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

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Via Videoconference
February 27, 2024
Commencing at 1:02 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Russ Ranallo, Chair

Lori Ritchey-Baldwin

Elaine Younce

Michele Lawless

Chris McClurg (not present)

P R O C E E D I N G S

MS. BICKERS: It looks like the waiting room is cleared, so if all the TAC members would like to turn on their camera so we can see if we have a quorum. I believe I saw one other member trickling in, and I can't find them on the list currently.

CHAIRMAN RANALLO: We've got Elaine -- I know we've got me, Elaine, and Lori. And that would be three out of the five.

MS. BICKERS: Lori, are you a new TAC member? I don't have you on my list.

CHAIRMAN RANALLO: Yeah. Lori was appointed a couple of meetings ago.

MS. BICKERS: Can you tell me who she replaced? My apologies. I didn't -- I didn't get an email on that.

CHAIRMAN RANALLO: Teresa Fite, I believe.

MS. RITCHEY-BALDWIN: Who did you say, Russ?

CHAIRMAN RANALLO: Oh, you may have replaced Steve Oglesby.

MS. RITCHEY-BALDWIN: I think

that's who I replaced.

MS. BICKERS: Okay. Thank you. I will get my list updated. Welcome, Lori. I apologize. I --

MS. RITCHEY-BALDWIN: Oh, no worries.

CHAIRMAN RANALLO: We've got a couple -- we've got several new ones, Erin.

MS. BICKERS: Oh.

CHAIRMAN RANALLO: Michele Lawless is on the TAC.

MS. BICKERS: I do have Michele.

CHAIRMAN RANALLO: Do you have Chris McClurg?

MS. BICKERS: Yes. I just -- I didn't have Lori. I think she's the only one I didn't have, so I apologize. I will update my information and the website.

CHAIRMAN RANALLO: Okay. Great. Thank you.

MS. BICKERS: And the waiting room is cleared, Russ, if you would like to go ahead, and I'll hand it over to you.

CHAIRMAN RANALLO: Thank you so much. So we have a quorum. Welcome. I'm

Russ Ranallo, the CFO at Owensboro Health and the chair of the TAC.

Lori and Elaine, you want to introduce yourselves?

MS. RITCHEY-BALDWIN: Sure. I am Lori Ritchey-Baldwin, and I'm the CFO for Saint Elizabeth Healthcare.

MS. YOUNCE: And I'm Elaine Younce. I'm the chief of payer administration at the University of Kentucky Healthcare.

CHAIRMAN RANALLO: Okay. And we don't have Chris or Michele, do we?

(No response.)

CHAIRMAN RANALLO: Okay. I need approval of the minutes of the previous meeting. They were -- they were sent out.

Any TAC members have any changes or edits?

MS. RITCHEY-BALDWIN: I don't. I'll make a motion.

CHAIRMAN RANALLO: Okay.

MS. YOUNCE: And I'll second it.

CHAIRMAN RANALLO: All right. All those in favor?

(Aye.)

CHAIRMAN RANALLO: Okay. Old business. Sepsis workgroup update. I think I could probably give this. We have a subgroup to talk about the sepsis movement from Sepsis 2 to Sepsis 3 that occurs next January, January of '25.

We met in January with the Cabinet to discuss, and we discussed multiple items and questions. And the Cabinet was going to come back and answer some of those questions and give us some additional information.

Our February meeting was cancelled due to some conflicts, so I believe we -- we've got one on the calendar for March. So we'll continue, then, on and report out that to the group.

Anybody from the Cabinet on the HRIP, the 2022 quality overview or a review results?

MS. PARKER: Yes, I am. Good afternoon. I am Angie Parker. I'm the Director of Quality and Population Health, and I have a few little slides to go over the Hospital Rate Improvement Program, also known as HRIP.

CHAIRMAN RANALLO: Thank you.

MS. PARKER: You're going to have to excuse me. I'm hoping what you're seeing is the presentation.

Okay. So I am going to address the quality aspect of the Hospital Rate Improvement Program.

MS. HOFFMANN: Angie, do you have a presentation up? Because I'm seeing your Excel.

MS. PARKER: Yes. I do have a presentation up.

MS. HOFFMANN: Double-checking, just double-checking.

MS. PARKER: Let me stop sharing that, and I'll be --

MS. RITCHEY-BALDWIN: There was a presentation up initially but then it flipped to the Excel.

MS. PARKER: Well, that was -- that's the HRIP measures for 2025, actually --

CHAIRMAN RANALLO: Yep.

MS. PARKER: -- that you saw in Excel. Okay. Now, can you see the

presentation?

MS. RITCHEY-BALDWIN: Yes.

MS. PARKER: Very good. Okay. So the Hospital Rate Improvement Program that most of you should be -- or are familiar with started in, I think, 2019 and then it got changed in 2021.

And we have been working on this directed -- what is basically a directed payment program that allows Medicaid to provide enhanced payments to providers, and it's based on quality and based on the utilization and delivery of services to -- and it's to advance at least one goal of Medicaid's quality strategy.

It's evaluated at the end of each program year. Unfortunately, we have to do this every year, and we have to submit it to CMS for approval annually. And this HRIP is funded through a hospital assessment, and it's per this specific statute.

The HRIP program is designed to achieve two main objectives, and that's, one, to improve quality outcomes and to maintain access to services.

And for whatever reason, that's not it. Okay. Can you still see where it says "2022 HRIP program"?

CHAIRMAN RANALLO: Yes.

MS. PARKER: All right. So we -- as I said earlier, we -- Medicaid and the quality department and our finance department, we work with Kentucky Hospital Association on determining what quality indicators or what quality measures we need to focus on each year in order to improve the quality of care.

In 2022, 84 percent of the hospitals achieved at least 4 of the 5 hospital-specific goals. And in 2022, 50 percent of the hospitals achieved all 5 hospital-specific goals.

So what are those measures and goals? And so here are the data metrics for calendar 2022. And if you'll notice, there's a lot of asterisks by the top four of these, and that's because it provides who is included or excluded in these particular metrics.

So CAUTI being the catheter-assisted urinary tract infection. That's what --

everybody in the hospital knows it as CAUTI. And then you have C. difficile, which is a gastroenterol- -- gastro issue. It can be obtained either via contact from person to person or for overuse of antibiotics.

Hospital readmissions, and that's a 30-day all cause. Sepsis screening and triage and bundle compliance.

So the psychiatric specific measures, we have those listed there and the safe use of opioids which -- for 2022 to determine provider education; rehab specific measure, which is discharge to community; and social determinants of health.

