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

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Via Videoconference
February 27, 2023
Commencing at 2:00 p.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Kevin Callihan

Keith Smith

Linda Basham

Dana Evans

Troy Walker

Joe Prewitt

Jacob Carroll

MS. SHEETS: Good morning, everyone. This is Kelli Sheets with the Department for Medicaid Services. I will be your host for today's meeting as Erin is on maternity leave. So I would like to ask all TAC members, in order to comply with the open records law, please turn your camera on when voting. I'm still clearing the waiting room, but it does look like you do have a quorum. I have five members currently on, I believe. So whoever is going to run the meeting, if you want to go ahead and get started, I think we're ready to go.

MR. WALKER: Is Keith on here yet?

MS. SHEETS: I'm sorry, I couldn't hear you; who?

MR. WALKER: I'm looking for Keith. He's our --

MS. SHEETS: Keith is on. I have admitted him through the waiting room. Keith, if you're trying to talk, you are muted.

MR. BECHTEL: Yeah, his mouth's moving, but I'm not hearing anything.

MR. SMITH: Can you hear me now?

MS. SHEETS: Yes.

MR. SMITH: Okay. I'm in a shared office today, and somebody had the speaker muted. I apologize for that. Gotta love adversity.

All right. So again, going and looking at the cameras, I think we've got most of our folks, even though the camera positions keep changing a little bit. With that, we've already established quorum; let's go ahead and talk about the minutes from the December meeting. Did everyone have an opportunity to take a look at the minutes, and are there any recommended changes, or can we have a motion to accept?

MR. WALKER: Motion to accept.

MR. SMITH: Okay.

MR. CARROLL: I'll second.

MR. SMITH: Thank you very much; appreciate it. I saw that Jacob seconded it, but I'm not sure who actually --

MR. WALKER: That was me, Troy.

MR. SMITH: Okay. Thank you, Troy. So we got a motion and a second. All in favor?

(Aye.)

MR. SMITH: Any opposed?

(No response.)

MR. SMITH: Any abstentions?

(No response.)

MR. SMITH: Very good. Hearing none, the minutes for the December meeting are approved as written.

All right. So we will go ahead and jump into our old business. We'll start with the EMS psychiatric transport conversation that started in December and was wondering if anybody on the call had any updates to that. I know one of the issues that I had a concern with was whether or not a fee schedule had been set up yet on this, whether it was -- if it was being done either by a tertiary company or if we use an ambulance to do it. Obviously, being an EMS provider, if our ambulances are doing these transfers, then we would be keenly interested in what that reimbursement rate would be, so does anybody have any updates on that?

MS. HOFFMANN: Hello. This is

Leslie. I think Leigh Ann's going to give an update based on the information we have, and then if you've got other questions that we can't answer today, we'll take those back. So Leigh Ann, do you want to go ahead and -- Leigh Ann wanted the ability to share.

MR. SMITH: Okay. Kelli, can you share that ability on the call?

MS. SHEETS: I will.

MR. SMITH: Thank you very much.

MS. SHEETS: I will make you a cohost; give me just a second.

MR. SMITH: Sure, thank you.

MS. FITZPATRICK: So I think back in December, we -- I presented to you the behavioral health crisis secure transportation that's a new provider type that's going to be created in order for -- someone is at the ED, and they need to go to a higher level of care, that that will be a covered transportation -- and if that type of transportation is wanted to be provided by a provider, they'll have to enroll as a behavioral health provider type. It is not

through the department of transportation. It's all going to be through just Medicaid and provider enrollment and behavioral health.

And then, Leslie, did you want me to walk through?

MS. HOFFMANN: Yeah. I think -- why don't you go ahead and give the information you have and see if we're covering what's on the agenda or if they have additional questions maybe.

MS. FITZPATRICK: Okay.

MS. HOFFMANN: Is that okay?

MS. FITZPATRICK: Yes.

MS. HOFFMANN: Is that okay with you, Mr. Smith?

MR. SMITH: Sure, absolutely.

MS. FITZPATRICK: Let me -- sorry. I'm used to Teams, so let me find my share screen. And I hope I get it right.

MS. SHEETS: It's under the "more."

MS. FITZPATRICK: Yeah. I just want to make sure I get the right -- okay. Here we go; got it.

So we have done some research; we've

had our consultant monitors and staffers assist us with this. And it's treat no transport. So we've looked at the HCPCS code A0998, which allows for medically necessary care provided for the EMS providers. And it will allow for, if that person does need to be transported somewhere, but was able -- you provided treatment to them at that spot. At that point, this code will allow for that to be billed.

Right now, we're looking at other states, but typically when we're going to be adding a new service, we'll look at what other states around us are doing, what codes they're using, what rates they're using, and then we will do a rate build-up with our consultant, and come up with the rate that way. So we're not really close there yet. This is in a lot of different states that we're looking at, but it's different in every state, of course.

What we have to -- to add this, we have to add this to our SPA, which is the state plan amendment, so -- which will need

prior approval from CMS. We are looking at what service components, service description, what provider can provide that service, and the language: Is this medical only, or does it include behavioral health or other services in the other states?

MR. SMITH: Okay. Just out of curiosity, and this may be addressed a little further in your presentation, but treat no transport is something that EMS has been keen on getting approved for quite some time. Would this also expand to not only behavioral health but also other conditions, such as diabetic emergencies, that we're able to reverse in a patient's home?

MS. FITZPATRICK: Yes.

MR. SMITH: Community paramedicine --

MS. FITZPATRICK: I think we had it -- we had that we were doing our research for any type of situation that you are called out, and you treat them, but you don't transport. So -- and that's what we're looking at what other states do and their description and how they're doing this, what all is included in that. But we

are looking at that -- everything in together.

MR. SMITH: Okay, good.

MS. FITZPATRICK: Yes.

MR. SMITH: That's fantastic.

MS. FITZPATRICK: So at the -- we have high-level information for you, but it looks like an estimated 2 percent of EMS calls may be related to services that are provided, but there's no transportation needed.

So the goal is to have this ready to go and implemented starting August 1st, 2024, as what's been in the house joint resolution bill. And I'm sorry, it sounds like the mud to a house is getting ready to fly away with that wind. It's a little unnerving, so I apologize. Of course, any change that will be involved will have to do a SPA request to CMS, and then any administrative regulations will also have to be revised.

And like I told you about the behavioral health secure crisis transportation provider, along with the

mobile crisis services. And hopefully, that will address some needs from when you have that person that's in the ED, and they need to go somewhere, but you can't transport them. That's going to open that up for you, as well.

MR. SMITH: Okay.

MS. FITZPATRICK: So, any questions -- any other questions?

MS. HOFFMANN: Leigh Ann, if I may, I'll just mention that our research that we've been looking at -- like Leigh Ann said, there's a lot out there, and they're all different -- they're different -- huge differences in what they cover, whether it be medical or physical or both, and so either it's a mix or it's not a mix. We feel like that we can probably meet on the behavioral health side a lot of the implementations we're making with our mobile crisis initiative, and we'll go over that a little bit later on the agenda.

So again, we're just trying to take a look at the other states and see what they've got in combination right now. And

there's about eight to ten states we're revisiting.

MS. FITZPATRICK: Mm-hmm.

MR. SMITH: Okay. Very good.

MS. CLARK: And --

MR. SMITH: Yeah, go ahead.

MS. CLARK: Oh, sorry. This is Tara Clark. I'm with Myers & Staufferm, working with Leigh Ann and Leslie. And I just thought I would maybe clarify because I know we kind of jumped -- so I think, you know, this -- what we're looking at here because we understand that it's a goal to consider the treat no transport reimbursement, this wouldn't be under the behavioral health transportation provider type that Leigh Ann mentioned. This would be for the, you know, regular, I believe, you know, ambulance provider type. So this is, sort of, in addition to the behavioral health transport, which Leigh Ann mentioned. For behavioral health transportation, that would be -- it's kind of a new provider type, but this would not -- this is kind of separate from that a little bit. It's kind of two different

initiatives.

