would assume that
2 they are recovering only their portion of it.
3 We're the ones that are at the lower
4 reimbursement rate.

5 MR. RANALLO: Yeah, you're the one
6 that's losing out on it because you can't bill
7 under your contract.

8 MR. WILSON: Correct.

9 MR. RANALLO: So that was another
10 ask that we had to have in workgroup to talk
11 about the definition of subrogation and
12 whether or not that applies in this situation.

13 MS. YOUNCE: And Chris, is Passport
14 the only MCO doing this at the present time?

15 MR. WILSON: We are aware of Better
16 Health also doing a similar process of
17 subrogation. As well as some offset
18 situation. So it's similar.

19 But for us in region three, we still
20 have a historical volume of Passport being the
21 largest member coverage. So, for us, Aetna
22 Better Health is a little bit further down in
23 the volume impact. For us, Passport is a huge
24 amount of our members that we see.

25 MS. YOUNCE: Thank you.

1 MS. DOLEN: Do we have any other
2 examples?

3 MR. RANALLO: Chris Turner, do we
4 need examples of that practice as well?

5 MS. TURNER: Yes. If you could,
6 please send those as well.

7 MR. RANALLO: And that template's in
8 the chat, as I understand it, right?

9 MS. TURNER: Correct. Yes.

10 MR. RANALLO: Thank you, ma'am.

11 MS. TURNER: Mm-hmm.

12 MR. RANALLO: Any more questions on
13 this item? Chris Wilson, thanks for attending
14 and weighing in. Appreciate it.

15 MR. WILSON: All right.

16 MS. WASH: So, Russ, excuse me.
17 This is Barbara Wash again. We do have Steve
18 Bechtel here online.

19 MR. RANALLO: Steve. Right. All
20 right. We'll go back up to the top to HRIP.
21 So, Steve, what we kind of described was, you
22 know, we are so appreciative of getting the
23 updated rates for 2026 and the 2026 approval.
24 There have been a lot of questions from the
25 hospitals that I have fielded.

1 What I understand is, is that, you
2 know, like I said, in 2025 we had a target of
3 2.4 billion. I understand we were running
4 closer to 2.7 billion at the end of the day,
5 and in prior years when we were over the
6 target, what I understand is that DMS went to
7 CMS and CMS approved that.

8 What I have heard is, is that in
9 2026 and going forward that there will no
10 longer be approvals for those overages. And
11 if that is the case, that is the first
12 question, is that correct?

13 And if that's the case in 2026, if
14 the target is, or the budget you can call it,
15 is 2.8 billion, what has -- has DMS thought
16 about the process of how that is going to work
17 to keep us from going over? Is it going to
18 put claims out until there is no more money?
19 Is it going to split equally by quarter?

20 Each one of those scenarios or any
21 other scenario, probably has pros and cons and
22 good and bad in a lot of different ways. Just
23 curious to what the Cabinet has thought about
24 or DMS has thought about and that -- if what I
25 understand is accurate.

1 MR. BECHTEL: Yeah. Thank you. Can
2 you all hear me?

3 MR. RANALLO: Yep.

4 MR. BECHTEL: Okay. Sorry for my
5 delay. I was trying to get in. I just got
6 the buffering little thing for like 10 minutes
7 to get in here.

8 But, yeah, Russ, that is correct.
9 As you know, in HR 1, it was passed July the
10 fourth and signed by the President. It puts
11 in there that we are frozen at the dollar
12 amount, so we will not be allowed to exceed
13 that 2026 amount, which is very -- even more
14 the better that we were able to work through
15 congressional leadership to get them to kind
16 of relook or revisit what they were going to
17 set as our grandfathered amount. That's what
18 they call it, is a grandfathered amount.

19 They were going to make it our 2025
20 amount, but we had not yet sent in the
21 amended, so it was going to really put this
22 program at a great under-funding mechanism.

23 So just -- yes. You are correct.
24 The original amount that was sent for '25 was
25 2.4. But when we pay it out you have to pay

1 it based off of actual utilization. And so
2 that utilization has increased a little bit to
3 where we were -- I will just say it's kinda --
4 without getting into the weeds too much, but
5 if you remember we set the calendar year '25
6 we used 2021 historical data.

7 And we did that; that's the same
8 data we used for the calendar year 2024. And
9 the reason why we did that, if you recall,
10 there was some ask or some request that we
11 speed this up so that we can get the approval
12 so hospitals can have a better way of
13 budgeting for it in the future.

14 So we tried to do that, but then as
15 soon as we submitted it, I believe we
16 submitted it in April or March. I can't
17 remember, of 2025. Then the House Resolution
18 1 got dropped immediately afterward. And I
19 believe it got dropped in May.

20 And so, therefore, you know,
21 everything at CMS got put on hold. They did
22 not want to proceed and everything got just
23 put on hold. So it kind of blew holes in our
24 plan, so to speak, of trying to get that sped
25 up, that process.

1 So now we're back to we got the
2 approval for 2026 at the higher amount that we
3 asked for. Not the '25 amount. So the amount
4 that we did for '25, like I said, the original
5 amount 2.4 billion, with actual utilization
6 and after quality, after you allow for
7 quality, it's going to come up to about
8 2.7 billion. So there's about 300 million
9 increase right there.

10 And then in '26 we did a
11 \$2.8 billion. It went up to 2.8 is what we
12 got approved. So that's another like
13 120 million I believe. So it equated to
14 almost a little over \$4 million when you look
15 at it compared to the actual what was
16 originally sent.

17 Now we have submitted the amended
18 preprint. We submitted it Friday to CMS for
19 the 2025 year to increase that amount up to
20 the 2.7. We don't believe that should be a
21 problem, because we're still below the
22 grandfathered amount of 2.8.

23 But I will just say this, that we
24 don't think it should be a problem, however, I
25 don't know how to interpret the waters at CMS

1 anymore, because it just seems like what I
2 think is going to happen doesn't happen. So
3 it's hard to tell, but we're going to do
4 everything under our power to make sure that
5 it goes through, because we can show that it
6 was based off the actual utilization.

7 So to your point of how we address
8 it, we do not have to put it into -- you know,
9 this is a program that is paid as a separate
10 payment term right now, which means it is not
11 built into the capitation rates that are paid
12 to the MCOs. We just funnel it through. It's
13 more like a pass-through payment through the
14 MCOs where they don't -- they don't assume any
15 risk at all on that. We make them whole and
16 they make you all whole, so to speak.

17 Then going forward, there's multiple
18 things that we have to consider in '28. '28,
19 we have our first 10% reduction per HR 1. I
20 don't know what that reduction. We're waiting
21 on CMS guidance on what that reduction is.

22 I mean, you can look at 10%
23 reduction. Is it 10% of the total? Is it 10%
24 of the add-on amount? Is it 10% of the ACR
25 level? What is the 10% reduction of?

