CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
EMERGENCY MEDICAL SERVICES
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
April 24, 2023
Commencing at 2:01 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Kevin Callihan (not present)

Keith Smith (not present)

Linda Basham

Dana Evans

Troy Walker

Joe Prewitt (not present)

Jacob Carroll (not present)

MS. SHEETS: I'm going to go ahead and just welcome everyone to the meeting. Again, this is Kelli Sheets. So it's good to see everybody.

I believe -- I'm not sure. I don't think we have a quorum on. I have Troy, Dana, and Linda. Am I missing someone?

CHAIRMAN WALKER: I know Keith and -- is not going to make it and neither is Joe Prewitt.

MS. SHEETS: Okay. I don't see Jacob, and I don't see Kevin. So you do not currently have a quorum. I can break in and let you know if somebody else joins. You need one more for a quorum.

So that just means that you won't be able to vote on anything, but you can still conduct the meeting and go over -- go over the agenda. You just won't be able to vote on anything.

CHAIRMAN WALKER: Okay. That sounds good.

MS. SHEETS: All right. I'll turn it over to you. Thank you.

CHAIRMAN WALKER: All right. We're

going to go ahead with the top of the agenda here. Approve minutes from our February meeting. I guess, was the meeting minutes sent out earlier?

MS. SHEETS: I believe they've been sent out. I can check. But, again, you can't vote on them so --

CHAIRMAN WALKER: That's true. I'm sorry. I wasn't thinking.

MS. SHEETS: That's okay. No problem.

CHAIRMAN WALKER: All right. Well, let's just go right into old business. Discussion of expanding House Bill 8 and if there's any changes with that. Is there anybody that has any information -- I mean, I don't know of any expansion of House Bill 8 as of right now from the state side, if there's anybody else that's got any information for that.

MR. BECHTEL: This is Steve Bechtel, CFO for Medicaid.

CHAIRMAN WALKER: Hey, Steve.

MR. BECHTEL: I'm not so sure if it's an expansion of House Bill 8, but I know

this is what we talked about last time, was we're looking at doing, like, a cost report type of methodology to help fund some additional funds for the governmental EMTs, the emergency transportation.

So that has been -- we've been going back and forth with CMS on some methodology. It's us -- I think there's three states currently looking at this. It's Kentucky, Arkansas, and New York. And all three of us are working through PCG and Myers and Stauffer to try to get some type of program in place.

But we keep hitting a snag with CMS. They don't like some of the methodology that's being used around kind of identifying the workforce type of thing. So we -- we have since reprocessed and came up with a new idea and resubmitted it to CMS.

And CMS has asked to have a meeting with us, and I believe that meeting is next week. So I don't have anything new to share or definite, but that's where we're at on that.

CHAIRMAN WALKER: Okay. I appreciate it, Steve. Any other remarks or

anything for House Bill 8? All right.

MR. BECHTEL: So I will say the House Bill 8 is a provider tax type of funded system. This governmental -- the GMT, what I call GEMT, Governmental Emergency Medical Transportation Program, it's looking at using IGTs, intergovernmental transfer instead of the tax.

So that's why I'm a little concerned with us identifying that as an expansion of House Bill 8 because we're not expanding House Bill 8. It's a separate and continuing program, if that makes sense.

CHAIRMAN WALKER: Okay. I appreciate you, Steve. Thank you, sir.

MR. BECHTEL: All right.

CHAIRMAN WALKER: The next for old business, 4B, pre-authorization for transportation out of the hospitals. This is the priority, I know, for EMS. This was one of the main reasons in setting up a TAC committee and trying to get some improvements done.

I know that they sent out a sample PCS form. I'm guessing that hit everyone. I

guess I don't know really where to start. Was there any ideas from any of our MCOs, pros, cons, to use in the PCS in lieu of a pre-authorization process?

MR. OWEN: Hi, Troy. This is Stuart Owen with WellCare, if I may.

CHAIRMAN WALKER: Sure.

MR. OWEN: Yeah. I had asked for a form -- because we had looked, and we were having trouble finding, like, the, quote, official Medicare form. And maybe there isn't one, but that's why we'd asked. And we got one. I think it was from a law firm or something. They had, like, just a suggested template. So we were just wanting to make sure that whatever form, you know, we all use the same form.

