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

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Via Videoconference
April 22, 2024
Commencing at 2:02 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Keith Smith - Chair

Linda Basham

Dana Evans (not present)

Troy Walker

Joe Prewitt (not present)

Jacob Carroll

Joshua Brand

Steve Eubank (not present)

P R O C E E D I N G S

CHAIRMAN SMITH: All right. It's 2:02. Let's go ahead and get started since we have quorum.

MS. SHEETS: I'm sorry. Can I just interrupt for a second? I need all members to please turn your cameras on for voting so that we can comply with open meeting laws. Thank you.

CHAIRMAN SMITH: Let me get a little light on the subject, too, there. Sorry about that.

All right. Okay. We'll go ahead and get rolling here. Is everybody's cameras on that needs to be on, Kelli?

MS. SHEETS: I don't believe so. It looks like we need to see Joshua and Jacob.

CHAIRMAN SMITH: Okay.

MR. CARROLL: My camera is on from my standpoint so --

MS. SHEETS: There you are. I see you. Sorry about that.

MR. CARROLL: That's okay.

MR. BRAND: But I can't see you,

but I can see --

CHAIRMAN SMITH: Okay. There's Josh.

MR. BRAND: Yep.

CHAIRMAN SMITH: Okay. Very good.

MS. SHEETS: All right. You're good to go.

CHAIRMAN SMITH: All right. Fantastic. Since we've got a quorum and it's been established, we'll go ahead and approve minutes from the January meeting. If everybody has had an opportunity to review the minutes from the January meeting, I'd entertain a motion to accept the meeting minutes.

MR. WALKER: Motion to approve.

MR. CARROLL: Second.

CHAIRMAN SMITH: I've got a motion from Mr. Walker, second by Mr. Carroll. Any discussion?

(No response.)

CHAIRMAN SMITH: No discussion. All those in favor, signify by saying aye.

(Aye.)

CHAIRMAN SMITH: Any opposed?

(No response.)

CHAIRMAN SMITH: Any abstentions?

(No response.)

CHAIRMAN SMITH: Meeting minutes passes without any issues.

Going into old business, wanted to check and see. We've been operational now for about three and a half, four months with the new Medicaid PCS form. Wanted to check and see if any of our EMS providers or if any of our MCOs have had any issues with the new PCS form that our ambulance providers began using as of January 1st?

(No response.)

CHAIRMAN SMITH: And not hearing any -- I personally have not heard anything from any of the providers on my end, from the KBEMS' end or otherwise that anybody has had any issues. That makes me feel pretty good that this thing has rolled out very well, and we haven't had any kind of payment issues, which is fantastic for our EMS providers. And with that, we'll consider that old business.

New business, we had a request from

Mr. Paul Phillips who is with GMR/AMR. He has a request for the MCOs and for the committee to hear. What he is going to talk about is an issue that is actually a significant issue for EMS in the fact that there's only certain types of transports that we can bill for.

There's other transports that we do that we're not able to bill Medicaid for. And in today's tight environment, especially with the economy being the way it is and the cost of diesel fuel and regular fuel, for that matter, we need to get every penny we can for our EMS providers.

So with that, Mr. Phillips, I'll turn it over to you and let you present the information that you would like to, please.

MR. PHILLIPS: Sure. Thanks, Keith. Do you -- am I able to share my screen? I was going to -- I've got a deck prepared.

CHAIRMAN SMITH: Yeah. Kelli, can you get Mr. Phillips the ability to share?

MS. SHEETS: I can do that. Give me just a second.

CHAIRMAN SMITH: Okay. Thank you.

MR. PHILLIPS: Awesome. Thanks, Kelli.

MS. SHEETS: No problem. Okay. You should be able to share now.

MR. PHILLIPS: All right. Can you all see that?

MR. WALKER: Yep.

CHAIRMAN SMITH: Yes, sir.

MS. BASHAM: Yes.

MR. PHILLIPS: Awesome. Well, as Keith said, I am Paul Phillips. I am with Global Medical Response. We have several brands in Kentucky including AMR, Lifeguard, and AirEvac. The one I'm going to speak to you about is -- are the ones that I oversee, which is ground operations so...

Just wanted to kind of share with you all some issues that we've run into with both coding and also on the side of, like, just general reimbursement.