1 I have asked that question to CMS in
2 person at various conferences, and I've asked
3 that on the phone and an e-mail, and I have
4 yet to get any direct answers just yet of what
5 that's going to be, but, you know, in order
6 for us to determine what to build into the
7 rates, we need to know how much our
8 grandfathered minus the 10% is going to be.

9 What we envisioned, like you said,
10 we had looked at several different ways.
11 There's pros and cons of every way. We are
12 trying to look at the best way to do it to
13 maximize the dollars coming into the state,
14 because they do have a statute that I have to
15 make sure that I follow that I maximize the
16 Federal participation. So we are trying to
17 figure out what is the best way from a
18 mechanism standpoint.

19 However, we are still waiting,
20 again, on CMS on what that looks like. What
21 they envision. What they will approve.

22 Do we, like you said, do we back out
23 the 10% of the amount and say okay, that's
24 going to be set aside for quality and then the
25 other 90 percent we split evenly over four

1 quarters and pro rate it out, or do we just
2 pull that 90 percent over to one pot and pay
3 every quarter until we get to the last quarter
4 and then that last quarter we prorate it out?

5 Or in cases that we're not -- that
6 maybe our utilization goes down, are they
7 going to allow me to change the add-ons for
8 that fourth-quarter to maximize it to the
9 total dollar.

10 So there's like three or four
11 options to look at. We're still in the
12 process of trying to think through that, but
13 again, it ultimately lies -- it comes down to
14 what CMS will allow us to do. So we have yet
15 to get that guidance. So that's big.

16 You know, the first thing that we're
17 going to do is submit the '25 amendment, which
18 I just did Friday. We had the '26 approved at
19 the higher amount. We know what the amount's
20 going to be in '27. '27 is still the 2.8.
21 That's our grandfathered, frozen amount, but I
22 still have to submit a preprint. So we are in
23 the process of pulling projected utilization
24 and things like that so that we can go ahead.

25 Our hopes is to get '28 -- I mean

1 '28 -- '27's preprint out sometime by the end
2 of May, if possible, so that we can try to get
3 that approval before last minute like we've
4 been getting here lately, so that we can give
5 you all some sense of budgeting and
6 forecasting on your all's end. But, you know,
7 the add-on may go down depending on if we
8 think -- you know, if we see utilization
9 increase and your add-on will decrease, right?
10 So it has to come up to that grandfathered
11 amount of the 2.8.

12 I know that's a lot of information
13 that I'm spouting off. It's nothing new.
14 Medicaid is a complex animal, and it gets very
15 complex when you're dealing with moving parts,
16 so to speak, with House Resolution 1 coming
17 down the pipe in 2028.

18 So I know that was a lot. If I can
19 answer any questions, I'd be glad to.

20 MR. RANALLO: I think I'll give it
21 to my TAC members, but again, I appreciate all
22 the efforts. Very appreciative that we've
23 gotten the higher amount, the 2.8 versus the
24 2.4 that we could have had.

25 I think, you know, knowing how we're

1 going to do it so that we can plan
2 appropriately, right, for cash flow and
3 payments and budget purposes I think will be
4 important to the hospitals.

5 MR. BECHTEL: And I will say this
6 too, Russ, when House Resolution 1 came out, I
7 started reviewing it, and I thought, I was
8 told by the CBO, Congressional Budget Office,
9 that if we had something submitted by the time
10 that the date -- you know, that the bill was
11 filed and the bill was signed into law, that
12 that would be my -- or our, I won't say mine,
13 but our grandfathered amount. So I was always
14 under the impression we would get the 2.8.

15 However, then in September we got a
16 dear colleague letter from CMS saying that,
17 "No, you are outside the date by one day.
18 You're going to have to go back to your 2025
19 amount."

20 And that's when I started getting
21 nervous, because I knew we hadn't submitted
22 the amended for '25 yet, and that was going to
23 put us at risk there. So I'm so glad that our
24 congressional leaders were able to, I don't
25 know how to say it, but just to be blunt but

1 talk some sense into some people up there.

2 MR. RANALLO: Yeah. I'm very
3 appreciative too. That was good news for
4 three years, right? The '25 and the '26 and
5 the '27. The 2028 will be the first year, as
6 the rules stand right now, they would have to
7 go into the MCOs, right?

8 MR. BECHTEL: Correct. Right now
9 it's 2028. It'll go into the -- see, we got
10 managed care final rules and HR 1 things that
11 we have to manage. It's kind of like juggling
12 a lot of things at one time.

13 So, yeah, we have to put -- no
14 more -- we are not allowed to do any longer
15 due to managed care final rules is, in '28 we
16 can no longer have separate payment terms.
17 Everything has to go through the MCO
18 capitation process, and we're not allowed to
19 do reconciliations any longer.

20 So those two things are problematic
21 for pretty much all of our preprints or
22 directed payments. I call them preprints. I
23 know you all call them directed payments, but
24 the preprint is the actual application that we
25 submit.

1 MR. RANALLO: Got it. Lori or
2 Elaine, any questions for Steve?

3 MS. RITCHEY-BALDWIN: Yes. Well,
4 first of all, I want to echo Russ that truly,
5 truly appreciate all the work that you did and
6 our legislators did to get us to the 2.8.

7 Do you have any -- and the answer is
8 probably no, but as we talk about as soon as
9 we know how those payments are going to be
10 distributed, and like you said, do they get
11 distributed and when the money runs out and do
12 you have a separate pool. Any approximate ETA
13 of when you may have an idea of how that's
14 going to work, again, just for cash flow
15 purposes and anticipating as we get through
16 this year?

17 MR. BECHTEL: What we envision right
18 now, until we get further guidance from CMS,
19 is to pretty much status quo of processing the
20 claims and payments with the effect that you
21 know, because we don't -- yeah, we're just
22 going to do status quo for now. We're going
23 to make sure that the 2.8 will pull out the
24 280 million that will be for the 10% quality
25 and then the rest of it will be the amount

1 that we'll monitor each quarter.

2 But that leaves the fourth quarter,
3 right? The fourth quarter, what does that
4 look like? And we can do two different
5 things. We can just say okay, we're going to
6 prorate it out until we get to the max or, you
7 know, we haven't come to that conclusion.

8 As far as an ETA, my biggest goal
9 right now is just to get the preprint
10 submitted for '27 so that we can get the
11 approval, and then we can discuss the
12 mechanics of how we look at that.

13 But my first indication would be
14 just to keep it status quo so that we don't
15 make any changes and make it look like we're
16 making changes to CMS. Because once you start
17 saying we're going to change this process,
18 then it halts the program a little bit,
19 because they want to vet it out.

