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

****

June 26, 2023
2:00 p.m.-3:28 p.m.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

TAC Members:

Keith Smith
Kevin Callihan
Linda Basham
Dana Evans
Troy Walker
Joe Prewitt
Jacob Carroll

MR. SMITH: Okay. Erin, are we getting close?

MS. BICKERS: Yes. It looks like the waiting room is cleared and it looks like Keith just joined us.

So if all -- and I do want to give -- we've been giving friendly reminders to all of the TACs. All voting members must have your camera on while voting. If we can, for the purposes of the minutes and the transcript, if we can utilize the raising the hand so we are not speaking over top of each other. And if you are not a TAC member and not speaking regularly, just identify yourself when you first speak, so that way the court reporter can capture who's speaking so that way our minutes are complete. So that's all I have. The waiting room is being cleared out, so Keith, I will hand it over to you.

MR. SMITH: All right. Thank you very much.

I will apologize ahead of time, I just moved into our new house two days

ago and from a technology standpoint, I am still getting all the bugs worked out. So if I drop out I will get back on just as quickly as I can. Hopefully, everything is going to go well, but just in case, I wanted to throw that out there.

First off, thank you everybody for joining this month's meeting. I see quite a few names on the list for today, so that's outstanding.

Erin, would you mind going and doing role for us we can establish forum?

MS. BICKERS: Absolutely.

I have Keith?

MR. SMITH: Present.

MS. BICKERS: Kevin?

(No response.)

MS. BICKERS: Linda?

(No response.)

I thought I saw her log in.

Dana?

MS. EVANS: Here.

MS. BICKERS: Troy?

MR. WALKER: I'm here.

MS. BICKERS: Joe?

(No response.)

And Jacob?

MR. CARROLL: Present.

MR. PREWITT: Sorry. I am.

MS. BICKERS: I thought I saw you log in.

Okay. One, two, three. That gives you five. You have a quorum, sir.

MR. SMITH: Thank you very much.

I'm sending a message to Linda real quick to see if she is planning on getting on or not because today's discussion, we need to have as many people present as possible.

MS. BICKERS: I thought I had seen her log in earlier. Let me scroll -- maybe she stepped away briefly.

MR. SMITH: Okay.

MS. BICKERS: I don't see her now. So --

MR. SMITH: Okay. One second here. Let's see if she answers.

MS. BICKERS: No. I do see her. Linda Basham, 911 Billing Services. So it looks like she is logged in.

MR. SMITH: Okay. Great.

MS. BICKERS: But I don't see her on camera either. There she is. I see her.

MR. SMITH: Hi, Linda.

All right. Since we've got everybody, we will go ahead and start up here from item number 3, which is discussing the minutes from the April TAC meeting. I was absent for the April meeting. We had several people out and we actually did not have quorum so, therefore, I don't believe we have any official minutes to approve however we did get the transcript from the court reporter. As a point of order I think we do need to go ahead and approve the court reporter's report. Since I wasn't able to catch that meeting, Troy, were you able to read those minutes and were you okay with them? You're on mute.

MR. WALKER: Yes, I was.

MR. SMITH: Okay.

And everything looked good on them --

MR. WALKER: Yes.

MR. SMITH: -- from your perspective?

MR. SMITH: Okay. So we will call for a vote for the April meeting. All of those in favor of accepting the minutes or with any changes? Can somebody make a motion?

MS. EVANS: I make a motion.

MR. SMITH: Second? Okay.

All in favor, raise your hand. Actually we have to do the reaction by hand, so --

MS. BICKERS: I apologize. Whoever is AMB Meeting, your camera was not on when you made a motion. I'm sorry.

MS. EVANS: That's Dana. It's okay.

MS. BICKERS: Thank you.

MR. SMITH: Okay. So all in favor again? Raise your hand.

ATTENDEES: Aye.

MR. SMITH: Any opposed?

All right. No opposed. Motion carries. The minutes have been approved.

MS. BICKERS: You may also approve your February minutes if you didn't have a quorum last --

MR. SMITH: Yeah. Good point.

MS. BICKERS: Sorry. I was on maternity leave, so I was trying to remember when that was.

MR. SMITH: Yes. It's been a busy year already. No doubt.

Okay. So going back to the February minutes. I have had a chance to read them. I didn't see anything on there. Hopefully everybody else has had a chance. Do we have a motion to accept the February minutes as written?

MR. CARROLL: I will make a motion to accept February minutes.

MR. WALKER: Second.

MR. SMITH: All right. Motion from Jacob and a second from Troy Walker. Any discussion? Okay. No discussion.

All those in favor?

ATTENDEES: Aye.

MR. SMITH: Any opposed? Okay. no opposition. Motion passes.

Again, thank you, Erin. I appreciate that.

All right. Going to old business. We have been discussing the issue of pre-authorization for transportation out of hospitals or healthcare facilities really since we started meeting in December. And there's been a lot of discussion going on statewide about this. We were able to get a position statement from EMS providers about how the pre-certification process is -- is harming EMS services. We had the discussion among the last KBEMS meeting -- the Kentucky Board of EMS Open Meeting -- we discussed this and the executive committee from KBEMS also discussed this issue. And the matter isn't so much that we don't want to provide information to the insurance companies; the problem is the current format with the form is not -- it just doesn't work. It's asking for information that hospitals can provide some of it, but they can't provide all of it, and it's asking for information that

EMS can provide some of it, but they can't provide all of it. It's kind of a nebulous form. The fact that nobody can actually complete it satisfactorily enough to be able to get it to go through unless they've got a dedicated person that does nothing but pre-authorizations.

If it is an ambulance service that is not fortunate enough to have office staff or a hospital EMS service that's not fortunate enough to have case managers that have enough on staff to be able to do the forms, it's literally impossible.

So what we are running into is that crews are having to try to get the information when they are picking up the patient, which it's not doing us any good because at that point it's not considered pre-certification anymore. And it's putting us behind the power curve, and even when they do send it in, it is getting denied anyway. So in a discussion with KBEMS, we discussed this at length about the issues that we are running into

and the number of EMS services that have voiced that they have issues with it, and we even sent out a questionnaire from KBEMS asking our EMS services in Kentucky if the form is causing issues amongst our services so that we got a better representation from the field as to how the pre-certification is working, good, bad, or indifferent.

And overwhelmingly, we have found that the current pre-certification form has had a very negative effect to the fact that the majority of our services -- almost 75 percent based off of the survey -- showed that most services have lost over $10,000 worth of reimbursement or more because of the pre-certification form issue.

So we've been saying for a while that we would like to see the Medicare Physician Certification Statement used instead, because it's a one-page form; its information that our EMS providers are accustomed to seeing; providers are accustomed to filling it out; they put

down on these forms what the condition is requiring the transport, and it's worked for us with Medicare for a number of years. So with all of this being said, we would like to ask that all of our Medicaid, MCOs, insurance companies, would please accept the Medicare PCS form in lieu of the pre-certification form.

I just saw an email that came out last Tuesday saying that Aetna Better Health now wants the pre-certification form. Again, if there was a way we could do it and comply with it, and we're to provide all of the information, I don't think our EMS services would have a problem with it, but the problem is that we don't. We don't have the information, and most importantly, we don't have the staffing available to go out and get all of this information submitted before the phone call comes in for us to do the transport.

And I see a hand raised by Dr. Cantor. So go ahead, ma'am.

DR. CANTOR: Thank you. I

appreciate that. I was looking at the form and UHC is not on the header up at the top.

MR. SMITH: Yes.

On the PCS forms, it doesn't have any of the insurance companies listed on that particular form. So basically what happens is when the crews get these forms, and get them filled out, they typically go to the billing company, which most EMS services that do charge for service do go through billing companies. We've got two of them represented today. We got 911 Billing and we've also got AMB on board, which they are the ones that typically take those PCS forms and submit them to the appropriate billing companies.

So if Linda or Dana, if you all would like to speak to that, please feel free to do so.

