

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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14
15 February 26, 2019,
16 commencing at 1:04 p.m.

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22 Lisa Colston, FCRR, RPR
23 Federal Certified Realtime Reporter
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A T T E N D A N C E

TAC Committee Members:

Russ Ranallo, Chair
Danny Harris
Stephen R. Oglesby
Michele Lawless
Nina Eisner
Kyle White
Chris Carle
Carl Herde
Debbie Bonn

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MR. RANALLO: We will call the TAC to order. We're going to go around the table and then we will go on the phone, who is there, for introductions.

I'm Russ Ranallo, TAC chair from Owensboro Health.

COMMISSIONER STECKEL: And I'm Carol Steckel, the Commissioner of Medicaid.

MS. BATES: Stephanie Bates, Deputy Commissioner of Medicaid.

MR. BECHTEL: Steve Bechtel, Chief Financial Officer, Medicaid.

MR. SCOTT: Jonathan Scott, Regulatory and Legislative Advisor, Medicaid.

MS. HUGHES: Sharley Hughes, the TAC liaison.

MS. BONN: Debbie Bonn, KHA.

MR. HERDE: Carl Herde with KHA.

MR. GRAY: David Gray, Cabinet for Health and Family Services.

MR. HARRIS: Danny Harris, CFO, ARH.

MR. OGLESBY: Steve Oglesby, CFO, Baptist.

THE REPORTER: Lisa Colston, court

1 reporter.

2 MR. RANALLO: On the phone.

3 MR. WHITE: Kyle White with Norton
4 Healthcare.

5 MS. ISAAC: Laura Isaac with Norton
6 Healthcare.

7 MR. CARLE: Chris Carle with
8 St. Elizabeth Healthcare.

9 MS. ALEXANDER: Kim Alexander, CHI
10 Saint Joseph Health.

11 MR. RANALLO: Okay. Michelle.

12 MS. LAWLESS: Michele Lawless,
13 Med Center Health.

14 MR. RANALLO: And go to the folks
15 back there (indicating).

16 MS. RUSSELL: Pat Russell,
17 Wellcare.

18 MS. IRVIN: Bonnie Irvin, Wellcare.

19 MR. PIAGENTINI: Anthony
20 Piagentini, Wellcare.

21 MR. CAIN: Micah Cain with
22 Passport.

23 MS. STEPHENS: Cathy Stephens with
24 Humana CareSource.

25 MS. GEORGE: Becky George, Anthem.

1 MS. ECLEBERRY: Jennifer Ecleberry,
2 Anthem.

3 MS. MANKOVICH: Paige Mankovich,
4 Aetna.

5 MS. BOWLIN: Christina Bowlin,
6 Aetna.

7 MR. RANALLO: Okay. Nina.

8 MS. EISNER: Nina Eisner, the
9 Ridge.

10 MR. RANALLO: Great.

11 MS. HUGHES: And this is the one
12 who is going to talk about the DSH regs.

13 MR. RANALLO: Okay. So we want
14 to lose some things on the agenda. This
15 gentleman is busy, just like we all are.

16 I want to go to number eight, the
17 DSH regulation. I think when we talked about
18 this, is, you know, with KHA sending in
19 comments I don't think there was anything
20 onerous or too heavy. I don't know if you
21 wanted to give any feedback you had on our
22 comments or anything else that you needed
23 from us. There was a work group of hospitals
24 that put those comments together on that reg.

25 MR. SCOTT: Sure. Well, we're

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still drafting our Statement of Consideration on that and that will be forthcoming.

Would you all like me to give you a general overview of the reg process? How can I best...

MR. RANALLO: Yeah, that would be great.

MR. SCOTT: Sure. We have a complex administrative regulations process. It involves extensive agency drafting, approval by the agency leadership, the Cabinet secretary, and often the Governor's office before a regulation is filed. After the regulation is filed, it will be published in the Administrative Register. A comment period and opportunity for public hearing will occur.

There's two committees with jurisdiction at the LRC, the administrative regulations for the qSOFA committee, and that committee has jurisdictions, such as in our case oftentimes the health and welfare committee. The reg process after filing takes between four and a half to twelve months.

1 If we receive comments during the
2 comment period, there is a requirement that
3 each comment receive a response. There is a
4 document called the Statement of
5 Consideration. This will result in a delay
6 of at least a month and it would allow for
7 the drafting process to occur. I was going
8 to tell you that we can also amend without
9 receiving comments after a regulation has
10 been filed. If you reach out to me I can do
11 an agency amendment. A committee amendment
12 can be offered at the meetings. We're always
13 happy to accommodate where we can during a
14 regulatory process.

15 I keep folders of all
16 administrative regs that are ongoing, even
17 ones that -- even if something is not going
18 to be filed right away or even, you know, it
19 could be something we're looking at years
20 down the road. So if you want to send me
21 e-mails, documents, I will keep a folder of
22 that and we will refer to it as the drafting
23 process of the new reg starts.

24 MR. RANALLO: Okay.

25 COMMISSIONER STECKEL: And by no

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means does that mean we're opening up every single reg.

MR. SCOTT: Correct.

COMMISSIONER STECKEL: So do not interpret that statement that way, in case there is any misunderstanding.

MR. RANALLO: I understand. So I guess, you know, the other item that I have on there, when the reg came out it was a surprise to me. And KHA had worked with DMS on this particular issue all the way through the approval process. And then when we got the reg there were some things in there that we thought were different than what we interpreted. And historically the TAC has not been used for review or even discussion of those regs that impact hospitals before they are published.

COMMISSIONER STECKEL: Uh-huh, uh-huh.

MR. RANALLO: And I feel like it's a misuse of the TAC or a lack of use of the TAC.

COMMISSIONER STECKEL: To not talk about regs or to...

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MR. RANALLO: Well, I think, you know, if -- if -- I didn't even know it was coming until we had three TAC meetings before that to say that this regulation is coming or have some kind of draft. We could have given comments or had discussion about it, especially when we were involved with, really, the creation of it.

And so it was just surprising to me. And I guess it's -- I don't know if there's opportunities to use the TAC when those regs -- before those regs come out to have that discussion or not. But...

COMMISSIONER STECKEL: And that is my goal for the TAC. I mean, I want us to get away from claims processing issues, which we can deal with in another forum. And you all already have an MCO forum. So that should be that forum. And we will get you -- I think we already have prepared phone numbers of who to reach out to if your facility has a specific issue.

The TAC, as I see it, one, your goal and your function is to advise the MAC, not to have us doing your work and not to

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have us running numbers for you. It's to advise the MAC.

Now, that being said, what I would like us to do is to have the type of relationship where we can bring you a regulation that we're thinking about revising or that we have to revise because of either federal law change or state law change or, as Jonathan has been going through over the past -- since I've been here in September, there's this law that we have to go through all of our regulations and determine whether they need to be updated, eliminated, or changed in any way. Correct?

MR. SCOTT: Yes.

COMMISSIONER STECKEL: So that is exactly, Russ, what I would like to do with this TAC.

You know, there's legislation that we've been talking about with the legislators that, you know, we -- and we deal with the Hospital Association. But the TAC may be a good opportunity for some of those dialoguing discussions also.

But that is my, some people have

1 said, fantasy, dream, pick your verb. But
2 that is what I would like to see the TAC
3 functioning as.

4 MR. RANALLO: Okay. Well, I don't
5 think -- I mean, I don't think anybody around
6 here is unwilling to provide input or serve
7 in any way in any kind of review of any
8 legislation or anything the Cabinet wants
9 input on as well. So...

10 COMMISSIONER STECKEL: Okay.
11 And so here's the bottom line. You all know
12 you are not going to get everything you want.
13 I am not going to get everything I want. But
14 unless we're sitting in the room together
15 talking it out, you won't understand us and
16 we won't understand you. And then we can
17 come to a conclusion where we either work it
18 out or we don't and we understand where each
19 -- we go to our corners and we prevail
20 ourselves of the opportunities that are
21 available to us.

22 And so far everybody has gotten the
23 legislature to do exactly what they want, to
24 the tune of \$1.4 billion worth of legislation
25 that is on the table for Medicaid. Just let

1 that sink in. So...

2 MR. RANALLO: And the budget for
3 Medicaid is 10 billion?

4 COMMISSIONER STECKEL: It is 13?

5 MR. RANALLO: Thirteen billion?

6 MR. SCOTT: Thirteen. But we don't
7 have 1.4 billion.

8 MR. RANALLO: No. I want to put it
9 in magnitude with the total budget.

10 COMMISSIONER STECKEL: Right,
11 right.

12 MR. RANALLO: It is about
13 10 percent of additional budget.

14 COMMISSIONER STECKEL: Correct,
15 correct. And that is a low-ball estimate.
16 Because some of the things that -- we are
17 just not going to be able to price out until
18 we know more of the details and are able to
19 operate the program, if it goes through.

20 But \$1.4 billion worth of Senate
21 and House bills.

22 MR. SCOTT: And that's total.
23 Because --

24 COMMISSIONER STECKEL: Total,
25 correct.

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MR. SCOTT: -- the other thing is, we don't know some of these bills if we will be able to draw the federal share or not, because CMS has got lines on medical necessity.

MR. RANALLO: Okay. Any others? TAC members, any other questions for?

(No response)

MR. RANALLO: Thank you. I appreciate it.

MR. SCOTT: If any hospital-related legislation passes, please feel free to reach out to me over the course of the interim. And I can start work on anything that you see.

MR. RANALLO: Scott, do we have your contact information or can we get that from you?

MR. SCOTT: Sure, sure.

MR. RANALLO: That would be great. I appreciate your time in coming to our meeting.

COMMISSIONER STECKEL: And so what -- the interim, what we hope to do in the interim, is: One, go through every piece

1 of legislation that passes. What are the
2 implications? What are we going to have to
3 do? What do we think we're going to have to
4 do to implement it? What is the timeline?
5 And then, again, that's where I see the TACs
6 being valuable, is sitting down with the
7 appropriate TACs, in some cases we may have
8 joint TAC meetings, we may have conference
9 calls where it is not an official TAC meeting
10 but it is the TAC members helping us go
11 through the implementation process so that
12 when we do start writing regs you are part of
13 that process. And, hopefully, where we can
14 avoid it, we avoid surprises.

15 MR. RANALLO: I appreciate that.

16 COMMISSIONER STECKEL: Oh, I hate
17 surprises.

18 MR. RANALLO: Me too.

19 COMMISSIONER STECKEL: So I'm very
20 empathetic.

21 MR. RANALLO: Me too. Good.

22 Okay. Thank you, sir. Appreciate
23 it.

24 MR. SCOTT: Thank you all.

25 MR. RANALLO: All right. Let's

1 start back at the beginning. So minutes, we
2 talked about minutes before everybody came
3 in. Minutes are going to be -- are the court
4 reporter's document. Once we get that from
5 the next meeting, we will send that out.
6 I've got some notes from the last meeting
7 that I will just hand out to the TAC members
8 to make sure they have them and the Cabinet
9 to make sure you guys have them. There's
10 nothing we need to approve today.