This is a list of all of those quality measures that we just saw and what the benchmark was for 2022 and what -- each individual hospital goal. As you can see, with a lot of these measures that -- in 2022, we were establishing benchmarks. And there were some activities that were to be done in that time period in order to help establish a benchmark.

And for the results. As you can see, the 30-day readmission goals for A and B and

could do a little bit better in that area. Also, this CAUTI standard infection ratio and the CAUTI low volume rehab, or LTAC facilities need to improve on those areas significantly.

Also, for -- continued on with these, the C. diff standard infection rate ratio could use some work as well as the -- for rehab, or LTAC. And the others that are benchmark years for metrics are looking pretty good as far as those that are applicable, for those facilities that are applicable.

So that's it, really a high level regarding the HRIP and the quality aspects of the program for 2022. I just wanted to show you this page which is on the Medicaid website that shows where -- the Medicaid managed care quality strategy and how it -- where it is located and how the HRIP also has -- is to connect with the Medicaid managed care quality strategy.

And we also have other quality reports not -- we don't have a specific HRIP on there now, but that may be something we will be

looking at in the near future.

CHAIRMAN RANALLO: Can you send that -- can you have -- send that link to Erin, so she can send it out to us?

MS. PARKER: I'm sorry, Russ. I can't hear you.

CHAIRMAN RANALLO: Can you send that link to Erin, so she can send it out to the TAC?

MS. PARKER: Absolutely.

CHAIRMAN RANALLO: That would be great.

MS. PARKER: And she'll be giving you this presentation as well.

CHAIRMAN RANALLO: The presentation. Oh, that's awesome. That's great.

Was there anybody that -- did we have any hospitals that didn't chase the goals at all? Do you know?

MS. PARKER: That did not?

CHAIRMAN RANALLO: That got zero goals, like did not -- either didn't report or didn't make an effort?

MS. PARKER: Well, I'd have to go

back and look. I don't -- to see whether or not that is -- was addressed in the report that I have.

I might have something on that, and if you want to go on to the -- if there's any other questions that I may or may not be able to answer, I can go look on a report and come back to that after you go through the agenda.

CHAIRMAN RANALLO: Okay. That's fine. I --

MS. RITCHEY-BALDWIN: Yeah. I have a question.

MS. PARKER: Sure.

CHAIRMAN RANALLO: Go ahead.

MS. RITCHEY-BALDWIN: Well, I have a question sort of related to Russ' question. If there are hospitals that, you know, got zero or maybe got one so it looks like maybe they weren't chasing some of that, I guess, the question is: What can we do as a hospital association to follow up with those groups in order to help them improve to get more than that?

CHAIRMAN RANALLO: Yeah. I think --

MS. PARKER: Well, I do know the KHA works with each of the hospitals that provide -- need data in order to help identify where there are issues and help with education and a lot of different things that they -- they are there for the hospitals to help in their quality initiatives.

MS. RITCHEY-BALDWIN: Thank you.

CHAIRMAN RANALLO: So is the hospital association aware of each individual hospital's results?

MS. PARKER: Yes.

CHAIRMAN RANALLO: Okay.

MS. PARKER: KHA obtains all the data, and we have a vendor in which we work with, Myers and Stauffer, who helps put all of that into an Excel spreadsheet and how all of that -- who's meeting and who's meeting and who determined the amount they get, amount of money they get, and it is looked at.

As I said, you know, we look at this at least annually and to see whether or not there are any changes that need to be made for the upcoming year. And we are already

working on 2025.

CHAIRMAN RANALLO: So, Lori, maybe that's a question we have for Deb Campbell; right?

MS. RITCHEY-BALDWIN: Yeah.

CHAIRMAN RANALLO: To ask her that. I mean -- and the point is, you know, the withhold is now 10 percent on both inpatient and outpatient. Because '22 was, I think, a 5 percent on just the inpatient; right? So it's a lot. It's grown a --

MS. RITCHEY-BALDWIN: Yep.

CHAIRMAN RANALLO: The amount of dollars has grown a lot.

MS. PARKER: Any other questions?

CHAIRMAN RANALLO: No. Angie, good seeing you. Thank you for -- so much for presenting.

MS. PARKER: Not a problem, and I'll see if there was -- I'll look back to see if I can find out whether or not any -- no hospitals met. And I'll get -- let you know if I'm able to find out during this meeting. If not, I'll let Erin pass that information on.

CHAIRMAN RANALLO: Okay.

All right. Moving on to new business. And I'll look to my -- I think Michele Lawless is here, Erin, as well. I saw her join the call.

Going into new business, some of the TAC members to help with some of these questions or issues that have come up through the membership.

The NDC issue, there's multiple -- and I realize that as we go through these, there may be -- there may be bring-backs after we've gone through what -- looked at some of the questions or concerns are.

On the NDCs, I think we have multiple hospitals reporting that they are -- they are getting denials for compound drugs for no NDC where there is no NDC number. From multiple MCOs that -- they've tried to resolve and cannot get any traction on. So the first item under NDCs.

I think the second item is, is that there's concerns that there's no uniform source of truth on NDCs. Apparently, as I understand it, there are multiple NDC tables,

and DMS has shared the DMS source of truth but did not mandate that the MCOs use the same source of truth. And we are seeing hospitals report a good volume of denials because the MCOs are using a different list or compendium of NDCs for their particular plan than has been published with -- from DMS.

And so the concern is, is that if there's not one source of truth and, you know, NDCs are based on vendors, on package size, on dosages, a lot of different things, that, you know, it's -- it is an administrative burden of multiple -- you know, maintaining multiple NDCs and having actually to purchase from multiple vendors or different -- to be able to get paid for drugs from the MCOs. It's -- there are concerns there.

So I think the question is: Should there be a source of truth or one NDC list to be used?

And then you have -- you have a variation in how some of these things are being administered by the MCOs. You've got

Revenue Code 250, which is a -- which is a drug revenue code but not a specific drug revenue code, and those are being treated differently by the MCOs. You're getting denials from some and not in others.

Anybody else from the TAC? Did I miss anything that you know of or have heard of in the hospital calls?

MS. RITCHEY-BALDWIN: I don't have anything else to add. I think you covered that.

MS. YOUNCE: I agree.

CHAIRMAN RANALLO: And I don't know if we have anybody from the Cabinet that can talk about it or we need to table it to bring back to the next TAC in April.