DR. CANTOR: Thank you.

MR. SMITH: Mm-hmm.

MS. EVANS: The form that he's referring to, the PCS form, is a standard form used across all EMS services. It's

used by Medicare, so that's why there's no payer information on the top of that as far as who that's going to. It is standard just for patient's condition, where the physician can fill that out and state the need for an ambulance transport.

DR. CANTOR: That helps. Thank you.

MR. SMITH: Thank you, Dana.

And I would also like to offer the option, if the folks have not had the opportunity to see the document, the questionnaire document, we can -- Erin, if you could bring that up on the screen, so we can go through it briefly, so everyone can see what the results of the questionnaire was in regards to the answers that the EMS providers gave us.

MS. BICKERS: Absolutely. Give me just a second. My screen was doing something a little weird a minute ago.

MR. SMITH: Sure. No worries at all.

While Erin is getting that pulled up, just so you know, the

questionnaire was basically four or five questions. It was very short. We wanted to keep it that way so that it basically wouldn't get into a lot of ad hoc conversations. It was to the point about asking specific questions.

Mr. Owen, I saw you were asking a question there. Go ahead.

MR. OWEN: This is Stuart Owen with WellCare. We've got a work group that has been looking at this. The key thing is it will be using the PCS form. It will be a manual claims processing process. And so we have to set rules, it's basically Claims Team, because a claim comes in -- I remember from a prior meeting -- the claim will come in with a diagnosis. The physician, the PCS form, basically has a physician testing that the member meets the criteria to be transported by ambulance. And so, you know, the Claims Processing Team, will have to look at; (A) Is there a form attached to the claim? Because I think that's what we talked about before. The

claim will come in with an attachment. This form would be the attachment. And so they will have to look and see is there a PCS form attached.

And then it has quite a few fields, and when I talked to the staff, I was like, "Well, does every field have to be filled out?"

And so that was kind of a thing that we were a little bit wondering about. Because I know that there was a physician attestation, the physician describes the conditions. But there are other forms -- other fields -- so they are wondering, well, if it's missing a couple of fields, do we deny it because it is incomplete? But we are definitely looking at it. But that's what they mentioned to me and they are definitely not opposed to that.

MR. SMITH: Mm-hmm. Okay. Thank you.

The issue that we are going to run into with having an electronic form being done before the transport gets done, again, is usually when EMS gets called to

do a transport, we know nothing about the patient until our crews arrive at the hospital to get that patient. So any chance of doing a pre-certification, if you will, is virtually impossible. Unless the hospitals complete all of the form for us, and then the hospitals, they don't have the staffing set aside to be able to do that either, which they've come to me and asked, "Who's going to fund the FTE to do all of the pre-certification paperwork for EMS to get paid?"

And then that goes back to, okay, well who is going to come get the patients out of your hospital, because we won't be able to do it, because we can't afford to do it without the reimbursement. So it's a really -- to use an expression -- it's kind of an ugly baby that we've got on our hands at the moment.

MR. OWEN: Yeah. And we were not looking at it as pre-cert. We were looking at it just filing the claim with the form, you know, after the fact. Not as a pre-cert.

Is this the vast majority of the scenarios going to be from hospital to, you know, either home or another facility? Is that, like, originating at the hospital, or are there other scenarios?

MR. SMITH: My experience has been out-of-hospital transfers, but let me open it up to the TAC and see what those folks think as far as the type of transport you folks are doing.

MS. BICKERS: I apologize -- oh, I'm sorry.

MR. WALKER: For me, personally, out of the hospital is the main concern. Most the time nursing homes and things like that have case management and usually don't have no problems as long as they have a designated case manager like a nursing home facility. Most issues we're having is from hospitals, especially ERs.

MR. OWEN: Thank you.

MR. SMITH: Erin, you were going to bring something up there?

MS. BICKERS: I was just going to say, I'm having a couple technical

difficulties, so I do apologize, but Kelly is also trying to work on getting the document -- there we go. Thank you so much, Kelly.

MR. SMITH: Awesome. Thank you.

So on the screen --

MS. BICKERS: It looks like Lisa has her hand raised with Humana, as well.

MR. SMITH: Go ahead. Go ahead, Lisa. Lisa, if you are trying to speak, you are on -- there you go.

DR. GALLOWAY: Now this is Dr. Galloway from Humana.

Couple things. Clarification. When you say you all want to use this form, are you asking to submit this in lieu of having a medical necessity review?

MR. SMITH: Yes, ma'am.

DR. GALLOWAY: Okay.

In Humana, we currently do pre-authorizations and we do accept the request up to two business days after the date of service. It's a grace period so, you know, we do allow you to submit it after the fact and have the medical

necessity review.

You know, I think our biggest hiccup is that you asking us not to be able to do the review, because we do feel like they need to, you know, be reviewed for medical necessity and not just accept the certification form.

MR. SMITH: Okay.

If I'm understanding Mr. Owens point, though, you all want it to be an electronic form and not necessarily a paper form; is that correct? Or would the paper form be okay in that case?

DR. GALLOWAY: Well, I can't speak for WellCare, because I'm with Humana, but --

MR. SMITH: I mean speaking on behalf of Humana. Would you all --

DR. GALLOWAY: Well, as I said, we would accept the form and it could be submitted with the other information when you request the authorization, which, like I said, we allow two business days after the date of service to be able to do the auth. We do not start applying our retro

review criteria until after the two business days from the date of service.

MR. SMITH: Okay.

DR. BRUNNER: This is Dr. Brunner from Anthem.

MR. SMITH: Yes, sir.

DR. BRUNNER: Question. I know -- I do have -- I know you are asking for a medical condition, but does Medicare require a diagnosis?

MR. SMITH: Yes.

It's not necessarily a diagnosis. It's a reason that has to be indicated on the form for the reason of the transport, so if the patient were transported to the hospital with stroke-like conditions, but yet we have to transport because of unable to ambulate, then the crew would check that the patient was unable to ambulate as being the reason for the transport, not that they suffered a stroke. So the conditions for the transports are what's indicated on the form, but that's usually done by the provider at the time we're picking the

patient up.

DR. BRUNNER: So we don't -- like, Anthem doesn't -- we don't require prior auth for those codes -- for those A codes for transportation unless it is an out-of-network provider, so this would be -- I brought up to our team -- their concern is, to build a claim there needs to be a diagnosis.

MR. SMITH: Okay. And would --

MR. WALKER: That's kind of the whole reason why we are doing this, though. We don't always have a diagnosis a lot of times when we are transporting and the hospitals aren't required to fill it out, so until after the transport we don't really have that, and by then we've already made the transport, so --

DR. BRUNNER: Understood.

MR. SMITH: And we are in a catch-22, because we're not allowed to diagnose.

MR. WALKER: Yeah. So.

DR. BRUNNER: Troy, so I was just looking -- so I was an ER doc in

Northern Kentucky for years and when we would send patients home, you know, we had the discharging diagnosis on the chart, or at least in Epic, that could be pulled sometimes, or the admitting diagnosis for inpatients. Is there a way to get that from the hospital?

MR. SMITH: That's part of our issue, too. The fact that it's in Epic, our folks don't have access to Epic or to the hospital's paperwork and, honestly, as the patient's hospitalization goes on, let's say it's a patient that's a difficult case. As they go on, they garner different diagnoses codes and if a crew or if a person looks at the wrong part of Epic, they may pull the wrong code which, then, is going to get the claim denied because they used a code that wasn't the proper code. We're really in a catch-22, folks. I mean, I swear to the Lord, we are not trying to get out of doing work. We are just --

DR. BRUNNER: Oh, I know. I get it. Trust me. I've been on your side

with this before as well.

MR. WALKER: Some folks -- some folks are able to get -- at times, there are some ambulance services that have the ability, sometimes, to get some of those diagnoses off of reports, Dr. Brunner, but a lot of them do not have access to that and can't get it. So.