20 So that's my first hunch, but I will
21 say that we are still analyzing all those
22 multiple possibilities but we wouldn't make
23 any decision. You all are represented by KHA
24 on our calls. We have a weekly call, HRIP
25 call that we talk through a lot of this. We

1 haven't gotten to these discussions just yet,
2 but when we do, you'll be a part of that.

3 MS. RITCHEY-BALDWIN: All right.

4 Thank you.

5 MR. BECHTEL: Mm-hmm.

6 MS. YOUNCE: I don't have any
7 questions, Steve. Just appreciate. You know,
8 very grateful for all the work the team did to
9 get to the '26 rates as opposed to the '25.
10 That was a big, big help to all of us. Thank
11 you.

12 MR. BECHTEL: And I appreciate your
13 saying the team, because it ain't me. I'm not
14 doing it all. I've got a team of people and
15 Myers and Stauffer has been a great partner,
16 as well as my staff, the staff that we have
17 here. The department that's helped us with
18 this. It's been a team effort.

19 KHA's been a part of the team as
20 well, even though they're not state or our
21 contractor, I still consider them a part of
22 our team, so it was a team effort. So I
23 appreciate it.

24 MR. RANALLO: Well, the hospital
25 side, we're all facing some not so fun going

1 forward years, right? With how these things
2 are changing. And, you know, I was getting
3 just, you know, hit after hit, and this was a
4 good positive outcome for us. And so, again,
5 we thank you very much.

6 MR. BECHTEL: Yeah. I will point
7 out though, Russ, you may have gotten some
8 calls from some of the losers, right? What I
9 call losers. We've got winners and losers,
10 because the way that this program works it's
11 an average, statewide average ACR. So there
12 are some people that are losing in this, but
13 we're still operating under the same
14 assumptions and the same process that we've
15 been doing.

16 I think where the disconnect was,
17 was some people I've heard from are saying,
18 well, we're not seeing the \$400 million
19 increase. Well, I don't think they were
20 looking at the '25 amount being increased by
21 like almost 300 and then the other rest of it.
22 About 70 percent of the 400 is in '27, which
23 you're already getting pretty much at this
24 time. Really the increase is like 125 million
25 is what you're getting from the new '27

1 through '28 amount.

2 MR. RANALLO: And I think, you know,
3 when you look at the actual spend, Steve, if
4 I've got the number right, it was over a 2.8
5 in 24, right? With our overages?

6 MR. BECHTEL: Mm-hmm.

7 MR. RANALLO: So, it running 2.7 now
8 looks to some people that it was less, right?
9 But it's really we've been over our target or
10 the preprint estimates both years, right?

11 MR. BECHTEL: Right.

12 MR. RANALLO: They were pretty
13 close, and so when you're looking at the
14 actual versus what we should have gotten under
15 the preprint, it kind of skews it a little
16 bit. And that's what I tried to explain to a
17 few of them is that, you know, '24 we had a
18 bigger number than we were looking at a '25.

19 So if you see the '25 number being a
20 little bit less than '24 that's possible
21 depending on your utilization, and then, you
22 know, when you're modeling that against the
23 new add-ons for '26, right?

24 Most people were seeing like a small
25 increase, right? Which you would expect.

1 Because, again, we're modeling on utilization
2 that is running a little heavier than the
3 preprint.

4 MR. BECHTEL: And I'll remind you
5 too, on the preprint, which is the
6 application, line four says, estimate amount.
7 Estimated amount. And so we put that as the
8 estimated amount, but now for '28 that is our
9 hard lined amount. So it's changed.

10 MR. RANALLO: Well, I'm glad it's
11 2.8 for '26 and '27. Very much so.

12 MR. BECHTEL: Yeah. All right.

13 MR. RANALLO: So, thanks, Steve.

14 MR. BECHTEL: All right, thank you.

15 MR. RANALLO: Appreciate the update.

16 All right. Back to the old items.
17 Prepayment reviews. This item I think came
18 out of a St. Elizabeth item that's been going
19 on for several months last year, and Wellcare
20 where there's a clinical program integrity
21 initiative. And that last May, I pulled the
22 Behavioral Health TAC presentation by Jennifer
23 -- I'm going to say this wrong -- Dudinskie --
24 on Medicaid audits, and it had a whole section
25 about prepayment reviews and what the new

1 rules were effective for calendar year '24
2 where the MCOs had to submit. You know, had
3 to do. It was a real deliberate process.
4 They couldn't just do a prepayment review
5 because they wanted to.

6 There were steps. The provider had
7 to be notified. There had to be, you know,
8 and it was a limited time frame, but there was
9 --there was a bunch of rules.

10 And this kind of fell out, this
11 clinical program integrity initiative, CPI
12 that Optum lead kind of fell out from that.

13 And I know there was a lot of
14 reports that were promised. A lot of
15 information back and forth. And I don't know
16 if Lori has anything else she wants to say
17 about it, but just want to bring this back up
18 to see. I know DMS had reached out to
19 Wellcare audit the last meeting, and there
20 weren't any updates. And I know Jennifer
21 hadn't received anything. And so bringing
22 this back to the forefront.

23 MS. RITCHEY-BALDWIN: Christine or
24 Kyle, can you address whether that's improved?

25 MS. PRESUTTO: This is Christine

1 from St. Elizabeth. I mean, we still get by
2 far the most volume of pre and post pay audits
3 come from Wellcare. I think when we had our
4 information session with Wellcare, we were
5 just trying to understand the program, and
6 also trying to understand what a provider
7 would need to do to be released from the
8 review.

9 Meaning like is there a quality
10 threshold or is there some point where they're
11 asking for records and then we've met the
12 threshold and then no longer would be reviewed
13 at that point.

14 So we did get some clarifying
15 information about their review. I think in
16 the last KHA call, DMS did state that it was
17 okay for them to be doing the reviews in the
18 way that they are because they're coding
19 reviews.

20 When I originally met with Wellcare,
21 they kind of were on the stance that it wasn't
22 that they suspected fraud, waste, and abuse
23 why they were asking for the records. It was
24 more of that's how they were maintaining
25 provider compliance with coding regulation.

1 So they're asking for records to check to see,
2 you know, are we being compliant.

3 What we did gain from the
4 conversation is we were able to work with
5 Wellcare to get a series of reports where they
6 could kind of identify where they were seeing
7 the most record request for St. Elizabeth. So
8 that kind of gave us an opportunity to see
9 maybe where they were focused.

10 I think our biggest issue with how
11 Wellcare does this process is they just sent
12 us a request from Optum requesting records,
13 but they're not really telling us what they're
14 looking for. They're not really telling us
15 what they're auditing. So we can't create a
16 medical record packet that is specifically
17 addressing the issue where they have the
18 concern.

19 So it's kind of a blind request from
20 the providers and we don't know why they want
21 the records. But we are obligated to provide
22 them.