But -- and we -- we're fine with using the Medicare PCS form, and we were looking at the Medicare -- I think it's called operational guide. And it is still PA based on the guide, but that form is submitted for the PA review.

And so is that what the TAC is looking for?

CHAIRMAN WALKER: Are you saying we'd use the form and still have to send it in as a pre-authorization?

MR. OWEN: Yeah. I mean, that's what -- or at least that's what we're looking at, the Medicare Operational Guide. That's how they -- they require that form to be provided as part of a PA process. And I can send a link, but so that's what I -- we were wanting to clarify as well, you know, mirroring basically the Medicare process, using that form but as for PA.

CHAIRMAN WALKER: The only thing we use that for is repetitive transports. The rest of it -- I don't know if you'd still consider it a PA process, though.

MR. OWEN: Okay.

CHAIRMAN WALKER: Yeah. But we don't use it for a pre-authorization unless it's a scheduled transport.

Linda, can you chime in here on that part of it, or Dana?

MR. OWEN: Yeah. Or if you could explain, like, the Medicare -- the regular Medicare process or whatever --

CHAIRMAN WALKER: Yeah. Our regular --

MR. OWEN: -- in using that form.

CHAIRMAN WALKER: I'm sorry.

MS. EVANS: Troy, I think what you're -- what you guys were suggesting, from what I read through the emails, was that you're all wanting to use the Medicare PCS form in place of getting a prior authorization. Am I correct?

CHAIRMAN WALKER: That is correct, yes.

MS. EVANS: That was the suggestion that was made, yes. And I believe the PCS form -- and I'm trying to remember. I'm sorry. It's been a bit. But the PCS form, I think, that was forwarded to everybody on the TAC committee was the one that PWW supplied. I don't think that anyone had attached anything from Medicare.

As far as there being -- and Linda may have to help me on this one. As far as there being an actual official one from Medicare, I haven't looked in a while to see if there is one. But we can -- I can certainly find out

if there is one. I know that we preferably use the one from PWW on our side.

But, again, the reason -- I think what the whole purpose here was they're wanting to use that, just attach that to the claim like we do with Medicare in place of a prior -- of calling and getting a prior authorization because it does have patient condition. It has the physician -- the overseeing physicians' information, diagnosis, signature, and that type of information on that PCS form.

MR. OWEN: Okay. So it's not a PA. It's just with the actual filing of the claim, the PCS form is attached, submitted with it.

MS. EVANS: Yes.

MR. OWEN: Okay. All right. Yeah. It would have the medical necessity information, basically.

MS. EVANS: Exactly.

MR. OWEN: Okay. Thank you. That's exactly what I was wondering.

CHAIRMAN WALKER: Okay.

MR. OWEN: And I may not be --

because I tried to find a Medicare PCS form, and I could not find one. So there may not be an official one that Medicare has, template or whatever.

MS. EVANS: There's a lot of requirements that they list out that are needed on those PCS forms, and we can certainly get those. I do have all those listed. But I'm not sure if they've actually published an actual form.

MR. OWEN: Well, if what you all sent out is the form that you -- the template you like, then that's fine. That would be fine.

DR. BRUNNER: Can this be re-sent to at least the MCOs, the template, the PCS template?

CHAIRMAN WALKER: Kelli or Erin, do y'all know if that went out to everyone? I thought it did but --

MS. SHEETS: I'm sorry. I did not hear the question. Could you repeat it, please?

DR. BRUNNER: Could the PCS, the Medicare PCS template or form be re-sent? I

don't recall --

MS. SHEETS: Yes.

DR. BRUNNER: I don't have record of receiving it. I could put my email in the chat.

MS. SHEETS: Okay. Erin will send that out.

DR. BRUNNER: Thank you.

CHAIRMAN WALKER: All right. Any other comments?

(No response.)

CHAIRMAN WALKER: Okay. I just want to harp a little bit more on this, how important this pre-authorization is and, you know, the effects. We was even contemplating an emergency order from Medicaid possibly to see if we could do something with this.

