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PHYSICIAN SERVICES TECHNICAL ADVISORY COMMITTEE  
MARCH 15, 2019 MEETING

TRANSCRIPT OF MEETING

MARCH 15, 2019

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The foregoing meeting was held, pursuant to notice, on Friday, March 15, 2019, beginning at the hour of 10:00 a.m., at the Cabinet for Health and Family Services, Public Health Conference Room A & B, 275 East Main Street, Frankfort, Franklin County, Kentucky, 40601, Vice Chairman William McIntyre, M.D., presiding.

1 DR. MCINTYRE: We have got a quorum now. I  
2 am Dr. McIntyre. We will call the meeting to  
3 order. I am vice-chairman of P-TAC.  
4 Dr. Thornbury, who normally chairs the meeting, is  
5 out. So let's get started.

6 Kelly Kelly is going to start our meeting.  
7 Department of Insurance, prevention services  
8 project. So I turn the floor over to her.

9 MS. KELLY: So Lindy invited us to come to  
10 see you today. We are just kind of wanting  
11 everybody to know the initiative that we are  
12 doing. We have -- and I won't read you all of  
13 this. It is just a little handout that we have.

14 But I am sure everybody knows about the  
15 Affordable Care Act and preventive care with  
16 insurance being no cost sharing. So that is kind  
17 of where we started. The Department of Insurance  
18 got a grant from the federal government to do a  
19 market conduct exam on insurance companies, just a  
20 little brief, insurers get market conduct exams  
21 from the Department of Insurance to make sure they  
22 are following all the rules and doing all of those  
23 things.

24 When the market conduct examiners go out,  
25 they look at all of the possibilities. This one

1 was a target exam. So we targeted just on  
2 preventive. We went to the 5 main insurers in  
3 Kentucky. And this is like a 2 or 3 year process.  
4 We got all of that information and looked at what  
5 we thought was a commonality between the 2, where  
6 what was the barriers in getting preventive care.

7 Once we looked at that, we had quite a bit of  
8 money left over. So we asked for an extension on  
9 the grant and got that.

10 Our second phase of our grant is going to be  
11 outreach to providers in the community to promote  
12 preventive health and to look at what we learned  
13 in our conduct exam and use that to try to  
14 decrease the barriers to preventive care.

15 So our mission, what we have done so far, is  
16 after we got all of the information, then we went  
17 to all of the insurers and looked at all the tools  
18 they have, which worked for them, what hasn't  
19 worked for them, so that when we disseminate the  
20 information, we can share what good practices  
21 there are, what bad practices that hasn't worked.

22 So we are seeing our last insurer today. And  
23 so hopefully we will get all of that information.

24 We are also looking -- a lot of the problems  
25 that we have found were like coding type issues.

1 So we are trying to bridge that gap to say why is  
2 there a problem with coding issues. And one of  
3 the main problems I think is with preventive care  
4 you look at the task force recommendations, United  
5 States Task Force, and nobody really says I see  
6 D-10, I see D-9s or should be preventive or 10s.  
7 These should be paid at no cost sharing.

8 So we are looking at -- so each insurer has a  
9 benefit grid that they put in their system in  
10 order to know what is going to pay at no cost  
11 sharing. So we are looking at those grids and  
12 kind of comparing to see what the differences are.  
13 Most of them are the same. But there are some  
14 differences and we are going to try to do that.

15 The other thing that we found with our  
16 talking to the insurers is how much information  
17 they have that's available to providers. And I  
18 don't know that that is utilized. I think some of  
19 it is. You know, some providers are just way out  
20 in the country and don't do email, don't do  
21 computers that much. But there is a lot of very  
22 beneficial tools that they offer.

23 MS. MITCHELL: So one of the things we want  
24 to do is promote information to the providers that  
25 these insurers have all of this stuff on their

1 website, on their portals. So we want to kind of  
2 connect the dots between the insurers and the  
3 providers. So I know providers are busy doing  
4 health care. But maybe the office staff can be  
5 trained on how to use these portals to go in to  
6 see.

7 We have been really impressed with what the  
8 insurers have, the tools that if they were just  
9 utilized by providers and their staff that we  
10 think there would be more preventive care  
11 utilized. And it is a benefit to the members  
12 because it is at no cost sharing. And I think if  
13 we can get that message out to members -- we say  
14 members because we are insurance -- but patients  
15 to you all is that if they, you know,  
16 colonoscopies are very, very important and nobody  
17 wants to do that and they have the cost. But if  
18 it is free, you know, and we are trying to get the  
19 message out.

20 If you follow the American Cancer Society  
21 Guidelines and utilize that, that's a very  
22 important tool to help your health. And we have  
23 seen in these grids, they will have like the  
24 mammograms and the Pap smears and all of those  
25 things. And one of the insurers had, it would be

1 red. Like you can log on and all of your patients  
2 come up and it will show on red if they have not  
3 utilized that service which we know providers are,  
4 you know, their time is very important. But if  
5 their staff can go out and get that and put it in  
6 your chart before you see the people, they are  
7 like, oh, you haven't had your colonoscopy. Oh,  
8 you know, we need to just remind you that you need  
9 to get these services.

10 And that's what we are trying to use this  
11 money to just get the word out that it's an  
12 important service. And as physicians, you all  
13 realize how important preventive health is.

14 So we are just trying to connect the dots  
15 between, you know. Because we see the complaints  
16 in our side when things don't go through if they  
17 are coded wrong or whatever. And what we have  
18 seen on these websites is the codes are out there.  
19 Like if you do this procedure and this, it tells  
20 you how to code it and it will go through the  
21 first time and you don't have angry patients  
22 calling you and saying I thought this was going to  
23 be paid at 100 percent. Because they call us and  
24 they say that. They are angry when they call us.

25 MS. KELLY: So I think where kind of Medicaid

1 kind of pulls in is just the education part of it.  
2 And when you are looking at payers so, I get it, a  
3 doctor has -- so he is going to see 5 Medicaid  
4 people today and then an Anthem and a United  
5 Health Care and an Aetna. And so it lines up like  
6 that. So he or she has 5 portals to get onto and  
7 try to figure all of that out.

8 So we are trying to get to where maybe we are  
9 also talking to coders, office managers, and  
10 trying to get to where we can try to collaborate  
11 everybody together so this can be a better system.  
12 Because the ultimate goal is so claims don't have  
13 to be reprocessed, people don't have to complain,  
14 you don't cost the insurers or the MCOs money when  
15 they have to reprocess claims.

16 And so that's kind of our goal of what we are  
17 doing.

18 MS. MITCHELL: Like here is the information  
19 and just making sure everybody knows how to get  
20 that information basically is where we are coming  
21 from. We can't tell you how to code because we  
22 are not medical people.

23 MS. KELLY: But I think it is nice to know as  
24 a physician, okay, I want this to be preventive.  
25 This is what I did. And it can be 90632 or 90633.

1 And 90633 is going to be a little bit -- pays  
2 preventive. And doctors are not necessarily  
3 seeing this because they are still getting paid.  
4 Whether you get paid. But it is the patients that  
5 are having to argue their point. Because they are  
6 either having to be cost shared or something gets  
7 denied that they thought should have been  
8 preventive.

9 And so that's kind of -- so we are trying to  
10 help decrease the cost of health care.

11 MS. MITCHELL: You want to give the examples  
12 that we have talked about? So the claims we had  
13 to deny that should have been preventive.

14 MS. KELLY: So in gathering this data, we got  
15 complaints, too. So we looked at what the market  
16 conduct examiners did at the insurers. So we  
17 looked at all of their complaints there, all of  
18 their claims. We also looked at the complaints  
19 the department had. So the complaints that we  
20 have had to work through because of a  
21 misunderstanding basically of preventive care.

22 So I think a big one -- and colonoscopies is  
23 one -- and so preventive is a colonoscopy. And  
24 you have got a polyp and you remove it. And then  
25 the polyp goes -- then they do a biopsy and they

1 say it is going to go to the pathology.

2 So there is kind of a line between the  
3 preventive and the diagnostic. So that's going to  
4 go to -- the biopsy is going to go as a medical.  
5 It is a diagnostic tool. So not everybody  
6 understands that. So even it is educating your  
7 patients to know that your colonoscopy is free.

8 However, if we find something, that biopsy  
9 now turns into a cost share. So -- I know  
10 Medicaid is a little bit different with that. But  
11 the -- and I don't know how you all reimburse so I  
12 am not -- I am not the Medicaid expert by no  
13 means.

14 But so that's the examples we see. I even,  
15 you know, we even looked at preventive like  
16 immunizations that's been, the pediatric one, and  
17 it's kind of like that's always been a preventive  
18 thing. So I would have thought they had those  
19 more in line. But we have gotten stuff on  
20 immunizations that -- or pediatric eye exams that  
21 should have been covered as preventive that  
22 weren't.

23 So I think there is just room for a lot of  
24 education on what is preventive.

25 Another thing that I think people are always

1 getting a difference between preventive and  
2 screening. So just because it is a screening  
3 doesn't necessarily mean it is a preventive  
4 screening as far as insurance is concerned.

5 So a lot of what we are talking about may not  
6 be exactly how Medicaid does. But I think if we  
7 can increase what people understand is preventive  
8 and help the providers not have to think that it  
9 is 8 different places we are going to have to look  
10 for Anthem versus Medicaid versus United Health  
11 Care, then if we can streamline that or try to get  
12 that better, then that's kind of what we are --  
13 kind of one of our goals.

14 MS. MITCHELL: There is tools out there to  
15 help, you know, like Anthem wants it coded this  
16 way. Humana wants it coded this way. And  
17 hopefully they are the same. And that's one of  
18 the things that Kelly is compiling is a grid that  
19 what are the differences. Are there differences  
20 between how you code a colonoscopy or mammogram,  
21 you know, just kind of preventive and you find  
22 something and now put a diagnosis code on it and  
23 then process it as diagnostic versus preventive.

24 Those are the kind of things we see. And  
25 mostly colonoscopies is when you find a polyp,

1 then you put a diagnosis code on it. And then a  
2 lot of times, it won't go through the computers.  
3 It will kick it out. And that's when we are just  
4 trying to say, you know.

5 MS. KELLY: And I think people don't  
6 understand that that benefit grid is an IT thing.  
7 It is in there. And when you are coding. And I  
8 understand that doctors -- because I am a nurse by  
9 profession -- and so, you know, I would never tell  
10 a doctor what to code, never a day in my life.  
11 But I think we have got to get over the fact that  
12 we are telling you what to code but saying here is  
13 the tool, here is how you can utilize it.

14 MS. MITCHELL: So when you talk to the  
15 coders, that will help.

16 MS. KELLY: And, you know, the other thing I  
17 think we have a -- because a lot of information  
18 out there will say, oh, ask your provider to  
19 recode it. Well -- and then the office, now they  
20 got to take a person that recodes something and it  
21 takes time and energy. And if we just do it right  
22 the first time.

23 The other thing that I was going to say was,  
24 this is kind of a side bar, so I am on the  
25 Kentucky Cancer Consortium also and I worked with

1 the colon group. And so we are trying to get a  
2 bunch of stuff together and stuff that I see that  
3 we are trying to invent is already invented. So  
4 stuff that -- we want to hand fliers to people and  
5 tell them to get preventive. And it is already  
6 out there. So we need to utilize what's already  
7 out there. And I think if it's -- we really have  
8 this as a collaborative effort, then we can  
9 accomplish more than everybody spinning their  
10 wheels and reinventing stuff that's already been  
11 invented. So that's kind of --

12 MS. MITCHELL: Because we didn't know all of  
13 those tools were out there until we started  
14 meeting with the insurers.

15 MS. KELLY: So I think -- and it's  
16 everybody's perspective. So basically if anybody  
17 has any perspective they would like to share with  
18 us or you all think we can help you all in any  
19 way, we would be glad to do that. And that's kind  
20 of --

21 MS. HUGHES: Can you tell the names of the 5  
22 insurance carriers you are --

23 MS. KELLY: Anthem, Humana, CareSource,  
24 Aetna, United Health Care, Golden Rule but United  
25 Health Care and Golden Rule is the same thing. So

1 we reviewed 6. But really the ownership is 5.