23 When they have a coding initiative,
24 this PPI process, you know, where they are
25 looking for something specific when they make

1 the request, but they're not making that clear
2 to the provider. I think that's kind of the
3 bigger issue that I have.

4 MR. RANALLO: But Christine, to me,
5 that's a postpayment review. Okay?

6 MS. PRESUTTO: We get them both. We
7 get them before we get paid and after the
8 payment.

9 MR. RANALLO: But the prepayment
10 reviews, again, I know Jennifer is on, but
11 there's requests that have to go to DMS.
12 There has to be a summary of the concern. The
13 provider ID. There has to be a provider
14 notice. A start date of the review. It has to
15 be very targeted and very specific. This is
16 my issue for prepayment from you.

17 Now, postpayment review is a
18 different animal. But the prepayment review,
19 and I've got the same issue with the E and M
20 downcodings. If you're putting something
21 through an algorithm and you're reviewing
22 every claim for every provider before you pay
23 it on an E and M level and there's no denial
24 letter, there's no concern of waste, fraud, or
25 abuse, there's no identified problem, that

1 shouldn't be a prepayment review.

2 You should pay it and then deny it
3 on the backside with a letter. And then we
4 talk about it. But the idea from my viewpoint
5 that these prepayment reviews are going
6 through without following the guidelines that
7 DMS put out there, I've got an issue with.

8 MS. PRESUTTO: I agree. It just
9 seemed like the conversation was leaning kind
10 of the other way in the call last week on
11 DMS's support of this being considered a
12 prepay review.

13 MR. RANALLO: I know Jennifer is
14 here. I don't know if she wants to weigh in.

15 MS. DUDINSKIE: Well, I don't know
16 if somebody from Chelsea or Jeremy's team is
17 on, because I think they were handling the
18 specifics with Wellcare on that. So I don't
19 know if there on.

20 MS. AGEE: This is Chelsea. I had
21 my hand raised, but --

22 MS. DUDINSKIE: Okay. I'll turn it
23 over to you for a second then.

24 MS. AGEE: Yeah. So I think there's
25 a distinction here that we have to make

1 between the prepayment review that's required
2 for Section 34.2 of the DMS NCO contract and
3 then the type of review that is being -- that
4 CPI is providing for Wellcare.

5 And so, you know, the prepayment
6 review process in the managed care contract is
7 applied only to providers who have
8 demonstrated a sustained or high level of
9 payment errors. So this is a targeted process
10 for specific providers, and it's not applied
11 across the entire network, such as Optum's CPI
12 program.

13 So, in other words, prepayment
14 review is kind of a corrective measure for
15 providers with a history of errors. While
16 Optum CPI is a claim management tool that
17 applies their edits formally across the entire
18 network.

19 So that's kind of the important
20 thing to note is that the CPI program does not
21 target specific providers. It reviews claims
22 across the board, and the requirement in the
23 contract that this fulfills for the MCO is
24 Appendix D, which is our management
25 information system requirements.

1 So, you know, CPI is a
2 state-approved claims editing initiative. It
3 applies to all claims across the provider
4 network. It's just part of the claims editing
5 and auditing process that's outlined in the
6 contract.

7 And the purpose is really to
8 identify potential billing errors and then
9 ensure that claims, you know, are
10 substantiated properly before payment.

11 MR. RANALLO: So, Christine, the CPI
12 that you're experiencing, is it claim edit
13 driven?

14 MS. PRESUTTO: That is what they
15 say.

16 MR. RANALLO: Well, what are they
17 denying on it?

18 MS. PRESUTTO: Hold on. Let me pull
19 up my report. Sorry, I wasn't ready to have
20 that.

21 MR. RANALLO: Sorry.

22 MS. PRESUTTO: Give me just a moment
23 and I can get that for you.

24 MS. AGEE: You know, I will say,
25 while you're working on that Christine, you

1 know, if our Wellcare folks are on and would
2 like to, you know, address any more context of
3 this, I know part of our, you know, DMS's
4 review that we wanted to ensure Wellcare made
5 clear with the vendor is that there is a
6 distinction between prepayment review
7 according to the MCO contract and this type of
8 prepayment review that's claims edit focused.

9 So I know they working on, they, you
10 know, including some tailored reports for
11 individual providers who were experiencing,
12 you, know really high volume of those flagged
13 errors.

14 MR. RANALLO: They're asking for
15 medical records. That doesn't sound like a
16 claim edit.

17 MS. PRESUTTO: So, what their
18 analytics look for is NCCI modifier override,
19 DRG rules, professional claims for select
20 surgical procedures exceeding targeted dollar
21 threshold. Facility unbundling of outpatient
22 services while inpatient, cross code or
23 outpatient facility surgical claims, multiple
24 E and M codes same day. Suspicion of
25 upcoding. Frequency of overriding CCI edits.

1 Frequent unbundled recipient services.
2 Unusual superficial deep impact -- excuse me
3 -- implant removals. Potential upcoded
4 musculoskeletal excision procedures.
5 Misbilling third order. Catheter placement.
6 Distal. Sorry, stay with me on pronouncing
7 some of these words.

8 Distal clavicolectomy incorrect
9 coding. Upcoding of complex cataract surgery.
10 High dollar hardware. High dollar IV
11 hydration. Hydration with IVP, IVBP. Facility
12 outpatient. Excessive hours of service,
13 unlikely frequency of radiation therapy
14 planning and management codes, and incorrect
15 billing of CPT 80305 for prostate biopsies.

16 MR. RANALLO: Okay.

17 MS. PRESUTTO: That was on the
18 crosswalk that we were provided.

19 MR. RANALLO: So it's a crosswalk,
20 but some of those are pretty gray and
21 nebulous, right? What's the parameter?

22 MS. PRESUTTO: I mean, they don't
23 tell us specifically. Like the DRG one I'm
24 assuming they are just looking for suspicion
25 of upcoding, but which codes are they

1 suspicious of.

2 MR. RANALLO: What's the threshold
3 for high dollar hardware? What's the
4 threshold for --

5 MS. PRESUTTO: Yeah, that's not
6 identified.

7 MR. RANALLO: What's the parameters,
8 right?

9 MS. PRESUTTO: Correct.

10 MR. RANALLO: So I guess from DMS,
11 should we not -- if they've applied all this,
12 should it not be the parameters that are
13 shared or do they get to change and make the
14 rules at will?

15 MS. AGEE: No. I mean, we, you
16 know, we requested, as far as our review,
17 again, that Wellcare, the one issue that we
18 saw was the communication. The transparency.