We are hearing now that we're having multiple agencies in the state of Kentucky. This summer, they're expecting to either shut down -- and this is from a meeting I got just last week, where they're going to be losing services altogether in counties but also losing counties from an advanced life support level down to basic life support.

I'm not going to say all of that is because of Medicaid and pre-authorizations, but there's multiple factors that go into it, from personnel and things like that. But I just want you to know we're at a very critical state for EMS in Kentucky, and it doesn't seem to be getting any better.

And our state meeting last week, there was a lot of data brought in and a lot of people talking. But we're in desperate need right now for EMS, and this right here is just one thing that could help some of the problems we're having with EMS and help with the pre-authorization, maybe look at something better than that. So that's -- it's a really important part for EMS Kentucky.

So is there any MCOs or anybody that just is completely against looking at using the PCS form as is for Medicare instead of using pre-authorizations?

MS. HARRISON: Hi. This is Samantha Harrison from Humana Healthy Horizons. We aren't against utilizing the form. I do want to bring up, you know,

outreach that we've performed to inquire more deeply into the problem with EMS.

When we did our claims research and review, the majority of the issues that we had causing denials was, you know, EMS providers billing codes that aren't on the fee schedule. We weren't seeing any -- you know, there was not a trend of a lot of denials as it relates to authorizations, but it's more surrounding EMS billing codes that aren't on the Kentucky Medicaid fee schedule. That's the experience from our standpoint.

But I did want to make that statement for you because we've really done a deep dive and actually reached out to providers that are in our network to educate them to the fee schedule so that if they were experiencing, you know, denials based on not billing the appropriate codes, they could, you know, resubmit those claims with the appropriate code on it.

Another piece that we want to make sure that you're aware of is even though -- if we choose to go down that road where we're accepting the PCS form, that document would

still need to have required information in order to be accepted, which I think is still similar to your challenge with going through the PA process. Am I right?

CHAIRMAN WALKER: I think the biggest challenge for the PA process is having it prior to the transport or within 48 hours. When you say code, did you mean the ICD-10 codes or the charges codes?

DR. GALLOWAY: The diagnosis codes. That is one of our barriers, is that when we get an auth request, we frequently don't get the diagnosis codes. And, I mean, correct me if I'm wrong, but when EMS picks up a patient, they get a report from the nurse or whoever, and my understanding is that they probably have the diagnosis of the patient. I'm just a little confused as to why they don't get submitted with the auth.

MS. BASHAM: They typically are not on all of the documentation. This is Linda.

DR. GALLOWAY: Yeah. I know it's not on your forms because there's no place to put it, but there is a report that the paramedic, the EMT gets before they take any

patient out of the facility.

MS. BASHAM: Well, no, not necessarily. They may hand us a sealed envelope with transfer papers, but they don't give that same information to the crews. Am I right, Troy?

CHAIRMAN WALKER: Yeah. We don't get a -- especially for an official diagnosis. There might be several things. But the big thing, do you want the actual diagnosis, or do you want the reason for them taking them by ambulance? There's a couple of different factors there. But we do not get an actual diagnosis, and we definitely don't get a diagnosis code at the time of transport.

MS. BASHAM: No. You know, they may give us a patient had a heart attack. Patient had a stroke. But that doesn't give you what you need to create medical necessity, does it? Or are you going to accept stroke, not knowing if it's a past stroke or a current stroke?

DR. GALLOWAY: Well, I think it's important. I mean, I would think the EMT

would know whether it's a current diagnosis or a past diagnosis. But, I mean, if it's a past diagnosis where they have -- they can't walk, and one side -- you know, one side of their body is nonfunctional and it prevents them, you know, from being able to walk or ride in a van chair, then I think that's pertinent information.

MS. BASHAM: It sure is, but they're not going to give us that information. They do not give us those ICD-10 codes by any stretch of the imagination.

CHAIRMAN WALKER: Yeah. We don't get anything like that at all. We know they're having a -- if they're going for a stroke, yes, like you said, that's obvious. But as far as the history of that stroke, when and where, the details like that is not something that we normally get at the time of transfer.