MS. FITZPATRICK: Yes.

MS. CLARK: So I just thought I would kind of clarify that.

MS. FITZPATRICK: Thank you. Thank you, Tara. I was hoping I was getting that across, but thank you for that clarification; appreciate it.

MR. SMITH: Very good. Thank you. Okay. Any questions from any of the members about that?

(No response.)

MR. SMITH: Okay.

MR. WALKER: Keith, I think we need to make a -- for our agenda, just separate that and make a treatment no transport item, and then a separate EMS psychiatric transport --

MR. SMITH: Sure.

MR. WALKER: -- because that was kind of confusing, so.

MR. SMITH: Yeah, I'll do that. Okay, got it. While we're still in here talking about -- under the old business and discussion of expanding House Bill 8, I did

have a chance to speak briefly with Mr. Jim Duke, and he gave me just a very quick update on that the SPA was going to also have to be changed for some of the items that have been discussed regarding this, and he mentioned that maybe Mr. Bechtel would be able to have a little bit more clarity on information in regards to one provider in northern Kentucky that they want to have a change in the program to where -- I'm not a hundred percent clear on this, but to where the billing can be tied to a CAD report instead of just the basic EMS ePCR report. Mr. Bechtel, if you're on the call, can you potentially elaborate a little bit more on that?

MR. BECHTEL: So, yeah. Let me see without getting too deep in the weeds here. That program is for government-owned facilities, for like your county-owned facilities that would -- what we would have to do is, we were looking at using CAD to where we can kind of use a cost report type of information, of doing -- kind of truing up some of the cost on those services where

you're running a fire and an ambulance out of the same organization. But the CAD would just -- all we're doing with the CAD is kind of doing an allocation type of thing, of what's fire and what's medical, and then what's Medicaid and not.

I can get you a more detailed kind of summary of the program. But right now, we're going back and forth with CMS on trying to get that approved. We keep running into -- how can I say it -- challenges with CMS. CMS does not like the use of the CAD, so we're looking at using a different type -- kind of a CAD, but kind of taking it a step further. And so that's the proposal that we're sending into CMS to see if that is something that they're willing to do before we bring it out to the individual providers.

MR. SMITH: Okay. And --

MR. BECHTEL: Oh, we have had, I think Joe, Joe Prewitt's been on those calls, as well as Jim Duke, and we're trying to make sure, and the one thing that I wanted to make sure, and I had Jim and Joe

reach out to you guys was to make sure that especially the smaller ones that you have the resources there. I don't want to -- I don't want to make it a kind of a provider, you know, cause provider abrasion of any kind. We want to make sure that we make it as seamless as possible, but I understand there's, you know, and there's some shared resources, and some of you are thin on resources.

I just want to make sure that we're not putting you in, you know, being a thorn in your side, so to speak, but that is something that I reached out to them to see if we thought that those smaller facilities would be able to give us that information. And the report I got back last -- we've been meeting -- we meet every two weeks, and Joe and Jim are on those calls. And so this last meeting we had last week was -- we got the report back that they reached out, and they don't think that's going to be an issue with those facilities.

So I hope that's what you're looking for, Mr. Smith, but that's kind of the --

without getting really weedy here and deep in the weeds. And I'm a little hesitant to do that just yet, anyway, because CMS may or may not approve of it, so I just want to make sure that that's a process that CMS will be open to before we bring it to you all.

MR. SMITH: Okay. All right. And please, everybody, feel free to call me Keith. I am very informal --

MR. BECHTEL: Okay. Now --

MR. SMITH: -- you don't have to call me Mr. Smith.

MR. BECHTEL: -- and I will say, this is a totally different thing from House Bill 8, okay? It's not what we call -- we call them two different things -- it's APAP, which is the Ambulance Provider Assessment Program; it is paid through a provider assessment. Whereas this is -- this would be funded through an IGT type of arrangement because it's a county government to state government type of transfer. So that's why it's only for the government-owned. It's so that we can do that through a transfer of

funds.

MR. SMITH: Okay. Yeah, I'm sure there'll probably end up being more questions on that, but to your point, I'll give you all a chance to get some of the --

MR. BECHTEL: Yeah, let us get the details ironed out --

MR. SMITH: Right.

MR. BECHTEL: -- because those details with CMS gets changed all the times, and that would just cause more confusion than anything, to be honest with you.

MR. SMITH: Very good. Does anybody have any questions about what Steve just covered? Is everybody good?

(No response.)

MR. SMITH: Okay. Hearing none, we already -- obviously, we just talked about the pre-authorizations for transport -- no, I'm sorry. I was just thinking about the treat no transport. Going to the pre-authorization for transport out of the hospital, since we did discuss -- start discussing that at the last meeting, you know, this is a huge issue amongst all of

our EMS providers, whether they're county services, hospital-based services, it's all the same. This pre-authorization or precertification issue has been a really big detractor in being able to get reimbursed for transports that are being done. And some of the comments I'm hearing from EMS providers that I've had the opportunity to speak with has been based around that no matter what they submit, it's getting declined by either not meeting medical necessity, or they didn't have all the information they could put into the request, such as mileage or the MPI of the facility. There's basically a lot of information with these forms that is not known to the EMS provider, and in some cases, it's the information -- the flipside that the information is not available to the hospital that is EMS service specific.

So with that, let me go ahead and open up to Troy, Linda, any of the other committee members that as directors of EMS services in your community, that you've run into with these pre-authorization forms.

Like I said, I've heard an awful lot from folks, but I'd like to hear some of the issues you all run into instead of everyone just hearing me talk.

MR. WALKER: I don't mind starting it off. I think some of the bigger issues that I'm hearing with Kentucky Ambulance Providers Association and other places is what we run into is most of the time is the ER transports going to higher level of care. That's the ones I'm -- my biggest concern.

Most of these, like you said, to be able to get a hold of HCPCS codes -- or ICD-10 codes, I'm sorry, and then the MPI information from the hospitals, all the information that's needed, especially prior to transport. Remembering that most of your ambulance services don't have billing dispatch billing capabilities where they can get pre-authorizations before transport, so most of us are doing it on a retro later, trying to meet those 48-hour to 72-hour windows. And then here we are, not being able to get a full patient chart because

we're not -- I'm hospital-based; I'm the exception to the rule, but most aren't. And then getting those ICD-10 codes and everything that's not there at that time because this is a ER patient that's not been reviewed and put into an IDC-10 --

MR. SMITH: Mm-hmm.

MR. WALKER: -- diagnosis code yet.

That's some of our biggest problems, and just getting them done. I wish we could look at either using the PCS form, like Medicare does, and getting rid of pre-authorizations for these ambulance ER transports is my recommendation, but that's just mine personally. So I just wanted to open up some of the problems that we were having.

MR. SMITH: Great. Thank you, Troy. Dr. Cantor, you had an item?

MS. CANTOR: Yes, I do. Good afternoon. Yeah, I'm Dr. Cantor, the CMO with United Healthcare, and we've been hearing of these problems, and part of our solution right now, working with Linda Basham, has been -- the plan is to

administratively approve the transport on the front end from the hospital-to-hospital transfer, and then give you all 30-days to be able to give us that PCS to prove -- to have the final documentation available to us. So that for our own purposes we're able to have it for our auditing and our internal management. But that's where we're landing right now. Hopefully, that will help solve -- at least with UHC.

MR. WALKER: You're saying using the PCS form like Medicare does?

MS. CANTOR: Mm-hmm, within 30 -- within 30 days.

MR. SMITH: Yeah, no, that's huge. That's a huge help.

MS. CANTOR: Okay, good.

MR. WALKER: Agree.

MS. CANTOR: Good.