2 DR. LIU: So I can start off with some  
3 comments.

4 My name is Gil Liu. I am the chief medical  
5 officer for Kentucky Medicaid. And this sounds  
6 like really, really valuable work. I am so glad  
7 the DOI is going in this direction.

8 So the first thing I wanted to bring up is  
9 April 1, the Kentucky HEALTH program starts which  
10 has this new feature called My Rewards. And it is  
11 meant to test. So it is a demonstration project.  
12 It remains to be proven whether it is  
13 incentivizing at an individual patient level  
14 preventive services will increase the rates at  
15 which those are delivered. So we know in the  
16 Medicaid population, we have a lot of opportunity  
17 to do more prevention.

18 So there are, you know, monetary rewards for  
19 engaging in preventive services. And then the  
20 member could use those rewards to pay for things  
21 like dental and vision services. And hopefully  
22 later on other health promoting things like  
23 physical activity programs perhaps. So just  
24 really wanted to remind everyone, there is a lot  
25 of hope in that approach. We will see how it

1 goes.

2 The second thing that I think is a little  
3 more important for us to talk about is how we get  
4 away from individual behavioral approaches and  
5 more at the system level approaches. So I think  
6 while provider education and patient education  
7 things are very good, they are often not very  
8 effective. And, in fact, that's been kind of the  
9 evidence of years and years of lack of success.

10 I think what we should go to more in the  
11 future is looking at things like how do we  
12 standardize codes, how do we use electronic health  
13 records and order sets, how we make the right and  
14 good choices the easiest choices. So I really  
15 have a lot of empathy for people in, you know,  
16 sparsely populated areas that don't have EHRs. I  
17 do think that is going to quickly become just like  
18 dinosaurs, interesting history, no longer relevant  
19 to current practice.

20 But to the degree that Medicaid could work  
21 with you to create better systems where people  
22 don't have to work so hard to find the right code  
23 or where patients, you know, they don't get  
24 presented with opt in. They get presented with  
25 opt out preventive service visits. I hope we can

1           commit to thinking more broadly and more  
2           organizationally. Because as long as we just give  
3           tool kits that are kind of reinventing the wheel  
4           to either patients or providers and expect them to  
5           do a lot of work in choosing, I am fairly  
6           convinced we will continue to have very, very  
7           modest success.

8           So we do need to, at the MCO level, really be  
9           careful about what edits bounce back, denials, and  
10          what things we can build at the practice level.  
11          You know, you push one button, all of these orders  
12          pre-populate, and then you have to actively  
13          deselect codes or, you know, preventive services.  
14          And for patients, you know, at the Medicaid level,  
15          we are going to think hard about how to make sure  
16          they get every My Rewards dollar that they are  
17          entitled to.

18          So I hope that's helpful. It is a little bit  
19          of a philosophical comment. But, again, some of  
20          your presentation made me worry that we are still  
21          kind of focusing too much on person by person,  
22          making them choose and not structure organization  
23          system.

24          MS. KELLY: And that's kind of where we are  
25          now. Most of what I said is kind of where we have

1       been. We are taking that information. And there  
2       are things that, you know, when I look at insurer  
3       things, there are some things that are  
4       proprietary. And until I get all of that  
5       information and discuss with everybody, it is not  
6       something that I can share with everyone at this  
7       point. Not that it is not transparent. But there  
8       is proprietary information involved.

9               So when we talk about systems, it's a  
10       little -- until we get the green light and stuff,  
11       it is something that we are looking at and working  
12       toward. I don't know how much of that will be --  
13       come to fruition. I will say everybody has been  
14       very well working with us. And, you know, it  
15       might be something if we just attack the  
16       preventive part first and not try to get  
17       everybody's coding for everything involved.  
18       Because then you are looking at reimbursement and  
19       you are looking at a lot of different stuff.

20               So if we do the preventive, which is, in the  
21       insurance world is a little different of a beast  
22       because there is no cost sharing. Everything else  
23       kind of has a cost sharing. So you have got to  
24       add a layer to that when you are reimbursing.

25               And so that is something that we are hopeful

1 of what you were just explaining. But it is  
2 something that in later on. And, really, just to  
3 explain one more thing. Our grant runs out in  
4 October. So we are kind of putting the cart  
5 before the horse in some places. Talking to you  
6 all. I am talking to other groups because we want  
7 to get the word out. And if anybody has any  
8 suggestions or thoughts, again, I don't have time  
9 to reinvent that wheel.

10 Now, our grant runs out in October. However,  
11 I don't know that my money would run out then.  
12 And that there might be an opportunity to extend  
13 it again. If this is successful, I don't know  
14 that -- the department might say this has been  
15 successful and we will take on that responsibility  
16 minus the grant. We will take on the cost. The  
17 cost to us has not been a lot. That's kind of why  
18 we have had the money. Because when you do --  
19 well, it paid for the market conduct exams. So  
20 that's where a lot of the money went. But other  
21 than that, just employees is where.

22 So I am a contractor. Jill works for the  
23 department. So when the department, you know, I  
24 would hope that if this was going toward a  
25 positive results that even now. But we really are

1 kind of on a time frame of saying what we are  
2 going to accomplish, if we got anything  
3 accomplished so we can at least hopefully get more  
4 down the road.

5 MS. MITCHELL: We realize that providers have  
6 to -- they have to know the Medicaid system,  
7 Medicare system, and all of the different  
8 insurers. And it is not easy. You know, so we  
9 have got as much information as we can get out  
10 there to make it easier for the providers is  
11 basically our goal is to let you know the tools  
12 that are out there --

13 MS. KELLY: Every payer, even if you take all  
14 the MCOs, I am sure every MCO has a different  
15 software system. I am sure everything is all  
16 different. And to get on the same page as all of  
17 that, that will probably be way down the road if  
18 ever. But I think that we can at least --  
19 hopefully we can at least get everybody working  
20 more together to know.

21 And just getting back to like the colon  
22 cancer, it amazes me how much we know we don't  
23 know. And from the provider perspective, from the  
24 insurer perspective, from member perspective.  
25 So --

1 DR. TRAN: Question? Suggestion?

2 One of the things I have heard, I agree with,  
3 I concur with, and that is physicians don't know  
4 what they don't know or staff don't know, you  
5 know. And I have become somewhat of a fan of  
6 these YouTube videos and I wonder -- I know that  
7 our practice would love to have a video for the  
8 patients while they are in the waiting room, they  
9 can watch. We have a little video that says and  
10 explains the preventive things. We can focus on  
11 colonoscopies. We can focus on breasts exams or  
12 whatever. And then have a separate video for  
13 staff that can delineate and help them walk  
14 through the different insurance types and how one  
15 codes for these sort of things, how does one bill  
16 for these sort of things.

17 And these videos don't have to be lengthy.  
18 It is a 5 to 10 minute video. And we can have  
19 these things loop. In our practice, we have a  
20 giant TV. And it loops through multiple  
21 educational things to teach patients. They are  
22 just sitting there. And instead of watching  
23 reality shows, they can watch these educational  
24 things and learn about colonoscopies, what is  
25 that, and explain to them the subtle details about

1 this part is the screening, the preventive part.  
2 This part.

3 Then by the time it comes to the doctor, they  
4 are only asking a few questions that are specific  
5 to them. Because we -- everything -- it is like  
6 reminders. At the end of the day after 20  
7 reminders, you don't have time to do anything  
8 else. So I think those might be beneficial  
9 things. I know that our practice would like to  
10 get screening videos.

11 MS. KELLY: That might be something that the  
12 insurers or the MCOs would be willing to do.  
13 Because they have a lot of that information. It  
14 would probably -- not talking for them -- but that  
15 might be a suggestion that they would consider  
16 looking at their preventive things.

17 DR. TRAN: If you are providing this service  
18 to your patient, this is how we would like for you  
19 to bill it. This is how we would like for you to  
20 code it. And these are the rules that we think  
21 make sense, you know.

22 MS. KELLY: And I think historically, there  
23 has been, like I said before, as a nurse, I am not  
24 going to tell a doctor what to do. As a coder, I  
25 am not going to tell a doctor what to code. I

1 think that just to say that. But if we were to  
2 come up with something like suggestions. If you  
3 are doing preventive, this is how it would look.  
4 And then you still can code it different if you  
5 feel like it is not preventive. But if it is  
6 going to be preventive, this is how we code. So  
7 we are looking at that, also.

8 DR. TRAN: I think that most providers -- and  
9 I don't want to speak for other providers -- but I  
10 think most providers are willing to listen because  
11 we recognize you don't know what you don't know.  
12 And I hate to be doing something wrong all this  
13 time and everybody in the room knew it and nobody  
14 said anything.

15 So I think I would be -- I think I would be  
16 amongst many physicians who would voluntarily say,  
17 please teach me, educate me on doing it right. I  
18 would rather do it right the first time.

19 DR. MCINTYRE: Going along with what Dr. Tan  
20 just said. I was in a dermatologist's office in  
21 Pikeville 2 days ago. And while I was sitting in  
22 the waiting room, there were these -- it wasn't  
23 really a video, it was more like a slide show  
24 of -- but things totally unrelated to dermatology  
25 like allergy prevention, basically just preventive

1 care generally. And I thought it was wonderful.

2 DR. TRAN: We did that for the flu and then  
3 when Hep-A became a problem in the area. So we  
4 had these little 5 minute things and it talks  
5 about Hepatitis A, how one gets it, what are the  
6 dangers, what sort of things should alert you to  
7 go see your doctor. And it just loops. This  
8 thing just loops and it repeats.

9 MS. KELLY: Most doctor's offices, I think,  
10 have that.

11 DR. TRAN: Yeah. And we can easily -- it is  
12 a great educational. Again, I don't have any data  
13 to show how effective it is. But it certainly is  
14 a start.

15 MS. MITCHELL: I think it is a really good  
16 idea especially for your office staff for  
17 insurance to provide those videos for your office  
18 staff so that they know how to code these when  
19 they get your medical notes and they have to  
20 transport it onto a claim form.

21 DR. TRAN: And when our staff calls the MCOs  
22 with questions, we don't sound so ignorant.  
23 Because we have at least seen the video and know a  
24 little bit about it.

25 MS. MITCHELL: I think that's a great idea.

1 We will pass that along.

2 DR. MCINTYRE: Thank you so much, Kelly.

3 MS. KELLY: Thank you very much.

4 DR. MCINTYRE: And I am sorry.

5 MS. MITCHELL: Jill.

6 MS. KELLY: Oh, I am sorry. I should have  
7 introduced you. We just started.

8 MS. MITCHELL: So we are trying to tag team  
9 with all of the meetings that are already in  
10 existence so we don't have to pay for our room.  
11 So we are just like, are you having a meeting?  
12 Can we come? So if you all have a meeting --

13 MS. KELLY: Thank you for letting us come to  
14 your meeting. And my contact information, my  
15 number, is on the handout in the back. If anybody  
16 wants to talk about it further or has any  
17 suggestions, feel free to contact me. I will  
18 update Lindy on our progress with what we are  
19 doing. So if she wants us to come back or if  
20 anybody has any questions, you can also contact me  
21 through Lindy. I just offered your services.

22 MS. LADY: That's fine.

23 MS. MITCHELL: She knows how to contact us.

24 DR. MCINTYRE: Thank you.

25 MS. MITCHELL: Thanks for letting us crash

1 your meeting.

2 DR. MCINTYRE: I should have introduced  
3 Dr. Tran when the meeting started. He just joined  
4 the TAC. He is a pain medicine provider in  
5 Lexington. And welcome aboard.

6 DR. TRAN: I actually do the opposite.

7 My name is Tuyen Tran. Thank you for  
8 allowing me the opportunity to serve. And I have  
9 quite a few hats on. I am a physician. I  
10 currently do medicine at the VA at UK, do some ER  
11 work on the side. My focus is administrative  
12 medicine or administration for any facility. I do  
13 mortality assessments. I do readmission  
14 assessments for the institution. Work flow  
15 assessment. Redesign. I also have an MBA  
16 background in training.