MR. SMITH: And one of the other issues that we run into is if the crew asks for a copy of that when they go to get the patient, then there could be a 20-, 30-, 40-minute delay at least for them to try to get somebody to get into Epic to get information to be able to jot it down. And even then, it's going to be on a paper form again. It's not going to be an electronic format.

DR. BRUNNER: Thank you, Troy. Thank you, Keith.

MR. SMITH: Are there any of the other MCOs that are on the line that have concerns about how we could go about doing this? Or any suggestions? And then we will jump into the questionnaire that we

took with our EMS providers.

Okay. Hearing nothing, we will go ahead and talk about the questionnaire.

KELLY, KY MEDICAID: I'm sorry. Keith, this is Kelly. I believe Dana has her hand raised.

MR. SMITH: Okay.

Yes, go ahead. I'm sorry. My screen is pretty small. I didn't see it. I apologize. Go ahead, Dana.

KELLY, KY MEDICAID: That's what I'm here for.

MS. EVANS: That's okay.

I just want to to let the MCO's know that the PCS form that we are asking them to consider does have medical condition described on the form by the physician, and that is what the billing agency would use to code a diagnosis code for the claim itself. So it's not like the PCS form, or not having the pre-authorization, we're not going to have a diagnosis for the patient. We will have a diagnosis based on what the physician or the provider at the hospital supplies on

the PCS form itself.

MR. WALKER: Would you think it would be a good idea to get -- I know there's quite a few requirements associated with the PCS form that Medicare has put out. Have we shared that with the MCOs, Keith?

MR. SMITH: We've sent a copy of the form -- I've sent a copy to the state Medicaid office along with the instructions that came from PWW to be sent out to the MCOs.

MR. WALKER: Okay, good.

DR. BRUNNER: Troy, we have it.

MR. SMITH: Awesome. Thank you, Dr. Brunner.

DR. BRUNNER: Sure.

MR. SMITH: All right, Kelly, if you wouldn't mind going ahead and pulling up the questionnaire for us.

KELLY, KY MEDICAID: Sure.

MR. SMITH: There we go.

So the first page of the questionnaire is basically introducing the information to the services to be able to

complete the questionnaire, basically saying why we are asking the information; basically, the topic of the meetings we've had along with the issues that a lot of services have run into with being able to get them completed.

If you wouldn't mind, go ahead and scroll down to question number 1. Again, the form here on this particular page, I believe its page 3, maybe -- doesn't have the page number on here -- but it talks about, there's -- all right. This is the copy of the actual MCO Prior Authorization Request Form that has been requested. This is a copy of the form that we have at Baptist Louisville. That's why it's that particular form on here. It's got the different areas on here highlighted that has been problematic for EMS to be able to complete, such as the NPI numbers for the hospital. EMS does not have the NPI numbers for all of the hospitals that we visit.

Under the Member Information, we also don't know what the MCO ID number is

for the patient. We don't know if it's a work-related injury or not. We don't know if the patient has any other insurance. The only way that we know about insurance is if we have a face sheet that we get from the hospital for that particular patient that gets included, and that doesn't happen all of the time. In fact, our billing companies, it's not uncommon for them to have to go back and contact the hospitals to get the face sheets in order to get the insurance information to be able to begin the claim to begin with.

Down under the Servicing Provider Information, most hospitals don't have the information regarding our EMS services such as their address, the city, the tax ID number, their contact information. They just don't have that information. And A lot of the EMS crews -- many of the EMS crews -- don't have that information for their own services, especially when it gets into what their tax ID numbers or their NPI numbers. That's just not information that

directors willingly share with the crews to be able to use for anything.

And then down below, is one of the biggest difficulties we have, is the primary ICD 10 code that it is asking for. Again, that is something that the hospital would have to indicate and, again, depending on what part of Epic you are looking at, you will het potentially a different ICD 10 code that could potentially be identified for the reason that you are transporting to begin with. That's why, typically, when the crews go to get the patient, and they are getting the PCS form from the physician or from the provider, they are able to discuss with the provider what the medical condition is, and they can then have the provider indicate on the form what is the reason for the transport itself. Not while they are in the hospital, but what is the reason why we are doing the transport.

Okay, go ahead. Next slide, please.

Okay, next.

This is the actual PCS form if you have not been able to see it. This is a generic copy that I got from Page, Wolfberg & Wirth law firm. They are one of the preeminent EMS law firms in the United States.

Essentially what we would be providing on this form, is the patient's name, birthdate, the Medicare number -- or in your all case, it would be the Medicaid number -- the transport date, where we pick them up at, and where it is originating. It is a very simplistic form. In the middle is where it talks about the medical necessity. This is where the meat and potatoes of this form is at. This is where the provider is going to indicate what is the reason we need to transfer the patient.

Now, we know that this is not broken down by the ICD 10 code. It's just not. To try to put the ICD 10 for all of these, it would have to be two pages long to be able to get all of the data, or

longer, to have that added on to it.

It's called out by its specific name so that the providers can simply check it. If we ask doctors to put in the ICD 10 code, they are going to be just as frustrated as everybody else trying to get into Epic and find what the official ICD 10 code is, since there are so many ICD 10 codes.

In section 3, is the actual signature of the provider saying that this is medically necessary. So you have the name and the position of the person who is validating that form that the patient needs necessity to go by an ambulance.

And then underneath that signature is where they indicate what level of provider are they. Are they an MD? nurse practitioner? physician's assistant? registered nurse? social worker? case manager? Yada, yada. That is what is indicated on it. It is a one-page form. It's a very simplistic form for us to be able to get all of the information that is needed to be able to

bill Medicare.

Now granted, we know that there's differences between Medicare and Medicaid. However, if this form will work for Medicare, we would like to see if it can work for Medicaid. And if it can't, where can we meet in the middle to make it work, because we have to do something better than what we've got.

Go ahead and go to the next page, please.

Okay. So this was the first page of the results of the questionnaire. This was the license number of the ambulance providers that were providing answers to us. We wanted to validate that the people that were answering were actually authorized to be able to answer for their services and that we didn't have services repeated in their answers; and it shows the date and time that they completed the survey.

Next page, please.

Just a continuation. We had 52 licensed ambulance providers that

responded. We've got a total of about, I think, 260 EMS providers in the state of Kentucky. That number may fluctuate a little bit, but that was one of the last numbers that I heard.

I got a text in the chat, there, from Dr. Cantor, and yes ma'am, we will go ahead and send this out to you to where you can review it on your own computer. That won't be a problem at all.

Next page, please.

Okay. Question 2. Has the requirement for completing the MCO Prior Authorization Form affected your ability to receive reimbursements since August 2022? Seventy percent, "Yes." Thirty percent, "No." The majority of the folks who indicated "No," were simply nos because they either don't bill for ambulance transports or, by and large, they don't do nonemergency transfers.

There is a great number of EMS providers in the state of Kentucky that have gotten out of the nonemergency transport and, speaking frankly, one of

the reasons they got out of it is it's cumbersome. There's no easy way to put it. There's a lot of requirements to being able to document everything that needs to be documented. Now, granted, there are some unscrupulous EMS providers that have caused us to have to document everything as much as we do because of what they've done in the past, but by and large, there is a large number of people that have gotten out of the nonemergency business.

We had them put down also their individual comments as to why they answered the way they did. It's going to be awful small for you to be able to read, so after the meeting, Kelly, if you don't mind, can we email this document -- actually, the whole packet -- out to all of the MCOs, so they have an opportunity to review all of this information?

KELLY, KY MEDICAID: I surely will.

MR. SMITH: Thank you.

MS. BICKERS: They should have

received that already.

MR. SMITH: Okay.

If you all wouldn't mind, if you did not receive a copy of it prior to today's meeting, if you wouldn't mind putting in the chat that you did not receive it, we will make sure that we send it out after the meeting.

Okay. Can we go to page 4, please?