MR. SMITH: Thank you, ma'am, very much for that information. Are there any other providers that are on the call that might be able to give us a little insight on your healthcare companies and what we may be able to use as a potential resolution to

this issue? Because to further add on to a little bit of what Troy said, the IDC-10 problem is even a little bit more hectic in the fact that some hospitals are Epic-based, some of them are -- like Cerner or other companies that are providers of data systems, so it's literally impossible for an EMS service to be able -- even if the hospital were to give them access to their programming, which I doubt very seriously they would do. Speaking on behalf of a hospital-based service, it's hard enough just to get myself and some of my other EMS staff into the Epic records. I can't imagine they would allow an outside EMS director or administrator to be able to get into the program in order to be able to pull the ICD-10 codes, and then finding the correct ICD-10 code is part of the challenge, as well because they may be diagnosed with one ICD-10 code, but the reason they're being transported to a secondary facility could be a different reason altogether from what they were being admitted for. So trying to speculate on

what is the correct code then opens the door for potential issues where the providers are listing the wrong ICD-10 code, which, you know, not intentional in any way, but all it takes is for somebody to start billing the wrong code, and if it becomes a trend then it opens them up to an audit, and potentially a situation of having to pay back money over a situation that they had no intention of creating, but unfortunately, got themselves into.

So are there any other healthcare companies online today that would like to talk about what your systems are willing to potentially do to help us solve this issue?

(No response.)

MR. SMITH: Okay.

MR. OWEN: Well, I can tell you -- sorry, this is Stuart Owen with WellCare.

MR. SMITH: Mm-hmm.

MR. OWEN: I don't know, but I will absolutely take this back. The United proposal to me seems reasonable, so I'll take it back and find out, but I honestly don't know.

MR. SMITH: Okay. Well, thank you very much for doing that. I'll tell you that most EMS services are very familiar with using the PCS forms. It's what we've used for years. Typically, when they get completed, they get the physician's signature, a nurse, case manager, whomever is allowed to sign the form will sign it. And if we can go back to that as the form of authorization, it sure would make things a lot easier for our EMS services and our billing services across the state. Because right now, they're having to use so much more of their staffing time to go back and file these appeals that, you know, this is eating into them just as much it is the EMS providers.

So a quick resolution simply saying go with the PCS would be fantastic, and I think you wouldn't get very much, if any, pushback from the EMS providers if everyone would be willing to accept that. So that would be great if everyone could consider that.

MR. OWEN: And this is used by

Medicare, right? And is it used by commercial insurance, do you know?

MR. SMITH: Linda, can you advise on that? You're on mute, Linda.

MR. WALKER: You're muted, Linda.

MR. SMITH: You're still on mute, Linda.

MS. BASHAM: (Speaking, but inaudible.)

MR. WALKER: Still nothing.

MR. SMITH: Still nothing, Linda.

MS. BASHAM: (Speaking, but inaudible.)

MR. SMITH: There you go.

MS. BASHAM: Okay. (inaudible).

MR. WALKER: Nope, Linda, you're out.

MR. SMITH: You're going back and forth. You're cutting in and out really bad.

MR. OWEN: It's not a big deal; I was just curious.

MR. WALKER: I can tell you Medicare is the one that is -- most people -- Medicare uses the PCS forms, the physician statement forms for nonemergency transfers,

especially in a facility, and things like that. Now, there are other insurances that follow along and utilize that PCS form. If that helps any --

MR. OWEN: Yeah.

MR. WALKER: -- but it is the standard; standard across the nation.

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

MS. SHEETS: Linda, if you want to drop your comment in the chat, that's always an option if your microphone is not working.

MR. BECHTEL: So I've got a question, Dr. Cantor if you could. What I heard was PCS form, and then you said something -- you said that was on the front end. Are you saying there's something that follows that process after the PCS form? You said something about 30 days, or I don't know what you're --

MS. CANTOR: So if a request comes in for a hospital-to-hospital transfer, we're going to auto-approve that. We're going to administratively approve it. And within the subsequent 30 days, our request is to

receive the PCS.

MR. BECHTEL: Okay. All right. Thank you.

MS. CANTOR: Then it should be done.

MR. BECHTEL: All right. Thank you.

MS. CANTOR: You're welcome.

MS. KAUFFMANN: So, Keith, this is Kathy Kauffmann. Sorry, I couldn't get off mute myself, but I just wanted to speak for Humana Healthy Horizons. We do not require prior authorization for facility-to-facility transport, and if there is an obligation submitted, we do auto-approve those, as well.

MR. SMITH: Okay. Is that used in the pre-cert or pre-auth form now, or do you think we would be --

MS. KAUFFMANN: No.

MR. SMITH: -- okay with just using the PCS form?

MS. KAUFFMANN: Yes, that would be great. I'm not that familiar with the PCS form, but yes, if that's the decision, then we'd certainly consider that.

MR. ELLIS: Yeah. I think what we're

trying -- Kathy, you're saying is that we don't even require the authorization for the facility --

MS. KAUFFMANN: Correct.

MR. ELLIS: -- to facility transfer.

MS. KAUFFMANN: Yes. I'm sorry. Thanks for clarifying that. We don't --

MR. ELLIS: So we're not looking for a form or anything.

MS. KAUFFMANN: Yeah.

MR. ELLIS: If it's a facility-to-facility, then we're not requiring the authorization. And you all are still billing with the NEMT, like the 426 or the 428?

MR. WALKER: Yeah, the eight.

MR. SMITH: Yes, using the HCPCS code.

MR. WALKER: Mm-hmm.

MR. ELLIS: Yeah.

MR. SMITH: Yeah. And I believe there was a question from Dr. Cantor about what the PAN codes were, and it was the prior authorization number is what Linda put into her comments.

Okay. Well, I'll tell you what I'll also do is since there are some folks that aren't familiar with the PCS form, I'll put in the agenda for our next meeting that we'll put that up and use that as a document that we'll go over so we can show everyone what the PCS form is, so that hopefully everyone on the call will be comfortable and hopefully will be okay with us using that as our way of being able to get these trips authorized and get everyone reimbursed afterwards.

MR. ELLIS: Hey, Keith?

MR. WALKER: Keith? Oh, I'm sorry, go ahead. Can I recommend that we just e-mail a copy of a standard PCS form to everyone now --

MR. SMITH: Certainly.

MR. WALKER: -- and see what their thoughts are and bring back to the next meeting -- I'm just trying to make it a little quicker here --

MR. SMITH: Okay.

MR. WALKER: -- come back to the next meeting, and we'll know if that's something

they could possibly utilize instead of a pre-authorization format.

MR. ELLIS: Yeah. Hey, question though, your to and from data in your loops and segments for the ambulance is still going to show facility-to-facility, right? So, I mean, that's other logic that for those plans who don't require authorizations for to and from facility-to-facility may be able to utilize. You know what I'm talking about? Your from destination, your destination, and your origination data?

MR. WALKER: Mm-hmm.

MR. SMITH: And using that for -- in lieu of what?

MR. ELLIS: In lieu of anything. So if the MCO is saying we do not require authorizations if it's a facility-to-facility transfer, then your origination would be the two-digit codes for the facility that it's at, and then the destination would be your two digits for the destination.

MR. SMITH: Yeah. I'll have to defer to any of the folks in the billing company,

whether Linda, if you can answer, or if anyone's on from A & B.

MR. ELLIS: There's abbreviations assigned for destinations and originations. Whether it's from the member's home, if it's from a skilled facility, if it's from a facility to a facility, that's what I'm talking about.

MR. SMITH: Okay. Yeah. Typically, that's nothing that the EMS provider enters. That's usually -- all the coding gets done by our billing company, so --

MR. ELLIS: Okay.

MR. SMITH: -- that's why I was deferring, and hopefully one of the folks could tell us if that what you're describing works or not. And I am looking here at the chat real quick; I know Linda just typed some stuff here. Okay. So the question Linda asked is if we are going to go or if we can use the PCS form, what is the best way for us to be able to provide the PCS form, and will all hospital-to-hospital claims have to be sent by paper?

MR. ELLIS: Oh, great question. So I

do know there's an enhancement to Availity to be able to attach forms to their claims, and I believe that's turning in March. So that way, you can submit an electronic ambulance claim and be able to attach a PCS form. I will say from a Humana perspective, we will need to look at that form to see if it's something that we can utilize, but I mean, as we said, right now, we're not even requiring prior auth for a facility-to-facility transfer.

MR. BRUNNER: Right. Same with Anthem, Keith. We're the same way. Those codes don't require prior auth as long as it's par provider. We do realize that there's some EMS that aren't par providers, especially in the western Kentucky area. So we do realize that, and we'll review those after the fact.

MR. SMITH: Okay. All right.

MR. ELLIS: And just to clarify, these are being submitted as non-ER transfers, right? So these are not the A0427s, or are these the ER transports?

MR. WALKER: These are the

nonemergency transports that's requiring authorizations.

MR. ELLIS: Okay. Okay, thank you.

MR. WALKER: Yeah. Can I ask a silly question? And I mean, this is just because I don't know. So would it be possible for Medicaid to come up with a, I don't know, something that Medicaid comes up as a guideline, instead of having to go to each individual MCO and do everybody the same way? That's one of our biggest problems is I've got a list sitting here beside me of just MCOs, and I've got six different ways to do this. Some do, some don't. Some require this; some require that. So could Medicaid step up and say, "Hey, this is the way we need to do this," and have everybody on one page?

MR. SMITH: That would be fantastic if it could happen. Are there any --

MR. DEARINGER: This is Justin Dearinger, director for division of healthcare policy. That's definitely something that we can look at. I've got extensive notes here from listening to you

all discuss this topic and this issue. And it's something that we've been doing a little research on previously, so I would be absolutely happy to look into that. Of course, as you all know, anytime you have MCOs, there are definitely some certain things that they're allowed to do, you know, their own way, depending on which MCO it is and what their contract is with that provider type. But we will absolutely look into this, and we can see if there's anything we can do to make any kind of uniform decisions.

MR. SMITH: That would be great. To Troy's point, with all the different ways of doing this, you know, I'm sure everyone has heard of the EMS challenges we've had with staffing, you know, we're doing good just to even get people who work in our offices to do the administrative work. So the easier we can make it, the better off we are. And with the challenges we've had with staffing, we're counting pennies now like we never have before as far as being able to make our reimbursements count so that we can keep the

doors open and the lights on.

So any relief our EMS providers can get to make the reimbursement process more streamlined, and we're not looking for a free handout from anybody. That's not it at all. We can justify anything we do, but we just -- if we can get one way of being able to do it, it sure would make it more time friendly for our administrators and our billing companies.

Let's see; we've got some chats going on here. Let's see -- let me go back up here real quick. And Dr. Cantor had that the PCS can be uploaded to the provider portal for United Healthcare. Thank you, Dr. Cantor, for that.

Linda has nonemergency trips can come from the floor or from the emergency room. Some hospital-to-hospital trips are emergency, and others are nonemergency.

Kathy Kauffmann provided that the provider will receive a prior-auth number if they do submit a request to Humana after it is approved for all facility-to-facility transports.

And then, Mr. Ellis commented that 427 would be the ER and that would be covered. And the issue would be 426 and 428, which is tied to facility-to-facility. Which that -- I'm kind of glad that you brought up 426 and 428 because here in a minute, one of our new business items we need to talk about are those two codes and specific, but we'll hold off until we get down to new business on that.

And from Mr. Spalding for Passport by Molina Healthcare, prior authorization's only required for nonemergent air transport. I'm not sure if we have any air transport companies that are represented. I don't believe --

MR. BRAND: I'm here.

MR. WALKER: We do.

MR. BRAND: Yes.

MR. SMITH: Okay. Kevin, Kevin Callahan.

MR. BRAND: I'm -- Kevin has asked me to sit in on this.

MR. SMITH: Oh, okay.

MR. BRAND: Yeah --

MR. SMITH: Okay, awesome.

MR. BRAND: -- all of these, as far as for the air side of it, would be a further grade for any nonemergent. So we have to go through our medical (indiscernible) unit. So --

MR. SMITH: Okay.

MR. BRAND: -- if it calls for any, then we would go through medical control. And then if there needs to be a COVID flight, we can handle that as it comes.

MR. SMITH: Okay. So this wasn't something -- new information for you, this was something you all were already doing?

MR. BRAND: Yes, sir.

MR. SMITH: Okay, awesome. Thank you very much. Okay. All right. Do we have any -- Troy, do you have any other questions -- or I haven't seen Joe show up yet. Joe, if you're on the call, do you have any further questions?

MR. WALKER: Well, I think one thing, I think Linda Basham had put on the thing, nonemergency trips can come from the floor of a hospital or the emergency room. And,

you know, making the decision there is just going to, you know, what we're talking about, is this going to include all hospital transports to other hospital? Is that the question, or is it just going to be the emergency room? And that's something we'll need to break down and ask and look at.

I know one just piece of information I have is emergency rooms don't usually have case managers 24/7. So that's the major part is emergency rooms for me, but I definitely see issues with the rest of the hospital, as well. So I think that's something we just need to look at.

MR. SMITH: Right. Right. There was something else that popped in my head, and I'll be honest with you, it just totally slipped my mind. We were talking about hospital-to-hospital, but just out of curiosity, for those of you that are on here, would that also apply for hospital to skilled nursing facility? Or when you're saying hospital-to-hospital, are you being specific about hospital-to-hospital, or are nursing facilities categorized as a hospital

for this conversation?

MR. WALKER: That's a good point because taking them back to the nursing home is a huge problem area, as well. The ERs are just wanting us to get them out of there no matter what, and it doesn't matter if there's medical necessity or not. And most places throughout the state don't have any kind of wheelchair vans or services after 4:00 p.m., so the ambulance services are being leaned on to do that after hours. So I don't know if that would be a separate topic or a part of this one, but that is an issue.

MR. SMITH: Right. Right. So can any of the providers on the call make a clarification for us on that: If the nursing homes or skilled care facilities fit in the definition of hospital-to-hospital, or will they be treated separately?

MS. KAUFFMANN: This is Kathy Kauffmann with Humana. We consider any facility-to-facility transfer does not need a prior auth, so whether that's a skilled nursing or another hospital.

MR. SMITH: Okay. Thank you, Kathy; appreciate that.

MS. KAUFFMANN: Sure.

MS. CANTOR: And this is Dr. Cantor from United Healthcare. We would feel the same way. Any hospital to any type of other facility that requires an ambulance service would fall under this same type of process.

MR. SMITH: Okay. Thank you very much. And then Linda did put a comment on here that the wheelchair broker contract used -- state that they're available 24 hours a day. And unfortunately, to Troy's point, there are many times of the day that you'll call, and you may not get an answer at all, or they'll tell you that they can't get to it till the next day or sometimes even longer. So then what happens is it goes from just a routine transport to a 911 call, and it's abnormal labs or something else that gets used, where the EMS service then at that point is obligated to take them in because it's an emergency call, which then takes that truck out of service.

For an example, just today, I got a

request from one of our system hospitals. They've got a patient in Richmond, Kentucky, that needs to go to Cadiz, Kentucky, for follow-on care. And right now, they're unable to get anybody, unfortunately, that the patient does need to go by ambulance because it's an ALS patient, but because it's in Cadiz, Kentucky, they can't find anyone that's willing to take that transport.

So transportation, in general, is really problematic, on top of the fact whether it's wheelchair or by ambulance. So just a taste of some of the issues we're dealing with.

MR. WALKER: Yeah, the wheelchair brokers also require up to 24-hour notice before they can transport, is what we're hearing a lot. So these patients can't sit in the ER waiting to go back to a nursing home for 24 hours.

MR. SMITH: Right.

MR. WALKER: That's when the ambulance also comes into play.

MR. SMITH: Yeah, yeah. You know,

and I believe, Troy, this is one of the things you talked about early on in this discussion is because of so many different companies that are involved with this and so many different rules and regulations, it would be helpful if we could come up with a document that -- I know it probably can't be all-inclusive, but if there's a way that we can have a frequently asked questions document that we can produce on behalf of the insurers, the office of Medicaid services, and potentially even KAPA that addresses a lot of these questions. So that we can have basically one book or booklet that our EMS services statewide could use for guidance on which companies will allow PCS, which ones require the pre-cert forms, that kind of information.