11 The first thing on the agenda is
12 the Issue Log Charts that we brought here to
13 every meeting. And these are, basically, a
14 summary of the KHA meetings and the issues
15 that are on the -- with the MCOs that happen
16 every month.

17 Carl, anything you want to point
18 out on these?

19 MR. HERDE: No. Obviously, we're
20 working well with the MCOs. Everybody is
21 working hard trying to get the issues
22 resolved. Look at all the trend lines;
23 you know, they are all showing improvement.
24 And I am getting calls every week with other
25 items that are getting cleared week by week.

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So...

So we're working on that. And, hopefully, we will continue to see that level of improvement.

MR. RANALLO: Good. Very good.

Okay. The second item on the agenda, Short Stay Inpatient Denials. So this was identified at the MCO meetings in October. I think we had a discussion of it with the UR people in the room at our last meeting, where we have MCOs that are denying inpatient admissions when the patient meets the intensity to qualify for an inpatient level of care and the denial being based solely on this charge in 48 hours. The MCO is using a length of stay, not level of intensity, to indicate the patient is observation rather than inpatient.

And I think what we saw or what was reported at the meeting was that they were having high turnovers on appeal, an overall 57 percent rate, but depending on the MCO as high as 77 percent on these type of appeals. So it was the -- the thought process was, we're wasting time and resources on appeal

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for things that already meet the InterQual criteria.

And I believe we were supposed to send examples. And from my knowledge, we sent examples. Do you know if we got anything back?

COMMISSIONER STECKEL: Can you give examples?

MS. BATES: Yes. Andy Barker is working on those.

MS. ISAAC: This is Laura Isaac from Norton Healthcare. I did send a large file of information over.

MR. RANALLO: Okay.

MS. BATES: And it is my understanding that Angie is reviewing those and was --

MS. ISAAC: I didn't receive any reply back, but I did send it.

MR. RANALLO: Okay. Yeah. Stephanie is reporting on that Angie Parker is reviewing those.

MS. BATES: Right. And that that was going to be handled at your KHA meeting. Is that not the case?

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MR. RANALLO: I am not aware that it has been handled at the KHA meeting.

MR. HERDE: Just we have not had a report back on it yet. So...

MS. BATES: So I think this kind of speaks to what we're talking about, is that when this was brought here we said, you know, talk about it in your meetings with the MCOs, whoever is doing it, and then reach back out. Now, I can check back with Angie. But this is a claims issue. So...

MR. RANALLO: So let's talk about that a little bit, so we can...

So, you know, at what point. So I hear you say that it belongs in another forum than the TAC. So when we have issues where we brought -- so like number five. We brought this issue here because it has been on the MCO list for 450 days. It is a mis -- they are not applying the Correct Coding Initiative edit, a CCI edit, correctly.

Four hundred and fifty days where I get denials. I've got -- we all do. I don't know how every -- if everybody else has taken them to administrative law hearings, but I

1 have. Because I am not going to --
2 regardless of the money on it, it is costing
3 me more to go through the appeals and
4 administrative law hearing to get them to
5 correctly do a CCI edit.

6 At what point is the KHA calls
7 ineffective and what other forum do I have to
8 bring to the Cabinet to say, "They are not
9 applying the CCI right." It is a CCI edit.
10 It is a national -- I mean, it is a Correct
11 Coding Initiative edit. I mean, where is the
12 forum? What other venue do you want me to
13 bring that to?

14 COMMISSIONER STECKEL: Well, you
15 brought it to the correct venue. And so what
16 we have said is that Angie is looking at it.
17 She will be able to go through the claims
18 that were provided by the hospitals and
19 ascertain whether, in fact, it is a CCI.
20 I am not distrusting you.

21 MR. RANALLO: I was talking about
22 number five, but, I mean, and not number one.

23 COMMISSIONER STECKEL: You can't
24 change issues on me, Russ.

25 MR. RANALLO: I know. I'm sorry,

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I'm sorry. Well, it is because this was one of the longest ones, and that is why it is in my head.

COMMISSIONER STECKEL: Well, so, but both are the same thing. So when something -- so you have the KHA meeting that is DMS is there as an observer, my understanding, and the MCO and the KHA duke it out. I'm being more aggressive than I mean to be. But you all work through the issues or try to work through the issues. On the 200th day, 300th day, or 450th day --

MR. RANALLO: Right.

COMMISSIONER STECKEL: -- it comes to the TAC as a systemic issue.

MR. RANALLO: Okay.

COMMISSIONER STECKEL: We have acknowledged that they are -- asked for specific claims information, to look at it. We now have -- we are looking at it in a systemic manner.

MR. RANALLO: Okay.

COMMISSIONER STECKEL: To report back, really, will take some more interaction, which should be KHA, the

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hospitals and the MCOs and DMS actually working through the issues.

And then, once everything is worked out and Medicaid has said this is the policy, this is their -- they are doing something right, they are doing something wrong, then the report back to the TAC is we have looked at this issue. Here's what we've done in conjunction with KHA and with the MCOs. And here's the actions we've taken.

MR. RANALLO: Okay. And I'm okay with that.

COMMISSIONER STECKEL: Well, I'm just so peachy glad.

MR. RANALLO: I know you are. So then this would be a pending. This was pending KHA discussion, MCO/KHA discussion to close the loop back.

COMMISSIONER STECKEL: Yeah. Right. Angie is in the middle of also drafting an RFP and a new contract. And, so, it will take time. I am not saying months of time. But when do you think you will be able to go back through KHA?

MS. BATES: I don't know. I just

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know that she -- but, so, she's there every month.

MR. RANALLO: Uh-huh.

MS. BATES: And, so, when you -- when -- there was a meeting this past Friday. So when she was asked about these issues, what did she say?

MR. RANALLO: I don't know. I wasn't able to make the meeting last Friday.

MS. ISAAC: This is Laura Isaac. You would like us at the KHA meeting to speak to you, Angie, about the list of cases that I sent you back in October; is that correct?

TAC MEMBER: Angie is actually not in this meeting. They are saying Angie is working on it and she will report back to the Friday meetings.

MR. RANALLO: Yeah. Hold on one second.

MS. ISAAC: Okay.

MS. BATES: Go ahead, Carl.

MR. HERDE: Typically the representative for the MCO will walk through the to-do list.

MS. BATES: Right.

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MR. HERDE: And to the extent something is being worked on, that is really all the statement is, "it is being worked on." And that is as far as the conversation goes.

COMMISSIONER STECKEL: So there was a meeting on Friday. Let's just aim for having a resolution to this on the next monthly meeting with the KHA.

MS. BATES: But until then, the resolution is, make sure you use your appeal rights that are afforded to you as a provider.

MR. RANALLO: Understood. So on this item I'm going to put pending KHA/MCO meeting.

COMMISSIONER STECKEL: Perfect.

MS. BATES: Uh-huh.

MR. RANALLO: And then the resolution -- whatever the final resolution is will come back to the TAC so we can close it off the loop.

COMMISSIONER STECKEL: Correct.

MR. RANALLO: Correct?

MS. BATES: And she had a meeting

1 at the same time. That's why she's not here.

2 MR. RANALLO: I understand. That's
3 okay. I get it.

4 MS. BATES: Uh-huh.

5 MR. RANALLO: Okay. So the next
6 one, I think in a similar vain, Utilization
7 Management. Staff described denials due to
8 length of stay.

9 MS. BATES: Yes. This is the same
10 thing.

11 MR. RANALLO: The same type of
12 issue?

13 MS. BATES: Uh-huh.

14 MR. RANALLO: So, again, this is
15 one that Angie is working on?

16 MS. BATES: Yeah.

17 MR. RANALLO: Okay.

18 MS. HUGHES: And she will report at
19 the next KHA meeting on this as well?

20 MS. BATES: I don't know.

21 MS. HUGHES: Okay.

22 MS. BATES: It is pending.

23 MR. RANALLO: The transportation
24 issue that we talked about on the psych and
25 chemical dependency forum meetings, where we

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had transportation and we were not able to move patients either because EMS wouldn't go out of state or there wasn't any EMS available but the MCOs wouldn't pay for that care.

What we had from the last meeting, that they were going to review and report back to the TAC. Do you know if anybody reviewed that for us?

MS. BATES: I don't know what the -- I guess I don't understand that. So they are saying they are not paying for the Medicaid-covered services?

MR. RANALLO: They won't -- they won't -- I will let Nina. She knows best.

MS. EISNER: The difficulty in getting patients moved around the state to the appropriate level of care to an available bed.

MS. BATES: So the transportation?

MS. EISNER: The transportation itself.

MS. BATES: So the transportation is -- I mean, so, basically, trans -- if it is a stretcher transportation, no matter what

1 it is the MCO is responsible for paying.

2 MS. EISNER: Okay.

3 MS. BATES: If they are sitting
4 up --

5 MS. EISNER: Which most of ours
6 would be.

7 MS. BATES: -- then that's
8 considered something that's paid for through
9 the state, through the nonemergency
10 transportation.

11 MS. EISNER: Okay.

12 MS. BATES: But there are rules
13 about that. So if it's emergency, then
14 that's considered a stretcher. If it is an
15 ambulance, then that's MCO.

16 So every situation is going to be a
17 little bit different.

18 MS. EISNER: Uh-huh.

19 MS. BATES: Because for
20 nonemergency transportation to be paid
21 through the state, there has to be, you know,
22 no car available, blah-blah-blah.

23 So for each one of those, if the
24 MCO is not responsible they will be the first
25 one to tell you. And if we are responsible,

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then it needs to go to the state through the nonemergency transportation process.

MS. EISNER: Okay.

MS. BATES: And those -- I have supplied before, more than once, information about nonemergency transportation. But I'm happy to do that again at the TAC.

MS. EISNER: And I think it might be helpful to clarify emergency, nonemergency. For example, if someone is showing up in one of our emergency rooms and isn't able to be -- and is going to an available bed in some other county, that would be considered emergency, correct, even though they are not on a stretcher?

MS. BATES: Not necessarily. So that's -- every situation is different.

MS. EISNER: Yeah, yeah.

MS. BATES: So, you know, transporting someone -- because we run into this with kids a lot.

MS. EISNER: And that's really where the biggest problem comes, is with kids.

MS. BATES: Right. And so there

1 are rules when it comes to nonemergency
2 transportation about the guardian being
3 there. There's safety rules. You know,
4 there's all kinds of rules.

5 So I will re-send the nonemergency
6 transportation information. But we really
7 need specific questions. And then --

8 MR. RANALLO: So what I heard last
9 time was, one of the issues that I heard at
10 our last meeting was, that they had -- they
11 were trying to move a patient out of county.
12 The EMS would not take the patient out of
13 county because of the low reimbursements and
14 having a bus, an ambulance, out of service
15 for so long for that reimbursement.

16 MS. EISNER: That's right.

17 MR. RANALLO: And that MCO didn't
18 want to pay for that continued stay in that
19 facility.

20 MS. EISNER: Right.

21 MR. RANALLO: So you've got the
22 provider stuck. You have got them with no
23 EMS transportation and an MCO saying, "I am
24 not going to pay for that patient to stay."