Okay. Would you support using the Medicare PCS statement in lieu of the MCO Prior Authorization Request? We had a 90 -- I think it's 96 percent said, "Yes," 4 percent said, "No." And again, the people that said, "No," said, "No," because they don't do nonemergency transports. So, by and large, it is a large amount of EMS providers that would like for us to be able to use the physician PCS form in lieu of the MCO Prior Authorization Request form.

Next page, please.

This particular question was asking about how much revenue has been

lost as a result of the implementation of the Prior Authorization form? Unfortunately, these numbers are very bad for EMS. We are already in a situation where we've got EMS services that are on the verge of closing their doors, and when we have some EMS services -- in fact, 43 percent of them, 14 of them that completed the survey -- that are over $10,000 in lost revenue because of the Prior Authorization form, that's simply a call to action. We've got to do something, because this is not sustainable in its current format. That's really the take away I have on this.

And then there are some areas, here, where folks could comment basically off of what their answer was there.

Okay. Next page, please.

And then page 6 of 6 is just the continuation of comments that were made by the providers. And I don't believe there was another page beyond that.

MS. BICKERS: No. That's everything.

MR. SMITH: Okay. If you wouldn't mind going ahead and pulling the agenda back up for us.

So that's -- that's kind of it in a nutshell, folks, as far as where EMS is regarding the Prior Authorization forms and the desire to use the PCS form. It's -- this is a difficult situation. And I would like to hear some more from the MCOs that are on the line, about what your thoughts are after hearing what we said; after showing what we've been able to show. What is your appetite for us to look at being able to use the PCS form in lieu of the MCO Prior Authorization form?

MR. OWEN: Keith, this is Stuart Owen with WellCare again.

We are definitely open to it. Would there be -- because I didn't see like a deadline on a form -- maybe a 30-day? Because we are talking about the services rendered, transport is done, and then you file a claim and a form. Like a 30-day window or something to file a claim, and if it's not filed within 30

days, then deny?

MR. SMITH: Sure. Sure. I don't think that would be a problem.

Linda, or Dana, would you all like to comment on that as far as what you typically see? Your audio has dropped out on you, Linda.

MS. BASHAM: Can you hear me?

MR. SMITH: There you go. You're back on mute again.

MS. BASHAM: Now I'm off?

MR. SMITH: You are off mute now.

MR. WALKER: It's not picking up.

MR. SMITH: You are inaudible, Linda. Your voice isn't coming through.

MS. BICKERS: Linda, if you want to drop it in the chat, I can read it if you are having microphone issues.

MR. SMITH: I don't read lips well, but I think she just said, "Okay."

MS. BICKERS: Zoom does not want to be our friend today, does it?

MR. SMITH: Not at all. Not at

all.

While she's typing that response in, I really think, Stuart, to your point, 30 days is more than enough time for us to be able to turn those forms in. In fact, I think it's going to be quicker than 30 days.

Troy, what has been your all's typical policy for getting those forms turned in?

MR. WALKER: Medicare already has that stipulation you have to have. That's why I was waiting to get that official Medicare number of days, what their maximum number is.

MR. OWEN: So just mirror whatever Medicare, Medicare's --

MR. WALKER: Twenty-one days.

MR. OWEN: Twenty-one. Okay. Thank you.

MS. BICKERS: Linda said, "Medicare has told us all PCS forms for 21 days pending receipt of a signature."

MR. SMITH: Okay.

And I think that's perfectly

reasonable for the crew when they turn in their PCS form. Really there shouldn't be a reason why it should go any longer than 21 days, unless there is the extenuating circumstance of patient, Jane Doe, or John Doe, that shows up to the hospital with no information, but you know, those are outliers. That doesn't happen very often.

So I think if we could adopt the same rules that Medicare uses, then that makes it much easier for everybody on our end to be able to keep up with what the requirements are. And if the MCOs were willing to do that, that would be absolutely huge.

MR. OWEN: Thank you. Appreciate it.

MR. SMITH: Thank you, sir.

MR. WALKER: And I think while we do that, Keith, I think it would be smart is, Medicare has regulations that require the hospitals to do their form, and while we are doing this, get the hospitals -- you know, Medicaid -- to get the hospitals, make them required to fill

out these forms as well.

MR. SMITH: Sure.

And then we've got a message here in the chat about, "Do we have a list of what EMS providers utilize third-party vendors to handle billing?"

I personally don't have a list, but we could probably ask everybody and get that back to you so that you all know exactly who does the billing for which services and who your point of contact would be for each of the services if the question were to come up. We will do that and be happy to send that out before our next meeting. In fact, and soon as we get the data, if everyone's okay with sending out information before the meetings, we will be happy to send it out as soon as we get the information. We will send it to the state Medicaid office and have them send it out to the MCOs that are on the TAC list.

Okay. And then, Shaun Collins asked, "How is this handled in the commercial space?"

Dana, or Linda -- and I know Linda you've got some communication issues there -- if you all can address these -- I'm not with the billing company, so it's hard for me to be able to discuss.

So Linda put on here that commercial insurance does not require PAs normally.

DR. BRUNNER: Correct, Keith. But I guess the question is, are you seeing claims denial for the same reasons with Medicaid as you would with commercial, like, you know, I said we don't require PAs for those A codes. It's what happens on the claims side. But I guess the same question, you know, Shaun's looking at them. What are you guys submitting for claims payment with commercial patients and members?

MS. EVANS: As far as authorizations or anything, there's nothing that is submitted to the commercial payer. You only submit the claim with the level of service, the mileage, and the diagnosis codes.

DR. BRUNNER: So commercial requires diagnosis as well?

MS. EVANS: Yes. Every claim would require a diagnosis.

DR. BRUNNER: So what are you submitting, I guess, to the commercial plans to get that? Is there a specific, separate, different form for commercial?

MS. EVANS: I don't -- I guess I'm not understanding your question. Because there's really not any forms that we -- we file claims electronically and there's no forms that are attached to the commercial insurance claim. It just goes out with, again, the diagnosis code we're getting from the PCR once the transport has been completed.

After the patients -- there is a chief complaint that is called in when the transport's requested and based off of the -- the observations of the EMS provider listing out, you know, the condition of the patient and different readings, then the TACs certified coders would code from that information in the

chart, just like a coder inside a physician's office would code from the chart after the patient has been seen.

MR. SMITH: And then, Linda, also, following up pretty much saying the same thing you did, Dana, that they submit the medical -- medically necessary reason code and that they file electronically as well to where there isn't actually an electronic paper form on that side.

DR. BRUNNER: So the smaller EMS providers are able to -- they're also able to file electronically?

MR. SMITH: Typically most of them all have billing companies that do that for them.

DR. BRUNNER: Okay.

MR. SMITH: Most -- and I can't speak for everybody -- but most every EMS service that I have visited over my years, none of them bill internally. They all externally hire billing companies to do it for them.

DR. BRUNNER: Okay.

MS. EVANS: And there have been

a few services that have come to us that done internal billing prior to being with us, but they've also been able to submit electronically. Just doing it internally you would just contract with the clearinghouse in order to submit your claims. Most billing software allows electronic claims nowadays.

MR. OWEN: This is Stuart Owen with WellCare again.

You know, I was thinking that it might be helpful to have one template that we all used. I know we've got the Medicare form, but maybe kind of customize it for Kentucky Medicaid. I don't know. Yeah. That would probably make it easier or more, you know --

MR. COLLINS: To your point, Stuart, I think if Medicaid said, "No. We have to do something to add a little bit more information." If we were to come up with the custom form that our crews would be able to do in the field with them, I think that is something that we could sit down together and potentially come up with

to be able to get that additional information, but make it to where that the crews will have time to be able to do it, and can do it to where they are not asking for a whole lot of information, or it's not asking for data that they simply can't provide such as the NPI numbers, tax code numbers, information like that. And if we could sit down and potentially build that form together, as far as EMS providers and Medicaid providers, that would go a long way as well.

MR. OWEN: Yeah. And I don't think it would take that much revision at all. Maybe, I was thinking, just a couple things or whatever to make it clear that Kentucky Medicaid -- whatever tweaks need to be done. I was thinking.