Just like also the wheelchair transports, as far as which ones are saying that they have to have 24-hour notifications and which ones will do immediate runs. It would be very helpful for all of our providers and our hospitals, quite honestly, so that they don't feel that they have to

potentially bend the patient's situation in order to get the patient transported out. You know, there's times that that happens where a patient is a BLS patient, the ambulance service doesn't have an BLS crew and won't be available for several hours, and then all of a sudden, the patient comes down with the condition that requires a paramedic to go and make an ALS, which then robs the county of the paramedic, in some cases for two or three hours in order to do that transport.

So we've got a lot of transport issues we need to get taken care of. And I think if we can come up with a document that we can address the major issues and get the input from each of the companies as to what their rules are, I think will help our EMS services. And the more that we can potentially combine if you will, to where let's say, if everybody were to agree to the PCS form after we have an opportunity to spread the word about the PCS and what they are, again, that would really make the whole situation be that much better. So, okay.

MR. OWEN: This is Stuart Owen with WellCare again. Do you think that like a grid -- I don't know how much -- how many different scenarios -- like maybe just a grid with each MCO, their PA rules. I mean, I don't know if it would -- if there's so many different scenarios, it would be hard, you know, to do like on a one-page grid or two-page grid, but --

MR. SMITH: Mm-hmm.

MR. OWEN: -- like a side-by-side comparison.

MR. SMITH: Right. I think, at this point, anything is handy because right now, we have to rely heavily on our billing companies to tell us who is requiring what and what information we need to get submitted. So to that point again, I think anything we can put together would be helpful.

MR. OWEN: Okay.

MR. SMITH: Thank you for the suggestion.

MR. OWEN: Sure.

MR. SMITH: Okay. Is there any more

comment we want to have on this? I will say that I do like the idea of getting the PCS form and the instructions to the PCS form out to everyone that's on this call today and any of the MCOs that have not been able to get on this call but are regular call-ins for the meetings so that they could see what we are talking about with the PCS forms. So I'll take the lead on getting that information to Kelli since Erin is out right now.

And then also folks, if you all have questions that come up, whether it be about these forms, the PCS forms, if you have questions about anything in general, please don't feel like you have to wait until one of the meetings to ask. You can either reach out to myself, Troy, any of the folks that are on the EMS TAC, and we will do everything in our power to answer the questions you have. Because the smoother we can make the process for each other, the better off we'll win as a group overall.

Okay. Any other comments we want to have on this particular matter, or go ahead

and jump down to new business?

(No response.)

MR. SMITH: Okay. Hearing nothing, we'll go ahead and move down to new business. I believe we had -- okay. Thank you, Joe. Joe just sent a message saying he has to leave the meeting for another meeting. In the last meeting, there was a potential -- or a discussion of a potential presentation by department or Division of Behavioral Health for the February meeting. Is there anyone that can confirm whether or not you've got this presentation? And if so, roll with it.

MS. HOFFMANN: Mr. Smith, this is Leslie. I am going to provide you with a PowerPoint --

MR. SMITH: Okay, fantastic.

MS. HOFFMANN: -- with our behavioral health initiatives. And then Kelli, can you make me a sharer, please?

MS. SHEETS: I just did. You should be a cohost now, Leslie.

MR. SMITH: All right. Real quick, Leslie --

MS. HOFFMANN: Yes.

MR. SMITH: -- before you get started, a real quick note: At 3:00, I have to sign out to get to an appointment that I couldn't cancel.

MS. HOFFMANN: Okay.

MR. SMITH: Troy will be taking over the meeting.

MS. HOFFMANN: Oh, okay.

MR. SMITH: Yeah, so you're good.

MS. HOFFMANN: Okay. So just in general, when I was thinking about behavioral health, I didn't know how much that this group knew about the beginnings for Medicaid. And I had recently provided a local rotary club information about the same thing, and they're not used to working with Medicaid on a weekly basis, such as yourself, so I embedded this document with lots of resources. And so I started to take all the resources out this morning, and I thought, why? You might want those, right? So I'll go through this fairly quickly. I've got a lot of slides, but I did a lot of explaining of acronyms and resources that

providers may want just in general or even members of Kentucky. So again, just forgive me that I've got some extra things in here, but I started to take them out, and I thought, no. I'm gonna leave them in there for you.

So I'm Leslie Hoffmann. I'm the deputy commissioner for the Department of Medicaid Services. And one of my administrative oversights is for the behavioral health initiatives. The first page -- can you see my screen, okay? And I'm going to leave it in this view if that's okay? Because I like to go back and forth to my slides if that's okay?

MR. SMITH: That's fine.

MS. HOFFMANN: This is just a resource for you, again. We are actually at this morning at 1.724 million members, which is unbelievable. Just to put that in perspective, there's a little over 4 million folks in the state of Kentucky, so we're getting really close to almost a half mark.

Over half of the Kentucky children are enrolled in Medicaid. We have 69,000

providers, and we're at $15.1 billion total budget. I did add the federal health PHE and the Medicaid unwinding, just again for a resource. And here's your resource page if you want to take a look at that.

As you may have heard Deputy Commissioner Veronica Cecil speak, there are changes coming about with all those wonderful flexibilities that we were able to put in place; some of those will stay, some of them may not be able to stay, and now we're kind of like unwinding. So that's kind of the term you'll hear from us is Medicaid unwinding. This is an actual link that you can click on in the PowerPoint, and I'll have Kelli send the PowerPoint out to you.

So this is kind of what happened with behavioral health, and I don't know if a lot of folks know this. Behavioral health expansion: In 2014, Kentucky Medicaid, with CMS's approval, expanded the state plan services to include behavioral health, and behavioral health encompasses both mental and substance use.

At that time, I was there, and DMS developed a behavioral health initiatives program that is located out of the commissioner's office, and that is totally different than the Department of Behavioral Health. Now, we work with them on an ongoing basis. Every day I'm on meetings with them. We partner a lot with our sister agencies. The behavioral health policy team was then comprised of subject matter experts. You will hear us say SMEs for behavioral health services.

And now we're getting to the meat of it. These are a couple of things I thought I would just mention to you so that you are aware. So with our behavioral health initiatives, as you can imagine, with the enrollment numbers still growing every month related to Medicaid, we also have a need of running crisp behavioral health services, and so I'm going to highlight some of those. Just to let you know, I'm going to go over each one of these, so if you don't know the acronyms, I'm going to go over them.

So we have the CCBHC demonstration

project, the multi-systemic therapy pilot project, the SMI/SED 1115 application, and the mobile crisis planning and implementation, which you've heard myself and Leigh Ann probably speak about several times.

So the Kentucky certified -- Kentucky Certified Community Behavioral Health Clinics is what the CCBHC stands for. I wanted to give you that. So how CCBHC got started: PAMA in 2014, it outlines the creation of a demonstration program that would allow integration. Like they really -- this is their first chance that they wanted to integrate physical health and behavioral health. And so there was availability of demonstrations back then, and we applied for it, but we did not get it. And actually, it was the Department of Behavioral Health that actually applied for that. But in 2020, they contacted us and said, "Hey, Medicaid. We want to add Kentucky and Michigan to this demonstration." So it was kind of strange because it had been from 2014, I think the

application was actually submitted in '16, and then in '20, we find out that we're eligible for it. And it would run eight quarters through January of 2022 to December 31, 2023.

But recently, through the Bipartisan Safer Communities Act, the BSCA of 2022, due to that passage, CMS said, "Hey, Kentucky and all the other states that are working on this, now we're going to let you extend that demonstration to 12/31/2028," which is very exciting. So it's not just the eight quarters now that we can share that.

The strengthening of care, this is really about what a CMHC -- sorry, CCBHC will provide. The CCBHC will provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals to increase access to services. So increasing access, we have to keep a lot of data for this program. We have to show CMS that we're increasing access and care and, hopefully that it's integrated along the way.