MS. BICKERS: Russ, that may be something we need to bring in our pharmacy group on. I'm not -- I'm not positive, but I will put that on the follow-up in case there's no one that can speak on it today.

CHAIRMAN RANALLO: Yeah. That would be wonderful. That's what I probably figured. But that would be wonderful, if we could invite the pharmacy folks to the next

meeting, see if someone from that group can attend.

MR. BECHTEL: This is Steve Bechtel, chief financial officer in Medicaid. Russ, it may be good if we have a couple examples so that we can do the research on our end as well.

CHAIRMAN RANALLO: 100 percent. I understand, Steve. We can get you those.

Okay. Thank you. Go to the next one. SB20 issues. I think there -- these are the appeals. I know there's a backlog that still exists, and I know we're trying to get through those. I know the Cabinet is doing the best that they can.

I think -- I'd like to see if we can get an aging inventory of the SB20 appeals and see if we can get that for the next meeting to kind of see how -- how many cases and how old they are so that we can discuss potentially a -- what the plan is to clear the backlog.

Anybody else from the TAC? Anything additional on that? I think that's my ask, if we can get an aging inventory report,

number of cases, how old they are by age and category.

(No response.)

CHAIRMAN RANALLO: Anyone on the Cabinet side want to chime in?

MR. BECHTEL: Well, I'm trying to understand where this is, Erin. Do we know who?

MS. BICKERS: Steve, I believe that would be under Edith's group. I believe she is the director over -- and Stephanie Hodges is the branch manager, so I have it on my follow-up list.

MR. BECHTEL: Okay.

MS. BICKERS: I don't see Stephanie --

MS. SLONE: I'm on here. I was looking to see if --

MS. BICKERS: Oh, thanks, Edith.

MS. SLONE: -- Stephanie -- I was looking to see if Stephanie was on the call. I'm sure we can pull some kind of report. I made a note for her to have it ready for the next meeting.

CHAIRMAN RANALLO: Okay.

Thank you.

The next item is retro authorizations. We're still getting numerous reports on inconsistent treatment from the MCOs -- across the MCOs on retro authorizations. We're seeing denials for lack of authorizations on retro assigned members, which isn't possible to achieve, and we're seeing MCOs uphold the appeals for those denials. And we've got questions from the member hospitals on a path to obtain payment for those.

Specifically, I've heard it in the behavioral health inpatient claims being denied for lack of prior authorization. I don't know if that's due to behavioral health being a different group than the medical side on some of the MCOs or not.

MS. BICKERS: Is there anyone from any of the MCOs that would like to speak on that?

MS. CARSON: Yes. This is Melissa Carson from Humana Healthy Horizons. We are aware of some of the concerns that the hospitals have brought forward, and they've

been escalated. And our policy is currently being reviewed by our senior leaders, and we'll provide an update once we have some additional information to share.

CHAIRMAN RANALLO: We'll be able to have that at the next meeting, Melissa?

MS. CARSON: Yes. Yes, we should. We should be able to provide information then.

CHAIRMAN RANALLO: Okay.

MS. CARSON: Thank you.

CHAIRMAN RANALLO: From the TAC members, are there others that you want to talk about there?

MS. RITCHEY-BALDWIN: I don't have any.

CHAIRMAN RANALLO: Okay. All right.

MR. BECHTEL: Are these just -- are you just seeing this in the managed care arena and not the fee-for-service, or are these retro enrollment people that are -- you know, they have 90 days to come back on, and it's retroed back to the date that they drop off, Russ. What are we talking about here,

just --

CHAIRMAN RANALLO: To my -- so they're retro -- yeah. They're retro assigned members. It's somebody that -- it's a date that's retro assigned. You know, they come into a hospital, and they're -- they don't have Medicaid and then they get retro assigned back to the day that they came into the hospital. And then there's -- we're being asked for an authorization and then getting denied for an authorization. I don't believe it's the indemnity side. I believe it's all MCO side.

MR. BECHTEL: Okay.

CHAIRMAN RANALLO: And I'll ask -- I'll make sure that we've got -- if there are other MCOs, we'll have examples, but we'll also ask them to bring the policies to the next meeting as well.

MR. BECHTEL: Yeah. It's always easier for us to do our research on our end if we have specific examples to kind of look into.

CHAIRMAN RANALLO: Yep.

MS. BICKERS: And --

MS. RITCHEY-BALDWIN: And I have a question on --

MS. BICKERS: Oh, good ahead. Lori. I'm sorry.

MS. RITCHEY-BALDWIN: No. Go ahead. Go ahead.

MS. BICKERS: I was just going to mention, I can send you guys the MCO dispute form. That department put together a very nice, laid-out form that might make putting some of your examples a little easier together. They've got a nice Excel sheet and everything, so I will email that to the TAC again after this meeting.

CHAIRMAN RANALLO: Thank you.

MS. RITCHEY-BALDWIN: My question isn't on retro authorizations, but it's more around pre-auths related to this whole Change Healthcare issue, so maybe we can get through these and talk about that as other items.

CHAIRMAN RANALLO: Sure. We sure can. Okay. I'm writing it down.

Next item, the MCO vendor requests. I think this is an issue that -- for MCOs that specifically use Optum. I think the -- as I

understand it, the hospitals have to go through PACEMAN and then they call Optum. They don't have a place to send the medical records and then they receive a denial. But they can't act on it immediately because they have to wait for Optum, in some cases, two plus weeks to send a barcode which identifies where records need to be sent.

But it sounds like it's a pretty awful process, from what we've been reporting on. They reach out -- when these hospitals have reached out to the MCOs, the MCOs have just told them to go work with the vendor.

And so, I guess, the question is: At what point, you know, with a frustration with a vendor that you can't get an issue worked out, that we have to address it, and what can we do from the TAC to address it?

MR. IRBY: Hey. This is Greg from UHC. This is the first that I'm hearing about this particular issue, so it may have just been outside of my radar. I would love to get more information about what this process looks like, if possible.

CHAIRMAN RANALLO: Okay.

MR. IRBY: I'd like to pass that along to some of my counterparts in the Optum organization. So I can put my email address in the chat, and if I could get just some quick bullets around, here's what the process looks like today. Here's the roadblocks that we experience. That would be really helpful to me.

CHAIRMAN RANALLO: And I don't know that it's with UHC in particular, surprisingly enough. I understand it's WellCare.

MR. IRBY: Okay.

MR. OWEN: And I was going to say, yeah, this is -- sorry, Russ. This is Stuart Owen with WellCare. This is the first time hearing it, too. I know we use Optum. I'll put my email in the chat. Just to kind of echo what Greg said, if you could put a description, you know, and we'll outreach Optum because I was not aware of this. But I'll put my email in the chat.

CHAIRMAN RANALLO: Okay. We can absolutely do that.

MR. IRBY: And, Stuart, I'll tell

you. You and I collaborate on different initiatives. If there's anything that I can do to help you to connect to the right people, let me know.

MR. OWEN: Thank you, Greg. Appreciate it.

MR. IRBY: For sure.

CHAIRMAN RANALLO: And as I understand, the process, as they've described it to me, just seems backward. And so I think it's just getting through it and seeing what we can do.

MS. PRESUTTO: Hey, Russ, this is Christine Presutto from Saint Elizabeth. I'm new to this format. I didn't know -- can I add some context to that conversation for you?

CHAIRMAN RANALLO: 100 percent, Christine.

MS. PRESUTTO: Sure. Okay. Some of the issues that we're having with this is that -- the way that the vendor manages the request for records. So with the MCO, let's say WellCare, is one that we have a high volume for, is that we will get a denial

issued with a CARC code requesting medical records.

So that goes to our team and then they are thinking that WellCare actually is wanting the records and then they're doing an upload and providing that to WellCare through their portal. Then through correspondence, which could be received a couple of weeks later, we would get a letter from Optum stating that the records actually need to go to their vendor, Optum.

So then now we've had this situation where we've already released the records once to WellCare thinking that's the initial request, but then now we actually need to go to Optum and submit it through their portal.

And we can't -- from the information in the CARC codes -- so in the denial information, we're unable to just act directly and go to Optum because Optum's site requires that there's a barcode that we have to put in in order to complete that submission.

So it's a burden for the provider in the aspect that we are then being issued a denial

for which we cannot act on for at least a couple of weeks until we determine if it's WellCare or Optum that needs the records. So that's one issue. The other --

MR. OWEN: Okay. Thank you. I appreciate that.

MS. PRESUTTO: The other issue that we have is whenever there is a disagreement with the outcome of an Optum review, there seems to be some discrepancy on who we're managing that with. So, you know, the plan will say, direct that to the vendor, and the vendor will redirect us back to the payer. And then the provider is stuck in the middle of that, with getting resolution on their claim.

MR. OWEN: And I --

CHAIRMAN RANALLO: Christine, is that a specific MCO issue, or is that multiple MCOs with that second item?

MS. PRESUTTO: The biggest -- the two MCOs that we have the biggest issue with with this particular issue is Passport and WellCare.

MR. OWEN: Does the letter -- so

you're getting a letter -- right? -- with some kind of whatever, decision, termination, or ruling. Does it not say send -- you know, if you want to appeal or whatever, send to wherever?

MS. PRESUTTO: It does, but it doesn't always give the full description of what the issue is.

MR. OWEN: Oh, of the actual rationale, I guess?

MS. PRESUTTO: That's correct.

MR. OWEN: Okay.

MS. PRESUTTO: So I think the recommendation that we've made through the KHA calls is that if an MCO is working through a vendor to secure records, then why would they not just issue the CARC code, allow us to upload it through the payer's portal, and then they can be responsible for forwarding that on to their vendor versus making that the administrative burden of the provider and causing duplicate work?

MR. OWEN: Okay. Yeah. I'd appreciate anything in writing from anybody to help research and investigate on the

WellCare side.

MS. RITCHEY-BALDWIN: So, Stuart, is the process that Christine described, kind of drafting that up and sending that directly to you, is that kind of what you're looking for?

MR. OWEN: Yes. Please. That would be wonderful. I've got my email in the chat. That would be wonderful, just some bullets.

MR. BECHTEL: And if you could copy Erin Bickers so that we have it for the TAC at the department level, so that we know -- know the -- you know, don't exclude us, you know, here at the department. We'd like to be a part of that.

CHAIRMAN RANALLO: 100 percent.

MS. RITCHEY-BALDWIN: And is there someone from Passport on that we could also send that to?

MS. BASHAM: Yes. I will -- this is Nicole. I will put my information in the chat. We've been working on this issue for a while. And, again, the process works as it is currently intended. But what we've

attempted to do is to see what we can do to enhance it so that there's not any duplicates, and it's really clear on where you're going and who you're going to. So, again, I'll put my -- drop my stuff -- my name in the chat.

CHAIRMAN RANALLO: Any other discussion on this one?

(No response.)

CHAIRMAN RANALLO: Okay. Thank you, everybody.

Next item, emergency department policies. So I think the MCOs -- we've had multiple reports on ER downcoding based on policies that the MCOs have adopted, so visit level downcoding from -- and based on policies that, I think, DMS has approved for the MCOs.

I think some of the questions that I've heard -- or what I've heard is, is that these denials or these downcodings, which are denials, are coming through remits of the MCOs. So the code is being downgraded and processed through a remit. There's not necessarily denial letters that are being

generated.

So when we talk about a denial, you know, a need to appeal or a desire to appeal, you have to know the rationale about why it is; right? So if it's going from a Level 4 to a Level 3 or a Level 3 to a Level 2, there should be some clinical rationale and reasoning that comes back to the provider in a letter. And I don't -- as I understand it, that's not happening.

It's -- from what I can understand, it is going through a program, an ED optimizer that is -- by a vendor for these MCOs, and it's generating a downcode. The problem with that is, is I'm not hearing any results of it generating upcodes. So if it's only looking at it one way, I have a problem with that.

The second thing is that I know folks that have this same tool on their own side. When they submit the claim, they're getting downcoded even though they're using the same tool. So knowing how the tool is working, what it -- or the rationale is for it to downcode, you can't -- you know, how it's set up is important in all this. Rather than

just something that may be arbitrary or wrong potentially coming through on a remit.

Anybody else from the hospital side or the TAC on what I'm saying? Am I misspeaking or missing something?

MS. RITCHEY-BALDWIN: Not from me.

CHAIRMAN RANALLO: So I guess my request is from the Cabinet side, you know, if it's a denial, there should be letters that are generated, and it has the clinical rationale or the rationale of the denial. Not to say that, you know, this level is a Level 3, and it should be a Level 2. Or this was billed as a Level 4, and it should be a Level 3. It has to have a reason.

And I don't think the hospitals are getting that at all. And if you're going to -- and I've had reports of having four figures, over 1,000 of these cases for at least one hospital.