I'm trying to get it to advance, and I guess it doesn't want to cooperate with me.

All right. So just to give some background, like, the only real appreciable

changes we've seen in the fee schedule since 2011 was the addition of the treatment, no transport. And while that is a very necessary addition and it is -- it's been appreciated, that's, like, a subset of a subset of actual patients for us.

So while it's appreciated, I don't know that the impact has been all that great. And we won't see that for quite a while because it just came into effect, and that's kind of yet to be seen.

In 2020, we added on the Provider Assessment Program where, you know, providers pay a portion of their Medicaid in. We get back federal dollars. But that only addresses emergency transports. So we've still got an issue with the nonemergency.

Last year, the legislature convened an EMS task force, and some of the recommendations included the direct for the treat, no transport, the No. 5 recommendation. And that was -- that was done, so that's why I have that in green.

But the No. 7 was to urge the Department for Medicaid Services to increase the

Medicaid reimbursement rates for ambulance services as funds become available.

Like, I know where we're at financially, so I'm not going to sit here and act like money is just growing on trees. But I also know that as we've gone through the past couple of budgets, there's also been a surplus at the end of the budget. So I'm just -- just kind of throwing that out there as food for thought. So -- and just to kind of paint the background of where we're headed.

I'll talk about the first issue that we've seen. Like, Kentucky codes for the fee schedule do not align with the CMS fee schedule. We don't have the A0426, A0428 which are the nonemergency BLS, ALS transport codes. Those nonemergency transports are being paid maybe with a T2005 supplemental code which covers per the regulation "nonemergency ambulance transportation during which the recipient requires no medical care during transport." I don't think that's what we do. Even BLS levels of care is care.

And, also, I think it's a little -- I

think it kind of puts us in a weird position because whenever you say that no medical care was required during transport, the patient wouldn't meet medical necessity. So if we're asked to use that for nonemergency transports for BLS care, it kind of puts us in a catch-22 as providers because we're billing for something that, per the, you know, code, we meet medical necessity.

There's also a lack of provider guidance. There is no readily available guidance pertaining to a crosswalk of how these are supposed to be billed, even with that T2005. Because I think when we -- especially with the ALS transports, we end up trying to square peg into a round hole just because we have no other place to bill them.

And that -- I don't think that is -- that is a good place to be from a provider's standpoint because I feel like we could be turned off at any point in time. Any existing guidance is not readily available nor is it -- nor is it very current.

This coding crosswalk was provided by Linda Basham, and thank goodness for her

keeping records because it was published in 2003. This is the last known coding crosswalk that we can -- that anybody can come up with, and even it -- I mean, we're looking at 20 years old. I wasn't able to find it anywhere online or readily available.

So it just kind of paints the picture of what I was talking about with the provider guidance, like, that it just doesn't seem to be there.

That's really the picture that I'm wanting to paint with the coding, but I think I would be -- and I may be stepping on the next topic when I do this. But I've got to paint this picture on where we're at with funding for the fee schedule. When you look at ours in the contiguous states around Kentucky, we are dead last when it comes to reimbursement for the nonemergency transports.

I want to take a step back to -- to the provider assessment. I will be honest. I think Kentucky EMS, with that windfall, if we didn't have that, would be -- if I say we're in a bad spot now would be -- I don't even

want to think about what the picture would be like without that. So that is very, very much appreciated.

So I don't want to mess with the emergency side, but we've got to fix or address at least or even think about addressing the nonemergency side.

The current reimbursement for nonemergency is $55 a transport, $2 a mile. Nearly all nonemergency transports -- and I say nearly just because I didn't want to speak for other providers -- are probably being conducted at a loss by the EMS providers. And this is an issue because it takes away from being able to add better equipment.

Everybody says we should pay our employees better. Well, we would love to, but especially in the impoverished areas of the state where we're trying to prop up a system that is already, you know, impoverished, like I said, it becomes an issue because we're conducting all of these -- all of the Medicaid transports nearly at a loss.

And just as a -- I wanted to paint the picture with an apples-to-apples comparison. I took a 50-mile BLS transport for all those contiguous states, and this is the reimbursement that would be provided for all of those transports. You can see Kentucky lags way behind a lot of them. And I'll just point out I don't want to ever be behind West Virginia in anything. So if we could fix that, it would be greatly appreciated.

I did a straw poll. And, again, this is not data. This is a straw poll. And about the estimated cost of the average ambulance transport is $400. We're losing money on all nonemergency transports that are less than roughly 170 miles.

And just -- I added some examples for scale. Like, Pikeville to Louisville is 213. Paducah to Louisville is 217. And then if you -- if you do those all the time, you're probably looking at more.

Keith was talking about it. Diesel fuel is way more expensive. You know, a lot of our ambulances are operating on gas, but that's not cheap either anymore. So medical

supplies are going up. It seems like every cost that we have is going up. The reimbursement has kind of lagged behind.

So I just wanted to make these requests of the TAC. I'd like to see us align with the CMS HCPCS codes and then look at establishing a workgroup to make recommendations to DMS for content on a Medicaid manual or some type of provider document that walks us through how we're supposed to bill, unless we can align the HCPCS codes, and then I don't know that that's wholly necessary.

And then lastly, I just feel like I would be remiss if I didn't ask to advocate for increased funding for the nonemergency. Again, I want to stick with the nonemergency. I don't want to mess with the emergency because I think that would -- that would harm us all.

Keith, that's all I've got. I just wanted to bring it to your all's attention.

CHAIRMAN SMITH: Okay. Thank you, Paul. And if you wouldn't mind, could you send your slide deck out to myself,

Mr. Walker? And if you've got the emails of the other TAC members, I'd like to get a copy of what you just presented because it's very good information.

And to tack on a little bit about what Paul was talking about there, part of the reason we have a transportation issue in Kentucky is because we do have a great deal of patients that are Medicaid patients. And when we have patients at the hospitals that need to go home, if they are Medicaid-related patients, you know, it becomes an issue when you're looking at a reimbursement as low it is.

Do you take a truck out of service to do a run that you're going to get paid, you know, about $78 to do, or do you stay back to make the emergency run that you're going to be making close to $600 for it?

And it's helping, in a bad way, create the traffic jam we have at hospitals, especially in the wintertime when we've got people parked along the hallways because we can't get them out because we can't get anybody to come pick up the patients because

most of the 911 providers are out doing 911 runs, which is resulting in hospitals actually having to start their own EMS services to get patients out, which in itself, helps fuel the fire that we have with our paramedic shortage.

So it's kind of a non-ending soliloquy of events that this is causing. And with the reimbursements that Paul cited there, considering the wages that my services have to pay for ALS runs and BLS runs, every time one of my trucks runs out of a station for an ALS call, that run is costing me $96 just for them to go out the door between personnel costs, vehicle costs, and that's for a 30-minute transport. BLS is a little bit cheaper. It's about $65 an hour. But be that as it may, as you can see, with just those two figures alone, we're losing money any time we do a Medicaid transport.

And we're not -- we're not saying that we want to go out and turn this into a cash cow or anything else. We would like to be able to make what we're spending on these runs, especially if you have a transport

that's nonemergency and it's -- like Paul mentioned, it doesn't meet the mile requirement to be able to even hit break even. You know, if we're taking somebody home two or three miles away, it's -- we're taking it in the backside.

So I'd like to thank Paul for presenting the information that he presented and would like to open it up to the TAC members for any comments that you all might have.

MS. SHEETS: Hi. This is Kelli Sheets again. Sorry to interrupt. But, Mr. Phillips, I dropped my email address in the chat directly to you. If you could share that presentation with me, I'll make sure that all the TAC members get it as well as DMS leadership.

MR. PHILLIPS: Absolutely. Thank you.

MR. WALKER: Keith, I think it's important. I know we did a survey, me and Jim Duke and a few of us here last year and the year before. For the private industry and hospital base, I know we was right at 325 to 375. That's our costs per run for an

ambulance run if you average it all out. So that just -- to drive this even further just to show you what our cost is versus what we're reimbursed so...

CHAIRMAN SMITH: Great point. Jacob, on the perspective of 911 based, with you all being in the Jeffersontown area, do you find yourselves having to do many Medicaid transports, or are they pretty much all emergent type transports y'all are having to do?

MR. CARROLL: So yeah, being from a 911 service, you know, most of our runs are emergency-based runs, and so this wouldn't impact as much. But I'm actually embarrassed from the state's standpoint that our rates are so low. And so, Paul, I appreciate you bringing this presentation to us, and it's definitely something that's got to be fixed moving forward for all providers.

MR. BRAND: Everyone, this is my basically -- I would say my newness of, you know, in the industry but yet not actively in it.

At any point -- or, I guess, now, when

the being discharged from a hospital, at what point did the hospitals, I guess, onus on that? Has that ever been to where, you know, they basically had their own services there or their own transport methods, especially for the nonemergent and those returning either home or to a nursing home or whatever?

CHAIRMAN SMITH: I can tell you that the hospitals are having to get into the business. Many of them used to not have any type of a transport service whatsoever. But out of necessity, we've had to step up and create -- I can tell you from the Baptist Health side of things, before 2019, all we had were affiliations with 911 providers.

And in 2019, we started with Baptist Louisville and Baptist Lexington, and now we've -- we're out to five different hospitals. And there are other health services. I know UK has drastically grown theirs.

Troy, you can talk about your all's hospital service where you're at with your transport needs. But it's -- we're having to grow these things because we've got to get

patients taken out. And the 911 providers, A, don't have the capacity to take the trucks out of service; and, B, that just puts it on the hospitals even more, which then causes the personnel shortage we have for paramedics and EMTs.

MR. BRAND: Yeah. And that was kind of my worry, is that, you know, when you're looking at this, that you're limiting yourself on -- you know, for our services that are designed to, you know, protect our communities, you know, make sure that they have the healthcare options they need and they can get there.

But when you start treating it like an Uber, you know, that's concerning to me. I know it is for the whole group. I just didn't know if at one point, you know, in history -- I usually have to rely on Troy for my historian on some stuff. He's been doing this a long time.

But as far as, you know, at one point, did we ever have it to where it was the hospital, and at what point did it get passed on to the EMS services in the areas?

CHAIRMAN SMITH: No. It's always been on EMS. Hospitals really haven't done it too much. I can tell you that for actual nonemergency where there is absolutely nothing that has to be done, there are vendors such as Caliber and Able Transportation that will come in. But because they can't bill insurance because it's not an insurance thing, they end up billing the hospital. So in a lot of cases, hospitals end up eating the bill for transportation even though they're not the payer of last resort.

And that's really a topic that has been coming up a lot, the term payer of last resort. We've had 911 providers that have tried to bill EMS for -- or tried to bill hospitals for transports for patients coming to the hospital because -- either they were a Medicaid patient and they didn't want to accept the low rate of pay from Medicaid. So they would turn around and send the bill for transport to the hospital despite the fact the hospital isn't the payer of last resort.

So the -- the low rate of reimbursement

has got many different effects having to do with patient transport, not just for 911 providers but also the nonemergency providers as well.

In fact, at Baptist, we're getting to the point that the amount of money we're spending on contract services to get patients out -- considering how much they're charging now, we're starting to internalize it. We're basically going to have to take it on the chin and start operating a fleet of wheelchair vans that we're not -- we're not going to basically charge anything for just to be able to get these patients out.

Obviously, if they're an ambulance patient, they have to go by ambulance. We have to charge because, otherwise, that would be a safe harbor violation. But if it's a patient that basically needs a wheelchair transport, the amount of money that we're being charged at the hospital level just to get these people out, it's not worth it.

So we're starting to get into the business of buying wheelchairs to get the -- or wheelchair vehicles to get these patients

out because patients need to go home at the end of their stay.

MR. BRAND: Yeah. And that way -- because you can't make any money, you know, if the bed is still being used. But I've thought about that with the last resort. We run into that in the air medical side with helipads that are shut done.

And for their alternate sites, you know, it's like: What kind of rush do they have on getting the other helipad up? And usually the hospital, you know, in certain cases have been responsible for that bill versus the patient and/or the company that's flying in. So that was -- I was just kind of curious.

CHAIRMAN SMITH: Yeah, yeah. No worries. Good questions.

And Paul just put something into the chat about not wanting us to forget about the coding misalignment. That has been something that Ms. Basham and myself have talked about several times as far as where we've had to basically accept the T2005 transport reimbursement because it's the only thing that's available, and it does not align.

T2005, to Paul's point, is a nonemergency transport provider fee, not an EMS-related fee. And we really should not be billing something that is not an actual HCPCS code because it then opens us up for a potential audit situation to where we're billing for something that the codes simply do not line up.

So I know we've talked a little bit. I'd like to open this up to the MCOs that are on the call to get your all's perspective, if you all think that there's any appetite at all for looking at the rates that are being reimbursed for EMS.

I know that on the MAC calls, I hear all the time about dentistry and behavioral health and some of these others that are getting bumps in their rates. But when it comes time to transport, other than the GEMT program, that service is basically the emergency side only.

Is there an appetite that we can go forward and try to get some type of a boost on the nonemergency transport side that the MCOs may be willing to support?

And I apologize. I don't -- my screen is not able to pop up all the folks on the call, so I don't know if somebody is trying to get on to speak or not.

MR. PHILLIPS: Hey, Keith. I just wanted to add in that I did some historic -- like trying to dig into these fee schedules. If I'm not mistaken, that T2005 was built for, like, nonemergency stretcher transports that there really isn't even a regulatory class for in Kentucky, and they're not even -- regulatory-wise, they're not even allowed. There is no license for those -- for those services.

MR. WALKER: It's for, like, a stretcher van, is what it was intended for, that we do not allow.

MR. PHILLIPS: Correct.

CHAIRMAN SMITH: Right. In fact, the -- and I'm sure I'm preaching to the choir, Paul, given your former position with KBEMS. But for those that are on the call that doesn't realize it, basically, the regulations state if a vehicle -- if a patient must go by a stretcher, they go by an

ambulance because an ambulance is the only thing in the state of Kentucky that is recognized as being able to transport with a stretcher.

And a lot of these providers that are going out and doing stretcher transports in the back of a minivan, they're doing so with absolutely no crash test data to determine whether or not, if they're in an accident, if that patient is going to be safe, which I can pretty much tell you, based off of how I've seen how they strap some of the stretchers down with the oxygen bottles just flapping around, the patient is not going to be safe.

We've got a quagmire of a situation here in the fact that everybody kind of just turns a head and lets these companies come in and do stretcher transports where, on the DOT side and the KBEMS side, it specifically states if you're on a stretcher, you need to be in an ambulance, and that's when the ambulance rates kick in. However, because of the mismatch that Paul is talking about, we can't actually bill for that.

MS. MCNAMARA: Hi. It's Wendy

McNamara from Aetna Better Health of Kentucky. Can you all hear me?

CHAIRMAN SMITH: Yes, ma'am.

MS. MCNAMARA: So, you know, I'm coming from the MCO perspective and, certainly, I'm coming from managing a team who -- we manage the inpatient authorizations for the Kentucky members. And, you know, it's incredibly frustrating when we get a request, you know, to assist in locating an emergency crew that can -- or I should say an nonemergency crew to transport a patient.

And I feel like we're getting those requests a little bit more frequently because the hospitals are getting in a situation where they're calling and, you know, they're unable to find somebody that can transport because of the lack of services that is offered.

And I feel like, you know, having sitting in these EMS meetings now for probably close to a year, the trend that we're hearing is, is that if you're not getting funding and reimbursement, then you're forced to close bases down, and that

seems to be the consistent trend.

So I do feel, you know, from the perspective of managing their membership and managing a safe transport for our members, we do need to come to some sort of a consensus to help keep you guys in business, if that makes sense, to simplify it as much as I possibly can. But I would stand in some kind of support for some sort of reform.

CHAIRMAN SMITH: Thank you, Wendy, very much. And to your point, yes, that money drives everything. And to that point, just this last week, Mercer County EMS, the service that was being provided there basically went out of business. And thankfully, AMR, the company that Mr. Phillips works for, has agreed to go into Mercer County to be able to provide some form of EMS coverage and try to fix their transport situation that they have there. Because the last company, despite every effort they made, simply couldn't make it work financially.

And because EMS is not considered a primary service or essential service in

Kentucky, there are -- there are a lot of protections that are simply not available.

And I'll tell you that Mercer County is not the only county that we're hearing right now that are having these issues. There are several other very large counties from the perspective of land mass area that happen to be rural that are in the same boat right now, that they are literally days from making the decision to pull out and get out of EMS altogether because they simply can't afford it.

It's not a matter of them making money. It's a matter that they are so far in debt, there's just not a chance of them making money.

So to your point, Wendy, thank you for being willing to carry on the conversation. We need some more of the other MAC members -- other MCO members, to see if you all are willing for us to be able to engage in these conversations to fix the misalignment and to talk about getting our reimbursement rates up to a higher level.