MR. SMITH: Sure.

MR. WALKER: It would be great to have one form that done it all, but I'm just going to be honest with you, if it took a Medicare or Medicaid PCS form I would be all in just to get away from pre-authorizations.

MR. COLLINS: Troy, Keith, it's Shaun at Anthem.

Are you guys aware of any states around us, like, Ohio or West Virginia, are they dealing with similar issues or do they have a, like, potential fix that we could kind of create that template?

I agree with Stuart at WellCare. That's where I was going down the road of, it sounds like we need one system template to make your life easier. There's been some -- we are creating some issues unintentionally, of course, but I think we've got to come to the resolutions.

I didn't know if you all talk to anyone in your circles around Tennessee, even though that might have a solution that they utilize.

MR. SMITH: No. I have not specifically spoken to any of the other states.

Linda did answer that not all state MCOs are requiring PAs. I think that's if -- how our EMS rules and regulations differ between states -- I can

tell you that it is usually dramatic. I can't imagine on something like this though, it would be hugely different, but my guess is that everybody does something a little bit differently. But we can certainly reach out and see what the other states do, but I'm liking the direction that Stuart suggested, if that's what we need to do to get all of the MCOs on board, and that we're able to satisfy what the insurance companies need, and we are able to satisfy what the EMS providers are able to provide.

MR. COLLINS: Yeah, I agree. I think Anthem would agree as well. And we'll reach out on our end and see if any of our sister markets have that kind of approach to see if there is anything unique.

MR. BRAND: One of the things we've noticed on our side is we notice that Indiana and Tennessee seem to be as far as closer aligned with what we moved towards in Kentucky then we're seeing in any of the other adjacent states, if that

helps anybody in one direction or another, but as far, like, some of our payer sources and reimbursement rates and different things. So if that helps, I think Indiana was primary and then Tennessee was right behind on some of the changes we're seeing.

MR. COLLINS: Thanks, Josh. That does help.

I'll reach out to Indiana and Tennessee at least on the Anthem perspective and see if they can --

MR. WALKER: Dana or Linda? I know you all both have clients outside of the state of Kentucky. Is there a certain form that any of those use or is it just pretty much they do have pre-auth or they don't have pre-auth? If you all could enlighten us on any forms that they might have.

MS. EVANS: It is a state-by-state requirement and they all have their own ways of verifying or getting pre-authorizations. Some are, you know, online, some are paper. It just

depends on the state and the actual payer.

MR. WALKER: Do any of them use something like the PCS form like for what we are proposing?

MS. EVANS: I don't know. I would have to check with the other teams to see and she said that she's not aware of any -- Linda does -- I didn't think there was, but I would check with the actual billers to make sure that there wasn't something new they had come on.

MR. SMITH: I muted myself and didn't realize it.

Are there any other comments that anyone would like to make?

Okay. Very good.

I think we had some really good information going back and forth on that. I appreciate everybody's input on it.

Why don't we form a small group of MCOs and the EMS TAC members to be able to discuss a form that both can work with, and be able to establish going forward, because it sounds like the Medicare PCS form, straight up as it is written now,

may not check all of the boxes or some of the main boxes that Medicaid needs, but perhaps there are some small tweaks that we can make to add to it to where our EMS crews can still get it done and be able to meet the needs of the MCOs and our providers.

Do we have any folks that would like to agree to work on that together?

MR. WALKER: I sure would.

MR. SMITH: Okay, Troy.

MS. BICKERS: Keith, I'm going to check on that. Because it's TAC business, it may have to be discussed in an open meeting. But Leslie, are you on? Is that correct?

MS. HOFFMAN: Yes.

MS. BICKERS: Okay.

So that does need to be discussed in an open forum, correct?

MS. HOFFMAN: Yes. As far as I know.

MS. BICKERS: Thank you.

MR. SMITH: Then would it be appropriate if we could schedule a

subcommittee meeting where it could be open but yet not necessarily during the actual TAC meeting --

MS. BICKERS: Yes --

MR. SMITH: -- not the entire TAC meeting?

MS. BICKERS: Yes, sir. What you can do is you can call an emergency meeting, and what you do in an emergency meeting, we will get together, and we'll schedule a date, and it runs very much like your TAC meeting, only with an emergency meeting, you are only allowed to discuss items on the agenda. So there's no general discussion, recommendations, things of that nature. So you can only discuss what is on the TAC agenda and we can call a special meeting for that. That is the option for that. Yes, sir.

MR. SMITH: Okay, great. And Dr. Cantor has agreed to meet as well.

MR. OWEN: Yeah. This is Stuart with WellCare. I definitely agree as well.

MR. SMITH: Okay.

MS. BICKERS: And Keith, you and I can get together with some dates coming up. I believe your next one is at the end of August, so maybe some time mid-Julyish we can look at some dates and see so it's kind of in between your two TAC meetings.

MR. SMITH: Yes.

Actually, if we can step it up and even potentially do it before then, not necessarily the week of July 4th, because there are a lot of people traveling then, but maybe right after that, because this issue is major for EMS and we need to try to get this handled as quickly as we possibly can.

MS. BICKERS: It looks like we do not have a TAC meeting that would conflict on July, Monday the 10th from 2 to 4. And that keeps it on a Monday in your all's normal time slot. But we can discuss that off-line and I can get all of that information out to all of the MCO partners and all the DMS staff as well, so we don't eat up all your time here.

MR. SMITH: Awesome. That would

be fantastic. Thank you very much.

MS. EVANS: You're very welcome.

MR. SMITH: All right.

Well, thank you all very much for the discussion on that. And it sounds like we are moving in a positive direction.

All right. Does anybody else have anything from Old Business that we need to discuss that I may have omitted from the Old Business as part of the agenda?

Okay. We will go ahead and jump over to New Business, which the only item I have under New Business at this point in time is the potential to update the payment grid for EMS for Medicaid transports for the next legislative session.

In the last MAC meeting, it was encouraging to hear the Medicare -- I'm sorry; the Medicaid adjustments -- that were being made for such things as dental, vision, and other areas, and we had talked before about -- and some of the

legislators had worked with Commissioner Lee -- looking to potentially make a positive change in the Medicaid reimbursement for ambulance, and, just curious, with the new session coming up and with it being a funding session, has there been any discussion, whether through Kentucky Medicaid or through any groups that anyone is aware of, where the issue of EMS funding can come up? Because with us still being reimbursed for nonemergency under the T2005 at $55 a run, you know, our average cost per transport with a BLS crew is $78 and that is for like a 45-minute run. So we really need to look at the nonemergency, especially the reimbursement.

Obviously, with the GMAT format or GMT program, there's some opportunity for EMS to be able to get some additional dollars and to be able to pick those transports, but not all EMS services are able to benefit from the GMAT program. So with that being said, is anybody aware, especially on the Medicaid side, if there

is any pending litigation, discussed litigation -- or, legislation, not litigation -- my mind's in the wrong spot there -- having to do with reimbursement for EMS?

MS. HOFFMAN: This is Leslie Hoffman, and I don't want to speak for Justin, specifically, about any payment or reimbursements. I was actually going to give you an update today on some other things that we have got going on. But it is my understanding that they are currently, right now, looking at ways to reimburse based on House Bill 8. I believe that's what she said. So I don't have any specifics, unless Justin does, but it is my understanding that they are working towards that.

MR. DEARINGER: Yes. This is Justin Dearinger.

Leslie, that is correct. There are studies currently looking into different reimbursement methods based on that house bill.

MR. SMITH: Okay.

And House Bill 8, that is the GMT program? Is that correct?

MS. HOFFMAN: Justin, do you know? I'm not sure about that. I know that was related to --

MR. PREWITT: That's not the same program.

MS. HOFFMAN: Okay.

MR. SMITH: Okay.