MS. BASHAM: Yeah. We're talking about nonemergencies.

CHAIRMAN WALKER: Yes.

MR. OWEN: Would the diagnosis be

on the PCS -- because you're basically saying after the fact, you would have the diagnosis and put it on a PCS form. Is that correct, or am I -- is that wrong?

CHAIRMAN WALKER: What's on the PCS is the reason for transfer, the reason they have to have an ambulance take them from one facility to another.

MR. OWEN: Okay.

MS. BASHAM: But it will not be -- it will not be in the form of an ICD-10.

MR. OWEN: Okay.

CHAIRMAN WALKER: And most agencies don't -- you know, we don't have access to that type of information so...

DR. GALLOWAY: So --

MS. BASHAM: You're only --

DR. GALLOWAY: I'm sorry. So you're saying regardless of whether you submit it on the back end or the front end, you're not going to be able to give us any clinical information?

CHAIRMAN WALKER: Just what's on the PCS is the reason they needed an ambulance to transport them from one to the

other. It could be, you know, cardiac services and needing cardiac monitoring. But as far as an actual diagnosis with a diagnosis ICD-10 code, that's not on there either.

MS. BASHAM: You know, and that's not something we really have control of because that's provided by the RNs or the doctors, and they typically do not -- they're not -- they don't code things with that.

CHAIRMAN WALKER: Yeah. This is not till a few days later till you'll see ICD-10 even at the hospital or ER setting so...

MS. BASHAM: You get your ICD-10 codes from your coders who work the claim and code it and set it up for billing. That's where you get your ICD-10 codes. We read what they put on there and apply the ICD-10 code.

MR. OWEN: So it would be on the claim -- the PCS form is submitted with the claim, and the claim will have the diagnosis?

MS. BASHAM: Yes.

MR. OWEN: Okay. Thank you.

CHAIRMAN WALKER: But even that's coming off the run form and not necessarily the hospital documentation.

Okay. Any more comments?

DR. RICH: I'm Dr. Rich with UnitedHealthcare. I just have a question. I am not real familiar with the PCS form at all, but what we were looking for for payment of a claim after was just a physician's statement of necessity. Is that something that you -- would be possibly included in that form? Is there a spot for that in that form that would fulfill just that simple request?

CHAIRMAN WALKER: This physician statement can be filled out by a physician but normally filled out by case management or nurses at the point of transport. You kind of broke up there. I don't know if that answered your question or not, though.

MS. BASHAM: There is a place on the form that asks if the patient meets the necessity, and that is they are not able to get up out of bed by themselves. They are not able to walk with assistance. Troy,

what's the third one? I've forgotten it.

CHAIRMAN WALKER: Medical -- and I'd have to look at it. I didn't -- I wasn't listening what you just said there. Sorry, Linda.

MS. BASHAM: That's okay. There are three things that qualify whether or not this patient can go by -- needs to go by ambulance. And when they sign this, they are asserting that the patient needs an ambulance.

CHAIRMAN WALKER: That's correct. By -- hold on just a second. I can see what the third one is.

MR. OWEN: I was going to say I'm looking at it. It says, "Can patient safely be transported by car or wheelchair van," I think, is the third question.

CHAIRMAN WALKER: Okay. Can they safely be transported? Yes. That is one of the questions.

MR. OWEN: Right.

CHAIRMAN WALKER: And the bad thing about, you know, the state of Kentucky is there is no stretcher vans, so car or

wheelchair van is the only other options. And most of the state of Kentucky, that's not something you have after-hours either, and usually the ambulance has to take them so...

Any other comments?

MR. BECHTEL: I've got a question.

CHAIRMAN WALKER: Sure, Steve.

MR. BECHTEL: We are -- the Department of Medicaid is looking and working to add treat without transport as a Medicaid reimbursement so -- reimbursable service. What kind of coding or what kind of things will you need to have in place for that? And will you all -- will the ambulances be able to do the coding necessary to show what type of service that they provided without transporting? Or is that even an issue with what we're talking about here but --

CHAIRMAN WALKER: Well, I don't think it's going to be an issue, what we're talking about here. This is hospital-to-hospital transports. But, you know, for that style, it's still going to be the run form filled out just like we was transporting a patient. There won't be any

changes there. So you should be able to pull that information from that run form, or we will, so...