19 And so that was one takeback that
20 they committed to, was identifying where they
21 could improve in those areas.

22 And I would love it if there's some
23 folks from Wellcare on who would like to
24 address some of this as well, because, you
25 know, just kind of maybe outlining the

1 corrective actions or corrective measures you
2 all are taking around at least the
3 transparency and ensuring that the provider
4 understands what they need to be providing or
5 potentially appealing, et cetera. Anyone from
6 Wellcare want to address that?

7 (No response.)

8 MR. RANALLO: I think that's part of
9 the issue.

10 MS. AGEE: Yeah. I agree, Russ.

11 MR. RANALLO: Their using an Optum
12 product and nobody understands it. It's like
13 the E and M piece, is that nobody understands
14 and nobody has the parameters that they can
15 share about why they're doing anything. Why
16 they are denying something.

17 What makes it a high threshold? Is
18 it 50 bucks? Is it 5000 dollars? What is it?
19 And we're left to guess.

20 Can't appeal it intelligently or
21 correctly because we don't know what the
22 parameter that it was denied under. And, I
23 mean, this is groundhog's day. This repeats
24 over and over and over again.

25 We've got to have transparency about

1 this is why this thing was denied. This is
2 the reason, so that we can adequately appeal
3 it and fight it and try to argue it. But not
4 knowing it because it's an Optum proprietary
5 software and it's a black box isn't
6 acceptable.

7 MR. RANALLO: Yeah. You know, I'm
8 inclined to agree with you, Russ. I
9 definitely, you know, again, as I said, that
10 was one thing that, you know, we were most
11 concerned about was the transparency piece.

12 And so, you know, I know we don't
13 have maybe the right individuals on the call
14 today from Wellcare to address. I will follow
15 up with them after this call today, because I
16 need to get a little bit more information
17 around that piece.

18 And I can provide a response back to
19 the TAC once I get some more information about
20 the transparency piece and what they're giving
21 to (Indistinct).

22 MS. RITCHEY-BALDWIN: That would be
23 great. And Chelsea, we're having monthly kind
24 of touch bases with me and the folks from DMS
25 on our items so that we don't have to wait

1 until the next TAC meeting. If you get
2 something, you are more than welcome to join
3 us at the touch bases that we are scheduling
4 to -- so we can discuss it more. But I
5 appreciate that effort.

6 MS. RITCHEY-BALDWIN: Are there
7 people on from Wellcare? Can we request that
8 someone who can answer this question be on the
9 next TAC meeting?

10 MR. RANALLO: We can request.
11 Rosmond, will you remind me to carry that
12 water to the Wellcare folks?

13 MS. DOLEN: Sure will.

14 MR. RANALLO: Thank you.

15 MS. RITCHEY-BALDWIN: Thank you.

16 MR. RANALLO: All right. The IMD
17 partial hospitalization, I think, as I
18 understand it, you know, this is kind of out
19 of my realm a little bit, but there were some
20 questions about the 15-day limit. I know
21 those days are changing.

22 I know we had an update at the
23 pre-call for this. Can someone from DMS talk
24 about this a little bit?

25 MS. GRAHAM: Hi. My name is Heather

1 Graham. I am a Behavioral Health Specialist
2 with the Department of Medicaid Services, and
3 I was asked to join today to talk about the
4 1115 for serious mental illness. And I'm not
5 sure exactly all of the questions that you
6 might have, but hopefully I can address
7 anything that you're needing to know.

8 As far as the SMI 1115 went live on
9 January 15th. And so that did extend the
10 15-day in lieu of service is what previously
11 has been acceptable for MCOs to pay for
12 inpatient short-term psych services for
13 beneficiaries who are 21 to 64.

14 As of January 15th, that has changed
15 to up to 60 days. So that definitely gave
16 some extra parameters there for being able to
17 bill those services.

18 MR. RANALLO: Well, what I
19 understood was that if it goes past that day
20 limit, the whole claim is denied, right?

21 MS. GRAHAM: Correct. The stay
22 cannot exceed 60 days.

23 MR. RANALLO: So if it 61, you don't
24 get paid from zero to 60.

25 MS. GRAHAM: Correct.

1 MR. RANALLO: Okay. Questions from
2 the TAC group?

3 (No response.)

4 MR. RANALLO: Rosmond, is there
5 something I'm missing on that?

6 MS. DOLEN: Yes. I think this
7 partial hospitalization item is left over from
8 a provider notice that was issued back in
9 2023, and we're still waiting on a rescission
10 from the department on that piece.

11 MS. GRAHAM: Rosmond, help me -- is
12 this a telehealth question for partial
13 hospitalization?

14 MS. DOLEN: Yes, it is.

15 MS. GRAHAM: Okay. So, I do know
16 that the guidance, the last recent guidance,
17 and I want to make sure that I speak to this
18 correctly, was going to be updated, but then
19 CMS has recently also been giving guidance in
20 October and December, and then again in
21 February about changing in any of their
22 telehealth where it had been acceptable during
23 the PHE, the Public Health Emergency, and then
24 what had been changed.

25 And so they've changed some of their

1 behavioral health pieces. I know that moving
2 forward we were going to look at what date to
3 retro or set an effective date for that based
4 on what CMS has provided.

5 And so from what recently came out,
6 it looks like the most recent one came out the
7 17th, and it looks like they're going to
8 possibly extend to December of 2027 for
9 whatever was existing, but we haven't gotten
10 clear guidance from them on if that also
11 applies in this other setting, because it came
12 out for Medicare, and so we're trying to
13 untangle and get that guidance back to you.

14 That did get brought up. It's on
15 the top of our to-do list. Friday, we had
16 another discussion about it too, to try to get
17 you guys an answer.

18 Like I said, I think it was ready to
19 be put out and then the guidance changed again
20 from CMS. And so I think that's where we've
21 been trying to untangle.

22 And I hope I've spoke to that, like
23 all of those pieces that are missing. And
24 I'll take it back to Angela and Sherry as well
25 and make sure that I didn't miss any of those

1 pieces.

2 MS. DOLEN: Yeah, we've asked for
3 additional information and a rescission on
4 that particular provider notice since October.
5 Since it came out. And we've heard in
6 different settings, yes, they were going to
7 issue it.

8 And maybe, to your point, the
9 guidance has changed. But we are just
10 continuing to follow up on this because it
11 does prevent people from accessing services
12 and none of the hospitals are willing to -- at
13 least as far as I know, none of them are
14 willing to start providing these services
15 without that kind of rescission and guidance
16 from the department. So we really appreciate
17 your follow-up on this. Thank you.

18 MS. GRAHAM: Okay. And it was my
19 understanding too that the services, if they
20 were previously being provided telehealth,
21 they are no longer being provided until this
22 guidance is given, right? That's what you
23 were referring to, Rosmond?

24 MS. DOLEN: Yes. When the
25 (indistinct) came out that said there was no

1 payment for these services and that they
2 weren't going to be allowed, those services
3 stopped.