17 But my recent love is the addiction for the  
18 last 11-plus years. Since 2008 since the epidemic  
19 hit us, I started looking into it and established  
20 a small clinic to address that. So I am very much  
21 interested in helping our community improve health  
22 care-wise. I don't -- as you all know, we as a  
23 state don't fair very well compared to the rest of  
24 the world. When we look at mortality, there is a  
25 very dense mortality increase in this region of

1 the nation. And we are about 2 and a half  
2 standard deviations above the mortality severe  
3 risk of the rest of the nation.

4 And, again, I am probably saying stuff you  
5 already know. But that worries me and bothers me.  
6 I am now a Kentuckian. So I would like to do my  
7 share to help our citizens and community.

8 Thank you.

9 MS. HUGHES: Welcome to the TAC.

10 DR. TRAN: Thank you.

11 DR. MCINTYRE: The next item on the agenda is  
12 provider enrollment on-line portal. And is there  
13 somebody -- is it you, Dr. Liu, or someone else  
14 from Medicaid?

15 MS. HUGHES: I can give you a little bit of  
16 an update on some of it.

17 I don't know. Have any of you all used the  
18 portal for the enrollment process? Probably not  
19 because you are not providers. In one of the TACs  
20 that we had this week, there was one of the  
21 providers that was actually complimenting the  
22 on-line enrollment. Said it was going great and  
23 that she was really very impressed and that she  
24 had heard some other good comments. So that's  
25 good.

1           The credentialing source, the RFP, it is in  
2           the process of going through the putting it out on  
3           our website and so forth. And so because of that,  
4           we can't really discuss it procurement-wise.  
5           Procurement laws prohibit us from doing that. So  
6           there is not a lot we can tell you on that.

7           MS. LADY: Has that gone out yet, Sharley?

8           MS. HUGHES: I don't think it's actually been  
9           released yet. But, you know, I had asked for an  
10          update. And they just said that it was at the  
11          point now where we really can't give much  
12          information out on it.

13          MS. LADY: So it is still in the process, we  
14          just don't have an ETA on when it is going to go  
15          to the website?

16          MS. HUGHES: Right. Right.

17          DR. TRAN: I am sorry. This is for providers  
18          to enroll with Medicaid?

19          MS. HUGHES: Yes.

20          The way I understand it, a couple of years  
21          ago, maybe last year, there was a bill that was  
22          passed in the General Assembly that required more  
23          streamlined credentialing of providers. And so it  
24          is requiring Medicaid to come up with basically  
25          one system that will credential our providers for

1 all of our -- for Medicaid and our MCOs that they  
2 can use, is that right, Dr. Liu? Do it all at one  
3 time and not have to go through 6 different  
4 credentialing.

5 DR. TRAN: It is a nightmare for us. We are  
6 a small facility with finite resources. And it is  
7 very, very cumbersome to get the application  
8 process through.

9 One of the things that I know that people  
10 stumble on all the time is this MPI designation  
11 aspect. There are physicians out there who have  
12 multiple hats and many have different areas of  
13 expertise. And when you have different hats --  
14 for example, some people voted in different areas.  
15 They may be pediatrics. They may be medicine.  
16 They may be ER, triple, whatever. And they do a  
17 mixture of different work.

18 The MPI -- and I don't understand it well  
19 enough to even describe it -- but the MPI doesn't  
20 work very well. It likes to have one designation.  
21 It likes it when you have one specialty. When you  
22 have multiple specialties, it doesn't seem to work  
23 well.

24 And this becomes problematic when you submit  
25 a bill and it doesn't match up, it is also a

1           problem. And even at the VA level, we run into  
2           that problem where the MPI, I guess it refreshes  
3           monthly, will change on you. And I don't know if  
4           it is related to that. But it has popped up  
5           numerous times and no one seems to know how to  
6           answer that question.

7           MS. HUGHES: I can check back with our  
8           enrollment folks to see if there is anything that  
9           could help with solving that. I don't know of  
10          anything. But I don't work in that area.

11          MS. LADY: It doesn't usually recognize the  
12          subspecialty I think is what. So you will have  
13          the primary specialty. And then the doctor may  
14          have 2 sub-specialties. But it only reads that  
15          very first one.

16          DR. TRAN: And, well, it goes -- it gets more  
17          problematic when I envisioned that when the coders  
18          get this, they didn't realize that some doctors,  
19          for instance, I may have my addiction board hat on  
20          one day. And then tomorrow or later in the day, I  
21          have my ER hat on. And later in the day, I may be  
22          teaching and doing my medicine hat.

23                 And that screws up the billing every time.  
24                 And my MPI -- it creates a lot of problems. So I  
25                 don't know if you guys have anything to do with

1 that. But we need somebody to look into it and  
2 start fixing it.

3 MS. HUGHES: I will ask them. I am not real  
4 sure that that is something that we would be able  
5 to do or what. But I can find out and let you  
6 know.

7 DR. MCINTYRE: Of course, Medicaid is a state  
8 agency. And the MPI is federal.

9 DR. TRAN: Federal.

10 MS. HUGHES: Yeah. It is different.

11 MS. LADY: But you still use it across all  
12 lines of insurance.

13 DR. TRAN: Person class. When your person  
14 class doesn't match up, it creates conflicts. And  
15 then the bill is rejected and nobody knows why.

16 MS. HUGHES: Okay. I will see what I can  
17 find out and get back with you and get you some  
18 information. If we can do something or where you  
19 need to go with it.

20 MS. LADY: I will just put that as a  
21 follow-up. I will leave that open.

22 And then on the credentialing, I am just  
23 going to say that is in process but not posted to  
24 the procurement website yet.

25 DR. MCINTYRE: There was a target date of

1 July 1 with the RFP. Is that realistic?

2 MS. HUGHES: That I am not sure of. I am  
3 sorry. When I asked for the update from Carl  
4 Ishmael who is kind of leading this, he just kind  
5 of wrote back and said that we are still working  
6 on it. And I am assuming that we are probably  
7 still going by any timelines that's been posted.

8 DR. MCINTYRE: I am sorry. Your name?

9 MS. HUGHES: Sharley Hughes.

10 DR. MCINTYRE: You said one thing is that you  
11 talked about a doctor who says the on-line  
12 credentialing is working well but you also said it  
13 hasn't been implemented yet. I am confused by  
14 that.

15 MS. LADY: Is it still in the testing phase,  
16 Sharley, right now?

17 MS. HUGHES: They have a pilot out there with  
18 some different provider types that are using it.  
19 And I think this -- I have had 5 or 6 TAC meetings  
20 this week so I can't remember which one it was.  
21 But it was actually a lady that was on the phone  
22 and she had used it. But the on-line, the  
23 Medicaid on-line, enrollment is up and running.

24 The one that we are putting the RFP out for  
25 is totally different. The RFP is for a new source

1 that will take all of the enrollment for all of  
2 the -- for Medicaid and the MCOs. That's not  
3 on-line yet.

4 But Medicaid itself has been working on an  
5 on-line enrollment system for some time and it's  
6 rolled out as in pilot. And I think now they are  
7 kind of opening it up to some more physicians to  
8 start using it.

9 DR. MCINTYRE: But at the present time if you  
10 use the on-line portal, that would only enroll you  
11 in Medicaid and not in the MCO?

12 MS. HUGHES: Correct.

13 DR. MCINTYRE: The next item is telehealth  
14 implementation. And I am sorry our chairman,  
15 Chuck Thornbury, isn't here because this is  
16 something near and dear to his heart.

17 Apparently there is federal legislation that  
18 allows Medicaid to set rates for telehealth.  
19 Dr. Thornbury's position, and he has a lot of  
20 experience with this, is that if you set the rates  
21 as proposed at 85 percent of the rate that would  
22 be paid for an office visit, that basically you  
23 are not going to get many takers. That the  
24 doctors will use that perhaps for acute care, you  
25 know, for cold, sore throat, that sort of thing.

1 But his belief is at least that to implement that,  
2 to get doctors to implement this for chronic care,  
3 isn't going to work well.

4 MS. HUGHES: Okay. Now, I know the  
5 regulations are out on the website and are open  
6 for public comment. Do you know if he has made  
7 these comments through --

8 MS. LADY: We opted not to. Is there anybody  
9 here that can speak to telehealth, okay, from the  
10 state?

11 We opted not to comment. We took a different  
12 route. Because at one of our telehealth  
13 stakeholder's meetings, a good point was made.  
14 When you comment on the, you have to look at all  
15 of the comments just like Medicare does. You  
16 could get hundreds and it sort of might slow the  
17 process down.

18 So what we did is we worked with the Primary  
19 Care Association and asked questions directly.  
20 And I am so sorry. I cannot remember the person  
21 that responded was fantastic. I think it was  
22 Jonathan Scott.

23 MS. HUGHES: Jonathan is the one that does  
24 our regulations.

25 MS. LADY: Okay. So it was so good. So he

1 clarified 90 percent of our questions. The one  
2 that remained had to do with reimbursement because  
3 there was a suggestion that, because Medicaid has  
4 that right to do that under the regulation, you  
5 can set your telehealth rate.

6 MS. HUGHES: Right.

7 MS. LADY: So it is a little different. So  
8 the suggestion that we understood was 85 percent.  
9 And as Dr. McIntyre said and Dr. Thornbury pointed  
10 out, I think that probably isn't enough. So  
11 Dr. Thornbury -- what we have tried to do is work  
12 kind of as a subcommittee with other organizations  
13 like the primary care who has the same issue that  
14 we do. And talk to the state directly about this.

15 So we got stuck on that one point. But  
16 Jonathan clarified everything else and we  
17 appreciated that.

18 But as Dr. McIntyre and Dr. Tran can probably  
19 speak to a lot better than I can is if you are  
20 going to want providers to use, which we want them  
21 to, I mean what a fantastic law this is, it is  
22 more broad than many, many other states and  
23 certainly blows Medicare out of the water with  
24 what they pay on telehealth. But it is going to  
25 cost them money. And that's where to get up and

1 running -- and I will let you all speak to that.

2 DR. TRAN: If I may have the opportunity to  
3 speak?

4 For the last 3 years, I was tasked by VA to  
5 spearhead and oversee the telehealth program here  
6 in Lexington and this side of the state. And so I  
7 have had the opportunity to learn quite a bit  
8 about telehealth in the VA. We had over 2.1  
9 million telehealth visits in 2016, 700,000  
10 uniques, and we have multiple outcome metrics. I  
11 look at outcome metrics that fall into mortality,  
12 co-morbidities, readmissions, over a hospital days  
13 of care, and, of course, you can calculate the  
14 cost savings by knowing that information.

15 The elements that we had we struggled with  
16 because, contrary to peoples' belief, the VA  
17 itself also bills their party payers. So we need  
18 to have that ability to understand how the  
19 economics work in the community. The short  
20 version is, after acquiring the technology, we now  
21 have the ability to actually conduct health care  
22 visits via telehealth. But not all of these  
23 visits are going to be amenable to that.

24 And as we do this more and more, we learn  
25 that not all patients will be properly served.

1 And so I would think that one of the things that  
2 Medicaid or any other agency would want to look at  
3 is what type of patients are amenable. And that's  
4 a very tricky question. After 3-plus years and  
5 the VA has been doing telehealth for 10-plus  
6 years, you know, if not longer, we have acquired  
7 an awful lot of knowledge.

8 I do know that if you don't make it easy and  
9 attractive as you said earlier, if the choices are  
10 the easier choice, the better quality choice,  
11 people are going to chose it. If we are going to  
12 improve access in our communities, we need to make  
13 the telehealth option more attractive. Otherwise  
14 it would not be utilized and implemented. And I  
15 can tell you that our access catchment is about  
16 70 percent rural. So it is critically important  
17 to improve access. And I think Medicaid has the  
18 same problem. Many of your enrollees are going to  
19 be potentially rural or they have need of  
20 specialty care that they can't access.

21 So this is a great way to improve that. The  
22 technology is very, very good. We can conduct  
23 most of our visits.

24 But I am going to probably voice another  
25 opinion. And that is in order to implement this,

1 we need to make the reimbursement as close to  
2 face-to-face as possible. It is important,  
3 however, to understand the limitations of the  
4 technology. We have clear stuff. We can examine.  
5 We have very awesome 4-K resolution cameras that  
6 can look down peoples' throats. We can look into  
7 their eyes. We can look into their ears. There  
8 is not much of an exam short of palpation that we  
9 can't conduct with telehealth.