MS. HOFFMAN: So they are looking at reimbursements for all providers through House Bill 8 right now. And this is one of the groups that the information came up, so I just wanted to let you know, and I can't speak to that today because Commissioner Lee is not on. But I do know that they are evaluating that currently right now, so that's a positive, not a negative.

MR. SMITH: Absolutely. Any talk we can do is a good talk. So.

MS. HOFFMAN: Now, Keith, do you want me to give you an update on the things that I had today? I thought we needed to give you an update. I think

Liam Fitzpatrick maybe has come to you in the past.

I'm going to share my screen and I'm not going to go through all of it. I promise. This a lot of information here. There's a lot of moving parts. I would suggest that if you have any questions, just to reach back out to us with an email and that way I can make sure that you get the information timely.

MR. SMITH: That would be outstanding.

MS. HOFFMAN: Can you see my screen okay?

MR. SMITH: Yes, ma'am. It just came up.

MS. HOFFMAN: Okay.

So I'm Leslie Hoffman. I'm the Deputy Commissioner for the Department of Medicaid, one of the deputy commissioners, and I've also asked for the Myers & Stauffer consulting team to be on today, just as there are so many moving parts. I want to make sure that I have accurate information related to questions, because

we've got lots of initiatives that we are working on.

And I'm going to leave it in this mode, if you don't mind, in case I need to go back to a screen. I should have it big enough where you can see it.

MR. SMITH: Certainly.

MS. HOFFMAN: So Treat in Place/Treat No Transport, we have a state plan amendment that has been drafted and is finished and is currently under DMS review and approval process to be sent off to CMS. We have an anticipated date of early July, maybe this week or next week. I am pushing Erin on that one. Anticipated effective date would be January the 1st of 2024.

So just to give you some information. EMS providers may -- if this is approved by CMS -- CMS providers may bill for Medicaid for medical services rendered at the scene of a call that does not result in a patient transport. So these are things that we are currently working on. All of this really started to

come about with our Mobile Crisis.

So just bear with me because I've got like four things to get through, and if you've got questions, we can go over those a little bit later.

Medical services must also be appropriate and medically necessary. This would be billable under the HCPCS Code A0998, which would be added to the Kentucky Medicaid Transportation Fee Schedule. Remimbursement would be linked to the existing AO49 BLS and that is the -- yes, the BLS. Sorry. Just making sure I've got that right. That is base life support. Which is $82.50. But any future changes that may come about to A0429 will mirror A0998. So what that's saying is if in the future those two that are connected, rate increases occur, then they will both be reevaluated.

If it's a Treat In Place, and there's no transport, then there's no mileage for reimbursement, of course, for your transporting, the expectation is that the MCOs will follow the fee for service

methodology that is in the future. Remember we are looking at January the 1st.

We would work with the MCOs that are on the line today and be sure that you have ample information and timeliness to make those things occur.

So again, this is Treat In Place/Treat No Transport. And I think this is part of House Joint Resolution 38 -- I believe that's right. So that was part of that as well. But again, we were already working on these things so it was good that we were already doing that.

MR. SMITH: Leslie, real quick, just a quick question. On Treat No Transport, would Mobile Integrated Healthcare or Community Paramedicine, would that work under that, where if we send a medic to a person's house to do a wellcare check on them because of a complaint or a checkup request, that that would be covered if the patient is a Medicaid patient?

MS. HOFFMAN: If that is a

behavioral health transport related to Mobile -- Bradford are you on? I'm correct, right? I want to make sure that I'm saying that right.

MR. JOHNSON: Yep. Hey. This is Bradford with Myers & Stauffer.

MS. HOFFMAN: Just making sure I get it right.

MR. JOHNSON: I think the intent of this is for, you know, if you are called out to a home, you know, maybe there is a diabetic patient, or if, you know, you are called to the scene of an accident and you perform some type of medical treatment on the scene and there is no transport that it would be used in those cases.

MR. SMITH: Okay.

MS. HOFFMAN: Sorry. I'm going back. Sorry, Keith. You were talking about the Treat In Place. I thought you were talking about the behavioral health piece. I'm sorry.

MR. SMITH: Oh no. You're good.

MR. DEARINGER: Again, this is

Justin Dearinger -- just to kind of clarify what Deputy Commissioner Hoffman said, any time that an individual from the EMS service goes out to do the evaluation process, that is -- under this state plan will be a billable service. So in the scenario you just asked, it would be billable to Medicaid.

MR. SMITH: Fantastic. That is awesome.

MS. HOFFMAN: Now remember, all of this is pending CMS approval and they may change it. They may say, "I agree to part of this, but not this. Or you've got to negotiate." You know, we would have to negotiate with them.

MR. SMITH: Right. Right.

MS. HOFFMAN: So this is the second part. Lots of moving pieces, like I said.

This is our Behavioral Crisis Transport or our BHCT. This state plan amendment's already been drafted. We've reviewed and approved it and we submitted to CMS last Friday. Our anticipated

effective date for this one would be October the 1st. The new provider type, a BHCT, would be a Provider Type 59.

So providers that are interested in being this type of provider would, of course, have to go through all of the proper procedures to be able to engage with this provider type. The intended use would be to transport of recipients of Mobile Crisis intervention to 23-hour Crisis Observation Stabilizations, Residential Crisis Stabilizations, or inpatient hospital.

Just stop two seconds. The 23-hour Crisis Observation and the Mobile Crisis changes are in a SPA that were actually submitted in April and we are on the clock with CMS, so that one has already been done.

The BHCT specifically was completed on Friday and sent to CMS. So we've got lots of movement going on.

The transport between facilities including, but not limited to, transportation from emergency room

departments to behavioral health crisis treatments, including that 23-hour that we are developing for the Mobile Crisis, residential crisis stabilization units, or inpatient psychiatric hospitals like next level of care, provider eligibility requirements -- now, again, we don't have all of this worked out, so I'm just trying to give you as much as I can. Provider eligibility requirements, meet transportation requirements in existing KARs, and other state and federal transportation requirements.

The vehicles have to be staffed by at least two employees; a driver and a staff person. We would want this provider 59-type, to be available 24/7/365 and there would be annual training requirements related to de-escalation, behavioral health, and, at least, CPR training.

This goes a little bit farther. Our Behavioral Health Crisis Transport would be the nearest appropriate level of care, is billable, and must be a vehicle

meeting policy specifications. So there are some things that we say that the vehicle must have. This would be billable under HCPCS codes. The base is T2003 at $80 a trip and then, plus mileage at A0425, would be $2 a mile following the existing rules and the fee schedules and all those kinds of things.

If EMS is acting as a BHCT, they must meet the BHCT vehicle requirements to bill the BHCT. So I just want to make sure that we understand that we'll have, for that provider type, there will be separate provider requirements and also the vehicle requirements. A provider who is both a BHCT -- and I'm sorry about all of the acronyms -- and provides Mobile Crisis Intervention Services, such as, the Mobile Crisis team may not bill for the BHCT in addition to the Mobile Crisis services being billed at the S9484.

So I know that that's confusing, but it will get clearer as we go along. A lot of is new to folks.

Vehicles must include separation

between the driver and the passenger; the passenger compartment must have at least two traditional vehicle seats with seatbelts; be free from all sharp edges; be equipped with doors that automatically lock and that are not capable of being opened while the vehicle is in motion or in drive. BHCTs will be required to comply with all data reporting to the state.

Everything that I've got going on related to Mobile Crisis, there is a huge, huge requirement for all these outcomes, data measurements, so there will be a requirement related to data reporting. I just wanted to make sure that you knew that.

Alternative destinations. Medicaid is currently exploring options for EMS transportation to destinations other than EDs. I believe, Justin, this would require a regulation change.

EMS transport to approved non-hospital destinations, such as crisis stabilization, and would be limited to

medically necessary low acuity patients.

I just wanted to make sure -- we've talked about putting this in here -- this is not supposed to ever be a substitute for non-emergency medical transportation. So we don't want it to be that method that everybody just starts using because it is available. It's not a substitute for the non-emergency medical transportation.

MS. BICKERS: Leslie, there's a question in the chat from Paul Phillips. It says, "Am I understanding that four personnel would be required on the BHCT vehicles?"

MS. FARRUGIA: It would be two people. Staffed with two. One of the individuals being the driver, and the other a support staff person.

MS. HOFFMAN: Okay.

MS. BICKERS: And we will email this presentation out to the TAC members.

MS. HOFFMAN: I was literally updating it seconds before I got on today. So Erin, I will send this to you.

MS. BICKERS: Thank you, ma'am.

MS. HOFFMAN: I wanted to share a little bit about Mobile Crisis and, again, I'm not trying to keep you all on here all day. But I want to share a little bit so that you are aware of what a huge endeavor that EMS would be a part of if they are interested in being a BHCT as well.

You probably heard me speak about this if you heard me at any of the MCO forums or any of the TAC meetings, those kinds of things.

We applied for a planning grant; we partnered with our sister agencies. We said, "How do we fill in gaps; knock down all of these walls; come together with blended funds?"

I've never been so, like, -- not just blended financially -- working together, all of our partners that came together to work on this to develop one all-inclusive crisis continuum. So that's what we did in September. We developed that planning grant, took a year. January

through March, we had stakeholder engagements and lots of research, literally three months, boots on the ground, talking to folks about what works? what doesn't work? where are the gaps? how can we help? Especially in our rural communities.

In April, we developed the Needs Assessment, and that's the link that is over to the left. I'm not sure if that is your left. Underneath the diagram. I don't share that because it is over 250 pages long and that is what we utilize to drive all the choices and changes that we've made going forward with Mobile Crisis, was from that 250-page document.

We designed and developed a couple of models. You will hear us talk about this. It's a Commonwealth Model and a Community Crisis Co-response Model. And those are complementary to each other. So we want those to work together. I've never seen this done in any other state. This Community Co-response Model and all of the opportunities within the

co-response.

This administration has done an awesome job to develop something very specific for Kentucky's needs. So January to March of 2023, we started working on the co-response stakeholder engagement research. March of 2023, Governor Beshear announced our proposal that went out. And then in May, Governor Beshear also announced opportunities in our CCCR Model and upcoming funding opportunity. And that's something I wanted to mention as well. So that is our Community Crisis Co-response Model. I'm trying to remember the acronyms myself.

We will have a governance and oversight for this Mobile Crisis Intervention Model, and we will have those two models I've talked about that are complementary of each other. We will have four regional service areas, which we will call RSAs to serve as the Commonwealth Model and we will be introducing the CCCR Model to increase access and availability of services. I'll tell you a little bit

more about that.

Just a second, please. Sorry. There's another meeting going on in here.

So our key outcome is to develop complementary models. You have the Commonwealth Model which is the two-person Mobile Crisis team, which is comprised of at least one behavioral health practitioner and a paraprofessional that will be available 24/7/365. That is dispatched primarily through 988 and local crisis call centers. Response in person at the location of the individual. We also have the CC -- our Co-response CCCR Model which is our CRU Unit which is comprised of law enforcement or first responders with a behavioral health practitioner, paraprofessional, or peer support. Availability may be based on local needs and resources and dispatch primarily will come through 911. This will arrive during the active situation and provide follow-up services after the situation has been resolved.

And I'm giving you a lot of

information today and I'm not going through all of it, I know.

The main piece of this is that we want to come together, divert from jails, hospitals, and emergency rooms. We want to build a comprehensive continuum using SAMHSA's national guidelines. We want them to have someone to talk to. Someone to respond and a place to go. This is a behavioral health crisis service for anyone, anywhere, anytime, with no wrong door. I'm just trying to explain to you that we want EMS to be part of this, if you are interested in it, and to help us with the access and services.

So someone to talk to would be 988 regional crisis call centers; public safety access points, which is PSAP; and 911.

Someone to respond would be regional Mobile Crisis providers -- we are looking at CMHCs, CCBHCs, and BHSOs. We are also looking for a special model, which is MRSS for children, which is out of Maryland and it has an extensive

follow-up of about eight to twelve weeks of extensive follow-up.

Community paramedicine, co-response and law enforcement, prevention, deflection, diversion and inclusion is what we want when somebody responds to these members in crisis. And we want the members to have a place to go with least restrictive next level of care 23-hour short-term crisis observation, first responder drop-off options, and postcrisis follow-up.

If you've recently seen any of the Twitter, Facebook, or any other social media -- Instagram -- we have posts that have buzz that are promoting our CCCR messaging, press releases, and announcements, and there is an embedded video in there if you are interested in that.

So one of the things that you will see is a CCCR Model funding opportunity, and this is where July of 2023 we will be releasing a NOFO -- which is a Notice of Funding Opportunity,

and again, I've never done this before, we will actually -- the cabinet will be actually be offering a NOFO to community municipalities, city government municipalities that want to develop a Crisis Co-response Model in their area. So this is very, very exciting and I think the governor also announced that as well.

Just one more thing that I want to throw out there is that, of course, I serve as Medicaid's -- one of Medicaid's racial and health equity champions, and we currently now have, just recently, a division of population of health, as well as a branch for racial and health equity, but everything that I explained and went over today, I want you to know that we've done it through a lens of cultural humility and that anything going forward, that we are constantly working on through racial and health equity.

I did just include -- I'm not going to read over all of this -- but one of the main things for you to know is that Medicaid has all of these racial and

health equity initiatives that we are working on. We have a particular tool that we utilize. It's called the GARE tool. And through the GARE tool, we run programs or projects or tasks through this, through the lens of cultural humility, and we are using Mobile Crisis, kind of, as our use case or our model for Medicaid, and so it's like a living document. Every time we change or add something, we go back and make that -- we incorporate that into the living document. So for example, because we want EMS to partner with us and we want to increase access, especially into these local and rural communities, that will go into our GARE tool that that is something also we are moving towards.

This is just to let you know what the Medicaid collaborative is, if you want to read about it later. We are participating in that in Iowa, Kentucky, Nevada, and New York.

These are the emails that I said. If you have questions, just send

it. If you send it to the DMS Issues box, that would be fine. It's dms.issues@ky.gov. And if you will just title it, you know, something related to EMS or Mobile Crisis, then I will make sure that the correct SMEs, our Subject Matter Experts, get that picked that up.

If you want to see anything related about the Mobile Crisis initiatives or other behavioral health initiatives we've got going on, there is the DMS webpage -- I'm sorry that's the Behavioral Health webpage that we designed last year -- and then we have, of course, the DMS homepage.

You are always welcome to email me. I'm leslie.hoffman@ky.gov. And then of course, questions. I know I probably took, Keith, more time than you wanted me to explain.

MR. SMITH: No. I appreciate you going over that.

MS. HOFFMAN: I want you to have it, though. Then if you look at it and have questions, we will keep participating

in your EMS TAC, and then we will keep you apprised as we are moving along.

I will say, I always say this with new programs and ones that are this large, this is the largest project I've worked on in my 27-year career. This is the most intense, multilevel spiderweb -- I don't know how else to explain it. So it's easy to get lost in the middle. It is even for us. We've got three SPA changes and a regulation change that we are all working on right now related to things, so it's very easy for us to even say the wrong acronym, right? But I want you to have this information and we appreciate everything that you all do.

MR. SMITH: Sure.

And I think it's good for us to have this, because any type of behavioral health transfer or transport, we do usually get right into the middle of it. So please don't feel like you have to apologize for taking so much time, because it is vitally important for all of our providers to be able to understand what

changes might be coming down the road for us, because we do our fair share of the behavioral health transports. And to that point, we've got, in this direction, one of our hospitals in Louisville is getting ready to expand to take on more behavioral health beds and there are several others I've heard of that are about to do the same. So behavioral health has definitely starting to get the attention that it is needed. Now if we can get our providers protected during some of these encounters because it's not uncommon for some of these folks to act out and to throw hands in the back of ambulances. So if we can find a way through de-escalation techniques that are effective, that would be phenomenal.