4 MS. GRAHAM: Okay. Thank you. I
5 wanted to just make sure I heard that
6 correctly. Okay. Yeah.

7 And that's where I know it was in
8 October. The date on the letter draft that I
9 have was October of 2025. And then the next
10 stall I got was from additional guidance that
11 came out in December.

12 So we're looking at it, and I'll try
13 to get a response as soon as possible. And
14 I'm sorry for the delay. It really is fun
15 trying to navigate some of the CMS pieces when
16 it is switching very rapidly.

17 MR. RANALLO: Thank you, Heather.
18 Any other input or questions on this?

19 (No response.)

20 MR. RANALLO: All right. Okay, move
21 down to denials, DRG downgrading. This one
22 was kind of in tandem with the newborn. So we
23 are seeing downgrades on neonatal DRGs to a
24 normal newborn DRG the MCO doesn't see the
25 level of care is on the account. So if a

1 newborn doesn't stay a night in the NICU, we
2 are seeing it says it's being downgraded
3 automatically. Sometimes not getting payment
4 at all.

5 What I understand is Wellcare is
6 specifically saying they can't substantiate
7 the DRG and they are paying zero. And that's
8 a newborn that they are paying zero on.

9 The contention from the hospitals is
10 that it is a diagnosis-related group
11 methodology. It's not a level, an
12 accommodation methodology where there would be
13 a per diem where you've got an ICU or a
14 Med-Surg or a normal newborn, and it's the
15 DRGs are driven by the diagnoses on the bill.

16 And I know I've seen my own share of
17 MCOs taking newborn or neonatal DRGs and
18 reviewing those diagnoses that are there and
19 challenging those.

20 But the automatic downgrade to a
21 normal newborn when there's not a NICU is out
22 of line from the viewpoint of our members.
23 And especially getting a zero payment on
24 something that they say that they can't
25 substantiate a DRG, which is -- should never

1 happen.

2 MS. WARFORD: May I add something to
3 what you just stated?

4 MR. RANALLO: Sure.

5 MS. WARFORD: I'm Danette Warford
6 with UofL Health. And a portion of the DRG
7 downgrades that we've been bringing to the KHA
8 group for quite some time now aren't specific
9 to the neonatal group. So I just wanted to
10 make that distinction.

11 I do know that that is an issue.
12 You're absolutely right in the way that you
13 presented it. But we have an older group of
14 an accounts that we've been working with
15 Wellcare on for quite some time, where they
16 reviewed accounts and said different things.
17 They used different verbiage at different
18 times they'll either say that they are
19 downgrading it. We fought with them quite a
20 bit over these. They've paid several of them,
21 but we still have like at least, I believe 12
22 accounts outstanding. They're very old where
23 they've either paid and then recouped the
24 money or they've never paid us any money but
25 we have no dollars.

1 And their reasons are that they said
2 that they couldn't substantiate a DRG. And
3 they claim that that is not a DRG downgrade.
4 They are trying to distinguish that.

5 But our stance has been, we've
6 provided you with the full medical records.
7 It was an approved inpatient stay. So there
8 has to be a reimbursable DRG.

9 You know, we may disagree on what
10 that is based on your review of the coding and
11 our review of the coding, but our stance is we
12 should, at a minimum, be paid what they
13 determined to be the DRG for that account at a
14 very minimum, and they've not done that. They
15 are paying us zero and stating that that is
16 appropriate.

17 MR. RANALLO: Well, I know DMS was
18 looking at this issue and reaching out to the
19 MCOs. Do we have any follow-up?

20 MR. CHAPMAN: So this is Jeff at
21 Passport. I can jump in and just say we've
22 been reviewing a number of different DRG
23 downgrade questions and zero pays. And we,
24 actually last week, even on a KHA call just
25 kind of broke it down into different

1 categories to identify what was happening
2 there.

3 So it looked like it wasn't a
4 downgrade or a no-pay for services that were
5 authorized, but it was just different edits
6 that were firing and different reasons for the
7 payment changing. And we've looked at a few
8 different things.

9 Some were because of an itemized
10 bill that weren't provided. Some were a
11 discharge status that was different than what
12 was billed. Just various reasons.

13 So on the newborn downgrades though,
14 I can say as long as it's a standard, not a
15 NICU inpatient stay, but a routine one, we
16 would pay that at the standard rate. If it is
17 a higher level of care, we would just ask for
18 those medical records to go with it and we can
19 reprocess that claim.

20 If there are any other kinds of DRG
21 downgrades we can look at those too if you
22 have any other examples.

23 And I'll actually tie that back to
24 the newborn Progeny authorization issue. So
25 we did have an issue there. So if you get an

1 authorization from Progeny for a NICU stay and
2 you bill a different code for it than what was
3 authorized, we had a system upgrade that was
4 denying those if the codes didn't match.
5 We've recognized that was a problem,
6 reprocessed claims and fixed that already.

7 So Progeny claims should no longer
8 deny. They should pay at whatever the
9 authorized service was. Does that help?

10 MR. RANALLO: It does, but I guess I
11 have a question. So how can an accommodation
12 drive a DRG change?

13 MR. CHAPMAN: On which one?

14 MR. RANALLO: So what I am hearing
15 you say is that if say I have a full-term
16 neonate that stays only in the newborn
17 nursery. And it gets billed out based on the
18 diagnoses that are on the bill as a full-term
19 neonate.

20 Am I hearing you say that because
21 there's no neonatal accommodation room code on
22 that bill it'll -- your system will downgrade
23 that to a normal newborn DRG?

24 MR. CHAPMAN: Well, if the claim is
25 submitted with medical records, we're able to

1 process it based on whatever the records are
2 there. So if there are records that reflect
3 the higher level of care being provided, then
4 it would pay it at a higher level of care.

5 If it's just being billed, knowing
6 that, you know, different diagnoses are
7 included in the claim for informational
8 reasons like a heart murmur, per se, when no
9 NICU stay was used or needed, then we would
10 just pay that at standard newborn rate.

11 MR. RANALLO: Then you're not paying
12 under a DRG methodology then, right? At that
13 point, Jeff?

14 MR. CHAPMAN: It would be the
15 standard inpatient --

16 MR. RANALLO: It's like saying, I
17 won't pay sepsis unless there's an ICU
18 account, an ICU room code on the bill. And
19 you can have a DRG of sepsis without being in
20 the ICU. It's a DRG. It's a diagnosis
21 related group, right? And it's based on an
22 average payment, right?

23 There's winners and losers in every
24 DRG, right? Because you have ones that are
25 more sick and ones that are less sick. It's

1 never that the cost of my care is never spot
2 on.

3 And so it's counter to the actual
4 methodology that's been agreed to. There's no
5 place in the DRG methodology that says,
6 because you had this accommodation, we're
7 going to change the DRG that is there. You
8 want to argue the diagnosis, that's a
9 different story.