10 But it needs to be at a rate that should be  
11 comparable to face-to-face or it is not going to  
12 get done.

13 MS. HUGHES: Okay. I will certainly take the  
14 comments back to Jonathan and the commissioner and  
15 so forth.

16 DR. LIU: Can I make a -- please, go ahead.

17 DR. GUPTA: My name is Dr. Ashima Gupta and I  
18 just have one comment about what you were saying.

19 With reimbursement, actually I feel like the  
20 reimbursement has to be better than face-to-face  
21 to get doctors on board initially at least.  
22 Because, again, it has got to be attractive and it  
23 has to be easy. And if we are spending that money  
24 to implement it -- that in our office, we have to  
25 train our patients. We have to train ourselves,

1           our staff. It is going to take more money and  
2           more time to get started.

3           So I feel like, especially in the beginning,  
4           that reimbursement has to be better than the  
5           face-to-face encounter. Otherwise, I mean, I  
6           personally I wouldn't choose it. I would have the  
7           patient just come in. Because it is hard enough.  
8           I am in private practice. It is hard enough to  
9           make ends meet in private practice and then taking  
10          that addition.

11          DR. TRAN: It is a huge expense. But most --  
12          again, from the VA's perspective, we get tons of  
13          equipment so that usually isn't something that is  
14          a worry. But I think that the technology has  
15          advanced to where the equipment cost up front  
16          isn't as horrible as it used be to.

17          But you are right. We don't have the funds  
18          to invest in a lot of this equipment.

19          DR. MCINTYRE: Dr. Thornbury's suggestion was  
20          that rather than start off at 85 percent  
21          reimbursement, just start off at 100 percent  
22          reimbursement. And look at it after 2 years. And  
23          if it is working out, if the numbers add up to  
24          reduce the reimbursement, look at it at that time  
25          after 2 years rather than trying to do that up

1 front.

2 His second suggestion was that there be 2  
3 modifiers for telehealth; one for chronic care,  
4 one for minor acute care, sore throat, cough and  
5 so on. Simply so the department can track it.  
6 And he made the obvious point that chronic care is  
7 where the money is, where the cost savings is, not  
8 minor acute care.

9 And just speaking to one of Dr. Tran's  
10 points. I am a Vietnam veteran. I have used -- I  
11 am a patient at his hospital, an out-patient. And  
12 I have been an in-patient of the VA Medical Center  
13 Johnson City. And my condition turned out not to  
14 be service connected. And they billed me, billed  
15 my insurance, just like a private hospital would.

16 DR. TRAN: The only problem that we have  
17 experienced is that as we get smarter and more  
18 wise with experience, it is not so easily broken  
19 down into acute care and whatnot. We are now  
20 involving urology surgery conduct through  
21 telehealth. And one of the beauties that has not  
22 been recognized is the capacity to have a  
23 multi-conference.

24 Let me give you 2 specific examples.

25 One is an elderly patient who has most of his

1 care provided by daughter who lives in Florida.  
2 So now when we conduct our visits, we involve her.  
3 So the daughter from Florida doesn't have to come  
4 up here physically. She can remotely enter the  
5 virtual conference room.

6 And many of our chronic patients require  
7 interdisciplinary care. To give you an example,  
8 patient with heart failure and a device, you need  
9 the heart failure cardiologist. You need the EP  
10 cardiologist together just to decide what medicine  
11 regimen works best for this guy and they need to  
12 do it together instead of one guy and the patient  
13 gets pinged back and forth. The primary care --  
14 the primary care doctor conducts the visit. The  
15 cardiology comments. The EP cardiology comments.  
16 The critical care pulmonary care comments. And it  
17 really becomes a very, very successful chronic  
18 care management visit.

19 So even though it is chronic care, there were  
20 lots of things going on. And we have this with  
21 dermatologic care. A guy comes it. Yeah, you can  
22 freeze it. I did. I took it off. It is not  
23 healing. Well, something else is going on. And  
24 the patient gets shot back to the dermatologist.  
25 The dermatologist looks at it and says, no. Now

1 that I have had a chance to study this picture  
2 more, let's bring him in.

3 So even if it is for acute processes, some of  
4 these things get really complicated quickly. But  
5 it is great to have the interdisciplinary  
6 approach.

7 DR. LIU: I just wanted to talk about a few  
8 fundamental important things that remember.

9 One is that government administrates the fee  
10 for service population fee schedules. It is a  
11 very limited, very particular population. Largely  
12 those on 1915 C waivers; traumatic brain injury,  
13 long-term supportive services, Michelle P.

14 Those fee schedules traditionally have been  
15 perceived as kind of the floor for payment levels.  
16 So managed care organizations are expected not to  
17 pay less than what we define as payment for that  
18 particular population.

19 But really what I am trying to get to is we  
20 don't mandate, nor should we, payment. Largely  
21 that's a function of managed care organizations  
22 and all of their corporate expertise and wherewith  
23 all and mission and strategy. You know, I just  
24 want to assure you we recognize the start-up cost,  
25 the promise of the technology, the need to have it

1 delivered to rural Kentucky. The more valuable  
2 things are, things in terms of policy  
3 deliberations about administrative data that can  
4 be used when measuring the quality and  
5 sustainability of the new approaches to care.

6 So I would just encourage you to focus on  
7 some of these more policy relevant and more  
8 detailed kind of recommendations. And also to  
9 focus your conversations with the managed care  
10 organizations which, unfortunately, are, you know,  
11 a company by company exercise in large respect.

12 The coding I think is very, very relevant for  
13 DMS. So I do want to thank you for that. I think  
14 that that is very, very insightful and some people  
15 will continue to wrestle with. We have a  
16 significant amount of staff involvement looking at  
17 telemedicine as I know the corporate partners do  
18 too. So just a little gentle nudging about, you  
19 know, how I think we could have the most  
20 productive conversation.

21 DR. MCINTYRE: Thank you, Dr. Liu. Any other  
22 comments?

23 The next -- Dr. Thornbury mentioned that he  
24 would be willing to work with the Department of  
25 Insurance and the governor's office on the

1 telehealth issue.

2 MS. LADY: I kind of like Dr. Liu's point is  
3 maybe we should get the MCOs together and talk to  
4 them, too, since they have the authority to --

5 DR. MCINTYRE: To set rates?

6 MS. LADY: Yeah. So I am looking at you to  
7 set the rates. So I mean that's worth a  
8 conversation with them. You might be able to  
9 convince them to pay.

10 DR. MCINTYRE: Yeah. Absolutely.

11 DR. TRAN: If that committee should arise,  
12 may I request that I get added to that? I would  
13 be real interested.

14 MS. LADY: Yes.

15 DR. MCINTYRE: We encourage volunteers.

16 MS. HUGHES: I thought reimbursement was kind  
17 of between each provider. Isn't that kind of the  
18 --

19 DR. LIU: You are on the right path.

20 MS. LADY: It is. It is. But I think you  
21 could generally talk to the MCOs on this subject.

22 VICE CHAIRMAN MCINTYRE: Or talk to them  
23 individually.

24 MS. LADY: Or talk to them one on one,  
25 however. And we could probably help you maybe set

1       some of that up. There are laws where we can't  
2       help you, you know, in Kentucky the association  
3       can't help you negotiate your rates. It doesn't  
4       permit us to do that. So you have to do that on  
5       your own.

6                But I do think, yeah, talk to the MCOs.  
7       Thanks, Dr. Liu. We hadn't tried to -- well,  
8       actually, Dr. Thornbury has talked. And so has  
9       the Primary Care Association with at least 2 MCOs  
10      I think. They are set up differently, though.  
11      The Primary Care Association has an IPA. They are  
12      not set up like KMA. They actually have an IPA  
13      that helps negotiate. We don't have that.

14               But we could get meetings where you could  
15      talk to them. We just couldn't -- all I can tell  
16      you is what Dr. Thornbury tells me and other  
17      people say.

18               DR. TRAN: But we are able to represent the  
19      physicians as a group --

20               MS. LADY: Yes.

21               DR. TRAN: -- and establish the structure --

22               MS. LADY: Yes. That's right.

23               DR. TRAN: -- the details of that structure  
24      may vary depending on the clinics and the doctor  
25      and the MCO. But at least the structure would be

1 built so we that could share with them. And the  
2 details they can explore individually.

3 MS. HUGHES: And that would be outside of the  
4 TAC and the DMS.

5 MS. LADY: It absolutely would be outside the  
6 TAC. One of the things, to Dr. Liu's point, too,  
7 is we have had several stakeholder meetings on  
8 telehealth. We are doing a summit -- there will  
9 be a telehealth summit in May. And, you know, the  
10 implementation date on this is July 1. And, no.

11 I mean there is so much policy behind that.  
12 We haven't gotten very far like even with the  
13 simple things like the use of 2 modifiers. What a  
14 common sense approach. This is a chronic. This  
15 is an acute. I mean we haven't even gotten that  
16 far. So there is -- I don't know about the July 1  
17 implementation date. We are sort of still up in  
18 the air on a lot of things I think where the  
19 telehealth is concerned.

20 So there is more to come. I will follow up  
21 with you, though, because --

22 DR. TRAN: I think I have had the opportunity  
23 to learn so much about the telehealth expansion  
24 that we have done in the VA. I think we have done  
25 an awful lot and have a lot of capability. And I

1 am hopefully going to work with UK and help spread  
2 that so that we've can involve some teaching, we  
3 can involve some nursing into telehealth  
4 utilization. I think it is care, future care. It  
5 is really where we need to be.

6 DR. MCINTYRE: Just a couple of ideas that  
7 popped into my head as we were discussing the  
8 rate. One would be what the experience -- I don't  
9 know if there are other states that are ahead of  
10 us on implementing telehealth -- but I wonder what  
11 their experience is with setting rates and the  
12 adoption of it by providers or non-adoption of it  
13 by providers, how successful they have been if  
14 they are starting out at a lower rate than your  
15 reimbursement.

16 MS. LADY: We could probably talk to some of  
17 the associations in those states, maybe get some  
18 more finer details.

19 DR. MCINTYRE: I don't know if there are  
20 states ahead of us in this.

21 MS. LADY: There are some that already --  
22 there are. I remember that from last year's  
23 telehealth summit.

24 DR. MCINTYRE: And the second point would be  
25 if this is adopted at the 85 percent rate, then

1 the MCOs need to look carefully at the  
2 implementation. How widely is this implemented.  
3 And if it is not implemented widely, how that  
4 correlates with the lower rate.

5 DR. PAYNE: Just a comment. I don't  
6 represent all the MCOs. I am just representing  
7 myself. One is, you know, we are real excited  
8 about this. This is a big deal for everybody. We  
9 want this to happen, also. It is a great  
10 opportunity to tie quality measures into new  
11 contracts which I think is the coming thing. If  
12 you haven't heard of valuation arrangements, you  
13 will. And this would be a perfect opportunity to  
14 do that.

15 So all of these conversation will happen  
16 around those sorts of opportunities.

17 MS. LADY: Thanks you, Dr. Payne.

18 DR. MCINTYRE: I am sorry. You are with?

19 DR. PAYNE: Aetna.

20 DR. MCINTYRE: Next item is public health  
21 trends. And the first subsection of this is  
22 substance use disorder. Dr. Liu commented in the  
23 last meeting about ER providers prescribing  
24 Suboxone in the ER in Washington State. Since  
25 that meeting, I have had an opportunity to talk to

1 our regional director for the central region of  
2 the United States for TeamHealth about  
3 implementing that in the TeamHealth facilities.  
4 And there are pluses and minuses. And there is no  
5 policy been established.

6 But he did say that providers don't need the  
7 X designation on their DEA number if they are  
8 simply dispensing a dose of Suboxone with a  
9 referral somewhere else for ongoing care as  
10 opposed to issuing a prescription for it. In my  
11 ER, you know, if there were an established program  
12 and a place to send people that could reliably  
13 follow-up, I wouldn't be opposed to dispensing a  
14 single dose of Suboxone.

15 DR. LIU: So may I go on for a little bit?

16 I am very excited to announce that a new  
17 policy has been decided since the last meeting of  
18 the Physicians' TAC. And that is for  
19 Buprenorphine prescribing up to 24 milligrams  
20 equivalent. And you can find the details of that.  
21 We have eliminated prior authorization for that  
22 prescribing.