MR. BECHTEL: Okay.

MS. SHEETS: Troy, Justin Dearinger has his hand raised. I think he has a comment.

MR. DEARINGER: Yeah. Hi. This is Justin Dearinger. I wanted to just say, Steve, based on what we had looked at on a treat and not transport, we've -- I think we've got those codes pretty much set in place to where there's not going to be anything extra that the EMSs will have to do differently than what they do now.

So the same way they bill now is going to be the exact same way they bill that code. We've already got those codes picked out and in place. We have amounts for those codes.

And so, basically, just even them showing up on scene and doing their evaluations and, you know, looking over the individual and making a determination on whether that individual can stay or whether they need to be transported to a hospital or

other facility, that's going to be what kind of triggers that code, just on their arrival. So everything should be in place for them to be able to have what they need for that process and scenario.

And hopefully, that will also assist with -- you know, I see new business EMS services in peril of closing. I know I spent some time talking with a couple of different county EMS providers, and one of the things that was interesting is neither of those providers billed for any of the times they didn't transport, which was close to 50 percent, if not more, of the calls that they actually go on on these two different counties that I looked at.

So a lot of the calls they were getting, they didn't actually transport people because of those calls. They were getting a large amount of calls where individuals just needed to be looked at, or they didn't actually need to be transported anywhere, or where they refused to be transported somewhere and somebody else transported them, or whatever the case may be.

And so this will assist those counties in generating a lot more revenue that they currently don't have access to even though they're doing the same amount of work. So they don't really have to do anything extra, and they'll be able to receive a different -- a new stream of revenue funding, so that's all I have. Thank you.

MR. BECHTEL: Justin, you're talking about specifically Lewis and Knott County?

MR. DEARINGER: No. It was actually Anderson County and Woodford County, is who I talked to.

MR. BECHTEL: I'm wondering if Lewis and Knott may have -- or may be experiencing the same situation. And if so, when do we plan to have the treat without transport in place for them to start billing? And maybe that'll help them stay open maybe hopefully. I don't know. I'm just thinking out loud here.

MR. DEARINGER: Yeah. The goal is to have that done by sometime in 2023. I don't really have an exact date, but the goal

is to have that completed, done, everything in process by some point in this calendar year. I think it's very doable. You know, it's still -- it's not really that early in the process, but we've rushed it to try to get it done in time because we have had these meetings with different EMS providers from different states.

And we do see that they have challenges, fiscal challenges due to -- you know, some of the biggest things that we've encountered are, again, you know, rates haven't changed for a long time. That's a part of it. But labor costs, you know, insurance costs, equipment costs, all those things have went up. So when you look at No. 2 and 3 there, labor challenges, inflation, those are two enormously significant challenges that are affecting all the EMS providers right now.

And so yeah, I think this is a huge help. I mean, I think at least for the two counties that I talked to, the economic benefits of this were -- would be a significant help. It may not make a difference -- you know, it's not a dramatic

difference, but it's a significant increase in funding that they did not previously have.

So -- and I think there's a lot of other things to look at, you know, with that treat and not transport where there's also, you know, a large behavioral health component to that. And so by using, you know, behavioral health mobile crisis units -- incorporating EMS into that process, which they're not really always incorporated into, will increase the number of interactions there. So there's some more increased revenue.

So -- and then also trying to figure out how we can do some transport to other facilities, not just hospitals. So how Medicaid can pay for transport to -- from a scene with interaction with the behavioral health task force via telehealth and some other ways and then being able to transport to some mental health hospitals and things like that, some other places that can manage where that individual goes from there.

So a lot of different things and steps that we're looking at to try to assist EMS providers in generating more revenue and

income. So those are just a couple of the key things. And hopefully that'll be done -- you know, I think the original goal was summer of this year, and I think we're still shooting for that. But I'm not -- I wouldn't promise anybody that, but I think that was the original goal, still kind of our goal.

Systems is always usually our biggest hang-up. So we'll see how quickly they get those systems in place to be able to actually bill for that. Of course, like anything else, once we get that completed and approved and done, we'll retro bill for whenever we decide to make that effective date. So we always have that option, too.

MR. BECHTEL: So have you been working -- or have we as a department worked with any of the MCOs to get them starting to look at their systems to get this so that they're not waiting on our systems to be updated? Have you already had that first discussion?

MR. DEARINGER: Well, we've had some kind of initial discussions with a few of the MCOs as far as what we had planned on

doing. I don't think we've gotten down in the weeds yet because we're still finalizing all those different codes and fees and pricing and everything like that. So, I mean, all that is almost complete.

We're just waiting for a couple of things. For instance, there's a couple of issues to work out with the transport to different facilities and some of the telehealth codes on when a clinician is trying to work with, like, an EMS driver, for instance, to try to give that acknowledgement. This individual is okay to stay, or this individual needs to go.

So there's a lot of little intricacies there that we're trying to finalize before we send that out. But yeah, we'll --

MR. BECHTEL: Okay.

MR. DEARINGER: Absolutely. Before we even send that -- or at the same time we send that for our systems people to create, we'll send that to the -- out to the MCOs to let them have time to, you know, work on their system changes, too.

MR. BECHTEL: Okay. The 50 percent

of calls being nontran- -- that was alarming to me when I heard that, and so I was just -- Troy, do you all -- do you know if any of these that are closing, if they're having a similar percentage of their calls?

CHAIRMAN WALKER: I don't know. I'd have to check into that, Steve. That's -- 50 percent for treat and transports is awful high, though. I can't imagine that. That's --

MR. BECHTEL: Yeah. That was alarming to me.

CHAIRMAN WALKER: I'd have to see that. We do --

MR. DEARINGER: It's a lot. You know, they include also -- and I don't know how many other counties do this. But they have a lot of individuals -- and they're kind of open to this -- that come to their facility or come to their place of service or place of business there and -- to be seen.

So I don't know how many other EMS providers do that. But people will come there to the ambulance service and, you know, kind of be seen to see if they can -- need to

go to the hospital or not. And so they have a lot of those kind of instances, too, that are included in that number.

But, again, that's something that -- that I think they've just started doing not that long ago but -- so that's kind of included in there, too. But yeah, it's pretty high, pretty high figure.

DR. THERIOT: And, Troy, is the paperwork basically the same? Like, if you have somebody that you go to see and they refuse to be transported or you treat without transporting, is the paperwork basically the same?

CHAIRMAN WALKER: It is. Really, honestly, our run forms, they fill out the same run form for every patient they respond on no matter what. They will -- you know, there's information that's not captured if they don't transport.

But if they -- especially if they treat and transport, that's where I was fixing to ask Justin if you have EMS as part of the committee that's helping look at that as far as, you know, what they're documenting and

how they're treating because I have a bunch of questions just based off what you said that, you know, I don't want to sit here and tie up this meeting for. But I definitely have a lot of questions on, is it treatment and transport or just, you know, on the scene, they didn't do much. They just talked with the patient. There's a big difference.

One of ours especially is the diabetic emergencies and giving patients either D50 or Glucagon on the scene, doing it ALS and then the patient refusing to go with us is the first thing that comes to mind because that's a lot more money vested by that service than just talking to someone and filling out a form. So I didn't know if there was any options, I guess, for --

MR. DEARINGER: Yeah. No. That's something we've discussed. Right now, it's the same payment. So when you go and you just do an evaluation and there's no actual assistance given, that's going to be the same payment as, you know, whether you go and you actually treat an individual for a specific incident or not.

However, there will be -- there's additional codes that you can bill on top of that. So you'll get that initial code that you can bill for that -- you know, for that, I guess, treat and not transport service incident and then -- but there will be some other codes we're looking at trying to add, too, for materials and things like that, you know, that you may use while treating that individual, if that makes sense.

So the code is the same. The price is the same whether you just talk to them and evaluate them because that's what we're really trying to pay for. I think that was one of the things that, you know, CMS wanted to make sure because -- I think, initially, kind of the argument was, well, if EMS just shows up and they don't do anything and then they leave, then we're not going to pay them.