MR. BUTTERBAUGH: Russ, this is Tom --

CHAIRMAN RANALLO: It's real easy to put in and program a system -- some program to apply some criteria that, from my

viewpoint, can be manipulated. Because otherwise, it would be the same when you submitted a bill versus the same on the review, and what that clinical criteria is and what the rationale and reason it is.

MR. BUTTERBAUGH: Russ, this is Tom with Baptist. And if I may, just very, very briefly. You know, our experience is, to Russ' remark, these are automated downcodes. They're not the result of a medical records review.

And when they come across, from what I've being told from our staff, there's not even the notation in really the remit that's noting any appeal rights or what you do if you're going to contest it on any kind of basis. It's just an automated, blind reduction in the coding and the reimbursement.

MS. YOUNCE: Yeah. Russ, I would agree with Tom in those regards. And, you know, we've had several lately, so I know exactly what you're referencing.

MS. BICKERS: If that could also -- sorry. This is Erin. If that could also be

something you could send us some examples, we can send over to policy and also the MCOs and have them do a little research into that and bring that back to the April meeting.

CHAIRMAN RANALLO: We can.

MR. BECHTEL: So -- and this is Steve again. I'm sorry. I wasn't sharing my camera earlier, I don't think, but I am now.

Here's my concern or my question. Is it predominantly under one MCO, or is it across the board of all MCOs that you're --

CHAIRMAN RANALLO: It's more than one.

MR. BECHTEL: Okay. My concern on --

CHAIRMAN RANALLO: Every one of them has a policy.

MR. BECHTEL: Yeah. I think --

CHAIRMAN RANALLO: Every one of them has a policy and how they're applying that policy. And, again, what we're getting back -- I know we're not getting back the denial letters.

So, Steve, you can't just say, you know, because -- you can't just deny it without us

knowing why you're denying it. I can't appeal something when --

MR. BECHTEL: Right.

CHAIRMAN RANALLO: -- I have no idea what the reason is.

MR. BECHTEL: Well, it sounded like to me it's not a denial. Well --

CHAIRMAN RANALLO: It is.

MR. BECHTEL: Well, in terms of getting a denial letter, you know. But you may want to get some type of notification and some information as to why it got downcoded and got reimbursed at a lower level. Is that what I'm hearing?

CHAIRMAN RANALLO: Well, yeah. So on a DRG; right? When they do a -- when a MCO does a medical record review on the DRG and they say we don't think it's this DRG, we think it's this DRG. I get a clinical rationale. I get a reasoning behind -- and the expectation is I get a reasoning behind of why they want to change a diagnosis code, or they want to change the assignment of a DRG.

And then I can look at that, look at my

coding. I have the ability to either appeal it, accept it, make a determination of: Do I want to fight it or not fight it; right?

MR. BECHTEL: Uh-huh.

CHAIRMAN RANALLO: So if I have somebody that comes in and they've got chest pain or they have some kind of procedure or they've got whatever, and we've, again, coded it as a Level 3 and the MCO comes back and says, through a remit and an automated computer system that has nobody looking at a medical record, nobody doing any clinical rationale, no, we're going to make it a 2. But there's no reason; right? They haven't given us the reason.

And, again, I've got -- I know folks that have this exact system; right? This Optum EDI analyzer. And then they're sending in the ED visit, and they're getting denied by an Optum EDI analyzer on the other side. They're getting downcoded on an Optum analyzer on the other side that's reviewing it.

So you can program the analyzer to do what you want it to do and make it as strict

or -- it appears to be, make it as strict or lenient as you want based on the criteria that you're putting in. So there's not a standard; right? What's the standard? What are you looking at? What's the rationale on why you're putting it at a lower code?

And if you're looking at these things, you should be looking to upcode them as well? You should say this was a 3; it should have been a 4. But I'm not getting one of these that say -- anybody is looking at it saying it was more intense than what we coded it.

So I've got a lot of questions behind what the criteria is in the tool, why you're -- why all these things -- why all these things are occurring. What's the reason for all these?

Because if I get one in a remit, I've got nothing to -- nothing to -- how do I respond to it? You've moved it from a 4 code to a 3 code for a reason. What's the reason? So that I can dispute it, I can argue it, I can take it through appeals. And it's no different than a DRG change.

MR. BECHTEL: Okay.

CHAIRMAN RANALLO: Still paying me. They still want to pay me. They just want to pay me less for what I've billed.

And we had this with the DRGs; right? When we first started doing all these DRG reviews, we were getting these things saying no, we're changing it, and there was no rationale. We brought it back here. The Cabinet said, you've got to have a rationale and a reason so that the provider has at least the ability to evaluate whether or not they want to appeal it.

MR. BECHTEL: Okay.

MR. BUTTERBAUGH: Russ, if I may. Steve, traditionally -- this is Tom Butterbaugh with Baptist, by the way. Traditionally, in those instances where a payer was going to deny or when a payer was not going to remit or do a downcode, it's been the position of the Department that they had to provide an explanation with enough specificity for the provider to be able to do something about it. And these are instances where not only is there not specificity, it's automated. It just happens.

CHAIRMAN RANALLO: So no one is looking at a medical record. They've got some kind of algorithm where you program the machine to do it this way. If you've got this code and this diagnosis, downcode it; right? There is no looking at the notes. There's no looking at the documentation.

MR. BECHTEL: Okay. So --

CHAIRMAN RANALLO: And if we're going -- I mean, if we're going to be transparent about what that -- what's in that system and how that system works and what codes are there, I mean, that's another thing. But nobody has been transparent about that.

MR. BECHTEL: So the MCOs who are on the call, do you all have anything to add to this or maybe take this back and come back with the parameters and why we would downcode it and everything? I understand the issue at hand is they just want to know why, you know, it sounds like, why it's being reduced.

CHAIRMAN RANALLO: Well, if we want to choose to appeal it, we have the ability to do that. And, again, I mean, I would ask

for a formal letter so that I know the time frame. I know when the letter gets done. I know that somebody has looked at it, all that kind of thing. It's just a real easy thing to put in an automated computer system and put whatever parameters you want in there to not pay what I think they should be paying.

MR. IRBY: Yeah. This is Greg from UHC. I'm really curious to see instances. I think without seeing some specific examples of that happening within our population, it's hard for me to tackle. But if you have them, I'd love to see them.

To the best of my knowledge, when we're downcoding things like the DRG payments, that is coming with a letter. There's appeal rights. And so this situation, I would think, is similar. So I would think that you have every right to appeal that and know why it's denied. So I'll make sure that that's the case on our side, but I would love to see examples if you have them.

CHAIRMAN RANALLO: We'll get examples for the MCOs.