The populations that are impacted are

those with serious mental illness, serious emotional disturbance, long-term chronic addiction, mild or moderate mental illness and substance use disorders, and complex health profiles. So that could be somebody that not only has a mental health condition but has a physical health condition, as well.

CCBHCs must provide care regardless of ability to pay or place of the residence, providing care for those that are on Medicaid, the underserved, the homeless, the folks who have low income, or the uninsured. Care is also guaranteed for those who are active military duty or veterans. This was the first time that I'd really seen a very specific population related to the veterans for us to partner with and to work towards increasing access.

So currently, in Kentucky, we have Seven Counties, NorthKey, New Vista, and Pathways. Those are our four demonstration CCBHCs. It just so happens that these are all community mental health centers, as well, so I know that it gets confusing. So

these four are actually CMHCs, as well as CCBHCs. And I don't want to confuse you on the acronyms, but just to let you know that that's what happened. We have four providers that actually happen to be both right now.

Multi-systemic therapy pilot: We have a three-year pilot, and I'll explain that a little bit more. We have three providers right now within the pilot, and that's Home of the Innocence, and it is Children's Home of Northern Kentucky and KVC of Lexington. We have an independent evaluator and assessor to make sure that we can continue the services and to evaluate if they're sustainable after the pilot project. We finished year one. I think we're between year one and two on that. And there will only be the three providers during the pilot project.

The multi-systemic therapy pilot is an evidence-based intensive treatment process for behavioral health disorders and environmental systems. Our partners, such as DCBS, DJJ; so that's the Department of

Community-Based Services, the Department of Juvenile Justice, our MCO partners here on the call, and other community partners, have all made referrals to this program during the pilot.

Again, it's a three-year pilot, and DMS partnered with our sister agency at DCBS for these three providers to provide this service. And they have to be licensed by the MST Institute, which is very lengthy, and the training is lengthy, for the delivery of these intensive services. So we currently only have the three providers that are in the pilot.

Who are the children that are involved or the population that's impacted? These are Medicaid-enrolled children that are between the ages of 10 and 17 that are at risk of entering the juvenile justice system. The goal is to work intensively with the youth and the family to prevent justice involvement and out-of-home placements. As many of you are probably aware, we have lots of initiatives going on for diversion of incarcerated members, and

we want to divert the children, as well, from any type of confinement.

So next in the PowerPoint is Kentucky's SMI/SED solutions. And we've been working through this for almost two years, got some really good things going on. We have submitted some drafts to CMS and working on those now -- the responses.

So for the SMI 1115 waiver, we have: What is an 1115 demonstration? It is our ability to be extremely flexible and to have the ability to be thinking outside the box, and it will allow us to go around some of the CMS or Medicaid requirements and we ask for CMS's approval to do those things and that we ensure, for the most part, that we will do it equal to or less than what the cost is now with a better quality or value of life.

We have: Asking to increase inpatient treatment stays. And we are asking to increase those from 15 to 30.

And we are adding or asking for medical respite. Medical respite is also known in other states in the CMS world as

recuperative care, and this would allow acute and post-acute care for people experiencing homelessness. So just for an example, this might be somebody that's homeless and needs to go in for a medical procedure. We want to provide them a clean, stable environment to do their pre-op, and then a place to go after their hospital stay because they might not have a place to go or a clean place out on the streets and to have adequate conditions and care -- wound care or anything like that. So this is something we're working on. Again, they call medical respite recuperative care in the federal world.

And next steps: So we submitted a draft 1115 with these things to CMS 12/31. And like I said, we're currently working through all those possibilities related to the responses -- our responses back to their questions.

We are also currently looking at an HCBS proposal that will be used in conjunction with the 1115. Senate joint resolution 72, I believe, wanted to ensure

that we could meet the members' needs, HCBS related, which means may need nursing facility level of care or they may not, depending on the severity of their diagnosis.

So we're currently working on a 1915(i) HCBS proposal that will include supported employment for SMI, supported housing, and planned behavioral health respite.

Sorry, I had a knock on the door.

Okay, so next is our Kentucky's all-inclusive mobile crisis intervention, and you'll see the terminology MCI used. This is one of our biggest initiatives that we've been working on for the cabinet.

So this is a lot of information, but pretty much just let me summarize it. CMS offered a planning grant to start thinking about what states could do crisis-related, and we wanted to develop an all-inclusive one-crisis model, so we've pulled all of our sister agencies together and said, "Hey, how can we do this?"

During that time of the planning

grant, we completed that, did a needs assessment, and I can go over that. But CMS also has a state health organization letter, that's called a SHO letter. And they said, "If you want to receive additional funds, Kentucky, you can do this, but you have to do it a certain way."

And so those are the things that you'll see under the qualifying services: Must be provided by a two-person team, licensed behavioral health professionals, and other professionals or paraprofessionals. Teams must be trained in trauma-informed care, de-escalation strategies, and harm reduction. Responses must be in a timely manner, as established by the state. And we must provide things as screenings and assessments, stabilization, de-escalation, and coordination with other supports.

Now, that's a lot to tell you. If you look down at the accomplishments, we've completed a three-month needs assessment, and that is an active link that you can go to the needs assessment on our page. It's

about 260 pages, so be prepared to read for a little while. But out of that needs assessment came all these other things that we need more than just those qualifying services that CMS was offering an enhanced match on. So our mobile crisis here in Kentucky is going to be extremely unique and have several other factors with it.

So Kentucky's mobile crisis intervention model currently looks like this. It's going to be one mobile crisis model. You can see where we've divided out the state here. These do kind of coincide with the existing CMHCs related to the 988 calling centers, as well as psychiatric hospitals.

Now remember, our mobile crisis wants to divert. We want to divert from emergency rooms, we want to divert from EDs, we want to divert from psychiatric hospitals, and we want to divert from jail systems. So we want to minimize the need for police involvement; however, we do know that there will still be some situations like that.

So all of those things that I'm

telling you kind of in combination makes us know because of our -- especially some of our rural areas, that we want to develop something that is much more robust than just what the SHO letter said.

So Leigh Ann, if you don't mind, I'd like for you to get on and just go through this as if you were a member walking through this process. This is very busy, but I think you'll enjoy listening to Leigh Ann.

MS. FITZPATRICK: Hi. Okay. So I am a Medicaid member that's in crisis. So I call 988, and that call will go to one of these 13 988 crisis centers, and the one closest to me. The person on the phone listens to what I have to say, listens to my crisis, listens to what I have going on. And from that, triage would be, "What needs to happen next?" And it's determined on that call that I need to have a mobile crisis team come out and see me because I'm not stable, I don't -- I can't figure out how to take care of my crisis. A mobile crisis team that's nearest to me -- we do have it in -- but they will be there within

60 minutes. Or if they can't be there in 60 minutes physically, that they are calling me, "Hey, Leigh Ann, you called and I'm the mobile crisis team and I'm on my way. I should be there." What have you. And if they need to stay the phone while they're traveling to me, then they can do that.

So finally, the mobile crisis team gets to me at my home, we talk, we determine that -- so there's kind of two scenarios. We determine that one, that the mobile crisis team is working with me, de-escalated me, they did an assessment and determined that I'm pretty safe to stay, but they're going to also refer me for a follow-up visit to the provider. Either a new provider, or if I'm already seeing a provider, back to that provider.

The second situation is that they've assessed me -- my crisis, I should not be at home, I'm not able to de-escalate. My home situation might be a part of that crisis, and they feel like I need to go to a higher level of care. And that could be 23-hour crisis stabilization, which is a new service

we're doing in Kentucky, or I need to go to residential, or worst-case scenario, I do need to go to an inpatient hospital.

So that is another reason where the mobile crisis, not mobile crisis, but the behavioral health transportation can come in and take me to that higher level of care. If the mobile crisis team and part of that provider they have behavioral health transportation provider, it could be them, or it could be someone else. And maybe one of the -- someone from the mobile crisis team is going to ride along with me to that destination.

And with all of this, from the call -- what we call an air traffic control model. And I know you all are familiar with that, and that's how we kind of wanted to do that with the 988, and the crisis calls that come into there.

So the mobile crisis provider has called the transportation, they've come, they've got me, and they're taking me to the 23 hours, I need to stay there -- start there and get assessed for 23 hours. And then, the follow-up is off of the mobile

crisis team, and then we'll begin there on the 23-hour crisis observation provider.

MS. HOFFMANN: So again, I know that was a little bit busy --

MS. FITZPATRICK: Yes.

MS. HOFFMANN: -- and we can come back and share more later, but it really -- the main thing is we want diversion, we want the person to get to the appropriate level of care, minimize law enforcement if -- but we know that there will be some situations that it's necessary, and always to keep that warm hand off. Like Leigh Ann said, we're not going to drop the call until the next group comes on or whoever the next step is, so we want to make sure that we can do that.

And then, like I mentioned before, we have partnered with our sister agency, the Department of Behavioral Health, throughout this whole process, so they're working with us for this continuum.

So our next steps with mobile crisis is like I told you before, we finished our planning grant, we are currently in the implementation, and our projected

implementation date -- sorry, planning. And then our implementation date we're hoping to be around 10 '23.

One more little slide here. So other notable projects -- and I just wanted to go through this with you all -- we're currently reviewing an SED initiative through the state plan amendment, which is for children. We are currently in the planning phase for an SED feasibility study for children that may include a children's waiver.

And then, racial and health equity initiatives: So our racial and health equity initiatives here in the cabinet are all overlapped with every division and department in the cabinet. And then within Medicaid, all of our divisions, plus Angie Parker's group, who is the new population health, and Danita Coulter is the branch manager for racial and health equity, but we all kind of work together on this one. So I just wanted to mention we have partnered with the Medicaid innovative collaborative, so that's MIC. And the MIC, along with New York, and Nevada, and Iowa, and a few other

states that wanted to participate with us, have been meeting on ways -- like a five-year plan of how -- where we want to go with racial and health equity here in Kentucky. And their states, as well. So we're doing lessons learned data gathering, what can we learn from each other, and we've also listened to states that have already finished this cohort that we're in, such as Tennessee. They were very nice to listen to the other day.

So one of the other things I wanted to mention is with the mobile crisis intervention, our racial and health equity, we're kind of using our mobile crisis as like the first step, or our first really trying to ensure that all of the racial and health equity needs are being met. And so we completed a GARE tool, and that's the Government Alliance for Racial Equity tool, which is a requirement for all of our programs now in Kentucky Medicaid. And we're utilizing that to look through the lens to ensure that all racial and health equity needs are being met. And so we have

our mobile crisis tool as a living tool. And so when I say "living tool," we're constantly revising our GARE tool for mobile crisis. And I think next week, or on the first, Leigh Ann and I will be going over the mobile crisis GARE tool on the Racial and Health Equity TAC, which is another new TAC that came about, I think about the same time as this TAC got started. So if you're interested in listening, you can join the racial -- I think it's called Racial and Health Disparities TAC at 1:00 on March the first.

And then, like I said before, I've got this embedded with tons of resources. Here's my e-mail, Leigh Ann's e-mail, DMS issues. If you have any questions after today, our DMS behavioral health page on the website, which is fairly new for us, and all these things that we're talking about today are all on that website. And then, our DMS home page, and then I also added in all of our social media, which you'll see us post a lot. We have -- I think Beth Fisher may be on the line with us today. She's wonderful

at getting communication out there and promoting, any time we can, helpful information to our Kentucky members.

So I know that was a lot. But if you have any questions, you all can feel free to reach back out to us. And we will send this PowerPoint out.

MR. WALKER: Thank you, Leslie and Leigh Ann. That was a great presentation. Any questions for Leslie and Leigh Ann?

(No response.)

MR. WALKER: All right. Can we get -- all right. There we go. Okay. So Keith slipped out for his doctor's appointment. This is Troy; I'll continue on with the meeting. If there's no further questions for Leslie or Leigh Ann, we're going to move on down to the new business.

Disparity and discussion in down coding A0426 and A0428 to the T2005. So don't know -- is there anybody that knows anything about this? Keith sent that and put that on the agenda.

(No response.)

MR. WALKER: I got an e-mail I know

from my billing office. Says there's a lot of denials going out for A0426 and 428, I think, because they should be T2005. Is that -- does anybody know if that's the discussion for this?

MS. SHEETS: Troy, Linda has put a lengthy comment in the chat that might be helpful.

MR. WALKER: Oh, okay.

MS. BASHAM: Can you hear me?

MR. WALKER: Linda, I can hear you just a little bit, but you're breaking up real bad.

MS. BASHAM: Okay.

MS. SHEETS: So she says back in 2003, providers were presented with the December 29th, 2003 transportation code changes page 3 to 32 presented A0426, A0427, A0433, A0434 to be billed A0427. The non-emergency trips were set aside under a separate provider number, Type 56. At that time, the only way to bill the non-urgent trips under Type 56 would have -- sorry, part of that's - I can't read part of that. I don't know why it's blocked out -- have

been billing A0428 as T2000, probably --

MR. WALKER: T2005.

MS. SHEETS: -- defined as nonemergency stretcher base rates. This is not identified as an ambulance transport. A0428 is the correct code for BLS nonemergency ambulance transportation. T2005, stretcher transport is not a legal type of transportation in the state of Kentucky. And she also says, I've sent a copy of this to Troy in his e-mail.

MR. WALKER: Oh, thank you for reading that, and the part you had, I didn't have, so it's kind of weird how the chat's acting here. Linda, I don't have an e-mail from you yet. I'm checking.

MR. ELLIS: And just to clarify, this is the -- these are the CMS Medicare billing guidelines, right, that you are quoting?

MR. WALKER: Medicaid.

MR. ELLIS: No. Medicare is what I'm saying. These are Medicaid, okay.

MR. WALKER: Yeah. These are Medicaid.

MR. ELLIS: And I think because, if I

remember correctly, the A426 and A428 is not on the state Medicaid fee schedule, right? So they're not showing up as covered codes. Okay.

MR. OWEN: Yeah, this is Stuart Owen with WellCare, and I'm looking at it right now. You're exactly right, neither of those codes are on the DMS fee schedule, but T2005 is on the DMS transportation fee schedule.

MR. ELLIS: So that's why we would expect those to be billed that way. Because if you were to bill as a fee-for-service to the state, I would suspect the state's fee-for-service system would probably also deny the 426 and the 428 as not a covered code.

MR. WALKER: And this is where we really need Linda. Poor Linda, I wish you could talk.

MR. ELLIS: Probably got a windstorm probably knocked something out or something.

MR. WALKER: Yeah, 'cause I know this has been an issue, and I'm not the one to speak on this as an ambulance -- this is more of the billing side of things for

billing providers, and I wish -- hopefully Linda can get with us next time.

But I do know -- of course, Medicare, we do have the 426, 427, all of them, all of the HCPCS codes. The Medicaid for some reason, I'm not sure why it got switched over to T2005 and why the other ones didn't get added. And I'm sure that's what Linda's point is -- I think is.

MR. ELLIS: I think, again, I think the A426 and A428 was the nonemergent transport without the stretcher. Whereas if -- I guess for the NEMT with a stretcher is a covered code or covered service. That's probably why the department has developed into that T2020 -- that -- yeah, the T202005 code.

MR. WALKER: I think the A0426 and 7 is nonemergency. That's what they are. With a -- with a stretcher and medical, it's a medical patient. Where T2005 is just a stretcher van-type --

MR. ELLIS: Base rate, yeah.

MR. WALKER: -- it's for. And I think that's what she -- the point we're

trying to make is the T2005 is for a stretcher van and not an ambulance.

MR. ELLIS: Right.

MR. WALKER: And I think that's --

MS. BASHAM: I'm here.

MR. WALKER: Oh.

MS. BASHAM: I called in on the phone.

MR. WALKER: Oh, there you go. That works. We got you loud and clear.

MS. BASHAM: Hopefully, I won't cause too much echoing. Is it echoing?

MR. WALKER: No, you're good.

MS. BASHAM: Okay. So that's the issue, is that in this same coding changes, they deleted the A0428 and made us use a stretcher van code and stretcher vans -- it's not even legal in this state. And that's how they justified the $40 or $50 that they've been paying us all these years. The A0426 that you're not able to get processed is because you don't have this instruction that tells you, you need to use it under A0427. Does that make sense?

MR. ELLIS: That last piece -- can

you run that last piece about run under A0427? Can you clarify that?

MS. BASHAM: Okay. A0426, A0427, 433, 434 are all to be billed to Medicaid as one code: A0427.

MR. ELLIS: Okay.

MS. BASHAM: So if your billing program can cross over all of those codes that you would normally code your calls at to A0427, and bill Medicaid that way, they will process.

MR. ELLIS: Yeah, so that's an issue because now we're changing codes from what it was billed to what goes to the state.

MS. BASHAM: Yeah. Because only Medicaid wants that change.

MR. ELLIS: Yeah, but Medicaid won't allow them sales to change procedure codes. They won't allow us to change the claim.

MS. BASHAM: We're not changing -- we're not asking you to change anything. The billing providers have to make that change when they send the code in.

MR. ELLIS: Got it. So the -- if it really is an A0426, the billing providers

need to change it to an A0427 and submit it that way to the MCOs?

MS. BASHAM: Correct.

MR. ELLIS: That's perfect. That would not be an issue. I think what we have seen -- for the MCOs -- we've seen the 426s coming over, and the 428s coming over and those are typically denied because they're not a covered code.

MR. WALKER: So Linda, you're saying that A0426 and A0428, which are nonemergency, need to be billed as A0427, which is an emergency?

MS. BASHAM: No.

MR. WALKER: Oh, sorry.

MS. BASHAM: Not the 428.

MR. WALKER: Oh, okay.

MS. BASHAM: Only the 426.

MR. WALKER: Okay.

MS. BASHAM: Because they bundled all the ALS-type calls under A0427.

MR. ELLIS: Got it.

MR. WALKER: Now I got you. Sorry about that.

MS. BASHAM: And they completely

separated --

MR. ELLIS: And the A0428 is the T2020 -- okay, sorry.

MS. BASHAM: They totally separated the nonemergent to a Type 56, specialty 16, which, if you research, you'll find specialty 16 is talking about stretcher vans. And therefore, that's where they told us we had to bill the A0428 as T2005.

MR. ELLIS: Okay. That makes sense, as well. Well, it doesn't make sense as to why they're doing it versus the code, but I see that the billing perspective, at least that T2005 is an accepted code, whereas the A0428 is not an accepted code.

MS. BASHAM: Correct.

MR. ELLIS: But yet, I will say that all the MCOs are seeing the 428s coming over, as well as the 426s.

MS. BASHAM: I'm sorry they weren't all around in 2003 like me.

(Laughter)

MR. ELLIS: Okay. So would it be then, Linda, a correct statement that as we do provide an education to these practices,

where we see that certain transports are still billing us with the 426 and they're billing them in the 428, then it would be a correct statement to say you really, for those 426s, they need to be submitted as a 427, and for your 428s, they really need to be submitted as a T2005?

MS. BASHAM: According to the transportation coding changes that are in the December 29th, 2003 transportation coding changes, yes.

MR. ELLIS: Okay.

MS. BASHAM: Now, the question and the reason that this is brought up here in 5B is the fact that 428 is totally different in definition than T2005, and ambulance services billing under T2005, is inaccurate. It's making us say that we're a stretcher van, which is not legal, instead of an ambulance. It's kind of like telling the chiropractor you need to bill as a MD instead of a chiropractor.

MR. WALKER: Especially when T2005 is a lot lower rate than what an ambulance A0428 would be.

MS. BASHAM: Yeah. We have had a rare occasion where A0428 was billed to Medicaid, and it paid $60.

MR. ELLIS: And so Linda, is it true, then, that the symmetry here -- or the concern is really geared towards the department's current process?

MS. BASHAM: Yes.

MR. ELLIS: Okay.

MS. BASHAM: That's why it's on here under 5B.

MR. ELLIS: Got it.

MS. BASHAM: And Keith asked me to speak to it, so I am. I mean, this has been going on a long time.

MR. WALKER: It has. What's the reimbursement rate for T2005, Linda, currently for Medicaid?

MS. BASHAM: T2005, I think it's $55.

MR. OWEN: Yeah, it's 55.

MR. WALKER: 55? Okay. I thought that's what it was, but I didn't know. Okay.

MS. BASHAM: But that's the only way that you can justify paying so little is

"it's just a stretcher van. Just one person can drive it." That's not right. We have to have two people in that unit. A stretcher van also probably would not have as strict of medical necessity.

MR. WALKER: Okay. Any other questions for Linda? I think we've kind of -- I think the points have been figured out here, what this is all about. Is there any other questions?

MR. ELLIS: Yeah. And this is Herbert; I'm with Humana, in case you didn't know who I'm with. Linda, so even on the facility-to-facility where we were talking about the NEMTs, that would also still fall into this same kind of billing?

MS. BASHAM: It could --

MR. ELLIS: Okay.

MS. BASHAM: -- if it was a BLS run.

MR. ELLIS: Okay. So we shouldn't be seeing the 426 or the 428 as a facility-to-facility, it should be falling back to the 427 or the T2005?

MS. BASHAM: Currently.

MR. ELLIS: Okay.

MS. BASHAM: Yes.

MR. ELLIS: Not that you like it, but that's how it should be right now. I got it.

MS. BASHAM: That's how the instructions are written.

MR. ELLIS: Okay.

MS. THERIOT: So, hi, this is Dr. Theriot. So Linda, are you suggesting that we take a look at the fee schedule and consider adding codes?

MS. BASHAM: I'm suggesting you add A0428 and delete the T2005, which is wrong.

MS. THERIOT: All righty. Well, we can bring that back and talk about it next time if that's okay.

MR. WALKER: Okay. Any other comments?

MR. ELLIS: No, this has been great, Linda. Thank you so much for that.

MS. BASHAM: You're welcome.

MR. WALKER: All right. Any other comments for 5B?

(No response.)

MR. WALKER: Thank you, Linda, for

getting on the phone. That made that a lot better and easier. I appreciate you.

Okay. So moving -- agenda Item No. 6, general discussion. I'm going to kind of open the floor for any of the general discussions, questions, or comments.

(No response.)

MR. WALKER: I hear none. Okay. I guess seven for recommendations. Sorry, guys. I didn't do the agenda, so I don't know what these are. If you do, please speak up. No. 7, recommendations? I don't think we have any at this time.

(No response.)

No. 8, the MAC meeting representation. I know me and Keith was on that meeting -- wasn't asked to speak, so any questions or concerns, or comments for No. 8?

(No response.)

MR. WALKER: All right. No. 9, our next meeting will be April 24th from 2 to 4:00 eastern standard time. Any other business before we adjourn?

(No response.)

MR. WALKER: Okay. That was some great discussions. I know we'll -- me and Keith, we'll get together and e-mail out you all a PCS and the guidelines for that to everyone, so you can kind of look over that.

And then we'll also discuss a little bit more what Linda brought up with the T2005. That will be at the top of the agenda for our next meeting. Can I get a motion to adjourn?

MR. CARROLL: I'll move to adjourn.

MR. WALKER: Motion to adjourn; a second?

(No response.)

MR. WALKER: Second for a motion to adjourn?

MR. ELLIS: Second.

MR. WALKER: All right. Thank you, guys. I appreciate everybody's time, and we'll see you next time. Thank you.

(Meeting adjourned at 3:28 p.m.)

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CERTIFICATE

I, Tiffany Felts, CVR, Certified Verbatim 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 15th day of March, 2023.

Tiffany Felts, CVR

Tiffany Felts, CVR