And we had to assure them that, no, EMS doesn't just show up and not do anything. They're showing up. They're evaluating that individual. They're determining whether that individual is fit to be able to be there on their own. Do they need immediate medical

services? Do they need to be transported or flown out? What needs to be happening to this individual? So there's an evaluation process that goes on if nothing else happens and even if there is no further treatment.

And so we were able to get a good rate based on that alone and then there will be some other things if you use some materials and things like that to add to that code as well. But it's just one code for everything.

Now, I think in the future, once we get this going, we can look and see if we want to, you know, make some changes and make that a little more -- you know, a little more drawn out to where we can have specific other codes for other things, and we can look at pricing. But right now, that was kind of the easiest to get off the ground and easiest way to do it. And I think that we've got that priced appropriately where it'll kind of even out.

CHAIRMAN WALKER: That's great work, Justin. And yeah, I mean, I was going to show y'all. I keep Glucagon on my desk here in my office. It's 300-and-something

dollars a vial. You know, you go out on a diabetic run, and you give a patient Glucagon and then you leave with no payment of anything. That ambulance service just ate that 300-dollar vial of medication.

So that's great work, and it's good to hear. That's promising. I appreciate your efforts on that.

MR. DEARINGER: Yeah. Absolutely. That's kind of one of -- you know, that was one of our biggest goals when we started this project, was to be able to assist EMS providers. You know, initially, I think they had requested -- a couple of years back, they had requested just an increase in transport fees.

And as we got to looking at it, you know, one of the things that we -- all these different cases where, you know, an EMS provider does a run. You know, they're expending their gas money. They're expending personnel based on how many runs they have, how many calls they get.

So you have all these different, you know, factors that are played in. And not

every call is getting a reimbursement for Medicaid providers. Of course, you know, this doesn't really help for providers that are not Medicaid eligible, but for those that are, you know, this will be a huge benefit, I think.

And, again, it's kind of something that's ever evolving. So, you know, this first year will be a good test, but it's an additional revenue stream that I think will help all EMS providers to be able to recover some costs that they've been eating for years.

CHAIRMAN WALKER: We're definitely going to add that as a subcategory, treatment and no transport. We'll add that as a separate category for sure and keep up with that in old business. So I appreciate you, Justin.

Back to kind of -- to B. We kind of jumped around here. But for pre-authorizations for hospital transfers, is there any more comments on that before we move on to the next?

(No response.)

CHAIRMAN WALKER: One thing I have for Medicaid is the possibility -- because I was asked by some of my board members. Is the possibility of an emergency order from Medicaid possible to get rid of pre-authorizations in order to help offset some of the problems with some of the services? Is that even feasible? Or do we go at it the way we are, all of us coming together with the MCOs and deciding what we can work with? What's the best solution?

I'm asking Medicaid if you have any recommendations because people has asked me about any emergency declarations or anything like that that would possibly help.

MR. DEARINGER: Hi. This is Justin Dearinger again. I don't think at this time that we have anything in place that would constitute us being able to do that with prior authorizations. You know, we have to do that through -- due to CMS requirements a lot of times.

And so we really have to have some -- you know, like the Public Health Emergency with COVID, we were able to loosen up a lot

of the restrictions. Of course, that Public Health Emergency was lifted statewide about six months to a year ago -- I'm not sure exactly -- and then federally just recently. And so we've actually just reinstituted all of the prior authorizations for a lot of different provider types who had some of those suspended there in that Public Health Emergency.

So I don't think that we really have anything to stand on to be able to do kind of a blanket emergency suspension of prior authorizations at this time. However, I think that we can always work together, work with the MCOs to try to figure out a way to make it easier for you all.

Any time we have an issue where, you know, we have county EMSs that are reducing services or, you know, losing services based on a procedural issue, we need to get that fixed and handled. So we're definitely going to be able to -- definitely want to work that out and figure out ways we can reduce that administrative burden and try to get payments quicker and more effectively.

But I don't think any kind of emergency declaration right now is going to be the answer, but I do think we can come up with some kind of strategy to be able to assist in helping you all with that.