23 And that really serves kind of 2 higher level  
24 goals. The first one you are addressing is  
25 bridging people into care. So by way of reminder,

1 we previously had an emergency Buprenorphine  
2 prescribing, prior authorization waiving for a 14  
3 day supply. Now any supply up to this dosing  
4 limit doesn't require prior utilization within the  
5 Kentucky Medicaid program for treating opioid use  
6 disorder. So that is a new liberalizing of  
7 treatment.

8 And the -- I am rambling a bit. The kind of  
9 goal there is especially to bridge people into  
10 care at the first diagnosis of opioid use disorder  
11 which unfortunately all too often happens  
12 resuscitating somebody after an overdose event.

13 So we know only 1 out of 10 people  
14 approximately who have opioid use disorder are  
15 willing to seek treatment. And that window of the  
16 first diagnosis, especially after a  
17 life-threatening event I think is really important  
18 to try to bridge people into care.

19 The second thing is just the lack of  
20 availability and access to medication-assisted  
21 treatment for opioid use disorder within the  
22 Medicaid population. So it is fair to say we are  
23 urgently, emergently trying to expand the number  
24 of people who are willing to prescribe  
25 Buprenorphine in conjunction with a comprehensive

1 care team and care plan for opioid use disorder.  
2 So having psychosocial services, employment  
3 support, peer supports with lift experience, you  
4 know, the list goes on about your dream team for  
5 helping somebody recover from opioid use disorder.

6 But generally what we want to see from the  
7 Medicaid standpoint, the vision of an appropriate  
8 team is just having behavioral health alongside of  
9 physical health and an ability to dispense  
10 Buprenorphine as a part of medication-assisted  
11 treatment as kind of standard approaches.

12 So we are moving. And I think our state has  
13 had notable success. Our deaths from opioid  
14 overdose events have declined for now 3 quarters  
15 in a row. That is very, very distinctive. So  
16 compared to states in the New England area, other  
17 states that have Appalachian populations, we are  
18 one of the few that is seeing a favorable trend in  
19 terms of reducing overdose mortality.

20 There is all sorts of other things we could  
21 talk about, sort of looking at concern about urine  
22 drug testing, wide panel definitive testing being  
23 a source of likely waste and abuse and potentially  
24 fraud. Just to put that on your radar, it is a  
25 great thing to talk about from the provider side.

1 We are wanting to launch in the near future a  
2 perinatal learning collaborative to look at the  
3 treatment of opioid use disorder among pregnant  
4 women. The coordinative of care for families  
5 after the birth of an infant with neonatal  
6 abstinence syndrome.

7 And going back to our fee for service  
8 population, it is really worrisome opioid  
9 prescribing among individuals the 1915 (c) waivers  
10 and among individuals who receive disability  
11 benefits. So we are in a super target rich  
12 environment. It is very, very challenging from  
13 any angle; quality, outcomes, sustainability,  
14 financing, infrastructure.

15 But I am really glad to say this is one of  
16 the times when I think all of us on the government  
17 side are seeing more collaboration than ever  
18 before, multi-sector efforts. We are engaging  
19 justice, public safety, employment, education.  
20 And I think we are doing good things. We are  
21 especially committed to a data-driven approach,  
22 too. So we have got a lot of new dashboards up, a  
23 lot of commitment, dutch-marking against other  
24 states and watching every quarter with updated  
25 results.

1           So I could go on for days about this. But in  
2           reaction to your question about bridging, people  
3           bridge models from emergency departments. I did  
4           want to emphasize, we are still executing the  
5           system edits to allow eliminating prior  
6           authorization but the policy has been declared.  
7           And some other policies are likely to follow suit  
8           to try to create a little more kind of  
9           standardization, minimize administrative burden,  
10          really take an all hands on deck crisis driven  
11          approach because that's what we are in is a  
12          terrible crises for our state.

13           DR. MCINTYRE: I would be interested in Dr.  
14          Tran's input to the remarks I am about to make.

15           I have got multiple mixed feelings, I guess,  
16          about the substance abuse disorder and prescribing  
17          Suboxone in emergency departments. One of the  
18          first things is anybody on Suboxone is immediately  
19          stigmatized in the emergency department as a drug  
20          addict. They are a different kind of patient.  
21          With some justification. I mean if you are a drug  
22          addict, you could get Suboxone in an ER or at a  
23          clinic, sell it, stay on your drug because it is  
24          marketable on the street.

25           I see a lot of people who claim an allergy to

1 Naloxone so they can get Subutex instead of  
2 Suboxone. And of course the Subutex is worth much  
3 more on the street than Suboxone is. Plus you can  
4 snort it, inject it, have a lot of fun with it.

5 I would be a lot more open to giving a single  
6 dose of Suboxone than I would be to sending  
7 somebody out with a prescription for which I  
8 basically would refuse to do.

9 DR. TRAN: If I may? Thank you.

10 One of the other hobbies that I have is I do  
11 addiction medicine. I got my board certification  
12 in 2015 and I started back in 2008. It takes 5  
13 years of clinical experience to be eligible sit  
14 for the boards. And so, anyway, I finally sat for  
15 my boards in 2015 and it was a monster of a test.  
16 It was challengingly difficult.

17 And we have a clinic in Lexington. And after  
18 11 years of doing this, I have learned quite a bit  
19 from the treatment. I have also established a  
20 little medical society where I invite clinic heads  
21 in the surrounding area to come every quarter.  
22 And what we wanted to do was share a standard by  
23 which we should all practice, a bar that is a  
24 little higher than just prescribing the medication  
25 itself.

1 I have done lots and lots of research. And I  
2 would like to specifically comment on the issue  
3 that we just talked about and that is the  
4 authorization of ERs to prescribe Suboxone.

5 In the hospital, by law we know that if you  
6 are treating in-patients, you can write for the  
7 Buprenorphine. In the emergency room, I have no  
8 problems with bridging with 1 or 3 days or 3 days  
9 max. What I don't want to happen is what  
10 happened -- I lived through the '90s doing ER and  
11 whatnot. You don't want to create an opportunity  
12 for people to keep using the ER as their  
13 Buprenorphine script site. If you are  
14 legitimately using Buprenorphine to treat yourself  
15 like NIH claims, and they have a large amount of  
16 data that does that, I am semi-okay with that.  
17 But if you are using the ER to get your stash of  
18 medication for nefarious reasons, we need to put a  
19 stop to that. And I don't know how you figure  
20 that out.

21 We also know from NIH literature looking at  
22 the world's experience with Buprenorphine, if it  
23 is the drug of availability like the Norway and  
24 France, it becomes abused. In other countries  
25 where it is not so easy to get, it is the lesser

1 choice. The fact that the Buprenorphine is a  
2 partial agonist limits the high factor and so it  
3 is not as attractive. But if you are an addict  
4 and you can get this by walking through the ER  
5 multiple times, I don't want that. That is no  
6 different than the guy in the garage writing a  
7 script for a patient every 3 or 4 days. And I see  
8 that as a potential huge threat to us.

9 In terms of the urine testing, allow me to  
10 share something with you. And that is, after 11  
11 years of practice we have learned how to do this  
12 correctly and how to make sure that patients are  
13 held accountable. We have about 12, 13 doctors in  
14 the clinic. We have about 14 or so counselors to  
15 provide individual psychotherapeutic counseling  
16 specifically looking at CBTs, specifically looking  
17 at MI contingency management, real psychotherapy.

18 All of our counselors have masters or better  
19 training. We have about 4, now 5 peer counselors  
20 who provide group support, that peer support to  
21 help them. We have about 4 or 5 case managers who  
22 help with the basic needs of food, transportation,  
23 housing, domestic violence, et cetera. We partner  
24 with The Nest to help with the domestic violence  
25 victims. We partner Jubilee Jobs to help get them

1 employment. We now are partnering with the  
2 Bluegrass Technical College to provide education  
3 training, vocational so they can get a job.

4 That's what a comprehensive program should  
5 look like. Because writing the script is  
6 definitely not it. The world's experience with  
7 that is it will come back to bite us because the  
8 Buprenorphine itself will be a problem. We will  
9 have a Buprenorphine epidemic in 10 years if we  
10 don't do it correctly.

11 MR. MUNIR: So just a question for  
12 clarification. You say Buprenorphine. You don't  
13 mean mono-product. You mean the combination  
14 product as well.

15 DR. TRAN: Our policy is very strict. If you  
16 truly have a documented allergy -- and I don't  
17 want it subjective. I want to see it in an  
18 in-patient record, as a discharge summary. I want  
19 to see it as an ER documentation. And just  
20 because you walked into the ER and the ER note  
21 says, he reported that he had an allergy is not  
22 sufficient. You have to have had hives or  
23 something and I wanted to see that the ER  
24 intervened with giving you Xyumentron, Zantac,  
25 whatever it is that they needed to have treated

1 something. Just having an allergy is subjectively  
2 is not sufficient for us to get the --

3 MR. MUNIR: So I just want to clarify your  
4 comment. If we are going to have this broad  
5 epidemic in 5 to 10 years, it is not limited to  
6 Buprenorphine. You cannot say Buprenorphine. You  
7 mean Buprenorphine combination products, right?

8 DR. TRAN: Correct. The Naloxone is simply  
9 added to prevent the abuse potential when you  
10 inject it.

11 MR. MUNIR: And there is abuse potential with  
12 combination product as well.

13 DR. TRAN: Oh, yeah. There is -- the NIH  
14 world literature has shown that there is abuse.  
15 And this is an article that was written in 2012.  
16 So it is a little outdated. But they looked and  
17 there is no abuse really in the United States of  
18 Buprenorphine. Certainly they can't catch every  
19 one of them. But the abuse that they recognized  
20 clearly it was in France where Buprenorphine is  
21 essentially given free. In Norway where it is  
22 essentially given free. And that's where they ran  
23 into that problem.

24 MR. MUNIR: I appreciate that clarification.  
25 Thank you.

1 DR. TRAN: So going back to this.

2 We have a very strict program where Naloxone  
3 allergy has to be firmly documented. In the  
4 northeastern states at ACOG, the American Board  
5 of -- OBGYN -- right now they have been reluctant  
6 to say it but reality is the minute amount  
7 Naloxone which is a teratogenic isn't that much  
8 absorbed. So I think that in the next few years,  
9 even for pregnancy, giving the Naloxone plus  
10 Buprenorphine products is probably going to be  
11 safe.

12 But right now those are the 2 indications.  
13 And ASAM is in agreement with that. There is only  
14 one other indication that they hinting at. And  
15 that is when you transition someone from Methadone  
16 to Buprenorphine, that is a very tricky process.  
17 And clearly it should not be undertaken by anybody  
18 who doesn't have a lot of experience. And in that  
19 one instance, using the mono-product might be  
20 better to mitigate the precipitative withdrawal  
21 aspect danger initially.

22 And now if I may, going to the drug testing.  
23 By KBML regulations, when you are a new patient,  
24 that first month you need to be seen every 7 to 10  
25 days. And our policy is that we see them every

1 week. And during that time, that's when they need  
2 to be stabilized. And that's that vulnerable time  
3 where they need to be screened and monitored  
4 closely. If they are stable and they progress to  
5 month 2, and that's when we see the patient every  
6 2 weeks. Again, they are not quite out of the  
7 woods. By month 3, if you are stable, if you are  
8 stable -- and 80 percent of our patients aren't  
9 quite stable by month 3 -- then you can proceed to  
10 once a month type of follow-up.

11 That's from the doctor's side.

12 Our experience has been, we feel that the  
13 need for psychotherapy, counseling is every 2  
14 weeks. If you don't touch them every 2 weeks, bad  
15 things happen. Our clinic policy is that when we  
16 see them for the doctor visit, we have a drug  
17 screen and we do that. When they come 2 weeks  
18 later to get their counseling and case management  
19 visit, we have the computer roll a dice and if  
20 your random number -- it's 1 to 100 -- if you are  
21 75 or higher. So 25 percent of them get chosen to  
22 go back and do a random sample.

23 The threat of being screened that frequently  
24 helps. You guys all understand that cocaine, all  
25 of the high level, the cocaine, the heroin, it

1 goes away in 3 days, you know. We recognize that.  
2 2 or 3 weeks ago, we found about 4 or 5 patients  
3 with Fentanyl that completely threw us all. These  
4 people are supposed to be stable and we just  
5 randomly did them. And, boom, we had 4 or 5  
6 samples of Fentanyl positive.

7 And so the Fentanyl is very short acting as  
8 well. So we need to be careful. I do say that on  
9 the wasteful end, I know first hand, there is  
10 absolutely very few indications for using anything  
11 more than a tier 1 comprehensive, the  
12 confirmation, the quantitative screen. I have  
13 never, never, never -- we outsource all of our  
14 confirmations. I have never, despite persuasion,  
15 never found an indication for more than 3 or 4  
16 elements. If a guy has got 3 or 4 things, he  
17 needs to be in-patient. He needs something else.

18 So I can't see why you would ever go beyond a  
19 tier 1. But I am sure you guys see it all the  
20 time. So I would be happy to help with, you know,  
21 I have been very fortunate. I am the treasurer  
22 for ASAM and, hopefully in the future, I am going  
23 to work with ASAM as well. But we needed the  
24 right way to do it. And I am very, very concerned  
25 about us not doing it right and having a

1 Buprenorphine epidemic. So thank you.

2 DR. MCINTYRE: There is -- on my breakout  
3 from the agenda, there is a Harm Reduction  
4 Conference on April 10. Can you tell us any more  
5 about that?

6 MS. LADY: Dr. Liu can probably talk about  
7 it. We just tweeted it out.

8 DR. LIU: Just a quick side.

9 DR. MCINTYRE: Prescribing Narcan along with  
10 narcotic prescriptions or along with certain doses  
11 of narcotic prescription.

12 DR. LIU: Well, I would start by saying the  
13 department of public health has created a broad  
14 new infrastructure for harm reduction. And Artis  
15 Hoven is a long time public health physician  
16 leader who is going to be overseeing a significant  
17 new investment and a lot of new infrastructure.  
18 And it runs the gamut from needle exchange  
19 programs to Naloxone distribution. And I think  
20 the tricky thing for Medicaid and for the health  
21 care providers is how to take kind of anonymous,  
22 you know, high level population work and connect  
23 it to getting people into care. And that would be  
24 something that I would love for to us stay kind of  
25 close to and figure out when people stray

1 positive, when people don't have medical homes how  
2 do we create really welcoming broad avenues for  
3 them to -- especially if they are Medicaid  
4 eligible to get really good service.

5 So the all day event is in northern Kentucky.  
6 They have very prominent national speakers coming.  
7 I think would be a great day for any healthcare  
8 provider to attend.

9 DR. MCINTYRE: Thank you, Dr. Liu.

10 Getting toward the end here. Under public  
11 health trends, the second thing was influenza and  
12 Dr. Jeffery Howard.

13 MS. LADY: So KMA has a, much like our TAC,  
14 we have a public health commission. And so our  
15 public health commission has worked a lot with the  
16 Kentucky department of health this year, the  
17 Foundation for Healthy Kentucky and this focus on  
18 flu. Dr. Howard has been wonderful in doing some  
19 brief videos and we put them on our website. And  
20 we, of course, don't know because we don't have  
21 data what kind of impact this has on encouraging  
22 people to get their flu shots. But we keep doing  
23 it.

24 And so it is been successful as far as  
25 getting the word out. We use television media.

1 We use social media. We have used everything,  
2 meetings, every possible kind of ways that we can  
3 talk about this, we have. So we are ramping that  
4 up for 2019. And then our public health  
5 commission will meet in April. And what we try to  
6 do is align our goals with Medicaid. We started  
7 out with Kentucky health goals. We look at the  
8 1115 waiver. And what we want to focus on are  
9 those same kind of health priorities.

10 So this year it happened to be flu. So we  
11 have 7 health priorities. One of them, of course,  
12 is substance opioid use. Obesity. Diabetes. So  
13 we haven't selected what we are going to do in  
14 2020. I just kind of wanted to throw that out  
15 here. So that if anyone has ideas from the MCOs.  
16 And actually Dr. Payne is on our public health  
17 commission and we talked briefly through email  
18 about diabetes prevention's program. And we have  
19 talked to staff at Humana. We do think that might  
20 be something we look at in 2020. It is like  
21 diabetes, obesity, and tying it together with the  
22 prevention programs and trying to stop it, you  
23 know, at the pre-diabetes level.

24 So I just really wanted to throw that out  
25 there. We are ramping up our flu. If you just

1 look at the amount of information, it would be  
2 successful. Again, we have no way of knowing what  
3 kind of impact that had on our state. So if you  
4 have ideas, anyone, either the MCOs, anybody, Dr.  
5 Liu, please let me know. And I will -- also, you  
6 are invited to come to our next public -- I think  
7 I copied you, Dr. Liu, in case you want to come  
8 with Dr. Howard.

9 So we also want to tie those measures in, and  
10 you know this, with quality. Because I think you  
11 know we worked on that big quality project the  
12 year before last to try to come up with some  
13 consistent quality measures that would attack  
14 those health priorities as well. And we had  
15 some -- so just everybody think about those. And  
16 then think about what we could put a focus on in  
17 2020.

18 I think we are sort of leaning towards  
19 diabetes prevention and obesity. But I don't make  
20 that determination. That will be the public  
21 health commission input from our members like you.  
22 So that's all I wanted to say about that.

23 Thank you, Dr. McIntyre, for allowing me to  
24 do that.

25 VICE CHAIRMAN MCINTYRE: And you mentioned

1 that diabetes prevention. When we talked on the  
2 phone, you said Cathy Stephens from HumanaCare.

3 MS. LADY: Uh, huh. I am working with Cathy.  
4 I have to follow-up with her because they actually  
5 are doing it.

6 MS. STEPHENS: Right.

7 MS. LADY: They have the diabetes program.

8 MS. STEPHENS: We have a pilot in place now.  
9 Dr. Gallaway can probably speak to that.

10 MS. LADY: Do you want to talk about that for  
11 a second?

12 DR. GALLOWAY: It is with KPCA. We partnered  
13 with them because they have practices that are in  
14 the Louisville, Frankfort, and Lexington area  
15 which is the 3 Y facilities, the YMCAs, that are  
16 actually doing the program. They are a recognized  
17 CDC program for the DPP, the national program. So  
18 they are administering the program for us. And it  
19 is just a small pilot. We are hoping to get about  
20 60 members.

21 MS. LADY: So then you will track the data,  
22 like if you have success, you will be able to show  
23 if that person improved or --

24 MS. STEPHENS: They will send us data. It is  
25 actually a year long program, the program they do.

1 And it is like weekly.

2 DR. GALLOWAY: I think they do a 12 or 14  
3 weekly session in the first 16 weeks or so. And  
4 there is some opportunities do makeup if they miss  
5 like a session or something. So the Y is going to  
6 give us data around week 20 so we make sure  
7 everybody gets through their sessions and stuff.  
8 And they track weight loss, minutes of activity,  
9 the KPCA providers will be tracking the hemoglobin  
10 and A1Cs. And I am drawing a blank. There is  
11 something else they track at the Y.

12 But they are going to give us data like at  
13 the 20 weeks, 6 to 8 months, and then at 12 months  
14 when they finish. Once they complete the weekly  
15 sessions, then it goes to monthly. And the Ys are  
16 also allowing them some membership at the Y to us  
17 the facilities.

18 MS. LADY: Do you know how many providers are  
19 involved in that?

20 DR. GALLOWAY: I actually do not know how  
21 many providers are at the clinics that are near  
22 those Ys. Those are the ones KPCA is targeting  
23 for that. I actually couldn't tell you how many  
24 providers.

25 MS. LADY: That might be something, you know.

1 Depends. But what do you think? Do you think  
2 some our members would be interested in working  
3 like that with a diabetes prevention program with  
4 an MCOs?

5 DR. MCINTYRE: It's certainly possible they  
6 would. I am sure some would.

7 MS. LADY: Dr. Gupta?

8 DR. GUPTA: I mean I think every physician  
9 deals with diabetics. And the number one thing is  
10 prevention. So I think many people would be  
11 interested.

12 DR. TRAN: Again, I am very biased because I  
13 look at the mortality associated with diabetes.  
14 And so I obviously am very passionate about  
15 preventing diabetes and management of diabetes  
16 properly. Almost every mortality that I can point  
17 to has diabetes mixed in that severity  
18 calculation.

19 My concern is, you know, I think that  
20 diabetes may be genetically pre-dispositioned.  
21 And even though you do everything that you can to  
22 mitigate the expression of that illness, it  
23 eventually happens. And not that I am a naysayer.  
24 But I think that we should probably focus on  
25 management of the illness and look at the

1 different stages of the pre, the actual, and the  
2 then the post years and not so heavily focused on  
3 just prevention with the dream and hope that we  
4 can prevent certain numbers from being expressed.  
5 Whereas looking at it globally, we recognize that  
6 we can delay the complications by delaying the  
7 onset.

8 But let's not put such a hard outcome on how  
9 many people did we prevent. Plus that's an  
10 impossible question to answer, right?

11 MS. LADY: It really is. I am going to table  
12 that. But just threw it out there. So if anybody  
13 has any other ideas --

14 DR. TRAN: I am sorry. It's just that I have  
15 been working with mortality so long now, that it  
16 is just --

17 MS. LADY: I will possibly still follow up  
18 with the MCOs after our public health commission  
19 meeting when they make a decision on the. And  
20 then, of course, the leadership at KMA will be  
21 very involved in that, too. So thank you, Dr.  
22 Tran. Thank you all. All right.

23 DR. MCINTYRE: On a personal level, I am a  
24 diabetic. I get my Metformin free from the VA  
25 which saves me \$.79 a month. But I also take

1        Invokana and take Victoza. And so my diabetes is  
2 managed extraordinarily well. I have had it for  
3 17 years. I am still working as an ER doctor.  
4 And obviously have my vision and my limbs and my  
5 kidneys.

6            And that's available to me as a physician  
7 with a nice income. But not available to Medicaid  
8 patients in the general population.

9            DR. TRAN: And I think that for the most bang  
10 for our buck it really needs to be focused on the  
11 proper management, prevention of the end  
12 complications, the retinopathy, the nephropathy,  
13 and the neuropathy, those things. And I think we  
14 should focus on that, recognizing that these are  
15 clinical entities that may express at a time where  
16 we don't -- we are currently not smart enough to  
17 know when it chooses to express.

18            And I think that the money would be better  
19 spend on ensuring that we get that monitoring for  
20 retinopathy, you know, those complications and  
21 managing your diabetes better.

22            DR. LIU: I think that's very debatable. I  
23 guess I would just fire back, you know, we pay for  
24 those right now. And actually one of the very  
25 interesting things about the DPP specifically was

1 the lack of physician referrals into a program  
2 that was found to be in very, very rigorous trials  
3 quite effective. And the lifetime rewards of more  
4 favorable weight status, more favorable life  
5 style, it is likely underappreciated.

6 So I don't diminish the value of managing  
7 diabetes well, especially preventing end-stage  
8 complications.

9 I guess I would offer one final comment is  
10 that our state employee health plan, the Kentucky  
11 plan which in some ways is a good comparison group  
12 to the expansion population, has had very good  
13 results with the DPP in terms of those things that  
14 are concerns; adherence and completion, and  
15 getting people into a program that requires a fair  
16 amount of commitment in terms of, you know, it is  
17 an intensive induction phase, a lot of course  
18 work, and then going on to make decisions that all  
19 os us struggle with; staying active and eating  
20 well, otherwise being well.

21 So I love how you are thinking about those  
22 things. I couldn't let you get away with an  
23 authoritative --

24 DR. TRAN: I preface it with my bias. That's  
25 because I look at the end secuelas so much.

1 DR. LIU: Yeah.

2 DR. GUPTA: Maybe instead of calling it  
3 diabetes prevention program, calling it obesity  
4 prevention. Because --

5 DR. TRAN: Really that.

6 DR. GUPTA: -- that's really what you are  
7 trying to do.

8 MS. LADY: I mean, that's a good point.

9 DR. GUPTA: But diabetes is more, you know.

10 MS. LADY: And our members has pointed out,  
11 yeah. Because before we had, we just had diabetes  
12 prevention. And they said and our public health  
13 commission said, no, you need obesity kind of as a  
14 separate component. Because you need to manage,  
15 you know, improve on that. So we did make that a  
16 separate health priority through the public health  
17 commission's good point.