25 MS. BATES: They are not going to

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pay or are they no longer meeting that medical necessity for the MCO?

MR. RANALLO: Well, they can't be in that facility and they're not going to pay anymore. But the hospital can't get -- the facility can't get the patient out.

MS. EISNER: Right.

MR. RANALLO: And it is not the facility's fault that the transport won't take the patient.

MS. EISNER: Right.

MR. RANALLO: So what happens, right? So the facility is responsible for eating that? That was the specific issue that came up at the last meeting that I remember.

MS. EISNER: And, Stephanie, we can get more examples, very specific ones. We do have a forum meeting on March 12th.

MS. BATES: Uh-huh.

MS. EISNER: Are you -- a lot of times -- like I know Dr. Brenzel is coming and Dr. Bores [ph] is coming.

MS. BATES: That might be a good forum.

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MS. EISNER: Yeah. Because that's really where it came from.

MS. BATES: They will be there.

MS. EISNER: Yeah.

MS. BATES: And, I don't know, when is it?

MS. HUGHES: March 12th.

MS. EISNER: March 12th, Tuesday.

MS. BATES: Yeah.

MS. EISNER: Okay. Maybe we can follow.

MS. BATES: What time?

MS. EISNER: It is lunch, like at 11:30. And we're done by 2. You would be welcome to come.

MS. BATES: Will you send me something?

MS. EISNER: Sure.

MS. BATES: Or, Debbie, will you?

MS. EISNER: Sure. Thank you.

MS. BATES: Okay.

COMMISSIONER STECKEL: So in the meantime, we're going to re-send EMT policies and procedures.

And the feedback that we could use

1 is where are we not communicating the
2 appropriate policies and procedures. So if
3 we're having a significant number of
4 questions about what to do, rather than
5 handling it on a case-by-case basis, which we
6 are going to have to do that for some of
7 them, but it may be that we have to look at
8 the way we've written those instructions and
9 try to figure out are we missing a big group
10 or are we missing a specific instruction.

11 MS. EISNER: Okay.

12 COMMISSIONER STECKEL: So we will
13 do that. But in the meantime, we will send
14 it out. So if you all have any comments or
15 suggestions, if you will get those to
16 Stephanie, that would be great.

17 MS. EISNER: Okay. Thank you.

18 MR. RANALLO: Okay. IV Hydration
19 Denials. So we kind of touched on this a
20 little bit. So, essentially, this issue, if
21 there is a CCI edit, CMS, basically, if you
22 have somebody that comes in on an emergency
23 basis or observation or is here on an
24 outpatient and they span two calendar days
25 and you start IV hydration on one day and it

1 continues on into the second day, there is
2 only one initial administration code allowed
3 on that bill because it is one episode of
4 care viewed as by Medicare. Denials that are
5 occurring by multiple MCOs are that on the
6 second day where there are fluids there's no
7 initial administration. And we're getting
8 denied those fluids on the second day because
9 there is not an initial administration code.
10 And it's a CCI edit.

11 So I've gotten pushback from my
12 compliance department that if we put that on
13 the second day we are going to be in
14 violation of a CCI edit. It is not a good
15 bill. We've asked the MCOs, how do you want
16 us to do it? We've brought this issue. And,
17 again, we've had denials. We've appealed the
18 denials. We've lost. We've taken them to
19 IPRO. We've lost. My process is mostly CCI
20 edit. And it's okay. And then we've taken
21 them to an administrative law hearing. It
22 has been a long-time issue on the MCO list
23 and it has really not gotten any traction.

24 MS. BATES: So I can't find it
25 on -- I've got four of them. Hold on. I'm

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trying to find the other one. But the February MCO list, I cannot find that on there at all. So which list is it on?

MR. RANALLO: I don't know the February list. I would have to look. I know it is on the list or it has been on the list.

COMMISSIONER STECKEL: So you said you lost in the first appeal and lost in the IPRO?

MR. RANALLO: We lost in the MCO appeal.

COMMISSIONER STECKEL: Right.

MR. RANALLO: We lost in the IPRO appeal.

COMMISSIONER STECKEL: So what did IPRO say?

MR. RANALLO: My recollection is, they pared it back to what the MCOs said, that you need an initial administration on the second day and that we would uphold the denial.

So this goes -- we will talk about the IPRO in a little bit. I don't think sometimes the IPRO reads the appeals. I mean, it feels that way. Because when we

1 get pared back on something that we feel --
2 that I feel is pretty straightforward is
3 pared back, what is an MCO denial and it
4 moved on. So there is a little bit of
5 frustration there. But...

6 COMMISSIONER STECKEL: So have you
7 had an administrative appeal go through yet?

8 MR. RANALLO: No. We're -- we're
9 -- I think we have -- because we're
10 continuing the -- no. Not one -- not one
11 that has gone through the attorneys yet, no.
12 I mean, it is at the attorney level, but it
13 hasn't gone through yet.

14 COMMISSIONER STECKEL: So what I'm
15 struggling with is the IPRO is our contracted
16 entity that makes these decisions for us
17 independent of the MCOs. Now, I hear what
18 you are saying about your thoughts about
19 IPRO's quality.

20 MR. RANALLO: Well, I mean, it is a
21 CCI edit. I mean, and that's -- I guess that
22 is a Correct Coding Initiative edit.

23 COMMISSIONER STECKEL: But why
24 won't IPRO pick that up?

25 MR. RANALLO: We put it in our

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appeal. I can't tell you why they wouldn't pick it up. So I just...

MS. BATES: So this is an -- so I've got all five pulled up now. And you said that this was on the log for 450 days, and I don't see it on all -- either -- any of the five logs right now.

MR. RANALLO: Okay. I don't know if it got taken off for some reason. I don't know why it would.

MS. BATES: I want to reiterate, that these kinds of things can be talked about at your regular monthly meetings.

And, so, the other part to that is that it -- through each part of the process that is afforded to you as a provider, the same -- so far the same decision has been made. And, so, from our standpoint -- and those are experts at IPRO that are making the decision. So we take the MCO out of it and it is an expert.

You know, at this point, unless we suspect something from our end is going on, I mean, it's -- IPRO doesn't find in favor of the MCO all of the time. So I just -- I tend

1 to lean toward the decisions that have
2 already been made. And then -- but that
3 doesn't mean that -- and I've already written
4 down to go back and look at this. But...

5 MR. RANALLO: Okay.

6 COMMISSIONER STECKEL: So what we
7 can't be in a position of doing, without hard
8 evidence, is questioning our contractors
9 because the decision didn't go in your favor.

10 MR. RANALLO: I understand. I get
11 you. But it's -- okay.

12 MR. HERDE: And, so, a couple of
13 clarifying points. I will go back and look.
14 I don't have the list.

15 But the most recent list, was this
16 one of the ones that you chose to send an
17 e-mail out? Was it hydration and sepsis on
18 the same e-mail, I think? Do you remember?

19 MS. BATES: That was a Wellcare.

20 MR. RANALLO: No. One was an NCD,
21 I think, Carl.

22 MR. HERDE: Okay.

23 MS. BATES: Yeah. No, this was
24 separate.

25 MR. HERDE: So I will have to go

1 back and look and see when and how it dropped
2 off. But there comes a point in time, too,
3 at some point if you don't get resolution, I
4 think the bigger issue is what are the
5 expectations for the IPRO. If they are
6 looking at let's look at what the MCO is
7 pointing as here's the rules of the road, if
8 you will, I mean, yeah, that's the rules of
9 the road, therefore, you lose your appeal,
10 you know, or is it -- or is there a broader,
11 bigger picture involved in this.

12 But at some point there is a
13 disconnect. And maybe we just need to talk
14 to the IPRO people and find out, you know,
15 what are the rules of the game. But from a
16 CCI perspective, I mean, I think that is what
17 the frustration, from what I've heard from
18 the hospitals, is you are asking us to
19 basically find two different ways to be doing
20 coding. There is a national standard. Why
21 aren't we following the national standard?
22 That is the question. That's what I keep
23 hearing.

24 MR. RANALLO: You know, and on the
25 flip side, if I put this on the bill that

1 way, I'm going to have other MCOs that are
2 going to kick it out and say I'm upcoding or
3 I'm putting -- I violated the CCI edit and
4 you are getting additional payment for that
5 additional code. So with two I can do it
6 their way and then the other three I can't do
7 it that way. So I have got two different
8 standards for the different MCOs.

9 MS. BATES: So --

10 MR. RANALLO: I mean, I'm just
11 telling you what will happen.

12 COMMISSIONER STECKEL: No. This is
13 helpful.

14 MS. BATES: So let's go ahead and,
15 since we're talking about IPR0, let's talk
16 about IPR0.

17 MR. RANALLO: Okay.

18 MS. BATES: Dr. Liu.

19 DR. LIU: Yes, ma'am.

20 MS. BATES: Can you comment on some
21 of the IPR0 processes, just on a general
22 basis of what you think that their process
23 is. Because my view of what I have seen of
24 the IPR0 reviews is that they are very
25 thorough. But can you comment, just

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candidly, to the group. And let's have a discussion.

DR. LIU: Sure. I'm glad to do that. You know, I would defer. You've had a longer length of time. I started my third year this January, so I'm into two years plus less than one-quarter.

I've worked with IPRO on a number of fronts I would say equally in time with their focus study reports and their supporting performance improvement plans for the managed care organizations and then kind of adjudicating disputes and utilization management decisions.

In all of those instances, the people I've worked with, Caroline Gallagher [ph] and Chuck Marleeno [ph], kind of are our two points of contact. From my experience, they seem to be up-to-date on their use of medical evidence. I haven't found them to be dogmatic. They have always been really open and interested in kind of soliciting input and trying to get a full view of the issue at hand.

And when I have looked at the

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utilization management disputes, of which there have been relatively few, I would say, way less than ten, from my point of view, I haven't returned any of the IPRO decisions, just to be candid.

I do think, you know, listening to there being a correct coding initiative edit that makes you, you know, count an initial administration on the second day of IV fluids, I'm a little stuck there. It doesn't make sense to me as a clinician. You could insert a bag, hang a bag, and let it run into the second day. And I don't think you should charge for another administration of IV therapy on day number two. So some of that I am just trying to figure out. I was looking up correct coding and just trying to see what that edit is supposed to support in terms of good care.

My final comment is, you know, the evidence is evolving. So I have -- the reason I was requested to be here is to talk to you about sepsis. And that is a clear case where Medicare, Medicaid, the emergence of the evidence has created a little bit of

1 uncertain footing for hospitals to determine
2 how they need to document excellent care and,
3 you know, substantiate, really, cost
4 utilization. So I think there are some
5 instances there where a third-party review,
6 you know, we need to be really, really clear
7 about what the basis of those decisions are.
8 And I think that is an illustration of
9 something that's challenging.