MR. IRBY: Thank you.

MR. OWEN: This is Stuart again with WellCare, and I'll -- I'll check with staff here about that, especially with the letter not giving rationale.

CHAIRMAN RANALLO: I know -- I believe, Stuart, that -- my understanding is WellCare is doing it through the remit.

MR. OWEN: Yeah, we are. We're using Optum.

CHAIRMAN RANALLO: All right. I appreciate that.

MR. BECHTEL: Is there any other MCOs on other than those two that can --

MS. BASHAM: Passport is on, but we don't have this in place right now.

MR. BECHTEL: Okay.

MR. ELLIS: Humana is on. We do have this in place, and we would also be interested in some examples.

MS. GEORGE: Anthem is on as well, and we would love to see some examples. Thank you.

MS. MARSTON: Hey, Steve. It's JoAnn with Aetna Better Health of Kentucky. I'm not aware of the process. So if you have

some examples, I'm happy to put my email in the chat to get those over to us.

MR. BECHTEL: Perfect. So, Russ, I guess we'll have to take this -- or table this and get some examples and do some research and put it on old business next time.

CHAIRMAN RANALLO: Okay. Got it.

Then incarceration issues. I know we've talked about this before. I think the general consensus is that we know the MCOs have gotten better at this and are working with the hospitals, I think.

I think we're seeing it occur more and more in fee-for-service, not knowing whether -- the process to recoup a claim because of incarceration. The patient is released from jail. I mean, are we -- who makes the eligibility updating?

I know we're just having a lot more noise reported through the hospitals on, you know, claims where, you know, the -- it says it's incarcerated, but we either have gotten a letter or we know that the patient has been released.

From the hospital side, I know I'm not doing a great job, you know, relaying this. Does anybody want to speak up?

MS. PRESUTTO: Yes. That will be me. This is Christine from Saint Elizabeth. I think part of the issue is -- well, you are correct in that the MCOs are working and collaborating with the hospitals to work through a solution for these. It seems now the issue is more with the jails directly, getting the information updated and them taking accountability for claims that they should be paying.

So I think that's some of the oversight that we're asking for assistance on, is: Who oversees the jails and their accountability in the workflow? And when they're not following what we understand to be the process, who is accountable to doing that outreach and helping us get that resolution?

MS. LAWLESS: And this is Michele with Med Center. We have the same issue in exactly the way Saint Elizabeth described and interested in knowing who can help us.

MS. HODGE: This is Billie with

Baptist. I would love an answer on who is responsible for observation accounts over 24 hours, especially state inmates. State inmates --

CHAIRMAN RANALLO: Incarcerated --

MS. HODGE: -- in the county jail. Uh-huh. It's a state inmate in a county jail, and the observation status goes over 24 hours.

CHAIRMAN RANALLO: So why is observation status, just for my own education, the trigger?

MS. HODGE: Well, if it goes to inpatient -- if it's an inpatient, then Kentucky fee-for-service picks up. If it's an outpatient, it typically goes back to the jail itself. But these are county jails with a state inmate, and they're not going to pay. They said they don't get reimbursed for it.

Particularly, the Jailer Mike in Hopkins County, he quoted some provision or something, but he never did email it to me.

MS. BICKERS: Billie, this is Erin with Medicaid. Do you mind to drop that exact question in the chat -- I was trying to

gather it all -- so I can try to get you an answer.

MS. HODGE: Absolutely.

MS. BICKERS: Thank you.

MS. HOFFMANN: Erin, this is Leslie. We might have to reach out to DOC, Department of Corrections, and see how that flow is working, if it's less than 24 hours.

MS. BICKERS: I was going to send it to you for guidance, so thank you for that.

MS. HOFFMANN: Yes, ma'am.

MR. BECHTEL: Yeah. I was going to --

CHAIRMAN RANALLO: That 24 hours -- go ahead.

MR. BECHTEL: I was going to make the comment that Medicaid, we reimburse once they become an inpatient stay. That's when Medicaid reimburses for incarcerated individuals.

Now, the issue is -- that you're describing sounds like, for your county jails, I think that's more of a discussion with Department of Corrections, maybe. But I

will say we have had issues with -- in the past and still do today in getting that incarceration date updated in the system by Department of Corrections.

MS. HODGE: Oh, yes. We're well aware -- yeah. We know those things are getting worked on, but this just seems to be an answer no one can give us. And no one wants to pay, of course.

MR. BECHTEL: We -- it's not that we don't want to pay. CMS won't allow us to pay.

MS. HODGE: Well, yeah. Yes. I get -- yeah. Everybody has their rules. I get that, yeah.

MR. BECHTEL: Right, right. So I think -- I think Leslie is right. I think we're going to have to reach out to Department of Corrections and see what's going on from their end. On the Medicaid side, if you have an inpatient stay, then yes, we would reimburse at that time.

MS. HODGE: Exactly. And this particular patient that I'm having issues with, Anthem had paid. That Anthem inmate

had paid, but Hopkins County sent something saying, oh, no, you shouldn't have paid. So Anthem took their money back. Because -- yes, it's a very frustrating one, to say the least.

MR. BECHTEL: Yeah. That would be a good example to send to us.

MS. HODGE: I absolutely will.

CHAIRMAN RANALLO: Who did Hopkins County say should pay?

MS. HODGE: He said it's a black hole. He's made the president of the Baptist down there aware of this black hole years ago, and he would send me documentation showing where he can't because he can't get reimbursed so that I could put it together with all the other documentation I have. But I didn't get --

CHAIRMAN RANALLO: So what I'm hearing you say is outpatient -- state inmates in a county jail for outpatient services, there's no -- there's no payment source.

MS. HODGE: Not if they go over 24 hours, no.

MS. PRESUTTO: It's like they're interpreting an observation stay, since it's greater than 24 hours, as inpatient.

CHAIRMAN RANALLO: Gotcha.

MS. PRESUTTO: But that's not the status of the account. It's still truly an outpatient service, but I think they're looking at the -- it seems like they're looking at the start and end time of service versus just the overall bill type, so to speak.

CHAIRMAN RANALLO: Got it.

MR. BECHTEL: So I think that's them identifying or, I guess, defining staying in an ER over 24 hours as it being inpatient, which that's not -- not the case.

MS. PRESUTTO: Right. That seems to be the issue, and I don't know if that's defined anywhere. What is their point of reference for making that determination?

MR. BECHTEL: Yeah. I'm not sure. Okay.

CHAIRMAN RANALLO: Any other comments?

(No response.)

CHAIRMAN RANALLO: Thank you, everybody.

Hey, Lori, general discussion. Change Healthcare.

MS. RITCHEY-BALDWIN: Yeah. So I'm sure everyone is aware of the Change Healthcare issues, and I think we have five questions. And we've sent out some of those questions, and we're getting some answers trickling back in. But, you know, what part of the MCOs' operations are impacted by the Change Healthcare? Is it pharmacy, inpatient, outpatient?

We're having some challenges with pre-certs. So if that's impacted -- if it is impacted and they're going to be delayed or they can't take place, will the need for a pre-cert until it's -- it is -- the issue is resolved be eliminated? How will payments be impacted? How will remits be impacted?

Those are all the questions that we have. Lots of questions. I can put them in the chat, but we'd like to understand how that's going to impact us.

CHAIRMAN RANALLO: If you could

send those to Erin. That way, then she can get them out --

MS. RITCHEY-BALDWIN: Sure.

CHAIRMAN RANALLO: -- to the MCOs, that would be great. And then, I guess -- from the MCOs that are on the phone, you know, can you share anything that you're aware of, that the Change Healthcare issue has had with your organizations?

MR. OWEN: This is Stuart Owen with WellCare. We've -- of course, it's very tight messaging. We want to be uniform. And we have updated DMS and the Department of Insurance with impact, and I would not want to say anything contrary to that. So I don't know. I mean, we have shared with them. I don't want to, you know, say anything else here. I know this is being recorded as well, so I don't want to start improv.

CHAIRMAN RANALLO: I guess, Steve, do you know of any operational impacts that we need -- that we can be aware of that's been reported to DMS?

MR. OWEN: Yeah. I mean, we've shared that with DMS and DOI. I'm not

comfortable right now saying that any -- you know, elsewhere.

CHAIRMAN RANALLO: I meant -- yeah. I meant Steve Bechtel. Sorry.

MR. BECHTEL: Yeah. I'm not aware of that, though, Russ. I'm sorry. I haven't -- it hadn't come across my desk. I'll put it that way. I can't say that it hasn't been for sure, but it just hasn't come to my desk for me to understand or to be, you know, aware of it.

MS. RITCHEY-BALDWIN: Well, could the MCOs let DMS know who you sent that information to so that DMS can share that information with the hospitals?

MR. IRBY: Maybe I --

MS. PARKER: This is Angie Parker with Medicaid.

MR. IRBY: Maybe I could jump in with you. I'm sorry, Angie. I didn't mean to cut you off.

MS. PARKER: That's okay, Greg. I was just going to say we are gathering that information from all of our vendors to find out what information -- or challenges there

are because of this. We are currently gathering that information.

MS. BASHAM: Yeah. It's Nicole from Passport. It's a pretty fluid situation. We have returned some information to DMS on whether it's impacted -- I'm not aware that it's impacted any of our clinical areas or any ability to get a pre-cert. But we will investigate that just to make sure and then we will keep DMS updated with the information for the particular areas that it may, in fact, be impacting.

MR. ELLIS: Yeah. And this is Humana.

MR. IRBY: I think I can get --

MR. ELLIS: Sorry, Greg.

MR. IRBY: No. It's okay. Herb, if you don't mind, I will jump in because I've got --

MR. ELLIS: Yes.

MR. IRBY: -- to drop at 2:00. So I'm getting a lot of information around the Change Healthcare situation, lot of things coming to me. So I can speak from -- just for our organization, Kentucky Medicaid, I

can tell you that the things that are impacted is the receipt of claims. And so a lot of our providers use Change as a clearinghouse, and so that flow has decreased. So the flow of claims into our organization for adjudication has decreased. Nothing else within our operational stack is impacted at this time.

So what I will tell you is that we are continuing to have conversations with DMS. I think every MCO is going to be impacted differently because there's different functionalities that Change provides for different MCOs.

I would say that it's also very dependent on which providers use Change for services. And so with Change being an entity that services a broad scale of organizations, the impacts are going to be very diverse depending on the organization that you ask.

So what I think is probably the best approach on this is all the MCOs to collectively send information in to DMS and for that to be consolidated there. That way, the associations can be made aware through

DMS.

MS. RITCHEY-BALDWIN: That would be very helpful. Because, ultimately, I'm just trying to figure out what we do with these patients because if -- if we can't get a pre-cert or pre-auth and then we're not going to get paid -- you know, that's the challenge that the hospitals are having to deal with. And ultimately, we want to do what's right for the patient.

MR. IRBY: For sure.

MS. BASHAM: Well, and just to confirm, in case any of that is Passport -- just like Greg has said, for Passport, it seems to be the biggest impact is inbound claims. And we have published two alternatives, at least in the short term, to get those claims in to us, but I'm not aware that it's impacting any ability to get pre-cert. We don't have those services through Change so...

MR. ELLIS: And Humana is in the same boat as Passport. We don't do Change Healthcare for the pre-certs.

I will say for the Department, I do

know, just because of the background in dealing with CMS over the many, many, many years, CMS uses Change Healthcare for crossover claims. So you just might want to be aware that claims processed on the fee-for-service side by Medicare a lot of times are being transferred over to the MCOs via Change Healthcare.

MR. BECHTEL: So when I said that it hadn't come across my -- we do not directly use Change Healthcare for anything on the Department's side. Now, our vendors, obviously Managed Care Organizations, probably our PBM and some for -- some sort of Change but -- or I think that there's another UM, I think, uses it some.

But we do not directly use it, so I just want to make sure I clarify what I said earlier. Nothing has come across my desk that we directly use. However, our contracted parties probably do and are impacted.

And it seems like it's mostly the prior authorizations that -- it's not like we're getting issues -- I won't say -- Rick

Washabaugh is our CIO, and I've talked with him about this. And he doesn't think that we've been -- as a breach, but it's more of a denial of items, is what we're experiencing.

MS. RITCHEY-BALDWIN: That's the issue.

MR. BECHTEL: Okay.

MR. LAMOREAUX: Yeah. This is Leon from Anthem. So Elevance Health Systems are not impacted as a result of this event. We did communicate on Sunday to all of our providers just the reassurance of being able to submit through the Availity system.

There is one very small program that we do contract through. It's a perinatal program, educational program that 174 Anthem Kentucky Medicaid members are a part of, one of the subsidiaries called Warm Health program that is part of the Change Health. But there was no interaction between that system and our system as a result.

So we would just reaffirm the submission of claims through the Availity system as has always been done.