18 DR. MCINTYRE: Just my personal experience  
19 with the 3 medicines. All 3 of them promote  
20 weight loss. And once I went strictly on those 3,  
21 I got rid of the Pioglitazone which makes you gain  
22 weight, I lost 30 pounds in about 8 months with no  
23 effort at all. In fact, I can't put on weight no  
24 matter what I do.

25 Again, it is an economic thing. If you can

1 afford those medicines, they are wonderful.

2 The last item was managed care audits. Any  
3 comments on those?

4 MS. LADY: Updates from the MCOs. I didn't  
5 know. I was kind of just going to give you an  
6 opportunity to share anything you wanted. I did  
7 want to mention as one of the updates, we did get  
8 some contact from more than -- from a few members  
9 about MCO audits. And that's retrospective  
10 audits. And I really haven't seen a lot of those.  
11 I have seen where a claim got processed wrong and  
12 you had to go back and fix it.

13 But I haven't seen audits. So I didn't know  
14 if you wanted to throw that out there if any of  
15 you all had any information you wanted to share if  
16 you are going doing that kind of audit. And there  
17 is things that we can tell our members. I would  
18 be happy -- KMA would be happy to share with our  
19 physicians. And if you have any other updates.

20 DR. GALLOWAY: Yeah. I am not aware that we  
21 do a lot of retrospective review for claims  
22 payment. I don't know. Maybe if they are talking  
23 about there has been a lot of a IPRO things going  
24 out, had to get charts for audits for different  
25 like MAS and several different things. I don't

1 know if that's what they are talking about being  
2 asked to send charts in and records in for all of  
3 these audits and stuff.

4 That might be what it is.

5 MS. LADY: But that's a different kind of  
6 audit, right? That's not really -- that's more  
7 like a quality.

8 DR. GALLOWAY: Uh, huh. Yeah.

9 DR. PAYNE: To me this is such a highly  
10 regulated industry as you can imagine. I can't  
11 walk in the office without somebody saying audit.  
12 So it depends on what specifically the question  
13 would be.

14 MS. LADY: So just work with the -- I was  
15 just asking kind of broadly. Because if there was  
16 some big issue going on that you were looking at.  
17 So there is not. So we will do what we normally  
18 do which is just take that member to the MCO and  
19 work it out.

20 DR. GALLOWAY: Yeah.

21 MS. LADY: Thank you very much.

22 MS. SMITH: And I am Jennifer. I am with  
23 Anthem. I know we do have a non-covered code  
24 audit that will start April 15th of this year.  
25 And basically it is just you may see denials come

1 through on codes that were once reimbursed. It is  
2 just because they are not on the DMS fee schedule.

3 MS. LADY: So once it's not covered?

4 MS. SMITH: Yeah. That's strictly all it  
5 entails.

6 MS. LADY: So then if that code had gotten  
7 paid, you would just ask for that?

8 MS. SMITH: Yeah. In the past. It is not  
9 going to be moving forward starting April 15th.  
10 And that is strictly because it is not on the fee  
11 schedule.

12 MS. LADY: Okay. Okay. They are kind of  
13 accustomed that. I mean that kind of happens.  
14 But, okay. We can certainly let them know.

15 MS. SMITH: And there is a couple of other  
16 updates I just wanted to mention here as well.  
17 Obviously, Kentucky health. We did recently host  
18 some webinars beginning in March, that first week  
19 of March. So we had some provider webinars.

20 And then I also want to mention our provider  
21 relations territory realignment. So we have kind  
22 of combined our Medicaid and commercial reps. So  
23 each rep is assigned their own territory across  
24 the state. And more to come on that. There is  
25 going to be more information announced formally

1 pretty soon. So I just wanted to make you guys  
2 aware of that.

3 MS. LADY: So the Anthem PR commercial reps  
4 handle Medicaid? They handle everything?

5 MS. SMITH: We are going to do all lines of  
6 business in assigned territories, yes. So it is  
7 really just a better way for us to best service  
8 the providers. And you have guys have that one  
9 point of contact moving forward.

10 MS. LADY: Okay.

11 DR. MCINTYRE: Just educate me if you would.  
12 You said you were assigned territories. So all of  
13 the MCOs don't cover the entire state.

14 MS. SMITH: I mean I can only speak for  
15 Anthem. Yes, we all cover Kentucky. But for  
16 Anthem, we have certain regions. We have reps  
17 across the state that cover certain regions of  
18 Kentucky.

19 So a lot of our outlier counties, we have  
20 reps that typically live in that area of town that  
21 can easily get out to providers and be in front of  
22 them. Just better service them.

23 DR. MCINTYRE: Are there any parts of the  
24 state you don't service?

25 MS. SMITH: No.

1 MS. HUGHES: I believe most of the MCOs are  
2 statewide. What they are talking about is they  
3 just have the little smaller breakout regions that  
4 allows them to have employees right there that  
5 most of them, I think, live in that region. And  
6 so they can -- basically it cuts down on travel.  
7 To travel the whole state, they just have  
8 employees out there.

9 MS. SMITH: Yeah. It is easier for us to get  
10 out in front of the providers and be that support  
11 system that we are supposed to be.

12 MS. LADY: I like that you mixed your PR reps  
13 where you have just got to contact the rep for all  
14 of the questions. It is kind of convenient.

15 MS. SMITH: Yes. And that's our goal. Want  
16 to make it more convenient, just provide that  
17 better service.

18 MS. LADY: So I can ask a Medicaid question  
19 and a commercial question in the same email.

20 MS. SMITH: Yeah, you can. Yeah. We are all  
21 working very closely together. Obviously there is  
22 a lot of cross-training going on, a lot to take  
23 in. But we are working very closely with each  
24 other. So just bear with us. Yeah.

25 MS. LADY: Thank you very much.

1 MR. MUNIR: I was just going to add to that,  
2 the conversation we have had around symptom abuse  
3 disorder, opioid abuse disorder, is an important  
4 one. And it intersects so much with some of the  
5 other items we discussed, including the  
6 reimbursement for telehealth and the cost of the  
7 care and efficiency.

8 Because, you know, I was trying to look up a  
9 code in terms of when we talk about reimbursing  
10 more, putting more money into the health care  
11 system, the Chairman for the federal reserve  
12 system said the in his testimony before congress,  
13 the U. S. federal government is a un-sustainable  
14 fiscal path. The thing that drives our single  
15 un-sustainability is health care spending. We  
16 spent 17 percent of our GDP, everyone else in the  
17 world spends 10 percent. It is not the benefits  
18 themselves are too generous. We deliver them in  
19 an inefficient way.

20 So one could argue, okay, telehealth is going  
21 to make it more efficient. But how do we know it  
22 is not going to be just added to the cost because  
23 there are so many other drivers here?

24 So they are projecting that 17 percent is  
25 going to go to 20 percent within a decade or so.

1           But bringing it back, you know, I appreciated  
2           Dr. Tran's comments about potentially creating a  
3           Buprenorphine mono-product or a combination  
4           product epidemic over here as the streets are  
5           going to be flooded.

6           The new rule allows a dose of up to  
7           24 milligrams per day for Buprenorphine without  
8           prior authorization. Most experts think 16  
9           milligrams should be the dose that's required. It  
10          now requires that you have a patient and greater  
11          than 16 milligrams after one year you try to wean  
12          them down to 16 milligrams.

13          So there may be odd incentives over here.  
14          And many of the things that Dr. Tran describes in  
15          his practice are similar to best practices that I  
16          have seen nationwide, including the University of  
17          Kentucky's addiction medicine clinic in terms of  
18          improved class, the random urine drug testing, not  
19          using the white panel test, and looking  
20          specifically --

21          But I can assure you from our claims data,  
22          that is not what we are seeing statewide. So when  
23          you take some of these controls off, you think  
24          about it from a public policy and societal  
25          perspective, in the effort to do good over here,

1 you know, what are we doing that might have  
2 long-term unintended consequences both in terms of  
3 potentially diversion but also cost to the system,  
4 right.

5 So if we are already at 17 percent and you  
6 are going to incur all of this additional cost,  
7 you may have practitioners who you don't need to  
8 be ABM certified to get an X license. There are a  
9 lot of practitioners that don't have 5 years  
10 experience and who are seeing 275 patients, as Dr.  
11 Tran's clinic are seeing, who are -- and I hate to  
12 use this word -- but kind of dabbling in opioid  
13 use disorder. It takes an 8 hour CME to get your  
14 X license.

15 So I think when you step back from a health  
16 perspective, the opioid use disorder I think is a  
17 great poster child from any of the other things we  
18 have talked about in terms of cost of care,  
19 efficiency, and drivers of the system. We haven't  
20 even talked about the new drugs, the gene editing  
21 therapies that are coming out, that may cost a  
22 million dollars a year for one patient.

23 So we think about how we can organize the  
24 health care delivery system. But I love opioid  
25 use disorder because it is so complex over here.

1 And I think and I appreciate that what Dr. Tran  
2 said in terms of trying to do something for the  
3 citizens of Kentucky.

4 There are people at risk over here who are  
5 suffering. And as he can speak better than I can,  
6 most people with opioid use disorder take 7 or 8  
7 or 10 cycles of recidivism, sobriety and then  
8 relapsing before they maintain long-term sobriety  
9 People may need to be on Buprenorphine for the  
10 rest of their lives. Some people are recommending  
11 that; up to 30, 40, 50 percent of patients. It is  
12 going to be a maintenance drug.

13 So we think about the state of Kentucky and  
14 the cost pressures over here. So it is hard to be  
15 able to sell people, give me 120 percent for  
16 telehealth as the cost pressure for that  
17 telehealth care budget is going up 25 percent as a  
18 result of all of these other things.

19 DR. TRAN: If I may have a chance to respond.  
20 Several things. Number one.

21 Health care cost reduction was something very  
22 dear to my heart. Like I said, I have an interest  
23 in macro-economics specifically in health care.  
24 And I know, for instance, at the VA where I  
25 practice, after I was tasked to look at this

1 project, we looked at interventions to reduce the  
2 readmissions rate for 3 modalities; heart failure,  
3 pneumonia, and COPD.

4 And in that year, we implemented several  
5 modalities to include the telehealth, specifically  
6 look at the patient monitoring aspect of  
7 telehealth as well as the frequent touches using  
8 telehealth. And after one year, our re-admissions  
9 for the specific entities that did decrease,  
10 some -- and I can't remember the data any more.  
11 But at the end of the year, I was able to save the  
12 VA close to something like \$2 million by reducing  
13 the re-admissions. So I can continue to show you  
14 those outcome measures. And on a national level,  
15 the VA -- and, again, I have so many numbers  
16 unless I fresh my memory it doesn't come -- but we  
17 saved something like 69 percent hospital days of  
18 care with the invention of telehealth.

19 Yes. In the beginning, you will see a  
20 greater up-front cost if you will of incorporating  
21 this technology. But I think that if done  
22 properly, you will see the return on investment in  
23 reducing overall hospitalization rate, decrease in  
24 re-admissions rate, and probably convenience that  
25 is intangible. How does a patient describe

1 traveling from Harlan, Kentucky to Lexington? How  
2 do we calculate that monetary value, especially in  
3 the winter when there is snow? I drove to Harlan  
4 and I realize how does one express that in a  
5 calculation? Okay.

6 The other comment is, you are absolutely  
7 correct, our clinic sees about 1200 unique  
8 patients a month. So that is a pretty big size  
9 clinic. And I can't think of one that is on more  
10 than 16 milligrams a day. So the only people that  
11 could even play with that question are the  
12 addictionologist. And it has to be pretty  
13 exceedingly rare circumstance. Again, I can't  
14 think of a case where -- and I go through that  
15 data. We don't have such a patient who is on more  
16 than 16 milligrams a day.

17 The other element that you touched on that I  
18 think merits discussion is, some of these  
19 people -- and I think that the California Society  
20 of Addiction Medicine, ASAM, many national  
21 organizations who have expertise -- have already  
22 stated several years ago that this looks to be a  
23 chronic illness and this looks like it needs  
24 maintenance therapy.

25 In terms of looking at the return of

1 investment, we have to look at opportunity, cost,  
2 prevention. If I have a patient who is left to  
3 his own, he acquires endocarditis. He acquires  
4 Hep-C. He acquires all of these other problems  
5 that will cost us a tremendous amount of money.

6 From the law enforcement standpoint, he will  
7 often get placed into jail or get involved in the  
8 legal system. That costs taxpayers an awful lot  
9 of money. If you have people who are unemployed  
10 because they are too busy with their habit, we  
11 have lost a productivity that, if pushed, I am  
12 sure we could figure out a way to calculate that  
13 loss. And so I understand that the accounts are  
14 in different buckets of money, different pots of  
15 money. But collectively looking at the economy as  
16 a whole, the prevention of these problems I think  
17 clearly justifies aggressively treating this  
18 condition.

19 If I am not mistaken, the Surgeon General  
20 said a couple of years ago, the CBO did a  
21 calculation. It is a very true calculation. I  
22 went through it. And it got really hairy. But  
23 they took all of these factors I talked about into  
24 play. For every patient that you treated for  
25 opioid addiction, you are going to save hundreds

1 of thousands of dollars downstream.

2 So, yes, I understand your concerns that,  
3 hey, these things that you are talking about,  
4 these new health care delivery models sounds  
5 expensive. But I think that you will be surprised  
6 to learn that the return on that investment will  
7 be worth it.

8 MR. MUNIR: My concern for the health care  
9 systems are paying for it and society is as a  
10 whole. And to Dr. Liu's point, if only 1 of 10  
11 patients are getting treatment, as physicians, as  
12 healthcare providers, if we want everyone who is  
13 at risk to get treatment, look at the current cost  
14 and multiply that by 9 or the incremental cost.

15 DR. TRAN: But then the savings from not  
16 getting these complications downstream will be  
17 worth it.

18 MR. MUNIR: For society, yeah.

19 DR. TRAN: Yes. Well, the healthcare and the  
20 MCO. If you have a member who has OUD and left to  
21 his own will probably contract the Hep-C, whatever  
22 you want to choose, liver cancer, whatever. But  
23 if you treat them now, you will prevent that  
24 complication downstream.

25 And I think that's been clearly shown to be a

1 favorable.

2 DR. MCINTYRE: All right. Next item on the  
3 agenda is TAC recommendations. And just for  
4 Dr. Tran in effect. We are kind of a, not really  
5 a subcommittee, but something like a subcommittee  
6 of the Medicare Advisory Committee.

7 DR. TRAN: Medicare or Medicaid?

8 MS. LADY: Medicaid.

9 DR. MCINTYRE: I am sorry. Misspeaking.  
10 Medicaid Advisory Committee. Dr. Gupta is our  
11 representative on the committee. She is a voting  
12 member of the committee. And I go basically in  
13 Dr. Thornbury's place and make a report on what we  
14 did in our committee to the MAC, the Medicaid  
15 Advisory Committee.

16 We can make formal recommendations to the MAC  
17 for them to pass on to the Commissioner if we  
18 choose to. And I guess the question at this point  
19 is, are there any recommendations for us to pass  
20 along to the MAC for them hopefully to pass along  
21 to the Medicaid Commissioner?

22 MS. LADY: I think one of the ones that we --  
23 Dr. Thornbury didn't have any official. But one I  
24 think we ought to probably make is using 2  
25 modifiers; an acute care and a chronic care

1           modifier. I mean that's -- from a coding  
2           perspective and a data gathering tool, it is a  
3           really good idea. And I can't believe that I  
4           didn't think of that.

5                     So I think that would be a recommendation  
6           that would be accepted. And I think Medicaid  
7           would be interested.

8                     Now I have a question for Sharley. How soon  
9           do we need to get our recommendations to you?  
10          Like is there a specific date?

11                    MS. HUGHES: If I am going to have them in  
12          the MAC folders that the MAC members get that day,  
13          I need them by Monday morning before the MAC  
14          meeting which is the 28th.

15                    MS. LADY: Okay. So we need to get it  
16          written up and submitted to you by the 28th.

17                    MR. LYSONGE: That just guarantees that they  
18          are copied and put in the folder. If you don't  
19          get it to me, then you just present it yourself.  
20          But I need them electronically and preferably in  
21          Word.

22                    MS. LADY: In Word? We can do that.

23                    MS. HUGHES: Yeah. Only because that  
24          saves -- especially some of them -- some of the  
25          TACs gets really wordy in their recommendations.

1 And if I have it in Word, I can cut and paste.

2 MS. LADY: We are good at that because our  
3 recommendations are usually 2 or 3 sentences.

4 DR. TRAN: I am surprised you didn't ask have  
5 for it HL7 format.

6 MS. HUGHES: I don't even know what HL7  
7 format is.

8 DR. TRAN: That is the standard for HR  
9 communications.

10 MS. LADY: And if you have the things that we  
11 have talked about today.

12 DR. TRAN: I would specifically like to  
13 augment -- add to that request that the  
14 reimbursement for telehealth services be on par  
15 with that of face-to-face. I think that most  
16 physicians are willing to buy an echo machine,  
17 spend that money with the knowledge that I am  
18 going to be able to provide additional care, more  
19 care to my patients and eventually I will be able  
20 to pay off that machine.

21 At a rate that is a less than desirable, you  
22 are going to put additional barriers to the  
23 implementation of telehealth which I think, you  
24 know, is so critically important. Before I die, I  
25 would like for Kentucky to be first in something

1 good. That would make it worthwhile. I would  
2 like for us to take this opportunity to run with  
3 telehealth and be one of the better states at  
4 implementing it with demonstration of outcome  
5 metrics that are worthwhile.

6 MS. HUGHES: It is a good thing you are  
7 young.

8 DR. TRAN: Quite ancient. So I have got to  
9 move quick.

10 DR. MCINTYRE: To Dr. Liu's point, that that  
11 should be addressed at the MCOs. Now, I am  
12 confused --

13 DR. TRAN: It is.

14 DR. MCINTYRE: -- because the 85 percent, the  
15 MCOs didn't come up with that obviously. The  
16 Department for Medicaid services came up with it.

17 MS. LADY: It was in a discussion between  
18 primary care, Medicaid, and someone else. And  
19 then Dr. Thornbury, I think, was in on that  
20 discussion. So that's how it came up.

21 We will formulate that recommendation.  
22 But -- and we can even tag on there.

23 DR. TRAN: Dr. Liu, could you help explain  
24 Senate Bill 112 which was passed and signed into  
25 law last year to be effective January 1st of this

1 year, implemented July whatever. I thought that  
2 the wording was such that the reimbursement for  
3 telehealth would be on par with face-to-face.

4 Then how do you translate that to  
5 reimbursement for Medicaid? How does that happen?

6 DR. LIU: I don't believe that that bill --  
7 Medicaid had an exemption to some of the clauses  
8 in that bill is essentially the answer to your  
9 question.

10 MS. LADY: They had an exception to that.

11 DR. TRAN: Because the law reads parody in  
12 reimbursement, right?

13 DR. LIU: But not Medicaid.

14 MS. LADY: So you will get it from commercial  
15 payers. But Medicaid, yeah, the exception is a  
16 good way to say that exemption.

17 DR. MCINTYRE: So we need to take a vote on  
18 our recommendations.

19 DR. TRAN: Could somebody repeat the  
20 recommendation so we can hear it in its entirety?

21 MS. LADY: Okay. So the one of the  
22 recommendations is to utilize an acute care and a  
23 chronic care modifier in telehealth services so  
24 that for data collection purposes and to make sure  
25 for coding purposes. So --

1 DR. TRAN: From my experience at the VA, I  
2 think another modifier that should be included in  
3 this -- and I am positive that once this gets  
4 implemented, you guys, the MCOs are going to be  
5 interested in this modifier as well -- and that is  
6 whether or not there was an exam included.

7 There is a limit to the exam when you conduct  
8 a telehealth visit. So whether or not you had an  
9 actual physical exam conducted or not makes a big  
10 deal. For instance, in the VA, we have a modifier  
11 that we check: TCT requested. That TCT is the  
12 telehealth technician who is on the patient side.  
13 And so if a patient lives in Harlan, the patient  
14 can go to a nearby satellite clinic, sit there and  
15 receive the telehealth visit from a specialist  
16 here in Lexington.

17 If I conduct a visit without much of an exam  
18 other than seeing the guy and whatnot, that's a  
19 plain telehealth. If I conduct the telehealth  
20 with an assistant at the patient's site helping me  
21 with the exam, looking into the patient's ear,  
22 looking down the throat, looking at the rash,  
23 looking at the wound, looking at these things, I  
24 have a tech supporting me.

25 That adds a whole layer of cost associated

1 with that exam which needs to be reflected in the  
2 reimbursement.

3 MS. LADY: Okay. So we might need to look at  
4 more than just -- there might be other modifiers.  
5 I liked your idea about talking to other states  
6 that have already implemented this. So there  
7 might be some others that we haven't thought  
8 about, too.

9 DR. MCINTYRE: So we would be --

10 MS. LADY: We could leave that broad and say  
11 use modifiers that would designate.

12 DR. TRAN: That would further clarify the  
13 services provided.

14 MS. LADY: And then we could say as an  
15 example that.

16 DR. TRAN: Acute, chronic, whether a TCT  
17 assists.

18 MS. LADY: Yeah. So just make it really  
19 broad. And I will get the KMA lawyers to -- Pat  
20 always looks at all of this so he will fix it up  
21 for us.

22 DR. MCINTYRE: Why don't we use 4 modifiers;  
23 acute, chronic, with TCT or without TCT?

24 MS. LADY: We'll just say use clarifying  
25 modifiers such as. But that will leave it broad

1 enough. So there is probably some other things we  
2 haven't thought of just like Dr. Tran just brought  
3 that up.

4 So I like that recommendation. I think that  
5 one would be one that would be accepted without --

6 DR. MCINTYRE: So all in favor?

7 \* \* \*

8 UNANIMOUS IN FAVOR

9 \* \* \*

10 DR. TRAN: How many board members do we have?

11 MS. LADY: We have space. We can have 5  
12 members. We have one open position because  
13 Preethi stepped down, our infectious disease  
14 doctor. So you just need to have 75 percent,  
15 three-fourths to get to a quorum. So you have got  
16 a quorum today.

17 So do we want to leave that reimbursed  
18 telehealth on par with face-to-face? Do you want  
19 to make that a recommendation?

20 DR. TRAN: I feel strongly that has to be.

21 DR. GUPTA: I think we still should, just so  
22 it is there. And it may not be deemed as a place  
23 to say anything about it. But it is there.

24 MS. LADY: Okay. All right. And I like the  
25 part where I will fix this up and get Pat to

1 concise it for us.

2 DR. MCINTYRE: All in favor?

3 \* \* \*

4 UNANIMOUS IN FAVOR

5 \* \* \*

6 MS. LADY: Thank you all.

7 DR. MCINTYRE: Wrap up, round table meeting  
8 ting and event reminders. Do we have anything?

9 MS. LADY: I think we did --

10 DR. MCINTYRE: We will adjourn. Thank you  
11 all.

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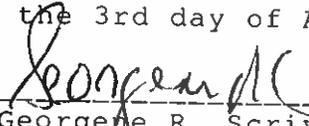
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CERTIFICATE

STATE OF KENTUCKY  
COUNTY OF FRANKLIN

I, Georgene R. Scrivner, a notary public in and for the state and county aforesaid, do hereby certify that the above and foregoing is a true, correct and complete transcript of the meeting of the PHYSICIAN'S TECHNICAL ADVISORY COMMITTEE, taken at the time and place and for the purposes set out in the caption hereof; that said meeting was taken down by me in stenotype and afterwards transcribed by me; that the appearances were as set out in the caption hereof; and that no request was made by counsel for any party that the transcript be submitted for reading and signature.

Given under my hand as notary public aforesaid, this the 3rd day of April, 2019.

  
-----  
Georgene R. Scrivner  
Notary Public - ID 445375  
State of Kentucky at Large  
CCR#20042109

My Commission Expires: 7/15/2019