10 But some of these other things,
11 about IV fluids and coding edits and just
12 kind of the pain of having to do things for
13 Medicare one way and Medicaid another, I am
14 not sure that's really, from my point of
15 view, a clinical subject matter kind of
16 determination as much as a painful
17 unfortunate administrative exercise. I would
18 love to, and I do work very closely with
19 Angie Parker, so as she's looking at short
20 stay, IV fluid, the management of sepsis,
21 you know, I just want to assure you I am
22 very, very eager to be a part of that team.
23 So you do have a clinical subject matter
24 expert that I hope you will find is kind
25 of -- I don't have a dog in the fight. It is

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just to make sure that my interpretation of the evidence is translated into the guidelines of care.

MR. RANALLO: So if we can talk about IPRO, which is number 12 on the agenda. So one of the things that the hospitals have experienced is clinical validations, where, you know, CMS is pretty clear with the regs that a coder and a billing specialist can't do clinical validations. So I've got one, an example, and I will give it to you, Stephanie, is we had a billing specialist that did a clinical validation on respiratory distress syndrome in a neonate, where they had respiratory distress syndrome. They upheld the denial, but it was a billing specialist. Now, I know a lot of billing specialists, some really good ones, and I've been doing reimbursement and I understand clinical stuff. But I can't tell you as sure as I'm sitting here after 25 years what respiratory distress syndrome is and whether I can clinically validate in a neonate. So for a billing specialist to do that on the IPRO I think is out of line.

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MS. BATES: Did you say you brought that one with you?

MR. RANALLO: I did. I have got coders doing the same thing with clinical validation. And we are not talking about a coding issue or a billing issue. Now, the billing specialist looks at the CCI edit and does that, that's one thing. But when we're talking about a diagnosis of RDS on a neonate, a biller cannot determine whether that's an error or not and then it's validated, from my view point. So I think there are some things in the IPR0 that we feel are inappropriate.

MS. BATES: Where is it? Do you have it with you?

MR. RANALLO: (Hands document to Ms. Bates). And here's another one with -- our coding one (hands document to Ms. Bates).

MS. BATES: Thank you.

DR. LIU: And, Russ, if I could respond directly.

MR. RANALLO: So I think we need to keep watching what is going on with the IPR0. Because I don't think those things should be

1 occurring. I mean, I'm asking you your
2 opinion as well, too, I mean, on some of
3 these. And look at those examples. Because
4 it -- it is -- again, it is -- we're spending
5 money to continue on with these things and we
6 want the reviews. You are spending money
7 with the IPRO and we want them to be
8 worthwhile for everybody.

9 DR. LIU: I completely agree in the
10 hypothetical scenario, that in every review
11 the clinician should be judging the merit of
12 a diagnosis in the documentation. And if
13 only a coder was the sole perspective that
14 made the determination, I do find that
15 inappropriate. So I think a resolution would
16 be that we could look at the work flow of how
17 IPRO receives these requests for appeal and
18 assigns an appropriate level of expertise in
19 order to -- and if they are -- you know, has
20 that person signed on that I was present,
21 this is my work or what have you, I'm happy
22 to, you know, verify that that's the process.
23 I just don't know.

24 MR. RANALLO: Right.

25 MS. BATES: Yeah. And the person

1 that actually signs off on this is the MD.
2 So we need to like you said --

3 MR. RANALLO: Well, if you look in
4 the second paragraph, it says the review was
5 conducted by a billing specialist.

6 MS. BATES: Right.

7 COMMISSIONER STECKEL: So what we
8 need to do here is look at the contract, do
9 an -- whether it is an audit, a review, or
10 whatever we want to call it on whether they
11 are complying with the contract.

12 MS. BATES: Uh-huh.

13 COMMISSIONER STECKEL: And if they
14 are and the two of you and Angie think there
15 is still an issue, then we need to amend the
16 contract.

17 MS. BATES: Uh-huh.

18 COMMISSIONER STECKEL: If they
19 found a loophole, and I am not saying they
20 have --

21 MR. RANALLO: Sure.

22 COMMISSIONER STECKEL: -- but if
23 they have, then we need to close it. So...

24 MS. BATES: Yeah. We will do it.

25 COMMISSIONER STECKEL: Okay.

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MR. RANALLO: Appreciate that.

Thank you.

COMMISSIONER STECKEL: Well, sure.

MR. RANALLO: While we are talking, do you want to talk about sepsis? Great.

DR. LIU: Well...

MS. HUGHES: You are just jumping all over this.

MR. RANALLO: I know. I'm sorry. I apologize. While Dr. Liu has the floor, I mean, that's number nineteen, an update on sepsis. I know, I think, several of us saw an e-mail about, you know, the recommendation that it is going to come out as sepsis three. It is number nineteen on the agenda, if everybody is looking at the agenda.

DR. LIU: Russ, could I just ask you to make sure that I'm on point, just to --

MR. RANALLO: Sure.

DR. LIU: -- just to give me a clear understanding of what you want me to respond to. I brought materials, but I could go on at length.

MR. RANALLO: Yeah. I understand.

1 So I guess from the TAC's viewpoint, in the
2 past, you know, the way the coding rules line
3 out for sepsis, so there are a couple of
4 things that I have heard in the meetings, the
5 coding rules line out for sepsis, we're going
6 to call it sepsis two, sepsis three. But for
7 sepsis two to be coded on accounts. And
8 that's the coding rules and laws set out by
9 CMS and the four bodies that generate the
10 coding, the coding rules.

11 I know you've got -- I know you've
12 met with the MCOs, medical directors, on some
13 of this, as I'm understanding it. I don't
14 know if you have met with any of the
15 hospitals. I know there are a couple of
16 hospitals that have expressed interest in
17 meeting to discuss sepsis.

18 DR. LIU: (Moved head up and down).

19 MR. RANALLO: I know I've gotten
20 pushback from my chief medical officer on
21 this issue when they saw the e-mail.

22 So I would like to have -- I don't
23 know if you are open for those meetings, but
24 we would like to have those meetings to have
25 that continued discussion. I am not a

1 clinician. But what I have heard from the
2 clinical folks is, so when somebody comes in
3 they have -- and we realize that they are
4 going into sepsis, we treat them for it.
5 But, basically, you know, the DRG is supposed
6 to line up with the expenses that you use.
7 But the way that coding is, it is not going
8 to be recognized as sepsis until there is
9 organ failure. So you want me to wait until
10 there is organ failure to treat the patient
11 for sepsis, which creates a whole host of
12 other issues, which is not reasonable. So
13 that's the pushback I have gotten back from
14 my medical staff about it.

15 DR. LIU: (Moved head up and down).

16 MR. RANALLO: And, again, I will
17 say this, I've said this before, is that if I
18 was taking something and going against coding
19 rules that were set out by CMS and the
20 American Hospital Association that everybody
21 agreed to, this is how you should code a
22 diagnosis, and I took it and I took an
23 article and I coded something differently to
24 increase my payment on the DRG, every MCO,
25 every payor would come back to me and say,

1 "You are upcoding. You are not following the
2 rules. And all you are doing is to get more
3 money for that." So if the shoe was on the
4 other foot, I would never be allowed to do
5 this. So that is the other concern, is that
6 it is a windfall for the MCOs. Hospitals
7 aren't going to wait, obviously, until
8 somebody gets into organ failure to treat
9 them for sepsis. They are going to try to
10 prevent them from having organ failure and
11 keep them out of that. And we are going to
12 be spending resources to do that. And, but,
13 we are not going to be getting credit for
14 that in the DRG or in the payment.

15 So that is the ball of concerns
16 that I have heard. And I've got to code one
17 way for this payor. And I have to have
18 coding another way for every other payor,
19 every other payor. And so that creates
20 another manual work-around that -- that we --
21 that costs us money. Because every time you
22 do something manual, it costs us more money.

23 DR. LIU: (Moved head up and down).

24 MR. RANALLO: So other folks from
25 the TAC, any other? Have I expressed that

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properly?

(Board Members moved heads up and down)

MR. RANALLO: So, but, I appreciate the work and the time and I appreciate you being here, Doctor, because I want to make sure we beat it to death, beat it like a rented mule, is what my CFO would say.

DR. LIU: Yeah. No. So let me offer. I did talk with Jim Frazier, who I think is a physician champion for the Norton organization, specifically about the post-payment recouplements related to sepsis.

So I just want to clarify. I don't think this is a prior authorization. I think of this as a post-payment issue. And you are right. I'm going to be careful about not appearing to move the target on you. But the definition of sepsis has evolved as of 2016. And I think some of the difficulty that you are talking about is managing patients who are at risk of sepsis but have not progressed to being diagnosed with sepsis. So ways that the diagnosis has evolved is they removed the word "severe." There is no longer severe sepsis versus sepsis. All sepsis is severe.

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It is defined by two criteria.

MR. RANALLO: So when you say "they," who is they?

DR. LIU: Yes. A group of subject matter experts within this Third International Classification published in the peer-reviewed literature in 2016.

MR. RANALLO: Okay.

DR. LIU: And that has bubbled up to both the national quality forum and -- I forget the organization that does, like, the leading quality improvement around sepsis, which is that early detection and intensive management that you are referring to, the sepsis quality bundle.

So sepsis now is defined as systemic infection with organ failure. And one of the tools that is used to suggest appropriate clinical documentation of organ failure is the quick sepsis-related organ failure assessment. And most people just say qSOFA.

So in InterQual are primary guide for utilization management around prior authorization. If you have a qSOFA score

1 less than two that explicitly states that
2 those patients can be managed in an acute
3 setting, not a critical care setting, so that
4 I think gets right at the heart of the matter
5 about how InterQual is going to drive you to
6 adopting the Third International
7 Classification of sepsis to justify critical
8 care level intensive utilization and cost.

9 I will pause there for a minute.
10 Does any of that, like, really strike people
11 as something that I need to go back and make
12 sure I have right? Because I think it is
13 pretty clear. If you have ability to access
14 InterQual, it is there very plainly to me.

15 So my interpretation is right now
16 our agreed-upon source for clinical criteria
17 related to sepsis has adopted a Third
18 International Classification, despite
19 Medicare and the quality improvement
20 organization around the sepsis bundle not
21 having gone in that direction yet. And I
22 think that's just a bureaucratic exercise. I
23 think that's inevitable. And I don't know
24 when it is going to happen, but I would put a
25 lot of my savings on a wager that that's

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going to be, you know, something that happens in the near future, just to offer my perspective on that.

So my final comments are, I would be glad and I consider it well within my job duties to meet with other counterparts in the Hospital Association or any other stakeholders in the community that just want to air out kind of concerns or suggestions for how we move forward in this gray area where Medicare, Medicaid, commercial plans, and quality improvement organizations have not quite aligned. I appreciate the difficulty in that.

But I think for Medicaid and InterQual and IPRO and where we've issued some guidance around my interpretation of the evidence and the best practices for patients, I think the Third International qualification, the qSOFA, or the definition of sepsis is the best thing for Medicaid on a population level, whether that's from clinical evidence, financial sustainability, quality improvement. You know, you run the gamut on comfortable, with that being

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something that I would endorse and from a --
from my role as CMO.

MR. RANALLO: So from a reporting
perspective, though, the -- as the
ramifications show, going to code sepsis the
way it is being coded for Medicare, Indiana
Medicaid, other populations, from an
intensity or sickness or predicted mortality,
any of those quality measures, right, by
doing this change Kentucky Medicaid
population would be more healthy compared to
another group, correct, if you coded it the
other way, right?

DR. LIU: Yeah. I don't know,
Russ. But part of what I am hearing you say,
and this is where I think we do need to meet
for this, patients who are at risk for
becoming septic that need early intensive
management, let's make sure that there are no
documentation expectations and risk of kind
of adverse payment consequences that would
keep you from reacting.

MR. RANALLO: I'm just trying to
understand the benefit, like what -- you
know, benefits and risk --

1 DR. LIU: Oh. What I was saying --

2 MR. RANALLO: -- benefits and risk
3 of making this change from.

4 DR. LIU: Yeah.

5 MR. RANALLO: So why are we going
6 off of -- why are we making a one-off on what
7 Medicare requires in coding? What -- what --
8 does it have us reporting better? Does it
9 have us looking better on some kind of
10 statistic? What is the driver for making
11 this change, I guess, for the Medicaid
12 population.

13 DR. LIU: Yeah, yeah, yeah.
14 I think it is a recognition the previous
15 stratification of sepsis in terms of severity
16 is not actually helpful. And I think there's
17 two places especially. One is quality
18 improvement around early management and
19 outcomes. And the other is somewhat related
20 to finances, just cleaning up kind of how we
21 have to manage utilization in critical care
22 environments. I mean, that is just a, you
23 know, very fundamental. That is some of the
24 most expensive care. You need clean
25 documentation to justify that intensity and

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cost. And this recognition that sepsis is a systemic infection and organ failure makes that, I think, more plain.

I think the difficulty and where I would really like to have some of the colleagues across the community help me understand the early risk -- the early management that is at risk for progressing to sepsis is something that I have some questions around and I would like some feedback on.

MR. RANALLO: Okay. So has the Cabinet adopted this?

DR. LIU: Well, I would just say, Russ, InterQual makes that really pretty plain.

MR. RANALLO: Well, I know. But it is not coding logic. And, so, I will give you the example. Sometimes coding doesn't keep up with medical technology and techniques, right? I've got an orthoped that screams at me every time he does an arthroscopic shoulder because there's not an arthroscopic shoulder code. It is only an open code. And I have to code it as a

1 miscellaneous code. And there are not the
2 RVUs for that miscellaneous code that there
3 are for that open shoulder. And it drives
4 him bananas. Coding hasn't caught up.

5 DR. LIU: Right.

6 MR. RANALLO: And I'm forced by the
7 rules of coding not to do that.

8 So, again, it's -- I hear what you
9 are saying. But it's -- it's -- we're going
10 off of the coding piece. And it's -- and so
11 if we're adopting it -- I mean, if we're
12 adopting it -- so right now the coding
13 guidelines don't say sepsis three. They say
14 sepsis two.

15 DR. LIU: Yeah.

16 MR. RANALLO: I mean, that's just
17 the way it is. And they may catch up in the
18 future. But until they do, is this what the
19 Cabinet is adopting? Have you adopted it
20 yet, I guess, or is it still up for
21 discussion?

22 DR. LIU: Well, I would say if you
23 experience denial on the front-end related to
24 sepsis, then I think InterQual makes plain
25 that you need to go to sepsis three.

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For post-payment reviews, where a patient may not have clear evidence of organ failure, a qSOFA score of two or less, then I would recommend to you documenting the components of qSOFA and the services that you have rendered and appealing for payment, recognizing that the patient hasn't met criteria for sepsis.

And I think that that's as far as I will go. Because now I'm starting to bleed over into telling you how to administrate your coding, which I am not.

MR. RANALLO: No, I understand. But, I mean, and it is really what the MCOs will hold us to and how the IPRO is going to look at it and where we take some of these appeals. Because they are all backside appeals. They're not front-end appeals or denials. And that may make a difference of what I recommend to the MAC, too. So, I mean, that's -- you know, that's what I am trying to understand.

So what I'm trying to understand is, so I guess the question is, the MCO is allowed to apply sepsis three to their claims

1 and go off, away from what CMS coding
2 guidelines are? And if that answer is yes,
3 then I think the TAC needs to talk about
4 whether we want to make a recommendation to
5 the MAC. If it is no, and we are still open
6 for discussion, then I think we have more
7 discussion. But I think -- and I don't know
8 the plain answer to it. Does that make
9 sense, what I am trying to get to?

10 DR. LIU: Yes. Russ, I will just
11 repeat a recommendation I have made to the
12 Commissioner --

13 MR. RANALLO: Okay.

14 DR. LIU: -- which is, InterQual
15 makes plain English of sepsis based on the
16 Third International Classification.

17 MR. RANALLO: Okay. I appreciate
18 that. Thank you.

19 So from the TAC, the TAC member
20 side, you have heard all of this. You guys
21 are familiar with this issue, I'm sure.

22 Is there anybody who wants to make
23 a recommendation to the MAC out of this, in
24 particular on this issue?

25 TAC MEMBER: I'd like to talk to my

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internal folks more about it before, if I could.

MR. RANALLO: Okay.

DR. LIU: Let me just reiterate. I really am interested in meeting.

MR. RANALLO: We are, too. I mean, I think the dialogue would be important.

DR. LIU: Yeah.

MR. RANALLO: And it is good to have, absolutely. So we are, too. And I know one other hospital, I believe St. Elizabeth, is one that asked to meet. And I don't know if there are others that I missed, but I know there were at least two.

MR. HERDE: It would probably make sense to have a meeting before you make a full recommendation to the MAC.

MR. RANALLO: I agree, I agree.

MR. HERDE: Let this meeting occur. I think everybody clearly understands the issue. And that is, we're being asked to do something, you know, that's not in synch with the rest of the industry and the requirements. I think and what I have heard from the hospitals, quite honestly, is

1 everybody kind of agrees, it is eventually
2 going to get there but it is not there. And
3 when it does get there, at least in theory
4 CMS will adjust DRG's reimbursement
5 accordingly, too. But they are going to have
6 these more intensive patients that used to be
7 sepsis three down to the lower DRG but with a
8 higher amount in the future. They will make
9 those adjustments when that happens. But it
10 hasn't happened yet. So...

11 And the question is, you know, in
12 certain respects, why do we need to be on the
13 forefront of all of that when, again, coding
14 guidelines says this is how it is done
15 nationally.

16 But I think you have a
17 conversation, Russ. I would suggest that you
18 just hold off --

19 MR. RANALLO: Yeah, I would agree.
20 We have other TAC members that want to do
21 that too.

22 MR. HERDE: -- and allow more
23 discussion.

24 MR. RANALLO: I want to have our
25 discussion.

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COMMISSIONER STECKEL: So who is going to coordinate the Hospital Association medical director participation with Dr. Liu?

MR. RANALLO: KHA will.

MR. HERDE: Yeah, we can do that. We have a couple of requests. We were actually waiting for today's meeting to kind of see where it went. So...

MR. RANALLO: All right.

COMMISSIONER STECKEL: So, Dr. Liu, you two need to get together.

MR. HERDE: We will connect up.

DR. LIU: If you will e-mail me directly or call me. And Nina knows how to get ahold of me and Nancy, too.

MR. HERDE: Yeah. Nancy would be here. Nancy's son is in the hospital. He has kidney stones and some other complications. But she is coordinating.

MR. RANALLO: And, Dr. Liu, thank you for coming. I appreciate you being here and talking to us about it. I really do. I know you are busy, and I know it is time and I know you are busy. But I appreciate you attending the TAC.

1 DR. LIU: Well, Russ, the new thing
2 is, InterQual I think only recently adopted
3 these things. So the last we spoke, I hadn't
4 clarified that. So I'm glad to bring that
5 back to you.

6 MR. RANALLO: Yeah. It is a good
7 piece of information I need to go back and
8 talk to my folks about, too.

9 COMMISSIONER STECKEL: And not to
10 beat a poor little animal of any kind. But
11 this is the exact kind of discussions we
12 should be having in this meeting. So...

13 MR. RANALLO: Okay.

14 DR. LIU: Would you like me to stay
15 or?

16 COMMISSIONER STECKEL: If you would
17 like.

18 MR. RANALLO: If you want, you are
19 more than welcome. But if you have things to
20 do, you can -- you are more than welcome to
21 excuse yourself.

22 MR. HERDE: Do you want him to wait
23 here for number six?

24 MR. RANALLO: The
25 pre-authorizations. So this is the one the

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UM staff we had at the last meeting where we were talking about surgery happens and we get pre-authorization for a surgery and during the surgery a change is made to the CPT code. So the CPT code that gets coded is not authorized.

So an example that I am familiar with recently is we had a patient that came into the ED and had a lithotripsy, kidney stones, and we pre-authorized a code. The patient was taken and they did the lithotripsy. But it came out as coded as a different lithotripsy code, so lithotripsy still, and it was denied. And we have 24 hours to update that code. It's impossible to update in 24 hours, I will just tell you. We had four or five utilization review directors here the last time. They all told you it is impossible. We don't have people that real-time code, right?

So you have got a discharge summary. That patient goes and sits in recovery, right, for how long. You have got a discharge summary that's ten hours after that surgery. Then that patient's

1 discharged. That goes into a queue. I don't
2 have coders that are on the day of, right? I
3 can't afford it, cannot afford it. So to
4 have it coded within 24 hours never happened.
5 So to have it coded within 24 hours and
6 recognize it was a different code and have a
7 call back to the MCO that says, "Hey, we
8 authorized this, it is something different,"
9 is virtually -- it is impossible. It just
10 can't be done in any hospital that I know.

11 COMMISSIONER STECKEL: So let me
12 ask this. And I should not do this, but I
13 will.

14 MR. RANALLO: Sure.

15 COMMISSIONER STECKEL: Is there a
16 reason why 24 hours?

17 MS. BATES: No. So what I was
18 going to say was, we will go back, Dr. Liu,
19 if you will get with your medical directors
20 and ask the MCOs to extend the amount of time
21 that's available to hospitals --

22 DR. LIU: Sure.

23 MS. BATES: -- to go back and
24 adjust that prior authorization.

25 MR. RANALLO: And my --

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MS. BATES: Right? Does that sound reasonable?

MR. RANALLO: And I appreciate that.

COMMISSIONER STECKEL: So, here, let me finish my thought --

MR. RANALLO: Sure.

COMMISSIONER STECKEL: -- because I will forget it.

MR. RANALLO: Sure.

MS. BATES: Me too.

COMMISSIONER STECKEL: So for the MCOs that are here, to me, the way I look at it, and somebody speak up if I'm wrong, but whether it is 24 hours or 72 hours or a week later, if it's a wrong CPT code you are going to be able to recoup that money and that effort anyway. And if it's right and the procedure notes and the discharge notes, everything lines up, that it is, in fact, a correct CPT code. So I don't see there being any benefit or loss to either Medicaid or to the MCOs for extending that time frame. Does anybody disagree with that?

(No response)

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COMMISSIONER STECKEL: Okay.

MR. RANALLO: And my point -- I appreciate that.

COMMISSIONER STECKEL: Sure.

MR. RANALLO: My point has always been, we've authorized a procedure, like a lithotripsy. The patient had a lithotripsy. And just because it was a difference of a number on the CPT code it wasn't a material difference of what was done for the patient.

COMMISSIONER STECKEL: Sure, sure. No. That makes perfect sense to me.

MR. RANALLO: Thank you. I appreciate that.

COMMISSIONER STECKEL: Okay. So, Dr. Liu, you are going to get with the MCO medical directors and make the timeline longer.

DR. LIU: I absolutely will. And I just wanted to make sure I get some sort of --

MS. BATES: Yeah. I will send something.

DR. LIU: -- statement of the issues so that I don't have to interpret

1 something messy --

2 MR. RANALLO: Yes, sir.

3 DR. LIU: -- that I generate myself.

4 I'm glad to do that.

5 COMMISSIONER STECKEL: And then

6 what would be helpful --

7 MR. RANALLO: Yes, ma'am.

8 COMMISSIONER STECKEL: -- is within

9 reason --

10 MR. RANALLO: Okay.

11 COMMISSIONER STECKEL: -- what do

12 the coders think is a reasonable time frame.

13 MR. RANALLO: My folks have told me

14 seven days.

15 MS. BATES: And that's where I was

16 going to go with it.

17 MR. RANALLO: We looked at it --

18 COMMISSIONER STECKEL: Excellent.

19 MR. RANALLO: We looked at it --

20 COMMISSIONER STECKEL: Hug it out.

21 Hug it out.

22 MR. RANALLO: Yeah.

23 COMMISSIONER STECKEL: Perfect.

24 Excellent. Whew. I don't mean to be flip.

25 MR. RANALLO: No. That was great.

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COMMISSIONER STECKEL: I am excited we are making progress. So...

MR. RANALLO: Yes, ma'am. Okay. The DSH process for the CMS decision. So CMS decided to back off their FAQs prior to, like, June of '17. And so I guess how that applies to Kentucky and does it apply to all hospitals and when and whether you filed an appeal or not filed an appeal. I don't know if we have any clarification yet on how that is going to work or...

MR. BECHTEL: Steve Bechtel --

MR. RANALLO: Hi, Steve.

MR. BECHTEL: -- for you. And I apologize. I'm going to read some of what I have written down because I don't want to miss anything.

For the 2011 through the 2015, we will be going back and filing addendums through CMS. We have already asked Myers and Stauffer to file those addendums.

MR. RANALLO: Okay.

MR. BECHTEL: They have asked to give them until at least May 15th to get all of those addendums and then to us. And then

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once we get those, we will have to review them and then forward them and file them with CMS. Once we do that and they are filed with CMS, DMS will issue revised UCC amounts to the providers that receive DSH recoupment notices for periods 2011 through '15.

MR. RANALLO: Okay.

MR. BECHTEL: So we're hoping to wrap it all up, Russ, for the 2015 prior DSH audit period. And the reason why not past that is because it is still in appeal.

So, but, for 2015 back we are going to make that adjustment. And we hope to have everything resolved. Obviously, some of the providers, some of the providers will have to pay funds back. And then once we get those, all of those funds back, we will redistribute those out accordingly.

MR. RANALLO: Okay.

MR. BECHTEL: And we're hoping, or our plan is to get it all resolved this federal fiscal year.

COMMISSIONER STECKEL: And to emphasize what Steve just said, the CMS has said they will not go back on states for the

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2011 to 2015 time period.

MR. RANALLO: Okay.

COMMISSIONER STECKEL: We are still at risk for 2015 going forward. So everyone needs to be aware of that, that if -- and we've -- we struggled with this. Because, you know, trying to guess will the Courts rule in CMS's favor or in our favor and by what percentage do we think that that will happen. And we finally decided we just can't run the program based on that type of strategy. So that's why we cut it off at 2015. But everyone should understand that there very well may be a different round of activity after the hearing is decided, after the Court decides.

MR. RANALLO: And so CMS --

MR. BECHTEL: For '16 forward.

COMMISSIONER STECKEL: Right.

MR. RANALLO: So CMS said they were not going to enforce that rule as long as the Texas thing was going to appeal, right, for things after June the '17.

COMMISSIONER STECKEL: Correct.

MR. RANALLO: But we are still

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going to do it the way we did it this last round, right?

COMMISSIONER STECKEL: Correct.

MR. HERDE: So for the fiscal years up to June, have you heard from them whether or not it is going to be, like, any claims adjudicated through June the 2nd or the fiscal years ending prior to June the 2nd versus after June the 2nd? I've been trying to find something.

MR. BECHTEL: I have not. We interpret it as using the, like, the 2015 DSH audit, is that time period. That's why we were looking at the 2015 back.

MR. HERDE: Yeah. That clearly, I think, will work.

MR. BECHTEL: We have not done anything further.

MR. HERDE: Okay.

MR. BECHTEL: I don't think I answered one of your questions. If there is an appeal on file that is not pertaining to this subject, that appeal will keep going forward. So just to let you know on that.

MR. RANALLO: Okay.

1 MR. BECHTEL: But we're thinking
2 that those appeals that are filed for this
3 reason should be resolved with this.

4 MR. HERDE: Okay. And what
5 about -- and I don't know if there are any.
6 But if there are any hospitals that did not
7 file an appeal that would be positively or
8 negatively impacted, their reports would also
9 be adjusted?

10 MR. BECHTEL: It's going to be all
11 hospitals.

12 MR. HERDE: All hospitals, okay.

13 MR. BECHTEL: We're not doing it
14 just for the ones that filed. We're doing it
15 across the board to be consistent.

16 COMMISSIONER STECKEL: There is no
17 need for them to file.

18 MR. HERDE: I got it. Okay.
19 Great.

20 MR. RANALLO: Thank you for that
21 update. Any other questions?

22 MR. BECHTEL: I knew I needed to go
23 through there, because I forgot to tell you
24 about the appeals process. Sorry.

25 MR. RANALLO: No, that's good. TAC

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members, any questions?

TAC MEMBERS: No.

MR. RANALLO: Okay. Thank you.

All right. We talked about the DSH reg.

So UPL. So, I very much appreciate all of the collaborative work with the Cabinet and the hospital folks on the UPL legislation. Just it was here, more of a do you need anything from us, is there anything you need our input on, or anything that we need to do to help you with anything.

MR. BECHTEL: I talked to Carl right before the meeting, and I'm asking for some assistance on the pre-grants. So we've already had that discussion, and we're going to need some help on that.

MR. RANALLO: Okay.

COMMISSIONER STECKEL: And your consultants will be able to do that in their sleep. Because it is -- we could use the help, just bandwidth-wise.

MR. RANALLO: Okay.

COMMISSIONER STECKEL: The other thing that we've worked with you all on is,

1 one of the things that makes Steve sweat is,
2 cash flow. And this is going to be
3 significant. Us, basically, carrying this
4 assessment until the assessment can be paid
5 can be very problematic if everyone doesn't
6 pay their assessment. So I believe that we
7 have worked with you all and actually you've
8 agreed to language that if a hospital doesn't
9 pay the assessment, then they don't get paid
10 by Medicaid for a certain period of time.

11 Now, what that does is it puts at
12 risk the entire process. Because then no
13 longer are we broad-based in our TACs. If
14 we're saying a certain hospital got away
15 with, however you want to say it, didn't pay
16 us for whatever reason, even though we're not
17 paying them, it's still that TACs no longer
18 becomes broad-based. So it really creates a
19 situation.

20 So the bottom line is, the
21 importance of every hospital making that
22 payment. And that assessment payment is
23 going to be critical not only for our cash
24 flow issues but also to maintain the
25 integrity of the assessment itself.

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PARTICIPANT: Yeah. I think it would put at risk future relationships with similar type requests.

MR. RANALLO: Okay. I got it.

PARTICIPANT: I can't emphasize that enough.

COMMISSIONER STECKEL: And we're excited to work with you all on this. It is one of those win-win situations. But we really could use your help if -- I mean, I could see scenarios from a small hospital that's in financial trouble and literally can't come up with the money. Somebody's got to figure out how to help them come up with the money. Or, you know, someone that just gets mad at KHA and, you know, damn the torpedos, they are not making the payment. Well, you all have to bring out the big guns. Because this is a slippery slope we don't want to get on. So...

MR. RANALLO: I hear you.

MR. HERDE: And we live that every year as we collect our dues from our hospital members. So most of them are really good about it. There are a few that we struggle

1 with. So we certainly understand that. And
2 so we're willing to make phone calls and
3 follow-up. And we have been emphasizing that
4 in our individual calls with our members.

5 COMMISSIONER STECKEL: Okay.
6 Perfect.

7 MR. BECHTEL: I just have a
8 question. Has KHA shared with all of the
9 hospitals what House Bill 320 is all about?

10 MR. HERDE: Yes, yes.

11 MR. RANALLO: Yes.

12 COMMISSIONER STECKEL: Yeah.

13 MR. BECHTEL: Okay. I just wanted
14 to sure that everybody...

15 MR. RANALLO: Everybody knows.

16 MR. BECHTEL: Okay.

17 MR. HERDE: Yeah. We've actually
18 set up individual calls. We've had, you
19 know, group and system calls. And...

20 MR. RANALLO: Yeah. There has been
21 multiple.

22 MR. HERDE: It's not to say
23 everybody has. But we've attempted to touch
24 everyone.

25 COMMISSIONER STECKEL: I'm

1 impressed.

2 MR. RANALLO: Many communication
3 points, yeah, very much.

4 COMMISSIONER STECKEL: That diverse
5 group together, that is impressive. So...

6 MR. HERDE: But it doesn't happen
7 without the Cabinet's support.

8 MR. RANALLO: No.

9 MR. HERDE: You know, no matter
10 what we are doing on behalf of the members,
11 it doesn't happen unless you say okay. So --

12 MR. RANALLO: We're very
13 appreciative, yes.

14 MR. HERDE: -- we are very
15 appreciative.

16 COMMISSIONER STECKEL: Yeah. We're
17 excited about it. It is a win-win. So...

18 MR. RANALLO: Yes, ma'am.

19 COMMISSIONER STECKEL: Okay.

20 MR. RANALLO: Okay. Impact of
21 Medicaid as Secondary versus Inability to get
22 a COB from Primary.

23 So as I understand this issue, we
24 have instances where Medicaid is secondary
25 and they require an EOB but we can't get an

1 EOB from the primary for whatever reason. So
2 if you have an automobile that's primary that
3 they are waiting for the PIP to be determined
4 by the patient or if you have got a primary
5 that is asking for, you know, other insurance
6 information and additional information from
7 the patient and does not turn in that
8 information and we don't get an E0 -- we
9 can't get an EOB from the primary, we're not
10 able to send it on to the secondary, is how I
11 understand it. And, so, is there anything we
12 can do in that situation? Did I frame that
13 right?

14 MR. HERDE: Yeah. That's the way
15 it was brought, was the fact that because
16 they have Medicaid second we cannot bill the
17 patient. Because typically, in the real
18 world, somebody can't get a primary to pay
19 because the patient hasn't supplied
20 information. You bill the patient and they
21 say, "Oh. I better get my information in."

22 MR. RANALLO: That's right.

23 MR. HERDE: And that creates the
24 incentive. So with Medicaid, as it was
25 brought to us, we can't bill --

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MR. RANALLO: We can't do that.

MR. HERDE: -- the patient.

Because they are covered by Medicaid as secondary.

COMMISSIONER STECKEL: Right.

MR. HERDE: And, honestly, I don't know if it is a federal law or a state law. You know, is there anything we can do to get this out of limbo, where the primary won't process the payment because the member won't do what they need to do to get it processed, including denied and sent onto somebody else.

MS. BATES: So there's two things there. One, I just want to reiterate, and it doesn't sound like this is happening with this, but if it is let me know.

The MCOs in their contract agreed that access to covered services shall never, ever be restricted due to inability to collect that coordination of benefits information. So...

So let that sink in. Because that's going to be if someone needs to go to the Ridge and Medicaid is secondary and you try to purvey off it and they say no, because

1 it is COB they can't do that. So just keep
2 -- think about that.

3 MS. EISNER: It is sinking.

4 MS. BATES: Yeah. And so there is
5 that.

6 MS. EISNER: Yeah.

7 MS. BATES: And then the other is
8 when they've already gotten the service,
9 right, and you are just trying to get the
10 money.

11 PARTICIPANT: Right.

12 MS. BATES: For fee-for-service we
13 have a process where, and I'm going to
14 completely mess this up, so I don't know
15 exactly, but there is a form or something
16 that's completed to where we actual pay for
17 that. So...

18 But we -- I don't think -- so I'm
19 -- long story short, I need to go back and
20 see if we can do that for MCOs. Because it
21 is something that's completed where the
22 provider says you verify that you tried.

23 MS. EISNER: Uh-huh.

24 MS. BATES: So, so let me take
25 that back --

1 MR. HERDE: That would be great.

2 MS. BATES: -- after they have
3 already received the service stuff back, so
4 that way we can figure that out.

5 MR. RANALLO: Okay.

6 MS. EISNER: Great. Thanks.

7 MS. BATES: Uh-huh.

8 MR. RANALLO: Okay. We talked
9 about IPRO.

10 Co-pays. So with the new co-pays
11 or with the co-pays that have come out, we've
12 gotten some reports. And I've seen some
13 Excel files where people are tracking and it
14 is not a real mismatch of responses. So you
15 have got the MCO system, you've got the
16 hospital's insurance verification system that
17 is supposed to pull the same information, and
18 then you have got the Kentucky Medicaid
19 system.

20 MS. BATES: Uh-huh.

21 MR. RANALLO: And on every --
22 I have seen examples on every MCO where the
23 co-pay has been different from the Medicaid
24 system to the MCO system, and the MCO system
25 may match the insurance verification system.

1 But it is not all cases for -- for -- and it
2 is not -- you know, it is not all cases for
3 one MCO. It is these five and not these
4 five. And it's a real variety. And so
5 people are trying to determine what the
6 co-pays are so they can collect upfront.
7 And the information is not matching between
8 the systems, and so they don't know what to
9 do. And just --

10 MS. BATES: So I have received some
11 questions from some hospitals and answered
12 those.

13 MR. RANALLO: Okay.

14 MS. BATES: But the MCOs have the
15 same code that you all have, that co-pay
16 guidance that was sent out.

17 MR. RANALLO: Uh-huh.

18 MS. BATES: They have that same
19 piece of paper to code their systems. So the
20 actual administration of co-pays should be
21 the same across the board, so I'm saying it
22 should be the same across the board.

23 MR. RANALLO: Uh-huh.

24 MS. BATES: I will tell you that I
25 added -- I made an addition that I need to

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send to you all. It is a clarification about rendering provider versus billing provider. But, anyway, I will send that out so you can see that.

So that being said, are you saying that the co-pays are being applied differently down to the service code level or are you saying that -- I'm just going to say all of the things that I have heard and you tell me. That or are you saying that the indicators with regard to co-pay yes or no, cost share met, et cetera are incorrect?

MR. RANALLO: I want to say -- I'm trying to -- I'm trying to picture that worksheet in my head. I want to say the second half of what you said, is that the indicators were different but the amounts of the co-pay were different. So it said this required a co-pay on the -- I mean, when you go in the Medicaid system it is saying no or vice versa. So it didn't match. So the MCO system said, yeah, you have got to collect a co-pay. But when you looked at the Medicaid system it said no, no co-pay was required.

MS. BATES: And we've --

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MR. RANALLO: So...

MS. BATES: Yeah. And we've looked. And everything in Kentucky Health Net is correct. So if you have an example of where an MCO is telling you something different by way of their system, we do need to know about that.

MR. RANALLO: And it was different within their insurance verification system, which is supposed to be pulling from your system too. So I think we can share that worksheet, right? Can we share that worksheet?

MR. HERDE: Yeah. I mean, I don't have it. But we could -- actually...

MR. RANALLO: Because it was pretty easy to follow.

MR. HERDE: Who prepared that?

MR. RANALLO: St. Elizabeth.

MR. HERDE: Okay. Yeah, we can do that. And we're going to have a meeting jointly with the MCOs to walk through the co-pays.

MS. BATES: And I will tell you -- and actually, David, do you want to talk

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about the screen for the MCO? Because the difference between hospitals is they don't usually -- they are using a different way to verify.

MR. GRAY: One of the things that we're doing with DXE is working on the Kentucky health screens. There is information on there that is, you know, from 2006 and it has PDF files that have not been updated. And I think there are some references from InterQual from years gone by. So if you were to depend upon those, it probably would not be timely and accurate.

MR. RANALLO: Okay.

MR. GRAY: Looking at trying to get, especially the co-pay information, upfront more in a summary type fashion. And so, you know, we're very, I think, optimistic that we will make that at least an easier interface for people to work with. So I don't know how much hospitals are using it. A lot of dentist offices and physician offices, it gets a lot of use in that world. I can't speak to hospital.

MS. BATES: Especially more of an

1 individual provider type of thing. And we
2 get that.

3 MR. GRAY: Yeah, yeah.

4 MS. BATES: But just so you know,
5 that those -- the suggestions that we hear,
6 though -- we're really bad about taking in
7 things and not spitting them back out as this
8 is what happened. And it is because we're so
9 busy. So we don't really do it on purpose.
10 We just -- you know, we take something in and
11 we fix it and then we just move on and we
12 don't tell you. So it is not for any reason
13 other than we're just so busy.

14 MR. RANALLO: Sure.

15 MS. BATES: But this is a perfect
16 example of where we've taken these
17 suggestions over time and we've listened and
18 we've changed things. And we really do try
19 to do that.

20 MR. RANALLO: Okay.

21 MR. GRAY: We have given a copy to
22 Nancy Alani [ph] to review and give input
23 from kind of the thought leaders that care
24 about these screens within the membership of
25 KHA.

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MR. RANALLO: Okay.

MR. GRAY: We've also asked the MCOs. I know they have got some thoughts about how we can make it more, you know, organized, easy to use. And, so, we're getting that input. So we're then passing all of this on to DXE that's, you know, heading that up. So that's the consultants the state uses to kind of do the background work.

MR. RANALLO: Okay. What was the addition you said that you needed to send?

COMMISSIONER STECKEL: The rendering provider.

MS. BATES: Yeah. There was a question. Because you know how the guidance says something like there's only one co-pay per day for the member provider combination but it doesn't take into account that some provider types in the Medicaid world only use the billing like versus rendering. So, anyway, I asked that question. So that way I could put it on there and that way I would stop getting e-mails asking the question.

MR. RANALLO: Awesome. Okay.

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Thank you.

MS. BATES: Uh-huh.

MR. RANALLO: All right.

Old business. Medical necessity criteria.

MS. BATES: Hold on a second. I'm sorry. I forgot to write down to send you the co-pay criteria.

MR. RANALLO: Okay.

MS. BATES: What is the question?

COMMISSIONER STECKEL: Is there written or verbal updates.

MS. BATES: Yes. And I have that that I sent to the KHA with regard to -- right? Didn't I send you all the medical necessity NCD, whatever they are?

MR. HERDE: Yes. Uh-huh.

MS. BATES: So...

MR. HERDE: It is part of that e-mail.

MR. RANALLO: Okay.

MS. BATES: But that one was kind of an MCO specific one. So I'm drafting, and just haven't yet had a chance to yet, drafting one that is more formal for everybody. That way, it doesn't have that

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MCO in the stuff. So I will send that over to you. It is just a matter of me drafting it.

MR. RANALLO: Okay.

MS. BATES: Okay.

MR. RANALLO: Credentialing status update.

COMMISSIONER STECKEL: Carl, unfortunately, had a death in the family.

MR. RANALLO: Okay.

COMMISSIONER STECKEL: So he's not able to be here. But we are moving forward on the credentialing and enrollment using the provider portal. I think everyone is going to be pleased with the way that is going to work out, in that we're moving the enrollment component up to the front part of it, the top part of it, so that someone would complete the Medicaid enrollment process. And we can start working on that. And then after that there will be a choice that they make, whether it is KHA or whether it is our contracted credentialing component. But that is fast moving toward an RFP and will be hitting the street soon.

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MR. RANALLO: Okay.

COMMISSIONER STECKEL: A lot of good input on that. And I think that the Cabinet has come together in a really neat way. And we're hoping to maintain that provider portal, make it more efficient, and have this as part of that also. So...

MR. RANALLO: Okay. Thank you. Waiver update.

MS. BATES: The update is that there's not really an update right now. We are fast approaching 4/1, and that's what we're working toward. And there's a lot of stuff going on behind the scenes right now to get all the systems ready. And it goes without saying that we're doing everything we can to wait until the very last possible minute to do some of the things. So that way -- because it is all of these things are very expensive. But there is no new update. I'm sure you have all heard, I don't know if I said it formally in here, but, you know, one of the things that we've done is we're waiving the premium for the first month, and that's so that way we don't mail out a bunch

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of invoices and there be confusion.

Community engagement is delayed to July 1.

MR. RANALLO: And July 1, that goes into effect for all counties on July 1?

MS. BATES: No. That has not been decided yet. Trust me, I would tell you if there was something. But that's all still being talked about.

MR. RANALLO: Okay.

MR. GRAY: It is somewhere between 1 and 120 --

MR. RANALLO: Yeah, okay.

MR. GRAY: -- that will go into effect on July 1.

MR. RANALLO: Okay. Thank you. The NDC update.

COMMISSIONER STECKEL: Right. We have a new pharmacy director. I should have had him come to this meeting.

MS. BATES: I know. I didn't even think about it.

COMMISSIONER STECKEL: Me neither. But Justin Joseph, he is a PharmD, MBA, and he is getting his master's in data analytics.

So what I have said is, for all of

1 my senior staff, but if anybody tries to
2 poach him I'm going to make your lives
3 miserable. But we are very, very --
4 admitting that I poached him from data
5 analytics. So...

6 But we're very, very lucky to have
7 him. He's an amazing young man. What I have
8 committed to, Russ, is for the two of you to
9 get together on this 340(b).

10 MR. RANALLO: Sure.

11 COMMISSIONER STECKEL: I know that
12 he and David Oyler, who is another pharmacist
13 from the University of Kentucky that is
14 helping us out, have started talking about
15 the 340(b) issue and the contracted
16 pharmacies. We have some issues with 340(b).

17 But what I would like to do is to
18 have them meet with you and whoever else you
19 would like to meet with and really get a good
20 grasp around what are the issues, what do we
21 need to do; you know, anytime that we can
22 save money, we want to do that. But we also
23 have to be careful because it affects the
24 rebates, it affects what CMS may or may not
25 claw back from us.

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MR. RANALLO: Absolutely.

COMMISSIONER STECKEL: So if that's acceptable to the TAC, I would like to have them meet with you guys and talk about this issue.

MR. RANALLO: I think that's acceptable to me. And then I've got a, like I said, a big accordion file the last time we went through this. And I will reach out to him.

COMMISSIONER STECKEL: Okay.

MR. RANALLO: And then anybody that wants to join me can.

MS. BATES: And you will be happy to know that he's very fresh and he's not jaded.

MS. HUGHES: Yet.

MR. GRAY: I will echo it, Carol, he is outstanding.

MR. RANALLO: Great.

MR. GRAY: We've talked about the fact that you have a lot of work to get done in the next year while we have him, you know.

MS. BATES: And he will listen. He does not have any preconceived...

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MR. RANALLO: Great.

MS. BATES: He is open to it all.

MR. RANALLO: Awesome.

I appreciate that. All right. I will have that meeting.

COMMISSIONER STECKEL: He and Mike Scholte, with our data analytic unit at the Cabinet, are responsible for the SB 5 report that we published last week and put out. It's on our website. If you all have not seen it yet, I would encourage you to look at it. I'm very, very proud of the work they did and the data that we were able to pull. It is the first of many steps. We have eight recommendations, and we're looking to implement those recommendations over the next year.

But then, also, looking at how we collect more fine data. I know that's not a data term. But there are some data points that we now know exist. And, so, we want to get ahold of that. So...

MR. RANALLO: Awesome.

COMMISSIONER STECKEL: More to come on that.

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MR. RANALLO: Great. Thank you.
OPRA edits. This is asking for an update on
being able to see the taxonomy, the providers
in the system.

COMMISSIONER STECKEL: Yes.

MS. BATES: And that will be all
part of the provider portal and all of that.

COMMISSIONER STECKEL: Yes.

MR. RANALLO: Okay.

COMMISSIONER STECKEL: And we are
working on that.

MR. RANALLO: Working on the
provider portal?

COMMISSIONER STECKEL: Yes.

MR. RANALLO: Okay. And then the
LCD, I apologize. This is the one that is
450 days plus, not the other one. I
apologize. I had them backwards. See.
I'm sorry. I'm sorry, Stephanie.

But so the LCD, I got the feedback
on the LCD and the NCD. I get it, right? I
agree that they should be applied. But the
issue that we had, particularly on the KHA
log that was over a year old, was that it was
a different state, so it was a different

1 locality for an LCD and it hadn't been
2 expired. And so, you know, I've made the
3 comment if I've got to be held accountable to
4 LCDs across the country at any given time,
5 whether they are active or retired, I am
6 going to have to hire a lot of people.

7 MS. BATES: Right.

8 MR. RANALLO: So I guess that was
9 the question. So I don't disagree that we
10 should -- you know, the application of NCDs
11 and LCDs that are applicable in Kentucky that
12 are active I don't have any problem with.
13 But the one issue we're getting denials on is
14 something outside of that.

15 MS. BATES: Yeah. And it was my
16 understanding that that particular one, tell
17 me if I'm wrong, that they've looked at that
18 issue and apparently there was not a Kentucky
19 specific LCD on that one.

20 MR. RANALLO: There was one?

21 MS. BATES: There was not one, is
22 what they were saying.

23 MR. RANALLO: Right.

24 MS. BATES: I'm just repeating
25 what -- they said there was not one and

1 they've gone back and talked with -- were you
2 the provider?

3 MR. RANALLO: I'm one of them,
4 yeah.

5 MS. BATES: But, anyway, it is my
6 understanding that that was resolved. So is
7 it not resolved? And that was right around
8 the time I sent that e-mail. Check and
9 see --

10 MR. RANALLO: I don't believe it
11 is. But...

12 MS. BATES: -- because they thought
13 that it was.

14 COMMISSIONER STECKEL: Who is
15 "they"?

16 MS. BATES: Medicaid.

17 MR. RANALLO: So I may have it
18 confused.

19 MS. BATES: That's okay.

20 MR. RANALLO: But the case I
21 thought I got back was -- from the MCO was
22 that they said we can apply NCDs and LCDs and
23 they were not going to resolve it.

24 MS. BATES: Look and see.

25 MR. RANALLO: I need to clarify.

1 MS. BATES: Yeah, clarify that.

2 COMMISSIONER STECKEL: He will get
3 it resolved in time.

4 MR. RANALLO: I will clarify it.

5 MS. BATES: They were not in the
6 middle of it, though.

7 COMMISSIONER STECKEL: Well, who
8 is --

9 MS. BATES: They have it.

10 MR. RANALLO: We will clarify
11 whether it has been resolved or not, that's
12 all.

13 MS. BATES: Yeah. And I will
14 circle back around, too. But, yeah, that was
15 my understanding.

16 MR. RANALLO: Okay. Any other item
17 from your side that you want to talk about?

18 COMMISSIONER STECKEL: Not that I
19 can think of. We talked about SB 5. We
20 talked about the 1115 waiver.

21 MS. BATES: I love that you skipped
22 number 11.

23 MS. HUGHES: I was going to mention
24 that.

25 MR. RANALLO: Did I skip number 11?

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COMMISSIONER STECKEL: I was going to say.

MR. RANALLO: Oh. The RFP status. I did skip it.

COMMISSIONER STECKEL: So the RFP, Stephanie and Angie have been working 24/7 almost on -- with our consultants Myers and Stauffer on the new RFP and the new contract that will be coming out soon. I promised myself I would never do what CMS does to me and say "soon." But that, unfortunately, is the appropriate thing.

I think I have said to this committee, if not I will repeat it, but we're looking to make the contract more enforceable, with more teeth to it, that when they don't do something that we think they should be doing in the contract that it's not just a slap on the wrist. But in addition to that, we are also looking to move to outcomes measurements instead of widget counting.

MR. RANALLO: Okay.

COMMISSIONER STECKEL: So the fact that we know that everybody had a hemoglobin A₁C test, okay. So what does that mean for

1 their feet, their eyes, their kidneys,
2 you know, all of the things that would
3 indicate true outcomes measures. So we're
4 looking to do that.

5 The third major thing that I am
6 interested in, and that we are putting in, is
7 that we stop the 100 quality measure RIFO
8 shots and that we look at -- now, they are
9 going to have to still do the HEDIS measures
10 and all of that for certification. But what
11 we're looking to do in our statewide quality
12 plan and across the program, not just MCOs,
13 but how do we pick out three to five quality
14 measures that we believe that if we focus on
15 it, so hypertension, obesity, COPD, that if
16 we focus on it and we create incentives
17 around those three to five measures for the
18 next three years that we can actually,
19 in fact, move the needle on it. So we're
20 working on that also.

21 What else did I leave out?

22 MS. BATES: Foster care.

23 COMMISSIONER STECKEL: Oh. Foster.
24 Go ahead.

25 MS. BATES: We're going to have one

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MCO for foster care.

MS. EISNER: That's great.

MS. BATES: And we have vetted that with CMS to make sure it is okay. DMS as the guardian wants that. And so I think that that will do -- it will improve things leaps and bounds for those children that need it and it will be a good part of this transformation.

MS. EISNER: When will that selection become effective?

MS. BATES: July 1 of 2020.

MS. EISNER: July 1 of what?

MS. BATES: 2020.

MR. GRAY: 2020 for foster care.

MS. EISNER: Can it at all be faster?

MS. BATES: No. I'm sorry. I wish.

MS. EISNER: It is going to make a big difference.

MS. BATES: But it will, just knowing that we're going that way.

MS. EISNER: Yeah.

MR. RANALLO: That has been

1 announced for a while, has it not?

2 MS. BATES: Yeah.

3 COMMISSIONER STECKEL: Yeah, yeah.

4 And Georgia is one of the states that we've
5 been learning from. But they did this with
6 their last, I guess two years ago, contracts
7 with the MCOs and have had great success.
8 So we're looking forward to having equally
9 good success. So...

10 I think that -- have I left
11 anything out?

12 TAC MEMBER: So did I hear you say
13 it is -- the plan is to have new MCO
14 contracts in place 7/1/20?

15 MS. BATES: That will be -- the
16 contracts that are awarded out of the RFP
17 will be for a start date of July 1, 2020.

18 MR. HERDE: 7/1, okay.

19 MR. RANALLO: Okay. Do the TAC
20 members have anything else?

21 (No response)

22 MR. RANALLO: Meeting dates. So
23 the next meeting date is April 23rd. And is
24 there anybody we can ask about the video
25 technology in case people can't be here?

1 COMMISSIONER STECKEL: Yeah.
2 Sharley can.
3 MS. HUGHES: We're still waiting on
4 the results, to get the Attorney General's
5 opinion.
6 MR. RANALLO: Well, do we have any
7 technology available that meets the current
8 requirements?
9 MS. HUGHES: That I don't know.
10 I will have to find out.
11 MR. RANALLO: Because that would be
12 helpful, especially if we're going to
13 discontinue the phones and if somebody can't
14 be here.
15 COMMISSIONER STECKEL: So let us
16 look into it.
17 MR. RANALLO: Okay.
18 COMMISSIONER STECKEL: And we will
19 get back with you on that.
20 MR. RANALLO: That would be great.
21 COMMISSIONER STECKEL: So...
22 MR. RANALLO: That would be great.
23 COMMISSIONER STECKEL: I mean, I'm
24 looking at that (indicating) and seeing a
25 camera and all of that. So...

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MR. RANALLO: That is exactly what I am doing. There is one over there (indicating), too. And there you have it. We have a couple here. So an ability to do that would be great.

COMMISSIONER STECKEL: Yeah.

MR. RANALLO: Awesome. So anything else?

(No response)

MR. RANALLO: All right. Well, thank you, everybody, for their time. Thank you for attending. I appreciate it. Thank you so much.

COMMISSIONER STECKEL: Thank you.

MR. RANALLO: And have a good day.
(Proceedings concluded at 2:39 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 Professor Reporter, hereby certify that the foregoing record represents the original record of the proceedings of the Hospital Technical Advisory Committee; 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 11th day of March, 2019.

 /s/ Lisa Colston

Lisa Colston, FCRR, RPR