Now I did have one question about -- you showed the billing rates for Medicaid patients. If we have to -- once all of this gets into place -- do you know if commercial providers are planning on stepping up and providing any type of benefit for their customers, or is this

strictly going to be a Medicaid initiative?

MS. HOFFMAN: So far what I've been working on is Medicaid. I can't speak for the MCOs or what they might do on the commercial side or in any other areas. But what I've been working on has been specifically for Medicaid.

Again, we've got a lot of moving parts here and I think the best thing for us to do -- and I said a lot and I talk really fast. I'm sorry -- is just to keep you apprised of where we are and what we've got going on. And I always say, you know, something of this magnitude -- will it have gaps? Sure. Will we find problems? Sure. Its part of growing pains. This initiative is huge.

So my Behavioral Health Team within Medicaid of course is partnering with Justin Dearinger's group, also in Medicaid, and we are working again -- collaboration is so key with tons of projects that we have going on right now. The Department of Behavior Health, DCBS,

Department of Community-Based Services, DOC, DOJ, I mean we're working -- DJJ -- we are working with all of our sister agencies right now to try to fill in the gaps to meet crisis needs.

So, yeah. This is very exciting, and like I said, even us trying to pull in EMS and trying to make some things happen with your group also increases access and meets some racial and health equity needs, and also workforce needs that you all may have. So hopefully we can all partner together and make Kentucky better, right? Have more available resources.

MR. SMITH: That would be outstanding. Especially on the part about finding the resources to be able to respond. Because we are getting critically low on EMS providers across the state of Kentucky and we have got to find something, some carrot to use to encourage people to come into the industry and it's going to take more than just EMS people thinking about what it's going to take.

MS. HOFFMAN: Sure. And I would suggest that you take a look at the NOFO that's coming out, maybe not necessarily you, but your local areas or city governments, municipalities that might be interested. It's kind of what you just said. It's -- we were trying to offer a carrot to help entice folks to get going and to meet a higher level of quality and need and clinical need if they need it. So, yeah. I would suggest that you do that.

And I will send this PowerPoint to Erin and she will send this out to everybody. Okay?

MR. SMITH: Outstanding, Deputy Commissioner. Thank you so much for presenting that and I am looking forward to reading it all again and digesting it.

MS. HOFFMAN: Sure.

And like I said, me or one of my staff, I think Liam Fitzpatrick has been on with you all before. Make sure that we keep you updated as to where we are with the SPAs and regulations and things like

that.

MS. BICKERS: And Leslie?

MS. HOFFMAN: Yes?

MS. BICKERS: My goal is to have the Treat In Place submitted by the end of the week. Thank you.

MS. HOFFMAN: Could you get it before 2 o'clock today? I would love to exceed their expectations?

MS. BICKERS: We tried.

MS. HOFFMAN: Okay.

So anyway, we will keep you apprised of what is going on and I will send the PowerPoint on once I drop off. So thank you so much.

MR. SMITH: Thank you.

MS. HOFFMAN: All right. Bye-bye.

MR. SMITH: Bye.

Okay are there any other comments or general discussion points that anybody would like to bring up?

Okay. If not, moving on.

Is there any formal recommendations that the TAC would like to

take up for consideration to go before the next MAC meeting next month? I don't think it's necessarily a recommendation, but I think that a briefing to the MAC is appropriate for letting them know where we are at in working together to come up with a useful form that both EMS and the MCOs can come together on to be able to use moving forward, and I think that's a good thing. I will be happy to brief the MAC about that.

Number 8. MAC meeting representation. I'm going to be 100 percent honest with you all. I don't know what I was thinking when I put that on there. And I am drawing a blank as to what that even is, other than the fact that there is a MAC meeting that occurs in our off months that we are not meeting. Everybody is welcome to sit in on it. It's usually scheduled for two-and-a-half hours and goes three-and-a-half. So pop some popcorn and have a drink if you are going to attend it because it can get rather long.

MS. BICKERS: Keith, we put that on the agenda as a template. Just so you -- if no one from your TAC is going to be there, when they're going through the TAC updates, I can just let the chair know so we are not just sitting there in silence. So that's the only reason that we added that to the template. You don't have to keep that on your agenda if you don't want to.

MR. SMITH: All right. Thank you. Because when I looked at that a minute ago when I was talking, I was like, "Oh my gosh, I don't know what I'm supposed talk about here." Sorry about that.

MS. BICKERS: No worries.

MR. SMITH: Okay.

So our next meeting is August 28th from 2 to 4. Obviously, we will have a special called meeting that we will get the word out so that everybody is aware of it for July 10th. So if everybody could pencil in July 10th from 2 to 4.

MS. BICKERS: Keith, if that is

a go, I can send the calendar invite right now. I've already got it prepped and ready to go. I was just waiting on the official call.

MR. SMITH: I think we do need to do it. If there's any opposition to that day. Please speak now or forever hold your peace. I think this is something that is extremely important and we need to move as quickly as we can on it.

MS. BICKERS: Invitation was sent.

MR. SMITH: Awesome. You are fantastic.

MS. BICKERS: Why, thank you. I try. If you can just get me an agenda ASAP so I can share that with the MCO partners and DMS staff, I will get that out and on the agenda and I will get our website updated with that date.

MR. SMITH: Fantastic. I will be happy to do that.

Okay. We do have a message here that Aetna Better Health does have a

conflict and will not be available on that particular day.

MS. BICKERS: Is that everyone with Aetna, Wendy, or just you, specifically?

MS. MCNAMARA: I believe it is going to be everyone with Aetna. We have our NCQA audit that day.

MS. BICKERS: Oh, okay.

MS. MCNAMARA: The 10th and the 11th. So we will be tied up.

MR. SMITH: Okay.

Do we want to still move forward with the 10th, or do we want to look at the following Monday?

MS. BICKERS: The 17th is clear, so that would be your call as the TAC.

MR. SMITH: For our EMS folks that are on the call still, does anybody have any objection with moving that one week to the 17th, so that we can accommodate all of our MCOs?

MR. CARROLL: The 17th works better for me.

MR. BRAND: Not a problem here.

MR. SMITH: Okay.

Joe, are you good on July 17th?

MR. PREWITT: I'll make it good.

MR. SMITH: Linda and Dana, are you all good?

MR. WALKER: I'm good.

MS. EVANS: I'm good.

MR. SMITH: Okay. Awesome.

Let's go ahead and make it the 17th.

MS. BICKERS: I just sent the update.

MR. SMITH: Okay. Very good. All right.

If we don't have any further -- let me ask. Does anyone have any further business to go forward for the TAC for this particular month?

MR. WALKER: Did you need a motion to go ahead and present the update to the MAC?

MR. SMITH: Present the update, oh --

MS. BICKERS: You don't have to vote on the -- all of the TACs give a

brief update. You only have to vote if there are recommendations that you want to present to the MAC.

MR. SMITH: I'm glad you clarified that. Because the last two months I've said stuff, but there hasn't been any formal recommendation, so thanks for keeping me honest.

Okay. So again, next meeting, August 20th, except for the special call on the 17th. Can we get a motion to adjourn?

MR. PREWITT: I'll move.

MR. SMITH: Second, anybody?

MR. CARROLL: Second.

MR. SMITH: Okay. I have a second from Linda or Jacob. All in favor?

ATTENDEES: Aye.

MR. SMITH: Opposed?

All right. Very good. We are adjourned. Thank you all so much for attending today. I greatly appreciate everybody's willingness to be able to participate in the conversation and I'll look forward to speaking again on the 17th

on the special call meeting. Thank you all very much.

(Meeting adjourned at 3:28pm)

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C E R T I F I C A T E

I, STEFANIE SWEET, Certified Verbatim Reporter and Registered CART Provider - Master, hereby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 30th of June, 2023.

_____/s/ Stefanie Sweet__

Stefanie Sweet, CVR, RCP-M