Again, we're not looking to get rich. I

don't think anybody doing Medicaid work is. We've got a subset of patients that we've got to take care of, and we're getting to a point that, financially, if we take care of them, it draws us to be in a position of: Do you make your payroll or not? And that's a very unfortunate situation to be in.

MS. MCNAMARA: Yeah. And those patients aren't going away, you know. There is always going to be a need so -- for sure.

CHAIRMAN SMITH: Right. Right. In fact, I see it -- and from where I sit, I think it's actually going to be growing considerably more over the next few years if the trend keeps going the way it is.

MS. LEWIS: This is Suzanne Lewis from UnitedHealthcare, and I'd just like to echo what Wendy said. We are seeing an increase on the care management and patient side of members who require stretcher transport. We even see it on the outpatient side with our care management team needing transport for members for nonemergent stretcher transport, and it seems like it's increasing as well, Wendy. It seems to be

happening more frequently, and I don't see that stopping.

I also see that if we're looking at a mismatch of data here that's being presented, we do have a challenge. And if we're seeing that ambulance companies are going out of business, that there's a problem.

So I would -- I would definitely be open to taking this back to our team at United and having a conversation in support of -- you know, open conversations, being involved with a task force if you guys are putting something together for that going forward, having conversations about this.

Absolutely. We'll be happy to participate in whatever the TAC recommends, as far as next steps and discussions, if you all are putting together a group or a committee to work on this.

CHAIRMAN SMITH: Yeah. I think it would be fantastic for us to be able to put a workgroup together of TAC members along with MCO members that would be willing to work together to come up with something both for the mismatch and the reimbursement point.

Troy, you've dealt with this probably longer than I have. Is that something that you would consider possibly heading up, for a workgroup to look at both of these angles for us? You're on mute.

MR. WALKER: Yeah. Maybe I'll do some remedial training in Zoom calls. Yes. I'd be glad to do that.

And I do have one question, though, Keith.

CHAIRMAN SMITH: Yeah.

MR. WALKER: With the MCOs, are all the MCOs using the T2005 or just a few of them?

CHAIRMAN SMITH: Great question. We need --

MR. WALKER: I think it's just a few.

CHAIRMAN SMITH: Yeah. I think we need to open that up to -- since Dana is not on, Linda, are you able to communicate?

MS. BASHAM: Yeah. I think they -- I believe it's my understanding they are using the T2005.

MR. WALKER: All of them or just a

couple of the MCOs?

MS. BASHAM: I could verify that with my Medicaid manager, but I think it's all of them.

MR. WALKER: Okay.

CHAIRMAN SMITH: Okay. Since Mr. Walker has agreed to be our workgroup person, do we have members from both the TAC and MCOs that would like to step up to be able to work together on this?

MS. BASHAM: This is Linda. I'd be glad to.

CHAIRMAN SMITH: Okay. Thank you, Linda.

MS. MCNAMARA: This is Wendy McNamara. I would be happy to.

CHAIRMAN SMITH: Okay. Linda, Wendy.

MS. LEWIS: Yes. Suzanne from United. You can put me down, and I'm probably going to add some folks from my team. I just need to grab a couple of people and see who the best representative would be.

CHAIRMAN SMITH: That would be fantastic.

MS. MCNAMARA: I'll echo that as well from Aetna Better Health.

MR. COLLINS: Yeah. This is Shaun Collins from Anthem. You can add me initially and then I'll probably add Dr. Brunner to support as well.

CHAIRMAN SMITH: Okay.

MR. MEEK: Hi there. This is Aaron Meek from WellCare of Kentucky. I put my contact information in the chat. I'd like to take this back to our team and find who the best people for this call will be and respond to you once I get ahold of them; okay?

CHAIRMAN SMITH: That would be fantastic. Thank you so much.

Are there any other -- besides Linda and Troy from the TAC, are there -- is there anybody else -- I don't think we can get many more because then we'd be hitting quorum. But I believe we could have one more from the TAC if we have any TAC members that want to be a part of this.

MR. CARROLL: Hey, Keith. I'll be happy to help out on that.

CHAIRMAN SMITH: And that was you,

Jacob?

MR. CARROLL: Yeah. It was Jacob.

CHAIRMAN SMITH: Okay. Very good.

All right. So it sounds like we've got a good group here. We'll go ahead and get the list of names and email addresses put together.

Troy, if you don't mind, I'll go ahead and pass this issue off to you.

Paul, again, thank you so much for bringing this up today and sparking this conversation. I think it was definitely something that's been needed for a long time, and timing couldn't be better since we just got the PCS form taken care of for EMS providers. This is a great segue for us to go into for our next project. So thank you all very much on that.

MR. PHILLIPS: Yes. Thank you to everybody for giving us the attention because it's -- this could really be a game changer for EMS in Kentucky. And I think it probably -- it should be at the top of all of our lists right now so greatly, greatly appreciate the engagement.

CHAIRMAN SMITH: Very good. Thank you, Paul. All right.

MR. WALKER: Keith, I've got a question real quick for you.

CHAIRMAN SMITH: Yes, sir.

MR. WALKER: And I don't know who to answer this, maybe Medicaid. So to make a change like this or to start the process, do we go from the MCOs to Medicaid or from Medicaid to the MCOs? What's the best way to handle this topic, and where do we need to start?

CHAIRMAN SMITH: That's a great question.

MS. SHEETS: Hi, Troy. This is Kelli Sheets again. Most of our DMS leadership is at another meeting today, so I can certainly take that question back and ask and then get an answer out to you guys.

MR. WALKER: Okay. Thank you.

CHAIRMAN SMITH: All right. Very good.

If we don't have any other discussion about Item 5, we'll go ahead and drop down to general discussion. Does anybody have any

other items of concern, any items you'd like to discuss or otherwise?

(No response.)

CHAIRMAN SMITH: All right. Hearing none, we'll drop down to 7. And I think really, from a recommendation standpoint, when we go to report out to the MAC, I don't think it was -- it's really a recommendation more than it is just an advisory note to let them know that we are going to start having this conversation within the committee about potentially raising the rates and taking care of the misalignment.

But I don't foresee having any kind of actual recommendations to formally propose to the MAC. Would the group agree with that?

MS. BASHAM: I agree.

CHAIRMAN SMITH: Okay.

MR. CARROLL: Yeah. I agree as well.

CHAIRMAN SMITH: Thank you. All right. MAC meeting representation. I was not able to make the last MAC meeting. I had a schedule conflict and was not able to

do it. I did not hear anything back that had any bearing on EMS. But I will be on the next MAC call and would be more than happy to brief the group on what we were able to discuss at today's regional meeting.

I will tell you that most of the TACs have gone to a quarterly meeting. So when we have the MAC meetings, more and more of the groups are reporting out quarterly instead of semimonthly. So there are -- it's getting to be a quicker meeting in the fact that there's not as many people to report out as what there typically has been in the past so...

But, again, I'll be more than happy to report out for our next meeting. But if anybody on the call wants to sit in on the MAC meeting, please feel free to do so. They usually start at 10:30 in the morning and go till about noon. Hopefully they'll be shortening up a little bit more with everybody going to the quarterly meeting type of format.

Our next meeting is scheduled for July 22nd from 2:00 to 4:00. However, I'm sure Mr. Walker will get together with the

workgroup and come up with a different meeting time and place and date to be able to discuss what we had talked about earlier today.

Troy, if you wouldn't mind, when you all come up with a meeting date, if you wouldn't mind just forwarding that along so that we're aware of what that date will be, not necessarily for us to jump on, but just so that we can keep track of the date. So we can report it out to the MAC that we are having the meetings.

MR. WALKER: I will. I'll do that, Keith. Thank you.

CHAIRMAN SMITH: Okay. Great. Thank you.

All right. With that, if there is no other business, call for adjournment. Do we have a motion to adjourn? You're on mute.

MR. CARROLL: I will --

MR. WALKER: So moved.

CHAIRMAN SMITH: Very good. Thank you.

MR. CARROLL: I will second.

CHAIRMAN SMITH: All right. We've

got a motion and a second. Any discussion?

(No response.)

CHAIRMAN SMITH: All those in favor, please vote by signifying aye.

(Aye.)

CHAIRMAN SMITH: Any noes?

(No response.)

CHAIRMAN SMITH: Very good. We are in adjournment. Thank you all very much.

(Meeting concluded at 2:42 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, 2024.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR