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PHYSICIAN SERVICES TECHNICAL ADVISORY COMMITTEE

TRANSCRIPT OF MEETING
NOVEMBER 21, 2019

 ORIGINAL

REPORTER: LINDA L. TAYLOR, CCR-KY



TAYLOR COURT REPORTING KENTUCKY
2901 SIX MILE LANE
LOUISVILLE, KENTUCKY 40220

1 Whereupon, the foregoing meeting
2 was held, pursuant to notice, on Thursday,
3 November 21, 2019, beginning at approximately
4 the hour of 9:00 a.m., in Room 129, Capital
5 Annex, in Frankfort, Franklin County,
6 Kentucky. Chairman Charles Thornbury, M.D.,
7 presiding.

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1 TAC Members

2 (Present)

3 Charles Thornbury, M.D., TAC Chair

4 Ashima Gupta, M.D.

5 William McIntyre, M.D

6 Don Neal, MD

7 Tuyen T. Tran, M.D

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PROCEEDINGS

DR. THORNBURY: Good morning,
everybody. I'm Dr. William Thornbury. I'm
here on behalf of the PTAC committee. I would
like to call this meeting to order.

We meet under Title XIX. I'll
have the record show that we have met a
quorum; that Doctors Neel, Tran, Gupta, and
McIntyre, and myself are attending. We have a
couple of guests and we'll get to them in just
a moment.

I have a little personal
business. The first thing I want to do is be
sure to welcome, again, Dr. Neel. Dr. Neel
has not only chaired this committee, but for
those that are unaware, he is a very, very
highly regarded physician leader in the
Commonwealth. We're very please to have his
experience and your talent.

Dr. Neel, thank you for making
time in your schedule to be here.

Second thing I would like to do
is I would like to thank publicly Dr. McIntyre

1 for most capably running the committee in my
2 absence the last few times that we've met.

3 Bill, I really do appreciate that
4 personally and, again, this committee would
5 not run without you and your effort. And I
6 think we all recognize that, and I just want
7 to do that publicly.

8 DR. MCINTYRE: Thank you.

9 CHAIRMAN THORNBURY: Well, thank
10 you.

11 That said, we do have a guest --
12 a couple of guests today. Commissioner
13 Steckel is here.

14 Commissioner, we appreciate the
15 work that you've done in your life and what
16 you've done for the Commonwealth in your
17 service. Thank you very much.

18 COMMISSIONER STECKEL: Thank you.

19 CHAIRMAN THORNBURY: I understand
20 that you have a guest that you'd like to
21 introduce.

22 COMMISSIONER STECKEL: Yes.

23 Dr. Judy Theriot is our medical director for
24 the Department of Medical Services.

25 Dr. Theriot, many of you know personally, but

1 she is - and I'll explain a little bit about
2 what we're going through during the next two
3 weeks.

4 But Dr. Theriot is on contract
5 from the University of Louisville, so they are
6 gracious enough - and we pay them - for her
7 services, and she is a full-time medical
8 director.

9 And in that capacity she oversees
10 all clinical policies in -- and which means
11 basically, everything we do. So she is very
12 -- has gotten -- you've been here how long
13 now.

14 DR. THERIOT: Six months.

15 COMMISSIONER STECKEL: Six
16 months. And she is now an integral part of
17 the staff and the work that we do. We are
18 thrilled.

19 As a contractor, you know, her
20 services can be terminated at any time, but
21 she is a contractor. So if it's okay, Mr.
22 Chairman, I'll explain the transition process.

23 DR. THORNBURY: We'd welcome
24 that, thank you.

25 COMMISSIONER STECKEL: And then

1 I'll let Dr. Theriot talk more about what she
2 sees as her future and the future of Medicaid
3 and Medical Services.

4 We are in a transition. As you
5 all know, there's a new governor-elect, and
6 when that happens our administration works
7 with the new administration. There's a
8 transition committee.

9 We met with them at Medicaid for
10 the first time yesterday, and we'll go over
11 everything that's going on in the Department,
12 all the good, bad, and the ugly, what issues
13 they'll have to deal with, what we're working
14 on and make that friendly transition into the
15 new admission. In that capacity they will
16 make the decisions about their leadership.

17 So as I said, my last day at
18 Medicaid is December 10th, and I'll be
19 returning back to Florida and then looking for
20 another adventure somewhere.

21 But this, I tell the staff at
22 Medicaid, I've been in three states and I've
23 been doing Medicaid for forty years. Coming
24 in -- I know I look very young, and hopefully
25 that's what you were thinking, right?

1 (Laughter.)

2 But this staff at Medicaid is the
3 strongest staff I have ever had the honor to
4 work with. So all the directors, all the --
5 you know there's always outliers, and you have
6 that in any group, but it really is a
7 phenomenal staff. You all are blessed to have
8 that kind of commitment, that kind of faith
9 and believe in the Medicaid program. So I'm
10 hoping that that -- and believing that that
11 will continue, but it may be with some
12 changes.

13 All of the directors, so people
14 like Stephanie Bates, Steve - who is the
15 deputy commissioner; Genevieve Brown has
16 already turned in her resignation, my chief of
17 staff, so she'll be leaving. But Steve
18 Bechtel, the CFO;
19 Lee Guice, you all have met - we think have
20 interacted with our policy and operations
21 director; our quality person, Stephanie -- not
22 Stephanie -- Angela -- Angie Parker, they are
23 all what we call non-merit employees. So they
24 serve at the pleasure of either the secretary,
25 the commissioner or the governor.

1 So depending on what the new
2 administration wants, there may be changes
3 there. But for sure, my last day is the 10th.
4 And I can't thank you all enough, I can't thank
5 the Commonwealth enough. This has been one of
6 the most blessed, enjoyable jobs I've ever
7 had, so thank you.

8 DR. THORNBURY: Thank you.

9 Judy?

10 DR. THERIOT: And I -- I have
11 been with Medicaid for six months, but prior
12 to that I was with the Commission for Children
13 with Special Healthcare Needs for almost six
14 years. So that's actually within the Cabinet,
15 but it's based in Louisville and so it was
16 very far removed and under the radar.

17 So I know a little bit -- and so
18 I've learned a lot in the last six months but
19 there's so much more to learn, but one thing
20 that I've learned is that there is a great
21 team, not only the team within Medicaid but
22 the team within other parts of the cabinet.

23 So I've done a lot working with
24 public health and with behavioral health on
25 different projects and with the office for

1 health, data analytics.

2 So these are just different parts
3 of the Cabinet, and it seems that every day
4 I'm talking to people in those other areas,
5 and DCBS.

6 So I think -- I don't know what
7 it was like before, but I think the Medicaid
8 team is actually really, at least now, used to
9 reaching out and working with the partners
10 around the table to address certain things,
11 such as the substance abuse epidemic.

12 You can't just do it by yourself,
13 and so we're having lots of projects go on
14 with partners from around the Cabinet to
15 address different parts of the opiate
16 epidemic, anywhere from the neonatal
17 abstinence center where we're working with
18 mommies to helping to increase immunizations
19 for Medicaid and people in public health to
20 working with justice involved individuals and
21 trying to get them care when they are released
22 from the correctional institutions instead of
23 them just having them released without any
24 safety net. So working with all of those
25 people is a lot of what I've been doing.

1 I've been working a lot with
2 Angie Parker, part of the quality branch and
3 part of the MCO. So all of the pips and the
4 focus studies and trying to decide once we get
5 these studies back, you know, what policies
6 can we put in place to address some of the
7 things that we're finding.

8 So instead of just looking at
9 numbers, you know, let's actually use the
10 information we're getting back and make
11 data-driven decisions based on actual real
12 data. So that's some of what I've been doing.

13 COMMISSIONER STECKEL: The MCO
14 contract is still an active procurement so we
15 can't say very much about it. However, one of
16 the things that we decided in the new -- the
17 new contracts for the MCOs that will go into
18 effect in July of next year are very different
19 from the existing contract and in one way
20 we'll focus on outcomes measures.

21 So instead of there being fifty
22 HEDIS Measures we really are looking to focus
23 on three or four or five very specific issues,
24 focus on them for two to three years. If we
25 can't move the needle, figure out why, and

1 then move on, but give the focus to those
2 areas so that we can actually make a
3 difference in some of the high COPD, obesity,
4 the diabetes, the usual things.

5 And Dr. Theriot will be leading
6 that effort with Angie about how we do focus
7 that to the betterment of the Commonwealth.

8 DR. THERIOT: I guess so of the
9 other things that we've been doing is reaching
10 out to our university partners to -- to
11 have -- or to ask them to help us look at some
12 of the state data. So it's a state university
13 partnership.

14 They say, Hey I want to research
15 this, I want to look at this data, that data,
16 this other data that the state has. So we
17 give it to them and then they do the research
18 for us.

19 Some of the people are -- and
20 it's Medicaid, you know, owns the data so it's
21 our research so we can use that, their
22 expertise to help us look at different
23 policies, to help form policy or inform
24 policy, and to look at different programs that
25 are happening, if it's working, if it's not

1 working. And that program is really growing.

2 And right now we have U of L, UK,
3 Western Kentucky University. And Northern
4 Kentucky University all proposing projects to
5 do.

6 COMMISSIONER STECKEL: And the
7 added benefit for that - she can talk about
8 the clinical, I can talk about the money. But
9 the added benefit is we put in an additional
10 50 percent. So for every dollar they spend,
11 we put another dollar in and it helps their
12 research work that they're doing in the
13 University. So it's a win/win for everybody.

14 DR. THERIOT: And it really
15 expands the capacity of the Cabinet to really
16 look at our own data.

17 DR. THORNBURY: Well, that's
18 quite a plateful.

19 I would say again, let the record
20 show that she's one of our great leaders at
21 U of L, one of many, and we're fortunate to
22 have your experience within the Cabinet and
23 particularly within the Medicaid Department.

24 Thank you for mantling this.
25 Your predecessor was equally well-respected as

1 are you.

2 We have a lot of work to do,
3 particularly, I think we're third in the
4 United States in childhood obesity, so I'm
5 hoping that we can make some gains, and I
6 think it's -- personally it's a much wiser to
7 pick a few measures that are high value and
8 try to focus our efforts on that and then see
9 if we can put those systems in to work for
10 other HEDIS Measures. But thank you very
11 much.

12 DR. THERIOT: And I think, you
13 know, a lot of good people have been working
14 on trying to change those ratings over the
15 last 20 years and it hasn't happened. In
16 fact, sometimes it's getting worse with, you
17 know, the health outcomes, obesity, things
18 like that, maternal mortality.

19 But one of the things that they
20 haven't done over the last 20 years is use
21 data to try and figure out where to -- where
22 to really address the needs. And that's what
23 we're doing now.

24 DR. THORNBURY: Well, I think it
25 walks us into the next item that I really want

1 to address which is when we have activity in
2 the Medicaid department like this and
3 priorities, it shows you that when we change
4 administrations, because we do every four or
5 eight years, that these are multi --
6 multi-department issues.

7 For example, childhood obesity,
8 well, we're probably going to have to talk
9 about the education, can we give children
10 fifteen minutes twice a week to exercise, and
11 is this the right thing when exercise builds
12 the hippocampus better than anything we have.

13 And so, I think you're looking at
14 again, the difference between tactics and
15 strategy, where the tactics are, you know, how
16 are we going to do our day-to-day work but
17 strategy will have to be led by our
18 legislature and the Governor. And I think
19 I'll make it clear that, you know, we serve
20 the MAC, and it would be my opinion that we
21 serve no matter who sits in the Governor's
22 chair, we give them our best game every day.

23 We do that with the legislature.
24 We're here to try to offer counsel because
25 sometimes we're in a position to see things

1 that other people aren't, and that's the
2 intention. So we want to support, again, our
3 new administration and we'll do whatever we
4 can on that behalf.

5 I do want to just back --
6 digress a bit, Linda. I want to apologize to
7 Dr. Tran. Since I've not been here, he's now
8 joined us.

9 Though it's been quite a while,
10 Dr. Tran, we appreciate you. And I didn't
11 mean to overlook that. I guess I see you so
12 often that I apologize.

13 Any final thoughts?

14 COMMISSIONER STECKEL: If I could
15 just add one thing to your point about
16 education. One of the legacies that I'm proud
17 of that we, as a cabinet, are leading is a
18 direct link to the Department of Education.

19 Medicaid recently announced the
20 lifting of some archaic, bizarre rules about
21 Medicaid paying for services in schools. And
22 so that partnership between the Cabinet,
23 particularly Medicaid, but public health, the
24 behavioral health and the school systems has
25 started to grow and so that's a legacy that

1 we'll be able to leave the new administration.

2 And for the first time you
3 actually have two agencies. I know in Alabama
4 used to argue with the administrator of the
5 school system that you can't educate sick
6 children, so Medicaid should be apart of their
7 program.

8 Well, in Kentucky we're making
9 that a reality, where the education department
10 actually recognizes that we've been able to
11 lower the barriers for Medicaid funding, which
12 is always a problem in school systems, they
13 never have enough money.

14 And so I think that the new
15 administration has a platform to really take
16 that to a great level and do exactly what
17 you're talking about, and how do we use the
18 school system to improve the health of kids
19 and how can Medicaid be a partner in that with
20 financing.

21 DR. THORNBURY: Well, there it
22 is. I think we'll have to leave it at that.

23 Again, I'd like to recognize
24 Lindy Lady.

25 Lindy, I know 64 was backed up a

1 bit. We had good word on that. You're
2 welcome to join us up here, if you'd like.

3 MS. LADY: I'm okay.

4 DR. THORNBURY: If there isn't
5 anything else then he'll probably advance this
6 to the next item on our agenda which is status
7 on the telemedicine implementation.

8 Who would like to speak to that?
9 Do we have anyone here? Do we have anyone
10 that can.

11 COMMISSIONER STECKEL: Are you
12 talking about telehealth in Medicaid or in...

13 DR. THORNBURY: Well, since we
14 serve just the Medicaid branch, the intent --
15 I will tell you that the intent on that
16 legislation from my view was we as a physician
17 community wanted to drive sustainability for
18 healthcare in the Commonwealth, and we feel
19 that long term the only way to really drive
20 sustainability is to move on chronic disease
21 care online and it can be not only more
22 accessible but it can be accessed in a
23 quicker, less emergent or urgent fashion.

24 It can be provided more
25 efficiently, we don't need as many providers

1 because we're probably very likely for the
2 foreseeable future going to be in a position
3 where we may not have enough providers but we
4 can make those providers more efficient.

5 And we believe in the long run --
6 I don't think you'll see that in the short
7 run, but in the long run we believe it's the
8 only path to sustainability and it may open
9 the dialogue down the road once we are able to
10 implement this throughout every provider, the
11 discussion of, you know, some type of
12 different payment models, shall we say.

13 Again, I don't think we can get
14 to consideration of capitation, or anything
15 like capitation, until we give the health
16 providers tools to make them sustainable so
17 they can work in our communities to forward
18 their mission.

19 But that was the intent. The
20 intent wasn't to pull a fast one on somebody.
21 The intent was to say our from great strategy
22 moving forward, we believe, has to be with
23 that and with one of every four Kentuckians in
24 Medicaid, and maybe one of every Medicaid --
25 four Medicaid children.

1 I think that you're talking
2 basically about the school systems, you're
3 talking about not all those things, and
4 that -- unfortunately that socioeconomic group
5 does have more chronic disease; they don't
6 seem to get the care that they need, and they
7 do -- they are very expensive for us. So we
8 have to address those high -- targeted high
9 value areas. That was the intent.

10 Now, as of July 1st, Senate 112
11 has now been enacted and so it is statute in
12 the Commonwealth and I would just open the
13 floor to anyone that has had some experience.
14 It's a little early on the turnaround time for
15 some of the billing on that, we've only been
16 in it three or four months, but if anyone can
17 speak to that, we would welcome -- I would
18 welcome that.

19 DR. TRAN: If I may?

20 DR. THORNBURY: Yes.

21 DR. TRAN: I think that one of
22 the most significant issues that we have in
23 the Commonwealth is access. We have
24 unfortunately too many rural Kentuckians who
25 don't have access. It's not that big of an

1 issue here in Lexington or Louisville, but
2 beyond these metro regions we have a
3 significant need.

4 And I think that one of the
5 issues that we need to -- and it probably is a
6 little bit outside but it's no different than
7 your point about sick children can't learn
8 very well.

9 Telehealth wouldn't work if I
10 don't have internet access. Telehealth
11 wouldn't work if I don't have resources. So I
12 think that as we think about implementing
13 telehealth we need to look at barriers that
14 our patients are going to have to address.

15 So for instance, during my
16 daytime job, one of the things I have
17 recognized is we need to develop these virtual
18 living rooms or facilities that already have
19 this infrastructure, such as our public health
20 departments, such as our public libraries, and
21 negotiate a situation where we can have a
22 room, a HIPAA-compliant room, so that patients
23 who live in the area who may not have
24 resources, who may not have access to adequate
25 broadband internet, to be able to come to

1 these places, reserve that will spot, so that
2 it can become an office space remotely for
3 physicians in the metro areas to deliver that
4 healthcare.

5 It eliminates the cost of travel
6 which we all recognize is a huge burden to our
7 patients who are underprivileged.

8 So again, outside the scope, but
9 if we think outside the box, if we truly want
10 to help our Commonwealth patients who need the
11 access, those are the things that we probably
12 need to investigate and perhaps collaborate
13 appropriately.

14 COMMISSIONER STECKEL: In our
15 regulation that we put out two months ago,
16 three months ago, it basically starts that.
17 It creates a parity, so both the receiving and
18 the sending entities are now at parity -- will
19 pay at both places and that's the first major
20 step is creating that.

21 The school-based services
22 program, that is exactly what we envision is
23 creating, particularly around behavioral
24 health, where children aren't having to be
25 pulled out of class, stigmatized, and then go

1 somewhere and then come back, that there is a
2 safe place for them to receive services. I'll
3 let Judy talk about the future.

4 DR. THERIOT: And well, that's
5 what I was going to say. I think it fits
6 perfectly with the school program that's just
7 getting underway especially for behavioral
8 health. It could also of course be for
9 physical health.

10 But with the school's new wish to
11 have behavioral health, people onsite and
12 counselors onsite, I think this will help them
13 connect with mental health providers.

14 The school is simple, you know,
15 it's a simple thing because it's an obvious
16 place to have -- one of the places that you're
17 talking about. Adult medicine would be a
18 little bit different, but it can definitely
19 happen.

20 DR. TRAN: I have experience with
21 developing three of those places, in McKee,
22 Kentucky; Harlan; London, remote areas that
23 could benefit from access enhancement.

24 The other thing that I think
25 would benefit our providers is the ability to

1 have someone in Medicaid, an expert, a
2 champion that could serve as a guidance
3 counselor for providers.

4 We would like to deliver this
5 particular service. How does that match your
6 model and explain to us so that at the end of
7 the day when work together and collaborate in
8 terms of how do we get the services that we
9 want delivered and get reimbursed that is
10 appropriate from Medicaid's eyes? And that
11 would save a lot of headaches later.

12 I've been doing this wrong all
13 this time. Nobody told me. It would be nice
14 if we had that collaboration proactively.

15 DR. THERIOT: Well, I think it's
16 almost like a perfect storm because now the
17 regulations are coming into play. People
18 aren't as afraid of doing things remotely.
19 Everybody is more acceptable to having a
20 virtual doctor.

21 And at the Office for Children
22 With Special Healthcare Needs we have eleven
23 sites or they have eleven sites around the
24 state and do telehealth in all of the sites.
25 And some of it is the state run clinics,

1 others are partners coming in and running
2 their own clinics out of the offices because
3 it is a telehealth site and they're running
4 telehealth clinics out of the state offices.
5 So the foundation is there.

6 DR. THORNBURY: Lindy, if I could
7 ask for your wisdom here, do we have anyone
8 that is -- that physicians can communicate to
9 say well -- if the office says, How do we bill
10 this properly? What are the particulars if we
11 want to set something like this up? Do we
12 have a contact person yet.

13 MS. LADY: You do. So at U of L
14 and UK Walt Spring is a really good resource.
15 And so what they tried to do since the
16 Telehealth Board was dissolved as part of that
17 of that regulation, we're trying to set up
18 kind of more of a committee-based board and
19 we've submitted -- the Primary Care
20 Association, KMA submitted names to
21 participate in that.

22 Right now we're doing a lot of
23 conversations, email, they're holding webinars
24 to talk about school-based services.

25 So usually when I have a question

1 I look at the reg and if it's still not clear
2 then he'll go to Rob or ask somebody that I've
3 worked with before to clarify.

4 When the emergency reg came out a
5 lot of us provided comments because there were
6 some things that really didn't need -- they
7 just needed to be clarified. And so the state
8 was good enough to clarify several points for
9 us.

10 I still get some questions. One
11 of the things that is still kind of up in the
12 air for people is -- Dr. Tran brought it up,
13 like group counseling, not psychotherapy group
14 counseling, but counseling for diabetic
15 education, say.

16 So I think that's been excluded
17 from telehealth, but a lot of people were
18 interested in doing that via telehealth, and
19 tobacco cessation, stuff like that.

20 So there are some questions out
21 there. So usually if you've got a question
22 you can certainly send it to me and then I'll
23 go to the experts. But there is a board or
24 committee, however you want to call it, it
25 just hasn't been put completely together yet.

1 It will be, I suspect in 2020.

2 DR. THORNBURY: Very good.

3 MS. LADY: We submitted several
4 of your names.

5 DR. THORNBURY: Sure.

6 DR. TRAN: And one of the -- I
7 know that the mental health aspect is primed
8 to utilize this technology; however, I think
9 we should set our range and targets farther.

10 With another capable with current
11 technology of actually, for instance, with an
12 iPad and peripherals I can remotely assess the
13 cardiac rhythm. I can see natural rhythm, I
14 can assess vital signs, I can auscultate
15 lungs, heart remotely using peripherals that
16 have Bluetooth to the iPad. And in getting
17 that information sent back to my her, wherever
18 I reside as the clinician, that technology
19 already exists and is already employed.

20 So I don't want us to limit
21 ourselves to thinking just mental health
22 because we have the capability of doing much
23 more.

24 In regards to the group, I think
25 that this is a perfect medium by which when

1 can reach many more of our Kentuckians and
2 guide them in terms of proper nutrition,
3 proper diet, cigarette cessation, diabetes
4 teaching, education. And then in the mental
5 health field there's no reason we can't have
6 an interactive, GoToMeeting online where all
7 participants may participate at the luxury of
8 their home.

9 And so these are -- these have
10 real practical applications and I think that
11 as a group we need to think about how will
12 this work and how will HIPAA come into play.
13 And I think that as a provider we need to look
14 to you and get some guidance in terms of 10
15 thousand foot view with all the regulations
16 that govern us, how do we make this happen.

17 COMMISSIONER STECKEL: And I
18 think it's going to be a two-way street. I
19 would recommend it be a two-way street.
20 Because what's happening is you've got
21 technology developing faster than -- using the
22 word fast in Federal regulations in the same
23 sentence is not appropriate.

24 But we've got so many federal
25 rules that say what we can't pay for, what we

1 can pay for, and then our own state
2 regulations. So for instance, group pricing
3 or paying for group education is not something
4 that we allow. Is it something we should and
5 that's why I think that discussion be a
6 two-way street.

7 And then even if we all think it
8 should or you all think it should, is it
9 something that the feds will allow us on the
10 Federal Medicaid side to pay for.