10 MR. CHAPMAN: So, if the NICU was
11 not used, we would pay at the routine newborn
12 delivery fee. If the NICU is used, we will
13 pay whatever was authorized.

14 MR. RANALLO: That's the issue. A
15 neonatal DRG does not necessarily require, you
16 know, for it to be classified as a neonatal
17 baby does not require necessarily a NICU
18 accommodation.

19 MR. CHAPMAN: Right. So in those
20 instances we would just require the medical
21 records that would reflect the need for that
22 higher level of stay. And then we would pay
23 at that billed DRG based on whatever is
24 reflected in the records there.

25 MR. RANALLO: Okay. I don't think

1 that's what's happening, but I will look to my
2 group and my own internal ones to bring back
3 more.

4 MR. CHAPMAN: And if you see
5 anything different happening, I mean, by all
6 means, we are happy to look at those examples
7 and figure it out.

8 MR. RANALLO: If that heart murmur
9 is driving it to a DRG and that is in a normal
10 newborn, and you challenge the heart murmur,
11 that's one thing, right? But if you don't
12 challenge the heart murmur and say yeah,
13 that's a good diagnosis but just because
14 they're in a normal nursery versus a NICU bed,
15 we're going to pay you the normal nursery and
16 downgrade the DRG outside of how it should be
17 grouped and how it should be paid, then that's
18 where I've got the issue. That's where we
19 have the issue.

20 MR. CHAPMAN: And that's just why we
21 need the medical records, because we don't
22 have any other way of really knowing.

23 MR. RANALLO: Okay. Any DMS
24 follow-up? I know this has been on and I know
25 they were talking to MCOs about this issue.

1 MR. DEARINGER: Yeah. We have a --
2 again, there's several issues. So, the issue
3 you just discussed with the newborns not being
4 in the -- having to be neonatal, that's part
5 of that issue we discussed that is in the
6 workgroup that we're still meeting on.

7 But another issue is on DRG
8 downgrading, E and M downcoding, all those
9 type things, and some of the things you talked
10 about earlier. I think specifically, and I
11 brought it up a little bit earlier too.

12 I have an MCO policy clarification
13 or an MCO policy letter that will be going out
14 either this week or early next week that's
15 going to talk about ensuring that any of our
16 providers that are denied a service or have a
17 service downcoded or downgraded in any way,
18 that they have clear and specific reasoning
19 why that was denied or downgraded or
20 downcoded.

21 And then that they are giving the
22 right and ability to appeal that, those
23 specific reasons.

24 So I think that's lacking in some of
25 these issues, and so we want to make sure that

1 our providers have that opportunity. So
2 that's going to be going out within the next
3 week or two. And then as we get some more
4 clarification from the meeting on the newborn
5 issue that you just discussed, we will be
6 getting back with you all on that as well.

7 MR. RANALLO: Okay.

8 MR. DEARINGER: If you have any
9 proposed language that you would, you know,
10 like to send over as far as what I just talked
11 about, feel free to send that to me. We would
12 always like to look at, you know, thoughts
13 before we send that out. Making sure that
14 we're being clear on what you all need for
15 those to be able to appeal those downgrades
16 and denials.

17 MR. RANALLO: Yeah, I think I would
18 like to talk to the TAC and have some input on
19 that.

20 MR. DEARINGER: Okay. I'll wait
21 then.

22 MR. RANALLO: Appreciate that.

23 MR. DEARINGER: Yeah, I'll wait.

24 MS. CARDELL: Can I ask a follow-up
25 question, Justin?

1 MR. DEARINGER: Yep.

2 MS. CARDELL: So, to your point on
3 the appeal, so what if we got to where they
4 say the DRG is going to downgrade it or they
5 can't substantiate the DRG?

6 In our mind, those two both mean the
7 same thing. There's going to be some type of
8 downgrade.

9 And let's say we agree with that
10 downgrade and we say, okay, we're not going to
11 appeal it based off the reason we don't really
12 know the downgrade to your point, maybe all
13 those details are in your letter.

14 So the clarification we're looking
15 for is if we don't appeal that, should we pay
16 zero? Should they pay us \$0? Because in our
17 mind, they would pay us what they downgrade it
18 to or what they were able to substantiate.
19 Not zero.

20 MR. DEARINGER: That's correct.
21 We'll address that too.

22 MS. CARDELL: Okay, that's what's
23 happening, and the issue that was described
24 earlier by Danette in our Wellcare downgrades.
25 And our Wellcare claims that say they can't

1 substantiate, if we don't appeal what they are
2 saying, they're paying zero.

3 MR. DEARINGER: We'll address that
4 as well.

5 MS. CARDELL: Okay. And then on
6 those claims, is the expectation to be
7 interest to apply to those claims if they were
8 denied in error or if they didn't just pay the
9 downgrade that they were able to substantiate?

10 MR. DEARINGER: That's a Chelsea
11 question on the interest payments for the
12 MCOs.

13 MS. CARDELL: Okay, so is that
14 something we should ask in the clarification
15 that Russ is going to put together? Because I
16 see she had to drop.

17 MR. DEARINGER: Oh, okay. Yeah,
18 absolutely.

19 MS. CARDELL: Okay. Thank you.

20 MR. RANALLO: So, appreciate that,
21 Justin. So that would kind of cover the line
22 item denials is another one, right? Where
23 it's we don't have really a process for
24 appeal. There's little transparency and what
25 they're doing, they are using a third-party

1 software or algorithm that really doesn't --
2 that we don't really agree with.

3 So that though for the E and M and
4 the line items that would kind of be covered
5 in the wake of --

6 MR. DEARINGER: Yeah. It all goes
7 together. You know, we have no problem with
8 our managed care organization partners
9 downgrading. We have no problem with them
10 doing line item denials. We have no issue
11 with them downcoding, but they have to make
12 sure that they give our providers specific
13 reasons why that happened. And when I say
14 specific, I mean it needs to be detailed so
15 that you all can appeal those things, and they
16 need to give you the same exact appealability
17 as they would anything else.

18 MR. RANALLO: That's what I've been
19 asking for, for a while, so I appreciate that
20 very much.

21 MS. WILEY: I'm sorry. This is
22 Jennifer at St. Elizabeth. Can I just ask one
23 quick question just to expand on something
24 that Russ mentioned, and that was, and it is
25 exactly what we're seeing. And that's when

1 the diagnosis code may be a heart murmur, and
2 yes, we diagnosed that. We may not treat it
3 here. We may have them follow up as
4 outpatient with a specialty like a children's
5 or something of that nature.

6 But we're still billing that
7 diagnosis. We still went through, you know,
8 the diagnosing part of that. So that's still
9 going to be on our claim, which is what drives
10 it to the level two, but then they aren't
11 paying that level two.