CHAIRMAN WALKER: Okay. Well, I appreciate it, Justin. And I was asked to -- you know, they wanted me to bring that up, and it was just one of those things we just needed to check on. I'm all about all of us working together in whatever we need to do to get it fixed.

Like I said, the pre-authorizations for EMS in the state of Kentucky -- I retired as chairman for Kentucky Ambulance Providers in January, but that's the one big thing. No matter where I went across the state of Kentucky, pre-authorizations was the top-of-the-line issue for services across the state.

So -- and it is. I have trouble with my own service here. We're trying to work through it, but you just can't get the right information and the stuff they need.

So thank you all for working it. If

there's no more comments for the pre-authorization, we'll make sure that everybody gets the PCS form. If you haven't, please put your email in on the chat line, and we'll get that to you but more to come on that. That's one thing that we're looking for any suggestions to try to fix. That's utmost of importance of anything.

So I'm going to move on down the list. If there's no more comments to new business -- I didn't realize, but they had added on the new business the perils of closures for services in the state.

Lewis and Knott County have given notice, as you can see, that this summer, they'll be closing their services. And we're hearing this quite a bit, especially in the eastern side of the state, so that's devastating.

And what's bad is we're working backwards here now. So when I first started EMS 34 years ago, we had a lot of basic life support ambulances. And we -- we worked and worked and got to where about all ambulance services in the state of Kentucky were

advanced life support ambulances.

And then here we are 2023, we've got services going back down to BLS because of multiple reasons. Pre-auths is not the reason for that. That's just one of the things that we'd like to improve for reimbursement.

But the low reimbursement, the labor challenges, and inflation are contributing to this problem. It's not just one. It's all of them. So it's sad to see that we're losing services and also losing services down to BLS instead of ALS.

So that's all I had. Is there any discussion or anybody have anything to say about the closing or questions -- closing of services or going down to basic life support services? Any questions or comments on that?

(No response.)

CHAIRMAN WALKER: No? All right. We'll just move on to general discussion. Anybody got any questions for general discussion or comments?

(No response.)

CHAIRMAN WALKER: Quiet bunch. Any

recommendations?

MS. SHEETS: You don't have a quorum, Troy, so you cannot vote on any recommendations. You can certainly discuss something and vote at the next meeting, but you can't vote today.

CHAIRMAN WALKER: Right. Does any of the MCOs or anybody have any other -- I mean, as far as recommendations, I was looking -- does anybody have any ideas or anything, the way we need to address even the pre-authorizations in discussion?

MR. OWEN: I just want to say -- this is Stuart Owen with WellCare again. I just want to say thank y'all very much for explaining it, the whole issue, going through it on the meeting today. And it's -- absolutely we understand it's a high priority. And we have been having some meetings and I'm sure other MCOs as well. So just appreciate you explaining it today.

CHAIRMAN WALKER: Sure. Thank you, Stuart. I appreciate your time.

Okay. Any other -- the MAC meeting representation -- I know I sit on the MAC

committee. Keith -- I think he sent out an email to everyone earlier about what was just discussed. It was just more of an overall and what we was working on with pre-authorizations, but that's all I have from that.

Does anybody else have anything else? I don't want to sit here and waste your time.

(No response.)

CHAIRMAN WALKER: Okay. The next meeting is June 26th from 2:00 to 4:00 Eastern Time.

And if there's no other business or no other comments, I'll entertain a motion to adjourn. Anyone for adjournment?

MS. SHEETS: You can just adjourn, Troy. You don't have to have a motion for that.

CHAIRMAN WALKER: Okay. All right. Is that all we've got?

MR. BECHTEL: I believe it is.

CHAIRMAN WALKER: All right. Kelli and Erin, I appreciate you all. And we never did reach a quorum, did we?

MS. SHEETS: No, we did not.

CHAIRMAN WALKER: Okay. All right. Well, we'll get together some more stuff. I don't know exactly what we need to do, what the next step is for the pre-auths. But I'll get with you all, and I'll get with Keith. And we'll send some more stuff out here in the next few weeks. Thank you all.

MR. BECHTEL: Thank you.

(Meeting concluded at 2:46 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 3rd day of May, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR