DEPARTMENT OF MEDICAID SERVICES
HOSPITAL TECHNICAL ADVISORY COMMITTEE

****************************************

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

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

Lisa Colston, FCRR, RPR
Federal Certified Realtime Reporter
APPEARANCES.

BOARD MEMBERS:

Russ Ranallo, Chair
Michele Lawless
Elaine Younce
Danny Harris
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?
(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.
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,
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
is, claim-level identification is hard to do at the point-of-sale. However, we have seen that both the GAO and OIG from the federal standpoint have recommended moving to claim-level identification. So from our standpoint, we have three duties. One is to stay compliant with federal law. Two is to protect ourselves from any recoupments that may occur due to the 340B program and duplicate discounts. And then three is the fiscal integrity of the Medicaid rebate program.

I think Steve can touch on this more than I can. But the Medicaid drug rebate program has provided Kentucky Medicaid a substantial amount in terms of our budget. And, therefore, when we do open this up to claim-level identification, the thought is that we will be excluding more rebates if it is identified at the claim level and, therefore, we do want to acknowledge the fact that 340B covered entities utilize contract pharmacies. And in order for us to stay compliant with that is to move to a claim-level identification process. The one
thing that Kentucky Medicaid would probably
not do is exclude all rebates from a contract
pharmacy. Because we know that all those
patients that go to that contract pharmacy
are not necessarily seeking care at a 340B
covered entity. But we do also know that in
recent months more companies have entered the
340B field to, essentially, identify
duplicate discounts for manufacturers and,
therefore, we will be seeking anything from
rebates -- anything considered a duplicate
discount. And so in order for us to stay
compliant and then to protect ourselves from
any future recoupments, the proposal was to
move to a claim-level identification process.

And then our final piece is that we
do want to ensure that when we do move to a
claim-level identification process, we are
ensuring that we are not going to be losing
out on such a substantial hit, in terms of
Medicaid rebates. You know, beyond the fact
that I acknowledge that and I think DMS
acknowledges that contract pharmacies and
point-of-sale identification of claims is
difficult. We know that more than half the
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
initiated those conversations. So, again, we
wanted to give ourselves at least the time
frame of pushing this to 1/1 to explore those
options and see if it is feasible. You know,
out of all honesty, I think these options are
feasible. However, the timetables to get
these up and operating would be more than the
three months that we get with the quarterly
updates. So, you know, the 1/1 point of
time, you know, I would like to at least
explore those options; however, I cannot
promise that that's going to be the way that
we move forward.

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

CHAIRMAN RANALLO: So one of the
questions that we got from several folks was:
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
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
do. And I guess generally for any EMR.

You know, we know, like, this is doable

for -- other parties and other states have it

with Epic, but we don't have it built in our

system.

MR. JOSEPH: Sure.

CHAIRMAN RANALLO: And building it

into our system and the testing of that will

take time.

MR. JOSEPH: Sure.

CHAIRMAN RANALLO: And, so, the

October date was something that we were not

going to be able to do --

MR. JOSEPH: Sure.

CHAIRMAN RANALLO: -- to get there.

MR. JOSEPH: Yeah.

CHAIRMAN RANALLO: And so knowing

the clarification of what it applies to and

what we need to do may be helpful for a

number of hospitals.

MR. JOSEPH: Sure.

CHAIRMAN RANALLO: Let's see.

Other questions? Does anybody have other

questions that they wanted to -- on this

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

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

MR. ALLEN: Okay. Thank you.

MR. THAMANN: I have a question.

CHAIRMAN RANALLO: Okay. And who
is talking?

MR. THAMANN: Can you then clarify
for hospital-covered entities billing on
UB-04. It is the state's policy currently
right now that they do not have to bill in a
claim line level any specific indicators for
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
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
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?
MR. JOSEPH: In terms of delayed or not. When we get it at Medicaid, that has been -- that claim has been processed by the PBM for our managed care organization. And then within about a two week time frame we will get it into our MMIS system. So the delayed about whether -- what they are doing at the pharmacy, I can't speak on. That's going to be a conversation that the covered entity has with the contract pharmacy.

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

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

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

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

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

MR. JOSEPH: No, no. Retrospective is -- so the retrospective model is the state would -- or the rebate vendor would be collecting a file from each of the covered entities at some point in time before the rebate collection process occurs at the end of the quarter. Our rebate vendor would then
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?
MR. JOSEPH: You know, reversals and resubmission, that's completely allowed. We're only looking for the submission clarification code 20 by the time it gets to our MMIS vendor, and that is DXE. So if it is on the claim by the time it gets to DXE after running through claims processing through the PBM of our managed care organizations, we don't see an issue with it.

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

So, yeah.

CHAIRMAN RANALLO: Okay.

MS. HALTON: And that was the model. I'm sorry. The one contract pharmacy that said they could do it, it was that model in terms of they have an administrative platform that could do it for their stores and for other stores that use their platform. But most of the hospitals already have contracts in place to use an administrative body. And it would not be feasible to switch to this one product or this one platform that
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.
MS. HALTON: Well, the option would have been to not seek the rebates and whenever that point, whenever that change, that was not communicated to the stakeholders, where we could have had a conversation about it so that the state would not be noncompliant. At this point, you are right, the state is noncompliant, not the covered entity but the state.

MR. JOSEPH: That's up for discussion.

MS. HALTON: Yeah.

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

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

PARTICIPANT: Thank you.

MS. HALTON: One of the other questions is about the impact. I know in the statements that we've had before, you know, the purpose is not to penalize the hospitals. But most of our critical access hospitals don't have pharmacies on-site, so we do have to rely on contract pharmacies to provide this benefit to our patients. So, and
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
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
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
know how easy it is to implement. Because I don't know how much that is or anything else.

MR. JOSEPH: Right.

MR. STELTENPOHL: But that makes sense.

MR. JOSEPH: Right.

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

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

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

MR. JOSEPH: From the covered entities, yes.

MR. HERDE: So 30 million?

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

MR. HERDE: Estimating?

MR. JOSEPH: Yeah. I mean, it depends on the total that we're missing out on from the contract pharmacy. Because we -- again, we have no mechanism of measuring
this. We have no claims that have these. Well, I guess we do. But we don't get them in our system. You know, the PBM of our managed care organizations may be able to identify a claim level. But DX -- our current MMIS system with DXE does not look at that.

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

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

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

We're not required to do this with a state plan amendment. CMS only asks for state plan amendments regarding our
fee-for-service program. And because this is impacting MCOs, we could just move forward with corrections in the MCO contracts or amendments or anything like that. But I think it makes most sense for us to just move forward with a set policy at this point, because the contracts have already been set up and signed.

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

MR. HERDE: Thank you.

CHAIRMAN RANALLO: Any other questions?

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

But I just wanted to get that adjustment, if you can confirm. I know you had indicated that the state is going to seek the full amount of a potential rebate for any claim submitted through a contract pharmacy to a Medicaid managed care organization. And
the Social Security Act has language expressly prohibiting states from doing exactly that. The language in that basically says that "Any 340B medication billed through a managed care organization is ineligible for a rebate." And, so, I just wanted to get your position on that. Because if a claim is submitted through the managed care system and, therefore, ineligible for a rebate, the state will not seek recovery of that rebate? Or is it kind of the opposite, that any 340B claim submitted to a managed care organization, the state is going to attempt to seek a rebate on?

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

CHAIRMAN RANALLO: He can't answer that question.

MR. MURRAY: Okay.

MR. JOSEPH: Yeah, yeah.

MR. MURRAY: Can you confirm what you said earlier, then, that the state is going to seek rebates on all claims submitted through managed care organizations. I'm just asking if I heard that correctly.
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
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
balance that against how important the rebate program is to the Commonwealth of Kentucky and the Medicaid program and, so, to work together to try to come up with solutions, you know, to that. We want the appropriate things to go through 340B that should get 340B. But then those things that should be, you know, the rebates to the state, to make sure we do that and we don't try to take it twice. That's going on right now, today.

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

So, you know, we're committing to working together to come up with solutions. Everybody is going to have a little different
angle with regard to what they think the solution should be depending upon their perspective. And, but, I think as much as we can focus on our common ground to come up with solutions, it is essential. Because we're running out of time. Because the one thing we can't negotiate about is October 1; is that fair?

MR. JOSEPH: 1/1.

MR. GRAY: 1/1, okay.

MR. JOSEPH: January 1, yes.

MR. GRAY: Okay.

CHAIRMAN RANALLO: Okay.

Thank you.

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

MR. JOSEPH: Sure.

CHAIRMAN RANALLO: I appreciate you coming to us.

MR. JOSEPH: Yeah. No problem at all.

CHAIRMAN RANALLO: All right. Back to the agenda. Number one, sepsis update.

On July 2nd, I think Dr. Clayborn is on the
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
that we brought up at the meeting. There was a difference between utilization management, at least in my head, and whether to use it for coding. And the MCOs are using it for coding under the DRG. And, so, it is a -- we're getting denials and we're taking appeals and we've got several hospitals that have an administrative law.

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

PARTICIPANT: So can I say something?

CHAIRMAN RANALLO: Yep.

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

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

PARTICIPANT: Okay. Let us go back. I know it has been eight months. Give us a little bit longer and let us dig into it
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.
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
things, too, though. I don't want you to think we're sitting around doing nothing.

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

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

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

So we have a lot that is still going on while we're waiting on CMS's decision. We have not stopped. We're going forward, as -- that it is going to be approved, and we're moving forward. That
way, when we do get the approval, we're ready
to hit the ground running as closely as we
can. And maybe, Carl, you may want to...

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

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

MR. HERDE: There is a lot to do.

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

PARTICIPANT: CMS -- I'm a blunt
person, okay? CMS, there's a lot of hurdles
they throw at us and we have to jump over
every now and then. So just bear with us.
Anytime I hear from CMS, the first e-mail I
send is to Carl, just to let you all know so
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
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
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
wasn't for all of the MCOs. And, so, when I brought that up, what I heard was, okay, they could have their own list. So they could be kicking it out because it is not on their list and it is on everybody else's list. So that is something that if you are seeing NDC denials, outside of what we want to still talk about is information on the main model to go down that road, but if you are seeing, from a hospital side, if you are seeing denials on that, that may be a route you want to take and look at from each one of those preferred drug lists.

Questions? So that was just really a clarification update.

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

The IPRO reviews. So I sent a
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
brought it. I know Stephanie and the Commissioner were looking at the contract with IPRO. But we're continuing to see this. And all what is happening is, is that the biller, the reviewer is just parroting back what the MCO said in their review. There is no real independent thought or independent reasoning in there. It is just, basically, regurgitating exactly what the MCO said in their appeal, and then they are upholding the appeal.

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

PARTICIPANT: Yeah.

CHAIRMAN RANALLO: But it is costing us money. Because we have got to
take these to an administrative law judge. I have got to have attorneys involved. I mean, you guys are paying for the IPRO, too. And I don't think that the Cabinet is getting their value out of the IPRO from a real review. And it is just frustrating from a provider side. Because when we say we don't think they read the appeals, that is what we mean, because somebody is just looking at what the MCO put on there, regurgitating the letter, and spitting it back out.

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

And in the case of the DRG review, those two examples that you gave me, I asked IPRO who specifically -- who was their billing specialist. So were they certified in anything? And, because, they had billing specialists and coding specialists, what does that mean? But they are a certified professional coder and a certified medical auditor in those two that you supplied to me. And she did say that, you know, a physician does sign this. So there is a quality
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,
they put in it is a Board certified physician and specialty and all of that. And we do see those. I don't want to make it like it is all.

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

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

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

CHAIRMAN RANALLO: And I will send you a --

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

CHAIRMAN RANALLO: So there is a difference between a sequence and, like, a diagnosis, which there are some of those. A coding specialist can do that, a sequencing,
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
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.
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
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.
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
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
this year in the acute care pool, you will
see a reduction because the university will
be able to retain the pool, is our
expectation. And we won't know that for
probably another two months officially.

PARTICIPANT: Yeah.

MR. HERDE: But...

PARTICIPANT: Everything you are
saying is correct.

MR. HERDE: Yeah.

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

MR. HERDE: Great.

CHAIRMAN RANALLO: Great.

Thank you. Questions?

All right. The KI-HIPP.

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

CHAIRMAN RANALLO: Yep.

MS. HUGHES: In case you don't
already know, it is the Kentucky Integrated Health Insurance Premium Program -- Premium Payment Program. And what it does is if we have Medicaid recipients that are employed and they have some employer-sponsored insurance available to them, they can send in the information on what their health plan covers. And we've got a system built that creates all of these algorithms, like their claims costs and the savings if we move them from managed care over to fee-for-service. And if it's feasible for us, Medicaid will pay their employer-sponsored health insurance premium for them.

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

Our website has a lot of information out on it geared just for the employer. It has, I know, a video and about
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
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
child is the only person that's on Medicaid. So if the mother or father working has employer-sponsored insurance, if it is cost effective for us to pay the family cost of the employer insurance, just to have that child covered, we will cover the employer full family plan for the employer plan.

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

I mean, we think it is a great win-win for everybody. So as I know most of you all work with hospitals, if you have employees that you think would benefit and you want some information, we would be glad to talk to you. We are working with, I think, the top ten employers in Kentucky. We're working with the state. We will be going to the benefit fares for state employees out in the state. If you want us to come and talk to your employees or if you want us to talk to somebody more about it,
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
MedAssist and sold that to FirstSource and then set up Bolder. But I know they do some hospitals in the state of Kentucky, too. So we would like to engage with Bolder Healthcare Solutions to make them aware of KI-HIPP.

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

MS. HUGHES: Yeah. Right.

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

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

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

The 10,000 was the people that in our system said, "Yes, I work" and "Yes, I have access to employer insurance." The other 70,000 are people that have just said, "Yes, I work." So it is just to send them an e-mail and say, "Hey, our system shows you work. Do you have access to health insurance through your employer? If so, please give us
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
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.
And, so, we called the MCO. The MCO said, "Well, the Cabinet has taken our premium back, saying they are not eligible. And, so, we're recouping our money from you." Well, when we looked in the system, there were two that had incarceration dates that were -- that covered the time period. When you look in the system, they are covered by the MCO for that time period as well. But the incarceration dates are wrong. So we called the jail. We had, like, a seven month incarceration date but they were only incarcerated for two weeks and it didn't cover the dates of service. So I don't know where those dates are coming from but they are wrong. And we found that on a couple of patients. And we're doing more research on it. So that's the first thing. I have to figure out where those incarceration dates are.

The other piece is, is that that incarceration goes back to '17. So I want to know when the Cabinet notified the MCO in this time frame and whether the MCO is just taking its sweet time or whether the Cabinet
is telling them, like, two months ago.

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

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

So I have got to get attorneys, then, to try to keep a payment that is right for me. And there was one that they never had -- never lost coverage. And I have no idea why it was there. And I've got copies
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
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
different insurances and coverage, so that we can streamline just to make sure that -- because we think we're trying to do the right thing. But, you know, when you have something that's two years ago and all of a sudden I have got, on 80 to 100 cases I have got, to put all kinds of resources in to defend payments that we think are right, it's....

MR. HERDE: Within 30 days.

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

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

CHAIRMAN RANALLO: Yeah.

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

CHAIRMAN RANALLO: I mean, the jail
said they were released. And, so, they had the release dates. We got letters from the jail. We called the jail.

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

CHAIRMAN RANALLO: I don't know.

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

CHAIRMAN RANALLO: Right. And I don't know where that date comes in from your system. So, like I say, when we got these, we called down to our local jail where they were incarcerated and we said, "Was this person in there?" They were like, "They were in here, but they were in here for two weeks. They weren't in here for that period of time." So we had them send a letter, because we're working on our appeal file. But it is generally -- I mean, I want to understand.
Because if we have got problems, I mean, it wasn't just one incarceration date, it was a couple, and we're looking at the rest. I mean, that's as far as I've gotten so far. But I was four for four where I think that we're right.

PARTICIPANT: And can you supply that back to me?

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

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

MR. HERDE: No. They just singled him.

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

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

MS. LAWLESS: How often does the
state recoup premiums from the MCOs? Is that a routine process? How often is the routine run to --

PARTICIPANT: We do it every month.

MS. LAWLESS: Every month, okay.

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

PARTICIPANT: Yeah. It goes back 24 months.

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

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

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

PARTICIPANT: I could have told them in October of '17.
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
managed care cycle. During that week, we look at the eligibility file. And at that time, it is what is on that eligibility file at that time that we run those managed care cycles. So sometime between the last cap file or the last month and the new -- and what is being processed this month we have gotten updated information on the eligibility file saying this person was incarcerated all the way back to this date.

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

MR. HERDE: Just curious. Two questions.

CHAIRMAN RANALLO: Yeah.

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

CHAIRMAN RANALLO: And they were not. That's the point. That was the point. Yes, we would.
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
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,
because it is coming -- there is nothing I can do to test that data other than talk to the local jail cells and say, "Is this person in your jail?"

CHAIRMAN RANALLO: Right.

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

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

PARTICIPANT: Yep.

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

PARTICIPANT: Yep.
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.
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
that was in two different jails at different periods of time but not during the dates of service or the month of service that he was there.

PARTICIPANT: Send Angie your examples.

CHAIRMAN RANALLO: Yeah.

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

CHAIRMAN RANALLO: Yeah. And, so...

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

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

PARTICIPANT: Yeah.

CHAIRMAN RANALLO: Anything else
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
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
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.)
CERTIFICATE

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