12 So I think their needs to be some
13 clarification and expansion on that in
14 general. I understand the DRG downgrade. And
15 yes, we should be getting paid at least a
16 level one there, but there also needs to be
17 clarification on whether or not that's
18 acceptable.

19 Because in one way, Passport is
20 stating that if they don't go to NICU that
21 they are just a level one. Then backed it
22 with, well, it depends on the diagnosis in the
23 medical records, but we are often seeing where
24 we do diagnose a higher-level problem, they
25 don't require a NICU stay, so therefore, yes,

1 it is a level two, but they are denying it as
2 a level two.

3 MR. RANALLO: Yep.

4 MS. WILEY: So, do we have more
5 expansion on -- I understand that yes, they
6 can downgrade, but should they be is the
7 question.

8 MR. DEARINGER: That piece that you
9 just talked about is a separate issue. So
10 that won't be an issue addressed in this
11 particular letter. We're still kind of going
12 through and reviewing that, but like I said,
13 with that group. But there's a specialized
14 group that is looking at the specific cases
15 for newborns who have extenuating medical
16 issues but they're not in NICU.

17 MR. RANALLO: Okay. I saw that in
18 the chat, I think Jeff at Molina put in the
19 Passport newborn NICU reimbursement link for
20 their policy. So I appreciate that. I'll
21 take a look at that.

22 Anybody from the TAC have any other
23 items on these things that we talked about an
24 old business?

25 MS. YOUNCE: I don't, Russ. Thank

1 you.

2 MR. RANALLO: Okay.

3 MS. RITCHEY-BALDWIN: I don't
4 either. Thanks.

5 MR. RANALLO: Thank you Lori. Thank
6 you, Elaine. Any other discussion or other
7 items?

8 MS. WARFORD: Russ, can I mention
9 something around the line item denials?

10 MR. RANALLO: Sure. Absolutely.

11 MS. WARFORD: Just to clarify, these
12 are, I believe the way these were addressed,
13 these are audits that are completed by the
14 payors where they disallow charges because
15 they feel that they should not be billed
16 separately. That's typically the language
17 that we see in those audits.

18 It's not that they're denying them
19 saying that they weren't provided. It's not
20 they are denying them saying that there's
21 reason why they shouldn't be -- their wording
22 typically says that they believe that this
23 particular charge, let's say it's a ventilator
24 charge, should be covered in the room and
25 board charge.

1 That's the type of language we see
2 with what we've been discussing is line item
3 denials in our KHA meetings are charge audits
4 where they disallow charges on our claims.

5 That effectively reduces our bill
6 charges, and based on the way our
7 reimbursement's determined, that reduces how
8 much we're paid. And because our
9 reimbursement is based on the charge master
10 that we all provide, they are, in essence,
11 reducing our rate that's already been
12 determined.

13 You know, we've already provided the
14 fact that we bill all of these things this
15 way. All of our charger masters are set for
16 all of our payors. That's the information
17 that's provided when our individual hospital's
18 reimbursement rates are determined.

19 But the MCOs are taking that and
20 saying, well, yes, that's your charge master,
21 but we don't think you should charge that way.
22 Therefore, we're disallowing this charge. We
23 are removing it from your claim. And what
24 that does is it reduces our reimbursement that
25 the department's already determined is

1 appropriate and at a level that helps us stay
2 in business.

3 So I just wanted to share that the
4 line item denials that are listed here are
5 those charge audit items where the MCOs or
6 their vendors are dictating how we charge
7 things after we've already presented that in
8 the reimbursement process.

9 MR. RANALLO: And I would even take
10 it further. So, when the methodology from a
11 DOG perspective, from the Medicare side, you
12 know, a lot of these happen on outliers.
13 Right? They don't look at inliers; they look
14 at outliers where there is an additional
15 payment.

16 And they take those charges. I've
17 said this before. They take these charges and
18 they say, okay, you shouldn't have charged
19 separately for that.

20 And I'll give you an example of why
21 that's hit me. So, an intubation kit, we
22 charge for the kit and we charge for the
23 handle. The handle is more than the kit
24 because we don't charge that handle in the
25 kit. There are different size handles, they

1 cost different. So we charge people for what
2 they use. We track it from a cost perspective
3 for each case rather than including it into
4 the kit where it gets lost, and where I may
5 charge for the higher item all the time.

6 The way the CMS rules work, and the
7 methodology works, is that it takes my charges
8 and it reduces it by my cost to charge ratio.
9 My own specific one. So CMS looks at my
10 charges versus my cost that is on the cost
11 recorder. So how I charge is already baked in
12 to the reimbursement.

13 So the reduction of charges, to say
14 that that's bundled is just a pure rate cut.
15 Because again, it's my cost to charge ratio.
16 Not Elaine's. Not Lori's. Not us state wide.
17 It's how my hospital charges and how I charge
18 is already baked in.

19 So when an MCO comes and they put it
20 through, again, a black box algorithm and says
21 you shouldn't charge that, then it's just a
22 pure rate cut. And it's not acceptable.

23 I've had ones where the patient came
24 in for a pacemaker and they have denied the
25 pacemaker. The actual pacemaker. That's what

1 they were there for. You know, a pacemaker to
2 put in their chest.

3 And, so it's, again, Justin, as we
4 do this, right, knowing specifically, right?
5 Why a pacemaker, when they came in for a
6 pacemaker or why this charge when this is how
7 I charge is specifically excluded, should be
8 specifically excluded, there's nothing that
9 they can point back to. They point back to
10 very nebulous and gray reasoning in a CMS reg.
11 But CMS doesn't tell you how to charge. They
12 just say you need to charge consistently.

13 So we went through this with
14 workers' comp payors about 10 to 15 years ago
15 and we continue to go through it with the
16 MCOs. And it's a problem because what you've
17 negotiated in your rates and the methodology
18 is, again, like the NICU newborn is not being
19 adhered to. All right. Anybody else?

20 (No response.)

21 MR. RANALLO: Any other items,
22 general discussion?

23 (No response.)

24 MR. RANALLO: I don't have a
25 recommendation today, but I'm getting closer.

1 The MAC meeting, the MAC has kind of
2 changed. We don't do reports anymore unless
3 we have recommendations, but I will be
4 attending the MAC to hear it.

5 And then our next meeting is April
6 21st, 2026. Tuesday.

7 Nothing else. I appreciate
8 everybody's time today. Thank you very much.
9 We'll be adjourned.

10 MS. WASH: Thank you.

11 (Meeting adjourns at 2:29 p.m.)

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C E R T I F I C A T E

I, THERESA PROKOP, Certified Voicewriter,
hereby 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 10th day of March, 2026.

Theresa Prokop

Theresa Prokop, Certified Voicewriter