11 So I would encourage that to be a
12 very healthy, robust, two-way street
13 discussion because it is so new that what we
14 tried to do with the regulation, and thank
15 you, we heard a lot of good comments. We're
16 all learning together about how to use this to
17 the best function for our beneficiaries, but
18 there are a lot of strings attached to that
19 money that we pull down and how we work
20 through those is going to be a big issue too.

21 DR. TRAN: I think this is the
22 opportunity for us to utilize this technology
23 to help our -- we've always identified one of
24 the key reasons why we as a Commonwealth have
25 such poor health outcome metrics is because so

1 many of our Kentuckians don't have access to
2 care. This is our golden opportunity to
3 change that variable.

4 DR. THORNBURY: Dr. Neel, yes,
5 sir.

6 DR. NEEL: I would like to speak
7 to a couple of things.

8 DR. THORNBURY: Please.

9 DR. NEEL: One is pediatrician
10 access has always been an issue with us and
11 mental health is second for us. First is
12 dermatology. That's always been a problem.

13 We cannot -- I'm working now in
14 Louisville with Norton's group and I couldn't
15 believe they had that much difficulty getting
16 kids in. Rashes don't last for six months to
17 be seen.

18 But second to that is mental
19 health where I spent 45 years in Owensboro,
20 and even though we had a psychiatric hospital
21 for children, we didn't have can child
22 psychiatrists because we couldn't recruit them
23 in to Kentucky, so most of the kids were being
24 seen by nurse practitioners, social work
25 people, and that sort of thing.

1 Our technology is there but we
2 don't have the mental health providers. And
3 part of that goes way back to reimbursement.
4 And they don't exist because psychiatrists
5 couldn't be paid for psychologists in there
6 office for a long time. That was an issue.

7 So you know more about that part
8 than I do. But I can tell you for
9 pediatricians, that many of the mental health
10 problems that we see as pediatricians are
11 acute emergencies and we really need to have
12 them seen right away.

13 DR. TRAN: In response to that.
14 So I don't know if people realize that there's
15 a feature, we call it Store Forward
16 Telehealth. Essentially there are standards
17 by which you photograph images of whatever it
18 is, lesion, rash, and then it gets forwarded
19 to the provider, the dermatologist who is
20 remote. And within forty-eight hours you have
21 an interpretation of those images. Even so
22 far as now echos are being sent for
23 interpretation. So that is possible.

24 In regards to the mental health,
25 if I could have someone in Medicaid look at

1 criterion -- one of the criteria is that you
2 must have a psychiatrist -- and I can't
3 remember the exact wording.

4 Let me give you an example. I
5 was asked by a group of people -- I have a
6 counselor who is independently licensed. So
7 that person can independently see a patient
8 face-to-face. However, when I try to do this
9 remotely via telehealth the regulations say
10 that that person has to have a psychiatrist
11 overseeing this. That doesn't seem right.

12 If I can do this independently
13 face-to-face, why do I need to have a
14 psychiatrist in the background supervising
15 that?

16 COMMISSIONER STECKEL: Right now,
17 everything that is -- you can bill for or
18 face-to-face you can do with telemedicine.

19 DR. TRAN: Again, this is
20 probably a year and a half ago when I read
21 through the regs, and indeed, it just slipped
22 my mind.

23 But that's something -- so I
24 encourage or I beg our Medicaid colleagues to
25 review some of this restrictive language so

1 that our providers -- because we really want
2 to start promoting our providers to acquire
3 experience.

4 And one of the things that I
5 would throw out there is very soon one of the
6 issues that we will probably confront is what
7 is appropriate for telehealth and what is not
8 appropriate for telehealth. Remember, this is
9 a modality of healthcare delivery. It is not
10 a substitute.

11 There are certain things that
12 must be seen face-to-face and then there are
13 things that are capable and appropriate for
14 telehealth. And defining that will be
15 something that we will have to figure out in
16 the near future. And I suspect looking ahead
17 that that will become an issue of much debate
18 in the future. So it might be best to go
19 ahead and start thinking about these things.

20 DR. THORNBURY: Well, let me step
21 in there. I'm sure -- do you have anything to
22 add, Bill? Anything?

23 Lindy, really what we want to try
24 to do is find a mechanism for us to solve
25 these enumerable problems that -- and they

1 will come up.

2 Lindy, do you feel that this new
3 committee, commission, do you think that this
4 would be an appropriate mechanism for that?

5 MS. LADY: I do. They're
6 bringing in -- it's been a few months now
7 since we got a request to submit names but it
8 went to all or many medical organizations, not
9 just the associations, but like -- healthcare
10 systems, and I think you'll have the right mix
11 plus, you've already got people that are very
12 involved in telehealth, like Tim Bickle and
13 Rob (inaudible).

14 So I think once we get that up
15 and running it will be a good way to be able
16 to submit questions. And I think
17 eventually -- I feel like in 2020 we'll
18 probably have a meeting for sure. We just
19 haven't gotten that far.

20 But right now, in the interim
21 of -- we haven't created a portal at KMA or
22 anything. Basically, people just send me
23 email or call me or text me and ask me a
24 question. And then again, if I don't know and
25 Corey doesn't know, we go to the (inaudible)

1 instead.

2 But I think once we get that
3 established it will be the right forum because
4 a lot of the healthcare systems have been
5 doing telehealth for a while too. And then
6 you'll have newbies that want to do telehealth
7 that haven't.

8 DR. THORNBURY: Well, perhaps --

9 MS. LADY: Which is why the kind
10 of calls you're probably getting.

11 DR. THORNBURY: Well, perhaps
12 Dr. Tran might consider donating his time to
13 such a committee that might be --

14 MS. LADY: Which is why I
15 submitted his name and your name.

16 DR. THORNBURY: -- the right
17 venue.

18 One other thought as we tie this
19 up, I would say that, Commissioner, I may have
20 some insight in to this.

21 When we developed the legislation
22 for this, the reason we asked for parity was
23 so that we could get everybody in the game.
24 If we don't have parity, people will not come
25 in the game and they wouldn't play the game.

1 They'll try to cheat.

2 The other thing is we wrote it in
3 such a way that we don't want the technology
4 to drive the statute. And so we want the
5 technology to flourish on its own but the
6 statute to be firm enough to give us some
7 leeway.

8 I think that in my decade of
9 experience in telemedicine what you're going
10 to see is when you move this away from central
11 Amazon telemedicine to the -- inside the
12 medical home where the patients all have a
13 familiarity with their health professionals
14 you're going to have things that we don't take
15 care of. We have chest pain, we're having a
16 stroke. Well, we're not going to do that
17 unless we're in controlled circumstances where
18 we're doing telestroke.

19 We have things that we're going
20 to do cough and cold, UTI, and we have two
21 decades of information that says it's going to
22 happen. We have a lot in the yellow. But
23 over time I think you're going to see that
24 yellow very quickly come from a very wide
25 bandwidth to a very small bandwidth.

1 The other thing I would just
2 suggest to you that maybe as we move forward
3 into our next administration, we want to carry
4 the -- not only do we have issues today with
5 defining these little pods of compliant areas
6 that might be appropriate, but what I might
7 suggest is working with the other parts of the
8 Cabinet to say as we move forward to develop
9 that final mile of bandwidth of internet
10 access, that those things do have a healthcare
11 consideration. It's not just business. It's
12 not just education.

13 But healthcare, we have a huge
14 economic stake in this and hopefully our next
15 administration can appreciate those things.

16 Yes, ma'am?

17 COMMISSIONER STECKEL: I would
18 make a recommendation. There is a -- and I
19 just met him yesterday, so I apologize, I
20 don't remember his name. But there's a
21 primary care doctor on the transition team
22 who's focused on Medicaid.

23 I would suggest you all have a
24 conversation with him so that at least it's on
25 there radar screen and they understand that

1 this is an issue.

2 I think the potential, and you
3 all have highlighted it, the potential for
4 cost savings, more effective, efficient
5 services is astronomical by utilizing the
6 technology we have. So I don't think you'll
7 find that anybody in Medicaid whether it's us
8 or whether it's the next administration will
9 not be supportive. But creating that robust
10 two-way communication is going to be essential
11 to doing it right.

12 DR. NEEL: Bob Hughes? I know
13 Bob Hughes.

14 DR. THORNBURY: Lindy, can you
15 facilitate that, opening up a dialogue with
16 Dr. Hughes?

17 DR. TRAN: I just thought of
18 something in response to what you just said.

19 At my daytime job I used to
20 review quite a bit of data in looking at
21 overall mortality, looking at hospital
22 re-admissions, looking at length of stay,
23 et cetera, systemic issues. And one of the
24 things that has received quite a bit of
25 support in the literature is the case --

1 intensive case management.

2 And so I don't know whether or
3 not this parity for telehealth services is
4 applicable to our social workers, our case
5 managers who would like to conduct these
6 visits.

7 To give you an example, heart
8 failure, number one issue with Medicare and
9 Medicaid. If we had better case management
10 that could be provided via telehealth, I'd go
11 direct to the person's home, not necessarily
12 physically but remotely, and I can provide
13 much of that guidance and counseling, and
14 probably can avoid a re-admission because I'm
15 addressing those issues as they happen, not
16 days later when the guy's already in the
17 hospital.

18 And so I clearly see a benefit to
19 cost savings for us in the long term if we are
20 able to allow our social workers, our case
21 managers to utilize this technology to
22 administer their services as well. And I
23 think it would benefit us in the Commonwealth
24 if we allowed that and encouraged our
25 ancillary staff to participate in these

1 activities.

2 COMMISSIONER STECKEL: Well,
3 another major player that will have to be at
4 this table are the MCOs because that's where
5 that occurs. And so it would have to -- they
6 have to be at the table.

7 DR. THORNBURY: Well, that might
8 be the good segue that we need to tie this up.

9 I think that there are a lot of
10 particulars that we need to work with and we
11 of, I believe, a direction to at least open a
12 dialogue with Dr. Hughes. And certainly DMS
13 understand that we are -- and our thinking on
14 this and that will help communicate that
15 forward. Is that okay? Can we leave it
16 there?

17 DR. THERIOT: Yeah. That sounds
18 great.

19 DR. TRAN: Well then I'd like
20 to -- if it's okay.

21 Commissioner, anything else?

22 COMMISSIONER STECKEL: No.

23 DR. THORNBURY: Then I'd like to
24 go ahead and open up the next topic. Which is
25 the MCO update.

1 Speaking of our MCO partners, is
2 there anybody here that can address where we
3 are with the -- yes, sir?

4 MATT HIBBS: And so I just have a
5 couple of updates. I'm Matt Hibbs, everybody,
6 with Anthem MCO. This is my colleague, Jack
7 Glass.

8 Just a couple small housekeeping
9 items. We had our standard yearly general
10 education fall webinar. It was November 12
11 and November 14. So we emailed out our slides
12 to any of our providers that are looking for
13 general information on Medicaid, best
14 practices with Anthem and things like that.
15 All participants who signed up will be getting
16 email.

17 And also we recently finalized
18 our territory maps for our network
19 consultants. So I believe that's been posted
20 online to our provider resources page. If it
21 hasn't today, it will be very soon. So it has
22 to be finalized.

23 DR. THORNBURY: Thank you.
24 Steve, anything?

25 PASSPORT REPRESENTATIVE: Sorry

1 was late. Steve (inaudible) with Passport. I
2 was in the impromptu parking lot known as
3 64 -- (laughter). Appropriate time of the year
4 to start thinking about over the river and
5 through the woods. But I chose not to break
6 the law and cross the median however.

7 So just a couple of direct
8 responses to one of the questions. The early
9 experience that we're been seeing with
10 telehealth adoption right now, we're seeing a
11 little bit of an increase.

12 It is early as was pointed out
13 just a few months in to a change, but we've
14 seen a little bit of an increase, not really
15 in chronic condition. Management from a
16 coding perspective, have seen more of an
17 uptick in behavioral health services, more
18 general behavioral health, not SUD at this
19 point in time and then urgent care.

20 A lot of inquiries we've been
21 receiving at this point in time have been
22 coming from established system, not really
23 from new adopters at this point. It is early,
24 I just want to disclose that.

25 And then I'll look to Lucy Howard

1 who really knows more of what's really
2 happening here. I'm the mouthpiece. She's
3 actually the content person, so Lucy if you'd
4 give us another update.

5 DR. THORNBURY: Lucy?

6 MS. HOWARD: The only updates --
7 we're just going to be focusing on
8 childhood --

9 DR. TRAN: Lucy, can you speak
10 up? Thank you.

11 MS. HOWARD: -- focusing on
12 childhood immunizations, closing some care
13 gaps, and working with the school-based
14 institutions and getting them up and running.
15 And that's it.

16 DR. THORNBURY: Well,
17 Dr. Hoagland, I'm not surprised, as I'm sure
18 neither are you that initially we're going to
19 see acute care from established organizations.

20 I think, what's been my
21 experience, is that this will probably take a
22 year, year and a half or two years to move
23 where we're teaching families how to do this.
24 And that's part of the reimbursement issue is
25 the providers will have to shoulder that, and

1 they know that.

2 But I think once the families
3 learn how to do this and the physicians become
4 more acquainted with it, you know over the
5 next two or three years we're going to see
6 some chronic disease move in and the hope is
7 that the three to ten years that we're going
8 to get the benefit. So I think that that's
9 expected.

10 Do we have any other guests for
11 MCO updates?

12 MS. ATCHER: Sammie Atcher with
13 Aetna.

14 DR. THORNBURY: Yes, ma'am.

15 MS. ATCHER: Right now currently
16 we're working open enrollment, and so we're
17 out and about across the state getting that
18 information out.

19 We're also working and the
20 information will be released probably within
21 the next month. We are compiling a provider
22 panel, helping through issues, common issues
23 like you speak about our panel.

24 We are actually inviting
25 providers who would like to attend. They're

1 going to be sectioned off primary care,
2 dental. So we'll have an array of
3 specialties, but more information on that to
4 come. We're hoping to roll it out by 1/1 and
5 get the first meeting going.

6 So if you want any information on
7 that, let me know.

8 DR. THORNBURY: This may or may
9 not be appropriate but you may want to
10 consider working with Lindy because Lindy has
11 a contact in might can open -- give you a few
12 extra colors to paint with there.

13 MS. ATCHER: Some yeah, it's
14 something like we've never done before so
15 we're actually bringing the (inaudible) in to
16 help us get through these transitions.

17 DR. THORNBURY: Thank you. Do we
18 have anybody else from our MCO colleagues?

19 If we don't, I'd like to advance
20 the agenda just a bit, please. Do we have any
21 new business that would like to be before the
22 committee?

23 Yes, Dr. Tran?

24 DR. TRAN: Yes, would like to
25 present a scenario for discussion. Recently

1 it was brought to my attention a situation
2 that I was very much unaware of.

3 Patient Medicaid -- Medicaid
4 patient comes to receive services, the
5 patient's enrollment is validated via looking
6 at the portal and the patient's enrollment was
7 validated, services were rendered, and later
8 the MCO came back with, Oh that patient is not
9 enrolled, we would like to recoup those
10 reimbursements.

11 So I guess I didn't know what to
12 do but I promised I would before I it to this
13 for discussion.

14 What happens in a scenario like
15 that?

16 COMMISSIONER STECKEL: There are
17 a variety of things and what I would suggest
18 is that at the next Physician TAC meeting you
19 have Stephanie Bates come and she can walk
20 through in detail. She oversees our MCO
21 programs.

22 But there could be several things
23 that happened. One is the person -- and this
24 is -- this happens to us. It happens to the
25 providers. They were eligible. They show up

1 as eligible but they weren't eligible.

2 So either they were put on the
3 program inappropriately or whatever happened,
4 happened but they were never -- should have
5 never be eligible for Medicaid. So you have
6 that circumstances.

7 You have the second circumstance
8 where they may not be enrolled in Aetna but
9 they're enrolled in Passport. And so Aetna
10 has to recoup it but Passport should pay it
11 and making that linkage happen, as you can
12 imagine, is a nightmare.

13 We recognize that this is an
14 issue, and to be honest, I don't have the
15 answer, but we will bring it up to Stephanie
16 and ask her to put it on her agenda and get
17 back with you

18 Mr. Chairman or to --

19 DR. THORNBURY: If it's okay,
20 Lindy, if we could just add that as a small
21 kind of footnote to our next meeting on the
22 agenda, just to kind of -- I don't want to
23 press that too hard. I think can we find away
24 to work through this if we have health
25 providers that believe these patients are

1 honorable, and they're providing honorable
2 service, can we find away to adjudicate that?
3 There needs to be some way to do it and maybe
4 just Stephanie can work on that for us.

5 Let us know where she's at.

6 COMMISSIONER STECKEL: We're
7 working with dentists particularly have
8 complained about this, appropriately so. We
9 recognize there's an issue. We're not sure
10 how to make the bureaucracy work so that it's
11 better, but we recognize the issue.

12 DR. THORNBURY: We have a new
13 administration coming in and so we'll let --
14 let that bake a little bit. But at least we
15 know that they're -- we'll follow up on that,
16 okay?

17 Any other new business? Yes,
18 Dr. Neel?

19 DR. NEEL: Just one quick thing
20 on that.

21 DR. THORNBURY: Oh, of course.

22 DR. NEEL: That's not new,
23 Dr. Tran. That's been going on for years
24 through a lot of administrations.

25 The problem is it costs you

1 money. That's all it costs you. But it
2 costs -- I don't like the word provider. It
3 costs the clinician time and mainly attitude.
4 And so it gives them a bad attitude toward
5 Medicaid. And that's what costs us in access
6 and I want to point that out because that's
7 more important than the money.

8 COMMISSIONER STECKEL: And we
9 absolutely agree with you. We absolutely
10 agree with you.

11 DR. NEEL: I've been preaching it
12 for so many years that I --

13 COMMISSIONER STECKEL: I've only
14 been here a year, so I can't speak for
15 anything outside of that year. It is one of
16 those Gordian knots that we're trying to
17 unknot and it will take a while, but -- but we
18 recognize it's an issue. To us it's more of
19 an access -- attitude issue than it is money.
20 So we very much would like to get it worked
21 out.

22 DR. NEEL: We're all on the same
23 team.

24 COMMISSIONER STECKEL: Yes.

25 DR. NEEL: And that's what's

1 hard --

2 DR. THORNBURY: That gives us the
3 opportunity, and I would point out gently that
4 Dr. Neel is not just a member of the
5 committee, he's really more of a chairman
6 emeritus, I should say. There's a lot of
7 wisdom there.

8 DR. NEEL: Thank you.

9 DR. THORNBURY: Do we have any
10 new items of business today?

11 HUMANA REPRESENTATIVE: Humana is
12 here.

13 DR. THORNBURY: Well, could you
14 give us an update? Would you feel comfortable
15 doing so? Just the MCO update for Humana.
16 Please stand up.

17 HUMANA REPRESENTATIVE: I
18 usually -- we usually have a rep. We don't
19 have a rep here, I apologize.

20 Well, we are moving forward with
21 the transition, and I think we've sent out
22 notifications that we are turning everything
23 in-house and trying to integrate our model of
24 care within Humana and as of December 31st our
25 partnership with Care Source (inaudible) and

1 it will be a one-stop shop at Humana. So
2 we're very excited about that. We're on
3 target and ready to go.

4 We have sent out communications
5 to providers and we will be sending out some
6 more details in the next weeks. So if you
7 have any questions or make sure you understand
8 that you can call if you have any questions.

9 So that's the main focus right
10 now is making sure that that transition
11 (inaudible) and the members are well taken
12 care of.

13 If anybody has any questions I'd
14 be happy to answer what I can.

15 DR. THORNBURY: Any questions?
16 Well, thank you very much.

17 Our next item on the agenda is
18 any recommendations. I don't believe we
19 really have any recommendations for today, do
20 we? Nothing?

21 And then lastly, the last item is
22 we have events. Anything from your end,
23 Lindy?

24 MS. LADY: Okay. So I talked to
25 some staff from KI-HIPP. KMA routinely adds

1 events. David Gray always gives me events
2 that involve matters so we're going to work
3 with KI-HIPP a little closer and they're going
4 to give us events they're doing throughout the
5 state. We're going to put them on there.
6 We're going to do webinars. We may eventually
7 even do something with them for our inverse
8 because
9 so...

10 In any other organization a lot
11 of people reach out like Foundation For
12 Healthy Kentucky. So if you have any -- if
13 you've got events, like Anthem, all you have
14 to do is shoot it to me and we'll put it on
15 our calendar.

16 And our members have gotten
17 really good at accessing -- we've revamped the
18 web a bit and it's a little easier, and they
19 really have used that calendar of events a
20 lot.

21 So if you have anything at Humana
22 or any of the other MCOs that you want to
23 share, just shoot it to me and we'll make sure
24 it gets out there. We, KMA, just -- when just
25 finished our annual meeting so we don't have

1 any events.

2 I would like to make a very sad
3 announcement and that is that our
4 president-elect, Dr. Robert Couch, also known
5 as Bob Couch, passed away completely
6 unexpectedly. He got sick very quickly.

7 He was kind on a famous physician
8 in the ER and he was a great public health
9 advocate. Something happened either viral,
10 bacterial. I don't know. I'm not sure. And
11 destroyed his lungs. He was on the transplant
12 list for a double transplant when he passed
13 away day before yesterday with his family by
14 his side.

15 But Dr. Couch was a terrific
16 physician, public health advocate, ER. I mean
17 it's just -- it's kind of sad and is
18 visitation is Sunday and the funeral is
19 Monday. If you need those details, just let
20 me know. But I think we just sent a notice
21 out yesterday. So you may not have seen it.

22 DR. THORNBURY: I have not, but I
23 know Bob personally. He's a friend of mine.
24 He is a friend of probably everyone at the
25 table. That's a great loss for the

1 Commonwealth. He was a very great leader in
2 emergency medicine. That is a terrible thing
3 to hear today.

4 Anything else?

5 I have one other item. Bill,
6 Dr. McIntyre, is as he's moving forward in his
7 career, he's had some adjustments he's making.

8 But Bill, I'm sure by
9 acclamation, you'll accept our invitation to
10 remain a part of this committee, you're a very
11 important part of it and I don't think we can
12 do the work we're doing now. I know damn well
13 we can't do it without you.

14 And I hope that you'll accept my
15 invitation, the committee's invitation to
16 remain part of this as your career moves
17 forward.

18 Would that be okay?

19 DR. MCINTYRE: Sure.

20 DR. THORNBURY: We'll make a note
21 to the affirmative then.

22

23 * * *

24 Affirmed

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DR. THORNBURY: If there's no
other business then we'll call this meeting
adjourned.

* * *

(Meeting adjourned)

* * *

1 STATE OF KENTUCKY)
2) SS.
3 COUNTY OF JEFFERSON)

4 I, LINDA L. TAYLOR, a Notary Public
5 within and for the State at Large, do hereby
6 certify that the foregoing meeting was taken
7 before me at the time and place and for the
8 purpose in the caption stated; that the
9 meeting was reduced to machine shorthand by me
10 in the presence of the committee; that the
11 foregoing is a full, true, and correct
12 transcript of my stenographic notes; that
13 there was no request the transcript be
14 submitted for reading and signature; that the
15 appearances were as stated in the caption.

16 WITNESS MY SIGNATURE this 2nd of
17 December, 2019.

18 My commission expires June 14, 2020.

19 /s/ Linda L. Taylor
20 LINDA L. TAYLOR, CCR-KY
21 Certificate No. 20042116
22 Certified Court Reporter, KY
23 Notary Public, State At Large

24
25 Lt/lr