MS. RITCHEY-BALDWIN: Great.

Thank you.

CHAIRMAN RANALLO: Lori, I think if you --

MR. ELLIS: Humana also uses --

CHAIRMAN RANALLO: -- send those questions so that we can get those answered. And then if any hospital is having pre-cert or authorization issues that they can't get due to a system issue or systems being turned off, I think, if they can report it either to the TAC or to the KHA so that we can get it addressed.

MS. RITCHEY-BALDWIN: And, Erin, I sent you that email.

MS. BICKERS: I've received it. Thank you.

MS. YOUNCE: Lori, I'll just say, at UK, we were able to start sending through our authorizations through the normal courses of business yesterday, if that helps.

MS. RITCHEY-BALDWIN: Great.

MR. BECHTEL: Through Change Healthcare, Elaine?

MS. YOUNCE: No. Through Optum.

MR. BECHTEL: Through Optum. Okay.

So that was going to be my next question, Lori, and to all the other hospitals. Do you all have other options of clearinghouses, or is it just the one that you have?

MS. RITCHEY-BALDWIN: It depends on whether it's pharmacy, PB, or HB. Some we have backups. Others we don't. The challenge with that is we've certainly reached out to backups but so are hundreds of other healthcare systems.

MR. BECHTEL: Yeah.

MS. RITCHEY-BALDWIN: And so implementing that quickly is -- has not been successful yet, but we're working on it.

MR. BECHTEL: Yeah. We understand.

MS. YOUNCE: As are we.

MR. BECHTEL: We understand how quickly systematic changes in things happen. It doesn't happen overnight or a flip of a switch. It takes a while, so I can --

MS. RITCHEY-BALDWIN: Yep.

MR. BECHTEL: I can relate to that. I was just curious if y'all had something that you -- in the meantime, is there a workaround, is my concern --

MS. RITCHEY-BALDWIN: Well, we have --

MR. BECHTEL: -- for submitting claims?

MS. RITCHEY-BALDWIN: Yeah. I mean, we have downtime procedures. Like, pharmacy is a big impact for us because we use Change directly. So we have downtime procedures that we're working through as well as trying to get another vendor.

But some of these, you know, pre-cert, pre-auth questions, it's not us who has the relationship with the vendor. It's us who has relationship with the MCO or another payer that has the relationship with Change. So that's why we're asking --

MR. BECHTEL: Okay.

MS. RITCHEY-BALDWIN: -- for the questions answered.

MR. BECHTEL: All right. We're in that same boat with you so...

MS. RITCHEY-BALDWIN: Yeah.

MR. BECHTEL: But yes. We'll talk more about that, I guess, on the next call, Russ. Maybe we can bring that back and see

where we're at.

CHAIRMAN RANALLO: Sure will. Okay. Any other --

MS. RITCHEY-BALDWIN: Yeah. And --

CHAIRMAN RANALLO: Go ahead.

MS. RITCHEY-BALDWIN: Well, I was going to say, Steve, do you mean the next TAC call? Or will there be an opportunity to kind of send out a communication in the near term, so we know kind of what we're dealing with?

MR. BECHTEL: I would think that -- I'm going to have to lean on Erin. Erin, what's our normal process in that manner?

MS. BICKERS: Typically, when we are asking follow-up questions, I try to give the MCOs about a two-week turnaround time to give them a little information. Sometimes they'll reach out and request a little more information depending on the ask and the research involved. But I try to give them about a two-week turnaround, so we can get that back out to the TAC for review since it's just follow-up questions.

CHAIRMAN RANALLO: Well, I think --

MS. BICKERS: If you need something more in depth like data and things of that nature, we tend to give them a little more time to fulfill those requests.

CHAIRMAN RANALLO: So I think I would ask that if they have -- if there's a pre-cert and authorization issue that we know straightaway, they should know it; right? I mean, they should understand it now. The Change issue has been out there for a few days. They should be able to report back if we have a pre-cert and -- the inability to get pre-certs and authorizations. And if there are, I would ask them to tell us straightaway.

MS. RITCHEY-BALDWIN: Yeah. I think this is a very unusual item, that it would be helpful if we had information really soon to understand how to deal with that.

MS. BICKERS: Okay. I think policy is at least three days, but I can ask them to send it back to me ASAP within that three-day time frame. So that way, I stick within our contract frame and -- but still get it to you as quickly as possible.

CHAIRMAN RANALLO: That would be fine. I mean, I just don't want to -- you know, some of the other peripheral systems and those type of things is a different issue. But I think the one that Lori brought up about the pre-authorizations or pre-certifications, I think --

MS. YOUNCE: And, Lori and Russ, I know you guys probably did this as well. But as a common courtesy, we notified all of our payers of what the impact was to UK Healthcare. And I truly expected the same from them, which we've gotten from some but not from all.

MS. RITCHEY-BALDWIN: Yep. Same.

CHAIRMAN RANALLO: Okay. Thank you, Steve. Thank you, Erin. Thank you, Lori.

Any other items for discussion?

MR. BECHTEL: HRIP payment went out to the MCOs today, so you should be receiving that within the next week or so.

CHAIRMAN RANALLO: Awesome. Thank you.

MS. RITCHEY-BALDWIN: Thank you.

CHAIRMAN RANALLO: Appreciate that. Yes, sir. 100 percent.

MS. PARKER: And if you didn't see my note in the chat, all providers received at least 1 percent out of the 5 percent available for the first year of quality.

CHAIRMAN RANALLO: Oh, thank you.

MS. PARKER: They would have made -- they may not have -- as I said earlier, the percentages that were 4 out of 5 were 83 percent, and 5 out of 5 were 50 percent. I believe that was right.

MR. BECHTEL: So your answer to your question is no, there was zero hospitals that didn't meet -- everybody at least got one.

MS. PARKER: Thank you, Steve.

CHAIRMAN RANALLO: Thank you. Thank you for that update.

MAC meeting representation -- no recommendations out of this meeting. MAC meeting representation, I will be on the MAC meeting. The next meeting is April 23rd, 2024.

Erin, if we could get, you know, some of

those folks, like the pharmacy, I think, invited. Or if you need me to do that, let me know who we need to invite. I can have --

MS. BICKERS: I'm happy to reach out and make sure a representative is present.

CHAIRMAN RANALLO: Thank you. Thank you, ma'am.

All right. Being nothing else, we will adjourn this meeting. Thank you, everybody. Have a great day.

(Meeting concluded at 2:13 p.m.)

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C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 18th day of March, 2024.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR