

1 DEPARTMENT OF MEDICAID SERVICES
2 HOSPITAL TECHNICAL ADVISORY COMMITTEE

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8 Cabinet for Health and Family Services
9 Public Health Building
10 275 East Main Street
11 First Floor, Suite A and B
12 Frankfort, Kentucky

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15 August 27, 2019,
16 commencing at 1 p.m.

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22 Lisa Colston, FCRR, RPR
23 Federal Certified Realtime Reporter
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A P P E A R A N C E S .

BOARD MEMBERS:

Russ Ranallo, Chair
Michele Lawless
Elaine Younce
Danny Harris

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CHAIRMAN RANALLO: We will call to order the Hospital Technical Advisory Committee meeting. I'm Russ Ranallo. I'm Vice President of Finance, Owensboro Health, and Chair of the TAC. Why don't we go ahead and introduce ourselves.

MS. LAWLESS: Michele Lawless, Vice President of Revenue Cycle for Med Center Health.

MS. YOUNCE: Elaine Younce, Chief of Payer Administration for UK HealthCare.

MR. HARRIS: Danny Harris, CFO, ARH.

(Non-Board member attendance is announced and is as noted on the attached sign-in sheet)

CHAIRMAN RANALLO: And we will get the people on the phone here in a second.

For those in the room, we're recording this. So if you ask a question, you may want to state your name to make sure we get it right.

Folks on the phone, who do we have on the phone?

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(Non-Board member speakerphone attendance is announced.

CHAIRMAN RANALLO: Okay. If everybody on the phone will put their phones on mute to eliminate the background noise, I would appreciate that.

Everybody has got an agenda. I think we're going move to number four on the agenda, the 340B policy review and update, to the first. Mr. Joseph has been so kind to join us. I appreciate it.

MR. JOSEPH: Of course.

CHAIRMAN RANALLO: Thank you.

MR. JOSEPH: Of course.

CHAIRMAN RANALLO: And I know that's why you have got a lot of people on the phone, because there are several questions about the policy that was put out. And, then, would you like to give us an overview of that policy so that we can start the discussion.

MR. OGLESBY: Russ, with the noise out here, can they hear him over here with the cutting grass?

CHAIRMAN RANALLO: I don't know.

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They can hear me, I know. Do you want to move down here, towards the phone, so everybody can hear.

MR. OGLESBY: Do you want to do introductions over here (indicating)?

CHAIRMAN RANALLO: Yeah. Why don't we go ahead and do that. I apologize. Back in the back.

(Non-Board member attendance is announced and is as noted on the attached sign-in sheet.

CHAIRMAN RANALLO: Okay. So back to the first item, which is the 340B policy review and update. Mr. Joseph.

MR. JOSEPH: Sure. Hopefully everyone can hear me now.

So the 340B policy that we released about a month ago here, let me just start off by saying that the policy right now is planned to go into effect on 1/1 of '20. We're going to be moving that date. It has to be at quarterly intervals. Because federal rebate systems, from CMS's standpoint, is done quarterly. And if we can't do 10/1, then we have to go to 1/1,

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just so everyone knows.

I think we have received a substantial amount of feedback, where we do want to make edits to what our proposed policy is. Right now, Kentucky Medicaid utilizes the Kentucky -- or, sorry, the HRSA Medicaid exclusion filed to exclude all rebate collection for Medicaid participants who use a 340B covered entity. That said, on the Medicaid exclusion file, only 340B covered entities are on there. No contract pharmacies are listed on that file. We use Magellan to do this. I mean, the easiest way for me to explain that is, they match up NPI's from those prescription claims that we get and the NPI on the file itself. So if the two files have the same NPI, then we exclude rebate collection from those specific claims.

Moving forward, we're moving to claim-level identification of 340B specific claims. The reason being is, one, we need to stay compliant with what the federal law is asking us to do and that is to avoid duplicate discounts. The difficulty of that

1 is, claim-level identification is hard to do
2 at the point-of-sale. However, we have seen
3 that both the GAO and OIG from the federal
4 standpoint have recommended moving to
5 claim-level identification. So from our
6 standpoint, we have three duties. One is to
7 stay compliant with federal law. Two is to
8 protect ourselves from any recoupments that
9 may occur due to the 340B program and
10 duplicate discounts. And then three is the
11 fiscal integrity of the Medicaid rebate
12 program.

13 I think Steve can touch on this
14 more than I can. But the Medicaid drug
15 rebate program has provided Kentucky Medicaid
16 a substantial amount in terms of our budget.
17 And, therefore, when we do open this up to
18 claim-level identification, the thought is
19 that we will be excluding more rebates if it
20 is identified at the claim level and,
21 therefore, we do want to acknowledge the fact
22 that 340B covered entities utilize contract
23 pharmacies. And in order for us to stay
24 compliant with that is to move to a
25 claim-level identification process. The one

1 thing that Kentucky Medicaid would probably
2 not do is exclude all rebates from a contract
3 pharmacy. Because we know that all those
4 patients that go to that contract pharmacy
5 are not necessarily seeking care at a 340B
6 covered entity. But we do also know that in
7 recent months more companies have entered the
8 340B field to, essentially, identify
9 duplicate discounts for manufacturers and,
10 therefore, we will be seeking anything from
11 rebates -- anything considered a duplicate
12 discount. And so in order for us to stay
13 compliant and then to protect ourselves from
14 any future recoupments, the proposal was to
15 move to a claim-level identification process.

16 And then our final piece is that we
17 do want to ensure that when we do move to a
18 claim-level identification process, we are
19 ensuring that we are not going to be losing
20 out on such a substantial hit, in terms of
21 Medicaid rebates. You know, beyond the fact
22 that I acknowledge that and I think DMS
23 acknowledges that contract pharmacies and
24 point-of-sale identification of claims is
25 difficult. We know that more than half the

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states in the country utilize this method. We know the other half utilize the Medicaid exclusion file and, thus, disallowed all contract pharmacies.

Oregon and Hawaii, to our knowledge, are the only two states that have started and implemented a retrospective model. This was the initial thought when we moved forward with moving to claim-level identification. So we reached out to Magellan back in February of 2019 to see if this was able to be stood up at our state. It's after speaking with them that it would both be an operationally difficult as well as logistically, too, to create those files. And the startup for that whole system would be more burdensome than what they recommended to us. So we moved forward with the next best policy for us, and that is still to move towards claim-level identification, however at the point-of-sale system.

In the time since the proposal was put out, we've had enough feedback where we are now exploring alternative solutions to a semi-retrospective model, and we've just

1 initiated those conversations. So, again, we
2 wanted to give ourselves at least the time
3 frame of pushing this to 1/1 to explore those
4 options and see if it is feasible. You know,
5 out of all honesty, I think these options are
6 feasible. However, the timetables to get
7 these up and operating would be more than the
8 three months that we get with the quarterly
9 updates. So, you know, the 1/1 point of
10 time, you know, I would like to at least
11 explore those options; however, I cannot
12 promise that that's going to be the way that
13 we move forward.

14 I mean, I'm here to answer any
15 questions or any concerns. I think, again,
16 we've heard a lot in terms of the difficulty
17 of doing this in chain stores, in independent
18 retail pharmacies. But this is kind of the
19 option that we see is appropriate for us to
20 stay compliant, prevent ourselves from any
21 recoupments occurring in the future, and then
22 maintaining Medicaid fiscal integrity of
23 rebates.

24 CHAIRMAN RANALLO: So one of the
25 questions that we got from several folks was:

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In the beginning of the policy, it says the manual doesn't apply to prescription drugs provided in an inpatient or outpatient setting. But then later on it talks about this includes outpatient hospital and outpatient professional services.

MR. JOSEPH: Yeah.

CHAIRMAN RANALLO: So they seem in conflict. And we would ask for clarification on that.

MR. JOSEPH: Yeah. And I apologize for that. We're going to be taking out that last sentence from that first paragraph. The point of that was to identify that we were putting claim-level identification at point-of-sales, so those that are coming through, either through your PMB or through your contract pharmacy, and then those on the CMS-1500 form, so the physician-administered drug list. I think what we were trying to do is avoid the UB-04 form entirely from hospital rate setting purposes, but I think that kind of just got mixed up in the jumble of everything. So we will be avoiding that.

And the point of this is

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specifically for claims being addressed through a CMS-1500 form or those being provided through a point-of-sale.

CHAIRMAN RANALLO: Great.

Thank you. And I think --

DR. CLAYBORN: Sorry for the interruption. This is Dr. Clayborn. And I just wanted to see if I was in the right meeting. Is this the Cabinet for Health and Family Services TAC meeting?

CHAIRMAN RANALLO: Yes.

Dr. Clayborn, this is Russ Ranallo. This is the TAC meeting. And we're talking about the 340B policy right now. We moved one of those items up on the agenda. You are in the right place.

DR. CLAYBORN: Thank you, Russ.

CHAIRMAN RANALLO: Yes, sir.

DR. CLAYBORN: Okay. I appreciate that. And pardon the interruption.

CHAIRMAN RANALLO: No problem.

Another question we got or comment was, you know, with the claim indicators, especially what was on Epic. So, like, we have Epic at our shop and a lot of hospitals

1 do. And I guess generally for any EMR.
2 You know, we know, like, this is doable
3 for -- other parties and other states have it
4 with Epic, but we don't have it built in our
5 system.

6 MR. JOSEPH: Sure.

7 CHAIRMAN RANALLO: And building it
8 into our system and the testing of that will
9 take time.

10 MR. JOSEPH: Sure.

11 CHAIRMAN RANALLO: And, so, the
12 October date was something that we were not
13 going to be able to do --

14 MR. JOSEPH: Sure.

15 CHAIRMAN RANALLO: -- to get there.

16 MR. JOSEPH: Yeah.

17 CHAIRMAN RANALLO: And so knowing
18 the clarification of what it applies to and
19 what we need to do may be helpful for a
20 number of hospitals.

21 MR. JOSEPH: Sure.

22 CHAIRMAN RANALLO: Let's see.
23 Other questions? Does anybody have other
24 questions that they wanted to -- on this
25 policy?

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SPEAKERPHONE PARTICIPANT: So this is Jeff with Baptist Regional Healthcare.

Will there be another version of the policy published with a comment based, based on comments that were just made?

MR. JOSEPH: Yes. So, we're planning on responding to all of the comments we get. Our plan is right now to take each individual feedback, see if it corresponds to somebody else's feedback; if it does, then we can provide that similar answer, at least to address the specific concerns. But our objective right now is to make sure that we respond to all of the comments. Whether or not that's provided in a policy format or if we reach out directly, I think I will have to speak to the Commissioner on that one.

MR. ALLEN: Okay. This is Paul Allen with Norton Healthcare.

Did you say anything about the 30 mile rule that you all were talking about?

MR. JOSEPH: I haven't spoken about it. But I think that was a question in the back as well.

So the 30 mile rule is specific for

1 contract pharmacies. The reason we went with
2 the 30 mile rule is there is a GAO report out
3 that identifies the average distance for a
4 contract pharmacy to be 30 miles. I
5 understand that this may be too little, in
6 terms of a lot of our rural health centers
7 that are treating 340B patients. So we will
8 have to address that as well as the specialty
9 pharmacy issue of certain entities only have
10 specific specialty pharmacies that are either
11 outside of this state but enrolled with
12 Kentucky Medicaid or farther than 30 miles
13 itself.

14 So we will be addressing that
15 hopefully -- or we will be addressing that in
16 the next policy update.

17 MR. ALLEN: Okay. Thank you.

18 MR. THAMANN: I have a question.

19 CHAIRMAN RANALLO: Okay. And who
20 is talking?

21 MR. THAMANN: Can you then clarify
22 for hospital-covered entities billing on
23 UB-04. It is the state's policy currently
24 right now that they do not have to bill in a
25 claim line level any specific indicators for

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340B draws at this time. Is that how you see it?

MR. JOSEPH: At this time, we're not -- I'm -- I can't -- I am not at liberty to talk about the UB-04 form, only because I'm not educated on what the UB-04 form does, really. I mean, the pharmacy department at Medicaid right now is focused very much on the point-of-sale system and the physician administered drug list.

If you give me some time, I can talk to our rate setting team and see if we can give you a little bit more clarification. But the policy itself right now does not impact the UB-04 forms.

MR. THAMANN: Thank you.

CHAIRMAN RANALLO: Who asked that question, please.

MR. THAMANN: This is Joe Thamann with Saint Elizabeth Healthcare.

CHAIRMAN RANALLO: Thanks, Joe.

MS. HALTON: Can I ask a clarification?

MR. JOSEPH: Sure.

MS. HALTON: So I think some of

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this may be semantics. But still regarding the point-of-sale versus retrospective versus a delayed submission of the claim.

MR. JOSEPH: Sure.

MS. HALTON: So I tried to talk to each of the systems, which are ranging -- mostly there are about five national chains that we contract with. And when I asked them could they achieve this at point-of-sale, the answer universally was no, that the pharmacists at the store don't know that those prescriptions are going to be eligible at the time they are billing it and it is virtually impossible to do that.

I've talked to other pharmacists who say, "Oh, yeah. We're going to do it. We're just coding all of our prescriptions with that code." Which again, to me, I feel like would be not accurate. Because I know that that's educated after the fact. And according to the contract pharmacy's agreement that we have in place, they would go through and look at the terms of that contract in terms of is it randomly or winners only and all of these different

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formulas about what rule is in and what captures or not. So even though it is written from an eligible provider, from an eligible Medicaid provider, that prescription claim really may not be captured as 340B. So my dilemma is, how do we achieve what you are proposing?

I've only talked to one pharmacy chain that we contract with who says this is even possible. And in their model when I asked about more details about is this point-of-sale done by the pharmacists at the store or is it retrospective, they are like, "Well, it is not really retrospective. But we just kind of hold the claim and do all of that background and then submit it."

So my question to you is: Is that delayed submission of the claim after it's been truly confirmed as 340B eligible going to be acceptable? Or will you give us an option and a way to go in then and tag those that really are captured as 340B from that pool of potential 340B prescriptions that we know our eligible physicians have written from eligible sites?

1 MR. JOSEPH: In terms of delayed or
2 not. When we get it at Medicaid, that has
3 been -- that claim has been processed by the
4 PBM for our managed care organization. And
5 then within about a two week time frame we
6 will get it into our MMIS system. So the
7 delayed about whether -- what they are doing
8 at the pharmacy, I can't speak on. That's
9 going to be a conversation that the covered
10 entity has with the contract pharmacy.

11 How you do that, what you do, I
12 think it's in the best interests of Medicaid
13 to not comment on that. What we will be
14 doing is we will be looking for submission
15 clarification code 20 for those specific
16 claims. And once our rebate indicates --
17 our rebate vendor understands that and
18 applies that logic to our claims databases,
19 then we will be excluding those specific
20 claims.

21 So I don't want to tell you to hold
22 off on submitting those claims or anything
23 like that, because, you know, that might be
24 fraud.

25 MS. HALTON: So I would like for

1 the Department at least to be cognizant that
2 you have to give us a feasible plan to be
3 able to comply. And I feel like at this
4 point you are not. So I would encourage you
5 to consider those options. I think the two
6 states that you have cited are just a drop in
7 the bucket. There are 10 to 12 that do
8 retrospective submission of claims that are
9 validated captured claims. And if we're
10 going to do this the right way, I would ask
11 that you consider that.

12 MR. JOSEPH: I would ask that you
13 just send me the name of the ten states, and
14 I would be more than happy to reach out to
15 them.

16 CHAIRMAN RANALLO: So is
17 retrospective the same as reversal on
18 resubmission?

19 MR. JOSEPH: No, no. Retrospective
20 is -- so the retrospective model is the state
21 would -- or the rebate vendor would be
22 collecting a file from each of the covered
23 entities at some point in time before the
24 rebate collection process occurs at the end
25 of the quarter. Our rebate vendor would then

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match up the covered entity claims to what is in the current rebate extract. And then we would exclude those specific claims.

CHAIRMAN RANALLO: Okay.

MR. JOSEPH: What that will require -- I will just say that the current rebate vendor for Kentucky has not done this before. The only rebate vendor that we know of that has done this is in Oregon, and we don't utilize them for rebate purposes. And so, I mean, you know, we took probably two months to evaluate whether or not we could do that. And we even reached out to Oregon -- we reached out to Oregon's Medicaid department, our rebate vendor reached out to Oregon's rebate vendor. And kind of the standup issues alone were what deterred us from moving forward on that end.

CHAIRMAN RANALLO: So I know with some of the contract pharmacies what I have heard about the 340B virtual inventory. And there are a couple of states, I think like New York and Texas allow for reversals and resubmissions. Would we have a mechanism to be able to do that here?

1 MR. JOSEPH: You know, reversals
2 and resubmission, that's completely allowed.
3 We're only looking for the submission
4 clarification code 20 by the time it gets to
5 our MMIS vendor, and that is DXE. So if it
6 is on the claim by the time it gets to DXE
7 after running through claims processing
8 through the PBM of our managed care
9 organizations, we don't see an issue with it.

10 I would only state that -- I mean,
11 and I think a lot of you will know this, but
12 reversal and resubmission does come at a cost
13 to the pharmacy through the switch.
14 So, yeah.

15 CHAIRMAN RANALLO: Okay.

16 MS. HALTON: And that was the
17 model. I'm sorry. The one contract pharmacy
18 that said they could do it, it was that model
19 in terms of they have an administrative
20 platform that could do it for their stores
21 and for other stores that use their platform.
22 But most of the hospitals already have
23 contracts in place to use an administrative
24 body. And it would not be feasible to switch
25 to this one product or this one platform that

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could do that.

MR. JOSEPH: (Moved head up and down).

MS. HALTON: You know, and definitely not in 90 days. I mean, most of the contracts are one to three years with the administrative platforms that we're using for contract pharmacies.

MR. JOSEPH: Right. You know, the only other thing I am going to add is that the way that we've been doing it right now, we've only been using the Medicaid exclusion file. So Medicaid recipients receiving prescriptions from contract pharmacies right now we have been collecting rebates on. And so, already, from our understanding and without, you know, due evidence, we have probably been collecting duplicate discounts. And that's just the honest fact.

I would like to turn a blind eye. But at this point in time, I don't think we can. So we do have to stay compliant. And, you know, the issue right now to what we're proposing, I understand that is difficult. But we need to stay compliant.

1 MS. HALTON: Well, the option would
2 have been to not seek the rebates and
3 whenever that point, whenever that change,
4 that was not communicated to the
5 stakeholders, where we could have had a
6 conversation about it so that the state would
7 not be noncompliant. At this point, you are
8 right, the state is noncompliant, not the
9 covered entity but the state.

10 MR. JOSEPH: That's up for
11 discussion.

12 MS. HALTON: Yeah.

13 PARTICIPANT: Could you state your
14 name and company, just for the record.

15 MS. HALTON: Joan Halton,
16 Ephraim-McDowell Health.

17 PARTICIPANT: Thank you.

18 MS. HALTON: One of the other
19 questions is about the impact. I know in the
20 statements that we've had before, you know,
21 the purpose is not to penalize the hospitals.
22 But most of our critical access hospitals
23 don't have pharmacies on-site, so we do have
24 to rely on contract pharmacies to provide
25 this benefit to our patients. So, and

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essentially, if we can't comply with what you propose, we will be forced to carve out, which would substantially impact the revenue and the benefit of the 340B program for critical access hospitals or even rural hospitals which rely on this to expand their services.

So I do feel that while the intent has been stated that this change is not to impact hospitals, it definitely has a direct impact.

MR. JOSEPH: Right.

MS. HALTON: When we looked at just our, you know, small operation, you know, some of our counties up to 40 percent of our prescriptions are Medicaid. And, so, it is a substantial impact. It is not like one or two percent of prescriptions that we're going to lose on from this. So I would beg you to consider that.

MR. JOSEPH: Thank you.

CHAIRMAN RANALLO: Any other questions?

MR. STELTENPOHL: I have one from Mr. Joseph. And I'm Bob Steltenpohl with

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Alliant. I work with a couple of different Kentucky hospitals.

But I appreciate what you said, Dr. Joseph, about looking at, I forgot what you called it now, kind of a modified respect to look at things. Would you be willing to let a couple of the hospitals to work with you as you are looking at that to try and see if we could maybe provide some advice and work with our pharmacies to see if there is a way to make that work? Because I understand where you are coming from, running a program and it has to be compliant. But as she stated, several of my facilities, too, have close to 40 percent of their business with Medicaid or Medicaid MCOs, and it could be very damaging to those facilities. But if we can find a solution that works working with you, that would be the best of both worlds.

MR. JOSEPH: Sure. I have -- I'm more than welcome to discuss other options. I think we've already discussed with a few hospitals. But, again, the more ideas we get to the table the better.

I will state that, after speaking

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with the Commissioner, whatever possible solution comes forward from this would require the covered entities to help with the cost of implementing such a solution. And then the state does require that we are able to recoup the missed potential rebates from the 340B contract pharmacies.

So if that makes -- I will explain it again. So it is the cost to set up the program itself would have to be funded by the covered entities. And then any potentially missed rebates from contract pharmacies would have to be recouped by DMS.

MR. STELTENPOHL: Could you explain what those missed rebates would be.

MR. JOSEPH: Yeah. So the 340 -- if the 340B, this is from our understanding, if the 340B discount is greater than the federal rebate that we will be receiving. So if we miss out at a rebate at a contract pharmacy, then the solution provided we should be able to make up that difference that we're missing out on.

MR. STELTENPOHL: Okay. I understand what you are saying, but I don't

1 know how easy it is to implement. Because I
2 don't know how much that is or anything else.

3 MR. JOSEPH: Right.

4 MR. STELTENPOHL: But that makes
5 sense.

6 MR. JOSEPH: Right.

7 MR. HERDE: Is there an estimate of
8 what that is?

9 MR. JOSEPH: I mean, from our look
10 right now, it would be above 30 million right
11 now, depending, you know, in total. I'm
12 sorry. I haven't broken this down by covered
13 entities. But...

14 MR. HERDE: And, so, that would be
15 recouped back from the individual providers?

16 MR. JOSEPH: From the covered
17 entities, yes.

18 MR. HERDE: So 30 million?

19 MR. JOSEPH: I'm speculating at
20 that point.

21 MR. HERDE: Estimating?

22 MR. JOSEPH: Yeah. I mean, it
23 depends on the total that we're missing out
24 on from the contract pharmacy. Because we --
25 again, we have no mechanism of measuring

1 this. We have no claims that have these.
2 Well, I guess we do. But we don't get them
3 in our system. You know, the PBM of our
4 managed care organizations may be able to
5 identify a claim level. But DX -- our
6 current MMIS system with DXE does not look at
7 that.

8 So, I mean, I guess we've started
9 the analysis on that more. But right now I
10 have no idea.

11 MR. HERDE: Okay. And I am curious
12 from an administrative perspective, this is
13 Carl Herde from KHA by the way, what is the
14 difference between a policy manual and a
15 regulation? And what is the official process
16 for that happening? Is this tied to a
17 regulation?

18 MR. JOSEPH: No. This is not tied
19 to a regulation. The policy manual -- so the
20 -- I think a question at some point to us was
21 whether this was going to be in a state plan
22 amendment.

23 We're not required to do this with
24 a state plan amendment. CMS only asks for
25 state plan amendments regarding our

1 fee-for-service program. And because this is
2 impacting MCOs, we could just move forward
3 with corrections in the MCO contracts or
4 amendments or anything like that. But I
5 think it makes most sense for us to just move
6 forward with a set policy at this point,
7 because the contracts have already been set
8 up and signed.

9 And, so, but this is just an
10 adjustment to what we're currently doing.
11 Yeah.

12 MR. HERDE: Thank you.

13 CHAIRMAN RANALLO: Any other
14 questions?

15 MR. MURRAY: Yeah. This is Bryan
16 Murray with Dinsmore & Shohl. And I'm sorry
17 if I'm repeating questions. It has been kind
18 of hard to hear from those in the back of the
19 room.

20 But I just wanted to get that
21 adjustment, if you can confirm. I know you
22 had indicated that the state is going to seek
23 the full amount of a potential rebate for any
24 claim submitted through a contract pharmacy
25 to a Medicaid managed care organization. And

1 the Social Security Act has language
2 expressly prohibiting states from doing
3 exactly that. The language in that basically
4 says that "Any 340B medication billed through
5 a managed care organization is ineligible for
6 a rebate." And, so, I just wanted to get
7 your position on that. Because if a claim is
8 submitted through the managed care system
9 and, therefore, ineligible for a rebate, the
10 state will not seek recovery of that rebate?
11 Or is it kind of the opposite, that any 340B
12 claim submitted to a managed care
13 organization, the state is going to attempt
14 to seek a rebate on?

15 MR. JOSEPH: I can't answer his
16 question.

17 CHAIRMAN RANALLO: He can't answer
18 that question.

19 MR. MURRAY: Okay.

20 MR. JOSEPH: Yeah, yeah.

21 MR. MURRAY: Can you confirm what
22 you said earlier, then, that the state is
23 going to seek rebates on all claims submitted
24 through managed care organizations. I'm just
25 asking if I heard that correctly.

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MR. GRAY: Yeah, this is David Gray with the Cabinet. I think that question should be submitted to us in writing. And since that is a law firm asking that question, we will have our legal counsel within the Cabinet take a look at that question.

MR. MURRAY: Okay. Thank you.

CHAIRMAN RANALLO: And the comment period is due September 3rd on the policy. Anything else?

MS. HALTON: I'm sorry. I still don't understand how that your proposal is to put it back on the hospitals to pay your rebate if we're getting 340B, essentially, so that you can also collect that revenue. So really there's no incentive for us to do this, and the state's trying to force us to carve out so you can get all the rebate. And if we choose to carve in and we get the 340B discount, we have to turn around and from our revenue pay the state what they would have received if we had carved out? Is that my understanding?

MR. JOSEPH: That's if a new system

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is developed. That's if a new system can be operationalized from our rebate vendors. The Commissioner has asked that we do protect the contract pharmacy rebates that we are going to be missing. And, so, how we do that, I don't know.

From a policy perspective, if we were to say that we need a claim-level modifier on those 340B claims, that's all we need to ensure that we don't collect a rebate from those specific claims. And if we express that to all of the covered entities, then that's how we would move forward.

MR. GRAY: This is David Gray from the Cabinet. I think, you know, this -- I would stress the importance of working together. Coming from the provider side, I fully understand the importance of 340B and just the financial and many times viability of facilities, not just the hospital but also the federally qualified health centers are equally interested in this topic. So that's another group that 340B is essential to.

MR. JOSEPH: Uh-huh. Yes.

MR. GRAY: We also, though, have to

1 balance that against how important the rebate
2 program is to the Commonwealth of Kentucky
3 and the Medicaid program and, so, to work
4 together to try to come up with solutions,
5 you know, to that. We want the appropriate
6 things to go through 340B that should get
7 340B. But then those things that should be,
8 you know, the rebates to the state, to make
9 sure we do that and we don't try to take it
10 twice. That's going on right now, today.

11 And, certainly, 340B hospitals have
12 to be very careful about how you, you know,
13 submit claims under 340B. And there are
14 things that are precluded on lists and you
15 have systems that scrub those and HRSA does
16 audits and sometimes they find things and
17 that has implications if they do. We're
18 subject to really the same scrutiny on the
19 rebate program by CMS. So just wherever you
20 get concerned about HRSA, we get concerned
21 about CMS with regards to recapture of
22 dollars.

23 So, you know, we're committing to
24 working together to come up with solutions.
25 Everybody is going to have a little different

1 angle with regard to what they think the
2 solution should be depending upon their
3 perspective. And, but, I think as much as we
4 can focus on our common ground to come up
5 with solutions, it is essential. Because
6 we're running out of time. Because the one
7 thing we can't negotiate about is October 1;
8 is that fair?

9 MR. JOSEPH: 1/1.

10 MR. GRAY: 1/1, okay.

11 MR. JOSEPH: January 1, yes.

12 MR. GRAY: Okay.

13 CHAIRMAN RANALLO: Okay.

14 Thank you.

15 All right. We're going to close
16 that down. Thank you for your time. I
17 appreciate it.

18 MR. JOSEPH: Sure.

19 CHAIRMAN RANALLO: I appreciate you
20 coming to us.

21 MR. JOSEPH: Yeah. No problem at
22 all.

23 CHAIRMAN RANALLO: All right. Back
24 to the agenda. Number one, sepsis update.
25 On July 2nd, I think Dr. Clayborn is on the

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phone from Saint Elizabeth, he, myself, Carl Herde, Stephanie Bates, and Dr. Farrow met to talk about sepsis. After that meeting, we've gotten no further update. I was wondering, from the Cabinet, is there an update on sepsis?

MS. HUGHES: Not that I am aware of. Not at this time.

CHAIRMAN RANALLO: Okay. I guess I'm requesting an update from that meeting.

So there was -- you know, I think one of the clarifying questions that we had -- we had out of that meeting -- I want to make sure that I get it right.

So when Dr. Lieu was here -- or Stephanie had sent an e-mail and it had Dr. Lieu saying the recommendation allowed WellCare and the other MCOs to base utilization management for sepsis on literature based on, you know, sepsis three. And that's what we were discussing. But one of the clarifying questions was:

Does utilization management include DRG coding and DRG validations? And that's never been clear, and that's one of the items

1 that we brought up at the meeting. There was
2 a difference between utilization management,
3 at least in my head, and whether to use it
4 for coding. And the MCOs are using it for
5 coding under the DRG. And, so, it is a --
6 we're getting denials and we're taking
7 appeals and we've got several hospitals that
8 have an administrative law.

9 So we've been batting this issue
10 around for quite a bit, at least eight
11 months, probably longer.

12 PARTICIPANT: So can I say
13 something?

14 CHAIRMAN RANALLO: Yep.

15 PARTICIPANT: All right. So
16 obviously Dr. Lieu is no longer with us. But
17 let me take that or let us take that back to
18 Stephanie. And, because, none of us were in
19 that meeting. Let us go back to her and see
20 about your DRG coding validations.

21 CHAIRMAN RANALLO: Yeah. That is
22 why we went with Judy, the new doctor.

23 PARTICIPANT: Okay. Let us go
24 back. I know it has been eight months. Give
25 us a little bit longer and let us dig into it

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and see what happened.

CHAIRMAN RANALLO: Okay.

MS. HUGHES: And we will try to get you an answer. We won't make you wait until the next TAC meeting.

CHAIRMAN RANALLO: And I appreciate that. I mean, and I know Carl sent something to the Cabinet. It was on New York state. And New York state actually mandated for the coding to use sepsis two.

PARTICIPANT: Okay. Who did you send it to?

MR. HERDE: To Stephanie, the Commissioner.

PARTICIPANT: So let's get together.

PARTICIPANT: Yeah. We will get back with you before the next TAC meeting.

PARTICIPANT: I don't mean to push it off, Russ.

CHAIRMAN RANALLO: No. I appreciate it. And I want to just keep it upfront. Because we had that meeting in July, because we have not met since then, and then just to make sure.

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All right. The next item, the UPL/HB320 update. I mean, that continues to move forward, ongoing meetings. I think it is going really well. So I will let you go ahead.

PARTICIPANT: We are working. We have a weekly meeting with Carl and -- what is her name -- HMA, they are consultants, as well as our consultants, Myers and Stauffer, and internal people in the state. So we have those weekly meetings.

We have submitted House Bill 320, the preprints and all of the assessments and all of the -- how we propose handling that, to CMS. We have received the first round of questions from CMS and have responded back to those. We have not heard anything else from CMS, other than today they had some questions about the assessment model, which I worked with Carl on drafting a response to that.

CHAIRMAN RANALLO: Awesome.

PARTICIPANT: And Sharley will be responding to that as soon as we get out of here.

Now, I want to kind of address some

1 things, too, though. I don't want you to
2 think we're sitting around doing nothing.

3 CHAIRMAN RANALLO: Oh. No, I
4 don't.

5 PARTICIPANT: There are a lot of
6 things that have to happen to make this go
7 through. And just to give you an idea, and
8 I've got to put my glasses on that I just
9 got, back on to see this.

10 But some of the things that we're
11 working on, and I wrote this down, is we're
12 looking at next steps to include some
13 encounter data testing to where we want to
14 make sure that we are -- how do we address
15 the encounter data on your discharges and
16 things like that. So we're looking at
17 validating the assessment model with cost
18 report data, reviewing the drafted
19 regulations that KHA has provided us, and we
20 have been submitting those to LRC.

21 So we have a lot that is still
22 going on while we're waiting on CMS's
23 decision. We have not stopped. We're going
24 forward, as -- that it is going to be
25 approved, and we're moving forward. That

1 way, when we do get the approval, we're ready
2 to hit the ground running as closely as we
3 can. And maybe, Carl, you may want to...

4 MR. HERDE: Well, this is Carl
5 Herde from KHA. And I know Russ reported out
6 to the Medicaid Advisory -- Oversight
7 Advisory Committee. And I would like to
8 state here, too, the Cabinet has been
9 extremely helpful in this process and
10 responsive to this whole process of trying to
11 get it implemented. So I know, Russ, you
12 reported that out to the committee.

13 CHAIRMAN RANALLO: I did. We're
14 very appreciative. And it has been a great
15 example of collaboration. And just I can't
16 say --

17 MR. HERDE: There is a lot to do.

18 CHAIRMAN RANALLO: There is a lot
19 to do, absolutely.

20 PARTICIPANT: CMS -- I'm a blunt
21 person, okay? CMS, there's a lot of hurdles
22 they throw at us and we have to jump over
23 every now and then. So just bear with us.
24 Anytime I hear from CMS, the first e-mail I
25 send is to Carl, just to let you all know so

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they can keep you all apprised of what is going on.

CHAIRMAN RANALLO: Thank you.

Thank you.

MS. HUGHES: And a perfect example, when Steve is talking about hurdles. We got an e-mail I think Friday asking one question. We sent that back on Friday afternoon. Got another question on Monday. We sent that back. And now we have got another question on Tuesday. Instead of sending me all of their questions at one time.

CHAIRMAN RANALLO: Okay.

Any questions on that?

All right. The prior authorization issue, time frames, update, authorizations. I just wanted to make sure that the TAC was aware and the folks. And, so, we had talked about this. You know, we had some MCOs that were -- if you had an authorization and something changed in a procedure, they were allowing 24 hours turn-around time to get them updated. Angie sent us an e-mail that Stephanie Bates had communicated to all of the MCOs that that had changed to seven

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calendar days. So that has been put in place.

So I just want to let everyone know that, you know, that 24 hours, the minimum is seven calendar days. All medical necessity rules still apply. But in order to get an updated CPT you have got seven days now. And I know, from my discussions with WellCare, I know they have put that in place and they've educated their folks.

So I wanted to make sure everybody was aware of that communication since our last meeting. Questions on that?

Okay. NDC meeting update. I had -- I think it was the beginning of June, we had a call on the NDCs about, you know, maybe looking at the main model to allow us to be exempt from NDC reporting. We're getting a lot of errors. And the one question, Dr. Joseph, I had was, if you can explain to me, you know, I know you talked about the different MCOs have different preferred drug lists, right?

MR. JOSEPH: Uh-huh, uh-huh.

CHAIRMAN RANALLO: And that may be

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where I'm getting some of these kickouts on some of my NDCs.

MR. JOSEPH: Yeah.

CHAIRMAN RANALLO: And I'm still researching that. We are still digging into it. But I don't know if you can explain that.

MR. JOSEPH: Yeah.

CHAIRMAN RANALLO: You will do a better job explaining than me to the group.

MR. JOSEPH: Yeah. I mean, the NDC update, it seems like some things are kicking out because of the specific NDC's. But all of our MCOs have the right to have their own preferred drug list. So if those differ based on the product you are billing for, that could be potentially a reason. So...

And maybe if that's the reason, I can't tell you if that is, I mean, five MCOs, five separate preferred drug lists, and those are all up to the discussion of the MCO and the PBM.

CHAIRMAN RANALLO: And, so, at my own shop we were experiencing some denials on NDCs, but it was for a certain MCO and it

1 wasn't for all of the MCOs. And, so, when I
2 brought that up, what I heard was, okay, they
3 could have their own list. So they could be
4 kicking it out because it is not on their
5 list and it is on everybody else's list. So
6 that is something that if you are seeing NDC
7 denials, outside of what we want to still
8 talk about is information on the main model
9 to go down that road, but if you are seeing,
10 from a hospital side, if you are seeing
11 denials on that, that may be a route you want
12 to take and look at from each one of those
13 preferred drug lists.

14 Questions? So that was just really
15 a clarification update.

16 The LCD application of claims.
17 This is -- we're not seeing any more of these
18 things happen. I don't know if anybody else
19 is. I know Steve was going to research at
20 Baptist. I don't think we have gotten our
21 older cases reprocessed yet. But this is
22 where we were having an application of
23 out-of-state LCDs and expired LCDs to claims.
24 We believe it stopped.

25 The IPRO reviews. So I sent a

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couple of these last week. I've gotten probably six more within the last week.

PARTICIPANT: Are they all related to DRG?

CHAIRMAN RANALLO: So, they are. So for the group, we have talked about this at past meetings, where we're getting clinical validations. So we've got something on a DRG and they say that sepsis isn't there or respiratory distress is not there or some clinical indication is not supported by the medical record. We appeal it. And what we're getting back is, we're getting back from the IPRO "Your appeal has been reviewed by a billing specialist or a coding specialist."

And to do medical justifications or clinical validations, CMS is pretty clear it is not -- the only person that can do that is a clinician. It can't be a coder. It can't be a billing specialist. There is no billing specialist in the world that I know that can look at a chart and tell whether that baby had respiratory distress or not.

So we continue to get these. We

1 brought it. I know Stephanie and the
2 Commissioner were looking at the contract
3 with IPRO. But we're continuing to see this.
4 And all what is happening is, is that the
5 biller, the reviewer is just parroting back
6 what the MCO said in their review. There is
7 no real independent thought or independent
8 reasoning in there. It is just, basically,
9 regurgitating exactly what the MCO said in
10 their appeal, and then they are upholding the
11 appeal.

12 So I don't think anybody is really
13 looking at it that should be looking at. And
14 I don't think it is appropriate, it is not
15 appropriate, for a biller or a coder to do
16 clinical validations. And, like I said, we
17 got -- I sent you a couple. But last week I
18 got, like, six. So I don't know if anybody
19 else is seeing those. But it is -- we can't
20 have that. And I know you guys were looking
21 at the contract and looking at how they were
22 billing.

23 PARTICIPANT: Yeah.

24 CHAIRMAN RANALLO: But it is
25 costing us money. Because we have got to

1 take these to an administrative law judge. I
2 have got to have attorneys involved. I mean,
3 you guys are paying for the IPRO, too. And I
4 don't think that the Cabinet is getting their
5 value out of the IPRO from a real review.
6 And it is just frustrating from a provider
7 side. Because when we say we don't think
8 they read the appeals, that is what we mean,
9 because somebody is just looking at what the
10 MCO put on there, regurgitating the letter,
11 and spitting it back out.

12 PARTICIPANT: Well, I can tell you
13 as far as the IPRO contract, it does say you
14 can use specially matched clinician.

15 And in the case of the DRG review,
16 those two examples that you gave me, I asked
17 IPRO who specifically -- who was their
18 billing specialist. So were they certified
19 in anything? And, because, they had billing
20 specialists and coding specialists, what does
21 that mean? But they are a certified
22 professional coder and a certified medical
23 auditor in those two that you supplied to me.
24 And she did say that, you know, a physician
25 does sign this. So there is a quality

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overview to that.

But to your point, if they are just parroting what the MCO is, I agree that there could be a potential issue that they are not actually doing a thorough review or to review. But, and, I don't know.

CHAIRMAN RANALLO: Well, I mean, I will bring it back to you. CMS, like this came up with the RACs, CMS was very clear that a coding specialist or a billing specialist could not be doing those medical validation reviews from CMS's viewpoint. They made the RACs basically say a clinician had to review them. And just because someone signed on the letter, I can tell you, I have got -- I have got -- how many times I've signed my name on things that are down the line. But I am relying on everybody else to do their job that I can't get into the absolute detail.

PARTICIPANT: I understand.

CHAIRMAN RANALLO: I do that all the time. And I don't know how many of these guys that these physicians have.

But when a physician reviews it,

1 they put in it is a Board certified physician
2 and specialty and all of that. And we do see
3 those. I don't want to make it like it is
4 all.

5 PARTICIPANT: Okay. Because the
6 medical necessities definitely are
7 reviewed --

8 CHAIRMAN RANALLO: It is not all
9 billing and coding specialists.

10 PARTICIPANT: -- by a physician.
11 And they have to be a like -- the medical
12 necessity has to be reviewed by a like
13 physician.

14 CHAIRMAN RANALLO: And I will send
15 you a --

16 PARTICIPANT: And the DRG
17 coordination is a little different. Because
18 you do have at your hospital, I'm assuming,
19 you have DRG coders or certified coders who
20 may be submitting these and putting the
21 group.

22 CHAIRMAN RANALLO: So there is a
23 difference between a sequence and, like, a
24 diagnosis, which there are some of those. A
25 coding specialist can do that, a sequencing,

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whether or not this should have been primary or secondary or whether it is there. Whether the chart from a medical standpoint contains a support for that diagnosis, our coders cannot do. They have to clarify with physicians. They cannot make that call.

PARTICIPANT: Yeah. The physician has to send those.

CHAIRMAN RANALLO: And so these reviewers, and I'm just taking the same position, that the reviewers, if they are a coding specialist cannot make that call.

PARTICIPANT: And I agree. I mean, a physician does have to sign off on that. But I do know there is -- and I am not saying what you are saying is, either, correct.

CHAIRMAN RANALLO: I understand.

PARTICIPANT: But to the point of that you are saying they are just parroting what the MCO is saying, then that -- I need to look a little bit further into that to make sure that it is -- because, to your point, we are paying for that. And I don't want to be paying for something that they are just, "This is what the MCO said," cut and

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paste.

CHAIRMAN RANALLO: Right.

PARTICIPANT: And, so, I can look. And I will be more than happy to look at the others that you had.

CHAIRMAN RANALLO: Okay. And I have got more for you to take. But I appreciate that. I am going to -- and I will re-send the CMS piece on that that I sent before. We can do that.

PARTICIPANT: Sure. Thank you.

CHAIRMAN RANALLO: We can do that. Okay. DSH. Any update in light of the recent CMS decision that they won in that children's hospital case?

PARTICIPANT: I can give you the update as I know it. The ruling does not impact the time periods prior to 6/2 of '17. So, therefore, the recent redistributions that we've been working on are going to be none impacted. So that being said, you should -- the redistribution checks are set to be mailed to hospitals September 13th for that 2010 through two-thousand -- I mean, 2011 through 2015 periods.

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So you should be getting those. There will be a letter sent with those as well. September the 13th of this year is when those checks will be put in the mail.

The 2016 exam, we should have those results within the next month. We're working with Myers and Stauffer on those, so we should be able to get those out to all of the hospitals within the next month.

2017, I believe all hospitals should have received your fee-for-service and crossover paid claims listings from Myers and Stauffer. And we have requested all of the MCOs to submit their paid claims listing to you guys August 31st, which is this week, the end of this week, for the MCOs to submit those paid claims listing.

CHAIRMAN RANALLO: I know I've seen a couple.

PARTICIPANT: You have only seen a couple?

CHAIRMAN RANALLO: I think I've seen three out of five.

PARTICIPANT: Okay. Well, they have until the end of the week. So hopefully

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we can get it in.

CHAIRMAN RANALLO: And that doesn't mean that somebody else in my shop hasn't gotten it, but I know I haven't seen it personally.

PARTICIPANT: So at the end of September of '19, at the end of September we hope to have the payments, the 10 percent that remain from fiscal year '19 payments. Federal fiscal year '19, we should have the 10 percent made out to all hospitals.

Now, the 20 is what is going to be bearing on this ruling. We have got to figure out how that is going to impact things. So we have a meeting with our consultants, Myers and Stauffer. We're going to be having a meeting within the next couple of weeks with them to give us what our options are.

And that's all I can -- that's all I can give to you right now. But we're hoping to make that decision on how it is going to impact so that we can get 90 percent of the payment made by the end of October and stay on the schedule.

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MR. HERDE: Carl Herde from KHA.
Would it be a good guess, the fact that it would be basically handled the same way it has been in the past, basically offsetting the crossovers when CMS won the initial appeal, is that a good chance, that process?

PARTICIPANT: I will give you a 50/50 on that.

MR. HERDE: Okay.

PARTICIPANT: But, no, I don't really want to say just yet, until we've had our discussions internally. Because I may tell you one thing and the Commissioner another. I don't want to give you false information.

MR. HERDE: Okay. And then as far as -- because some of the hospital fiscal years go into the state fiscal year '16 calculation. So '15 is done, behind us.

PARTICIPANT: Yep.

MR. HERDE: But some of that will have pre Federal Register, prior to 6/2/17 --

PARTICIPANT: Right.

MR. HERDE: -- fiscal year data and some will not. Have you all had any

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discussion how you would deal with that if
CMS --

PARTICIPANT: We have not.

MR. HERDE: -- wins from June 2nd,
'17 forward?

PARTICIPANT: We have not.
Just for -- as a matter of fact, June 30th,
there's only 28 days there. But I see your
point. I will mention that to Myers and
Stauffer, and we will have that discussion.

MR. HERDE: Yeah. If you would not
do crossovers prior to that date and then,
assuming CMS continues to win, offset the
crossovers for going forward or not.

And also just so everybody knows,
everyone should know, last year there was a
significant transfer from the university pool
over to the acute care pool. And speculation
is that that same transfer for this upcoming
distribution will probably not occur. In
other words, the university's pool will
probably stay intact. And, so, again, we've
been communicating that to everybody and
everybody should know that. But just if you
look at last year's distribution compared to

1 this year in the acute care pool, you will
2 see a reduction because the university will
3 be able to retain the pool, is our
4 expectation. And we won't know that for
5 probably another two months officially.

6 PARTICIPANT: Yeah.

7 MR. HERDE: But...

8 PARTICIPANT: Everything you are
9 saying is correct.

10 MR. HERDE: Yeah.

11 PARTICIPANT: And, so, but we will
12 have you a definite answer hopefully within
13 -- well, by the end of September. Because I
14 have to send those out to you on what we
15 propose to pay.

16 MR. HERDE: Great.

17 CHAIRMAN RANALLO: Great.

18 Thank you. Questions?

19 All right. The KI-HIPP.

20 MS. HUGHES: I can give you a brief
21 update, because I know the Commissioner has
22 asked that we do one of these in one of our
23 TAC meetings.

24 CHAIRMAN RANALLO: Yep.

25 MS. HUGHES: In case you don't

1 already know, it is the Kentucky Integrated
2 Health Insurance Premium Program -- Premium
3 Payment Program. And what it does is if we
4 have Medicaid recipients that are employed
5 and they have some employer-sponsored
6 insurance available to them, they can send in
7 the information on what their health plan
8 covers. And we've got a system built that
9 creates all of these algorithms, like their
10 claims costs and the savings if we move them
11 from managed care over to fee-for-service.
12 And if it's feasible for us, Medicaid will
13 pay their employer-sponsored health insurance
14 premium for them.

15 I know that at the MAC meeting when
16 we talked about it a little bit, Chris was
17 saying that he thought they may have some
18 employees that would qualify. So if any of
19 the hospitals have employees that you think
20 might qualify for Medicaid and you offer them
21 health insurance as an employee, we would
22 certainly love to work with you.

23 Our website has a lot of
24 information out on it geared just for the
25 employer. It has, I know, a video and about

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five or six different documents and Q and A. There is also a lot of information out there for the beneficiary to look at, and there is a handbook and everything about it.

We've always had an employer-sponsored insurance program. But we are really gearing it up more. It's got the potential to save the Commonwealth quite a bit of money. Because, basically, the employer-sponsored insurance plan will pay first, Medicaid would pay secondary.

But it is not taking away any Medicaid benefits whatsoever from anybody. They have still got it. It is just that if -- let's say, for instance, if you are -- like for state employees, our health insurance has a \$1,250 deductible. We would look at that. And if it's beneficial for us, they would pay for the deductible -- or for the premium. So that at that point the employer insurance is going to pay first. I've got a \$1,250 deductible. Medicaid would pick up the \$1,250 deductible and then would pay, I think it's, 80 percent after I've met my deductible. So they would pay the

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20 percent. So the member is still going to be made whole.

If there is no dental or vision for the employer, they are still going to get that through the Medicaid, just like it always is. So it is still going to make that Medicaid beneficiary whole. It is just going to get them used to also operating under the employer insurance.

The Department of Insurance has said them coming onto your plan is a qualifying event, that they can go ahead and sign up now. They have said that they cannot control that if, for instance, if they receive the rates and it makes them ineligible for Medicaid, so they come off of Medicaid, of course we're not going to continue to pay the premium, so it's not a qualifying event for them to change their employer-sponsored insurance. So they may have continued paying that if the open enrollment period comes around again.

In the middle of that there was something else. Oh. We have a lot of times, especially on our waiver programs, where the

1 child is the only person that's on Medicaid.
2 So if the mother or father working has
3 employer-sponsored insurance, if it is cost
4 effective for us to pay the family cost of
5 the employer insurance, just to have that
6 child covered, we will cover the employer
7 full family plan for the employer plan.

8 So the family's not on Medicaid.
9 It is still just the child. But the employee
10 gets the benefit of having their entire
11 employer insurance paid for by Medicaid.
12 So it is helping the family's to be able to
13 have access to insurance paid for.

14 I mean, we think it is a great
15 win-win for everybody. So as I know most of
16 you all work with hospitals, if you have
17 employees that you think would benefit and
18 you want some information, we would be glad
19 to talk to you. We are working with,
20 I think, the top ten employers in Kentucky.
21 We're working with the state. We will be
22 going to the benefit fares for state
23 employees out in the state. If you want us
24 to come and talk to your employees or if you
25 want us to talk to somebody more about it,

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you know, let me know and I can get you in touch with somebody. We would be more than happy to talk with you. I think it is a win-win for everybody concerned.

MR. GRAY: And, Russ, I would add, this is David Gray with the Cabinet, that we have been working closely with Kentucky Hospital Association. Some of your staff, those that were focused on, you know, revenue cycle, we did have a webinar with them, with the hospitals. We also did a phone call. We've done a couple of phone calls with MedAssist, which does a lot of eligibility applications for a number of hospitals in the state.

So we've been providing educational information to them. I would ask if any of the members of the TAC or anybody on the call that has any relationship with Bolder Healthcare Solutions, I know they are I think kind of a competitor to MedAssist, we would love to get that contact information and we would like to reach out to them. I think they were actually founded -- Bolder was founded by the folks that established

1 MedAssist and sold that to FirstSource and
2 then set up Bolder. But I know they do some
3 hospitals in the state of Kentucky, too. So
4 we would like to engage with Bolder
5 Healthcare Solutions to make them aware of
6 KI-HIPP.

7 But it does have potential for a
8 lot of savings, I think up to roughly 80,000
9 Kentuckians that --

10 MS. HUGHES: Yeah. Right.

11 MR. HERDE: -- work. And...

12 MS. HUGHES: Right. Yeah, I did
13 forget to say that.

14 We've already sent 10,000 letters
15 out in May. We sent 35,000 the 1st of
16 August. And we are going to send out another
17 35,000 in September.

18 The 10,000 was the people that in
19 our system said, "Yes, I work" and "Yes, I
20 have access to employer insurance." The
21 other 70,000 are people that have just said,
22 "Yes, I work." So it is just to send them an
23 e-mail and say, "Hey, our system shows you
24 work. Do you have access to health insurance
25 through your employer? If so, please give us

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a call or contact us and so forth." So with that, I think we've got 100 -- last week it was a-hundred-and-thirty-some-odd people that have already signed up. And it is, like, around 40,000 a month that it is saving Medicaid just on those 130 people. So it is a cost saving benefit for us.

And not everybody is going to qualify, you know, for it, for us to pay the premium.

CHAIRMAN RANALLO: Right. I know they updated the handbook. The handbook is nice and the website is nice. We've been on those calls and they are well done. So any questions?

MS. YOUNCE: This is Elaine Younce at UK. I also was going to say, we often use Change Healthcare. I can get you their information.

MR. GRAY: Can you do that? I will get you my card. Thank you so much.

CHAIRMAN RANALLO: Okay. Other discussion. I had two items. One, I know we have talked about equity in the past. And I wanted the Cabinet to know that I think we're

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up to three MCOs that are doing those equity outlier audits. I don't think we resolved that discussion or it was finalized. So I will probably be bringing that to the next TAC meeting to discuss again.

And then I had another question of something I reported at the MAC last week. So I got -- we received a recoupment letter from one of the MCO's, a couple hundred thousand dollars and a lot of patients. And about two years ago they took payment where they said the patient wasn't eligible for the service. So my folks put some resources on it, diving in. And my main question was:

Well, what does the system show today? All right. Did we mess up, this and that. So we had patients come in, generally we pulled four out of the eight that came in in August, had service, they were eligible for one of the MCO's, we billed the MCO, the MCO paid us in September. Now we're two years later, August, or 23 months after, and we're getting these back.

And what we found on all four of them, they had coverage on a couple of them.

1 And, so, we called the MCO. The MCO said,
2 "Well, the Cabinet has taken our premium
3 back, saying they are not eligible. And, so,
4 we're recouping our money from you." Well,
5 when we looked in the system, there were two
6 that had incarceration dates that were --
7 that covered the time period. When you look
8 in the system, they are covered by the MCO
9 for that time period as well. But the
10 incarceration dates are wrong. So we called
11 the jail. We had, like, a seven month
12 incarceration date but they were only
13 incarcerated for two weeks and it didn't
14 cover the dates of service. So I don't know
15 where those dates are coming from but they
16 are wrong. And we found that on a couple of
17 patients. And we're doing more research on
18 it. So that's the first thing. I have to
19 figure out where those incarceration dates
20 are.

21 The other piece is, is that that
22 incarceration goes back to '17. So I want to
23 know when the Cabinet notified the MCO in
24 this time frame and whether the MCO is just
25 taking its sweet time or whether the Cabinet

1 is telling them, like, two months ago.
2 Why is it taking so long? Because if this
3 all happened in '17, why am I getting it in
4 '19? What it feels like is the MCO doesn't
5 really care, because they are paying
6 85 percent out and they are not caring if you
7 are right on that take-back, so they are not
8 doing any audit, whether that person was
9 incarcerated or not, and they are just
10 recouping from the providers.

11 So I'm the one that gave medically
12 necessary care. I was right. I'm the one
13 that has to put resources in it to keep my
14 payment two years later. And I'm going to
15 get denied when I appeal it, because the MCO
16 is going to say, "Well, the state told me
17 that they are not eligible." And whoever is
18 the appeal person is going to agree with them
19 and I am going to have to take it to an
20 administrative law hearing.

21 So I have got to get attorneys,
22 then, to try to keep a payment that is right
23 for me. And there was one that they never
24 had -- never lost coverage. And I have no
25 idea why it was there. And I've got copies

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of the stuff. And, so, there are a lot of questions there. So if it is happening to you, it is happening to you, it is happening to you. And, so, I mean, because it is not -- it can't be isolated.

But I've got a lot of questions about this process. And it goes back to the eligibility. Because we had this, a couple of meetings ago, where I gave the Cabinet some letters where WellCare and Aetna are coming back and saying, "Hey, this person had different coverage and had Blue Cross." And you look in our eligibility system, they had Blue Cross but it was two years ago. And, so, somebody from the Medicaid system is telling them they have Blue Cross, but it is two years ago and it is not right.

So this churning of resources trying to keep payments is frustrating. When, you know, providers say they are frustrated or having problems, it is this. Because we're the only ones that feel like we're at risk at the end of the day. And we're the ones that have got to put in the resources behind it to make sure everything

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is right when others -- I mean, there's got to be other people that have skin in the game that can help us with us.

So I want to sit down, I guess, and talk about how that flows, where the incarceration dates come from. Because those -- I mean, those are not right at all. I mean, it was wild. I was seeing these big swaths of dates and the guy was incarcerated for, like, a week. The other one was, like, two different weeks and it was, like, eight months.

And, so, there is -- and then my fear is, is that even if I win my appeal, the MCO is taking back from all of the providers in that time, the doctors, the nursing home, whatever. And those people may not be as a jerk as me or as hard on it as me to try to recoup it, and they may just let the check go back in and not do that research. And then if I win and I'm right, the MCO may never pay them back. So that is the other concern. So I have got a lot of concerns on this.

But the issue is, how are things getting into the system on eligibility, on

1 different insurances and coverage, so that we
2 can streamline just to make sure that --
3 because we think we're trying to do the right
4 thing. But, you know, when you have
5 something that's two years ago and all of a
6 sudden I have got, on 80 to 100 cases I have
7 got, to put all kinds of resources in to
8 defend payments that we think are right,
9 it's....

10 MR. HERDE: Within 30 days.

11 CHAIRMAN RANALLO: Within 30 days,
12 yep. And they have had it for two years.
13 And I have got 30 days or I'm out. And
14 they've had two years to go back and say,
15 "Hey, you know, research this or do this."
16 And they give it to me on the 23rd month.

17 MR. HERDE: Do you have some of
18 those examples with you?

19 CHAIRMAN RANALLO: Yeah.

20 MR. HERDE: Hey, Russ, is there any
21 chance that they were actually physically
22 incarcerated for the two weeks but they were
23 on home incarceration? Are they still not
24 covered if they are on home incarceration?

25 CHAIRMAN RANALLO: I mean, the jail

1 said they were released. And, so, they had
2 the release dates. We got letters from the
3 jail. We called the jail.

4 PARTICIPANT: So there is the
5 challenge of making sure that we get that
6 information timely and that it is put in the
7 eligibility file that goes to the MCOs. So
8 if for some reason we're not getting that
9 information --

10 CHAIRMAN RANALLO: I don't know.

11 PARTICIPANT: -- it has to be going
12 in. Whether or not they are incarcerated or
13 if they are no longer incarcerated, there is
14 both that challenge.

15 CHAIRMAN RANALLO: Right. And I
16 don't know where that date comes in from your
17 system. So, like I say, when we got these,
18 we called down to our local jail where they
19 were incarcerated and we said, "Was this
20 person in there?" They were like, "They were
21 in here, but they were in here for two weeks.
22 They weren't in here for that period of
23 time." So we had them send a letter, because
24 we're working on our appeal file. But it is
25 generally -- I mean, I want to understand.

1 Because if we have got problems, I mean, it
2 wasn't just one incarceration date, it was a
3 couple, and we're looking at the rest.
4 I mean, that's as far as I've gotten so far.
5 But I was four for four where I think that
6 we're right.

7 PARTICIPANT: And can you supply
8 that back to me?

9 CHAIRMAN RANALLO: Yeah. I have it
10 for you today to take back.

11 MS. LAWLESS: Is that a routine
12 process? I am not actually aware. Is that a
13 routine? Should all providers be getting --

14 MR. HERDE: No. They just singled
15 him.

16 MS. LAWLESS: I know. I'm
17 wondering.

18 PARTICIPANT: I mean, yeah, I can't
19 speak for, you know, each facility. But,
20 I mean, that would be -- if identified, the
21 MCO identified that eligibility that they
22 received from us, that they could go back two
23 years and recoup, if they were ineligible
24 during that time in which a claim was paid.

25 MS. LAWLESS: How often does the

1 state recoup premiums from the MCOs? Is that
2 a routine process? How often is the routine
3 run to --

4 PARTICIPANT: We do it every month.

5 MS. LAWLESS: Every month, okay.

6 CHAIRMAN RANALLO: But is it two
7 years? So like --

8 PARTICIPANT: Yeah. It goes back
9 24 months.

10 CHAIRMAN RANALLO: Okay. So, like,
11 they could have known in July. You could
12 have recouped in July, from 22 months ago,
13 and they just sent me a letter.

14 PARTICIPANT: Uh-huh. So let's say
15 the Department of Justice updates an
16 incarceration date and it goes back two
17 years. We get that in July or in the August
18 capitation in July. I recoup all the way
19 back those caps. Because I'm being told by
20 the Department of Justice they are in jail.
21 So...

22 CHAIRMAN RANALLO: But, also, you
23 could have told them in October of '17.

24 PARTICIPANT: I could have told
25 them in October of '17.

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CHAIRMAN RANALLO: And now they are coming back on the last month after that --

PARTICIPANT: That's what I was going to say. I hear what you are saying. But I don't think, until we look into it, that we can say that what you are saying is true.

CHAIRMAN RANALLO: Well, I don't -- the timing of when you told them, right, and the timing of when they told me is important to me.

PARTICIPANT: Right.

CHAIRMAN RANALLO: Because I want to know how long they are holding onto it, right?

PARTICIPANT: Right.

CHAIRMAN RANALLO: Versus -- or how long you guys took to get there. I want to understand that time frame.

PARTICIPANT: I can tell you, if we get told, we run our managed care cycle the last Thursday before the last Friday. Say that again. The last Thursday before the last Friday or the Thursday before the last Friday of each month is when we run the

1 managed care cycle. During that week, we
2 look at the eligibility file. And at that
3 time, it is what is on that eligibility file
4 at that time that we run those managed care
5 cycles. So sometime between the last cap
6 file or the last month and the new -- and
7 what is being processed this month we have
8 gotten updated information on the eligibility
9 file saying this person was incarcerated all
10 the way back to this date.

11 Now, I understand you're calling
12 the local jail cell or whatever and they are
13 saying, "No. That's not right." But we have
14 to -- our source of truth has to come from
15 their database, which is from the Department
16 of Justice.

17 MR. HERDE: Just curious. Two
18 questions.

19 CHAIRMAN RANALLO: Yeah.

20 MR. HERDE: One is, wouldn't you
21 know if they were incarcerated at the time
22 you were giving the care?

23 CHAIRMAN RANALLO: And they were
24 not. That's the point. That was the point.
25 Yes, we would.

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MR. HERDE: But just generally speaking --

CHAIRMAN RANALLO: Yes, we would.

MR. HERDE: -- operationally you would know.

CHAIRMAN RANALLO: Because the jail would be the guarantor.

MR. HERDE: Right.

CHAIRMAN RANALLO: And because the jail wasn't the guarantor, that's why when we see it we know it is not right.

MR. HERDE: So just intuitively it doesn't make sense.

CHAIRMAN RANALLO: Right. I mean, that's why we start making the calls.

PARTICIPANT: But, now, I will say this. CMS allows me to draw down the federal match on those incarcerations that have an inpatient hospital stay.

CHAIRMAN RANALLO: Okay.

PARTICIPANT: The problem is, is that where eligibility is month pure and the cap is month pure, that entails the issue.

CHAIRMAN RANALLO: Okay.

PARTICIPANT: Sometimes we have to

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take that and go back to a fee-for-service claim and pay that from a fee-for-service agreement.

CHAIRMAN RANALLO: And we have one here that I don't see why was -- why it is on the list. I mean, it looks like the person had coverage all the way through. There were no issues that I could see.

So it is sort of a long question. But I'm just trying to understand it. And if we've got issues with incarceration dates, we have got to get them fixed.

PARTICIPANT: Right.

CHAIRMAN RANALLO: Because it is costing us money.

PARTICIPANT: And we deal with this every time we bill the MCOs. Every time we bill the MCO cap payments that we're paying the MCOs, we always have to look at the incarceration dates on processing those payments, setting those rates. And there are issues with that. So it is all tied to when do we get that information from the Department of Justice and is it correct information. We have to assume it is,

1 because it is coming -- there is nothing I
2 can do to test that data other than talk to
3 the local jail cells and say, "Is this person
4 in your jail?"

5 CHAIRMAN RANALLO: Right.

6 PARTICIPANT: But I hear you, Russ.
7 And I just wanted to chime in, though, and
8 say, you know, I hear it, you have got
9 questions, we all have questions about the
10 incarceration data. But until I see some of
11 your examples, I don't know -- I don't think
12 -- I would gather -- I would -- I would make
13 an 80 percent chance that it is not the MCOs
14 holding onto something for two years and then
15 deciding to go back two years. It is
16 something that we've given to them on the
17 eligibility file to cause that recoupment.

18 CHAIRMAN RANALLO: And I hear you.
19 But I know they are coming -- it is real
20 coincidental that it is right before the
21 24 month date, too, for them, right --

22 PARTICIPANT: Yep.

23 CHAIRMAN RANALLO: -- that I'm
24 getting all of these, right?

25 PARTICIPANT: Yep.

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CHAIRMAN RANALLO: So what is feels like is they are, okay, I have got to do this before this deadline. It has been out there. It has been out there for a while.

PARTICIPANT: So every -- again, every cycle, though, every month we look back 24 months every managed care cycle.

CHAIRMAN RANALLO: And that's what I want to know. So the two questions I wanted to ask. One, when did you get it? The second thing is, when you got it, what due diligence do you get to do what was right? Are you just saying hey.

If you don't care about your premium, I mean, again, I'm the one that is at risk, right, because they are paying 85 percent out of whatever of that premium, so they are at risk for 15. I'm at risk for my whole payment, something I am not going to be able to go back and get.

PARTICIPANT: I lose the federal match when we get audited by CMS that I have paid a cap payment and they are not supposed to.

CHAIRMAN RANALLO: I got you.

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PARTICIPANT: So I can understand where you are at risk, but so is the Department.

CHAIRMAN RANALLO: So...

MS. YOUNCE: What we often see, and I don't know if you do or not, but this is in particular from the local jails, is they will release a prisoner and then they will re-arrest them immediately.

PARTICIPANT: When they come back out, yeah.

CHAIRMAN RANALLO: So we had that in our community a long time ago, probably when I first started, which is probably 20 years, you know, in the last 15 years. And we ended up coming to arrangements with the jail and how they covered and everything else. It was a big to-do. And they have stopped doing it.

MS. HUGHES: I wonder if the inmate could have been in another county jail and got transferred to Owensboro.

CHAIRMAN RANALLO: We looked at the other jails. I mean, like the one. So, I mean, I have got some -- I have got one

1 that was in two different jails at different
2 periods of time but not during the dates of
3 service or the month of service that he was
4 there.

5 PARTICIPANT: Send Angie your
6 examples.

7 CHAIRMAN RANALLO: Yeah.

8 PARTICIPANT: And then we will get
9 with our eligibility people and get with the
10 cap people and we will figure out what
11 transpired.

12 CHAIRMAN RANALLO: Yeah. And,
13 so...

14 MS. LAWLESS: And I will ask our
15 shop and I will send -- if we have any, we
16 will send.

17 CHAIRMAN RANALLO: I don't know
18 what the safeguard is, if I'm right and I win
19 the appeal and I keep my payment, you know,
20 what other providers are in that downstream
21 with that MCO and what that MCO does with
22 them. And that makes me concerned, too,
23 because it is not just me.

24 PARTICIPANT: Yeah.

25 CHAIRMAN RANALLO: Anything else

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from you guys? Thank you for that.

The next meeting is October 22nd. I did want to -- I know we didn't do the minutes. I sent the minutes out to the group. We had one correction from the last minutes. On page 10, line 16, it had Carl Herde spoke and I believe Commissioner Steckel was the one that was attributed to that. And I have that, if you want it. But that was the only change that I had.

Do you guys have any other changes? Move to approve minutes?

MS. LAWLESS: Move to approve.

MS. YOUNCE: Second.

CHAIRMAN RANALLO: Okay. The minutes are approved.

October 22nd is the next meeting. And then December 10th we're going to be working on the next 2020 dates. So if you have any dates on the week that are particularly bad, Mondays are always bad for me, I have different committee meetings, let my assistant know.

MS. HUGHES: I don't think you all fall into this. But two weeks before the MAC

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we have about eight TACs that likes to meet during that week. But you all typically have not been following in that.

CHAIRMAN RANALLO: Yeah. We're trying to be a month before so that we can get our stuff in and have a little bit of breathing room, we are not butting up right against the MAC.

Besides that, I can't -- you know, it is a whole day for me to come up here for any meeting. So I want to try to space it out as much as I can.

MS. HUGHES: Right.

PARTICIPANT: Can I bring one more thing, announce one more thing?

CHAIRMAN RANALLO: Yes, sir.

PARTICIPANT: The GME, we did get that approval from CMS to be effective May the 10th of '19. We are working with those providers who get GME payments. The enhanced portion will be handled from the fee-for-service arena. So we will be working with Myers and Stauffer on calculating that prorated version of payment from May 10th to June 30th. And I just wanted to get that out

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there.

CHAIRMAN RANALLO: Great. Awesome.

MS. LAWLESS: So you say you have been working with providers?

PARTICIPANT: Yeah, yeah.

MS. LAWLESS: Okay.

PARTICIPANT: We have kept all of the GME providers apprised of the situation, as well as the hospital association, of where we have been on this. So...

And, so, we are -- we have received the approval from CMS and so we are ready to move forward.

CHAIRMAN RANALLO: Anything from the gallery?

(No response)

CHAIRMAN RANALLO: All right. Thank you, all. We're adjourned.

(Proceedings concluded at 2:21 p.m.)

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C E R T I F I C A T E

I, LISA COLSTON, Federal Certified Realtime Reporter and Registered Professional Reporter, hereby certify that the foregoing record represents the original record of the Hospital 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 16th day of September, 2019.

 /s/ Lisa Colston

Lisa Colston, FCRR, RPR