TECHNICAL ADVISORY COMMITTEE

ON PHYSICIAN SERVICES (TITLE XIX)

****

Kentucky Medical Association

9300 Shelbyville Road, Suite 850

Louisville, Kentucky

Meeting held on

September 21, 2018,

Commencing at 10:05 a.m.

Tamara Duvall-McClain, RPR

A T T E N D A N C E

MEMBERS:

William Thornbury, MD, Chair
William McIntyre, MD, Vice Chair
Ashima Gupta, MD

MEMBERS PRESENT:

(See List Attached to Back of Transcript.)

DR. THORNBURY: I want to call this meeting to order. Let the minutes show that we have met a quorum. We have Dr. McIntyre, Vice Chair, and Dr. Gupta, who of course serves on the MAC on our behalf. Thank you all for coming.

We want to firstly recognize our new Medicaid Commissioner, and hope the minutes will show --

MS. LADY: Our new Medicaid Commissioner, I haven't officially met her yet, it's Carol Steckel, S-T-E-C-K-E-L, is that right?

DR. THORNBURY: Uh-huh. We want certainly to acknowledge that. Do we have any -- good morning. Your timing is perfect. So while we're doing that, just a little housekeeping. Most of the people -- a lot of the people around the table I know. Some of you that I don't, particularly if we have guests. Would it be possible to kind of go this way to at least identify for the stenographer who you are and what you represent.

MS. ROOF: My name is Casey Rutledge

Roof. I'm an audiologist with the University of Louisville Physicians, but I'm here today on behalf of the Kentucky Academy of Audiology.

MS. SCOTT: I'm Jena Scott and I'm also with the Kentucky Academy of Audiology.

MR. HOUCHIN: Hey, everybody. I'm Tim Houchin, I'm the new BA Medical Director at Wellcare, and I'm sitting in today for Howard Chaps. I do have to be at the Medical Director MCO meeting in Frankfort, so I may have to tag out a bit early. So if I leave, it's nothing anyone said.

MS. MANKOVICH: I'm Paige Mankovich. I am the Director for Strategic Planning at Aetna Better Health Kentucky.

DR. TEICHMAN: I'm Jeb Teichman. I'm Deputy Chief Medical Officer of Aetna Better Health Kentucky.

MS. WILSON: Hi, I'm Abbi Wilson with the Kentucky Primary Care Association. I'm sitting in for David Boley.

MS. SWINGLE: Jennifer Swingle, Department of Medicaid.

MS. JOLLY: And I'm Jeana Jolly with the Department of Medicaid.

DR. GUPTA: Ashima Gupta, board member.

MS. CAHILL: Jennie Cahill, Passport Health Plan.

MS. PARKER: Angie Parker, Medicaid. I've only been there two months, so there may be some things I can't answer.

MR. BROWN: Thomas Brown, Humana Caresource.

DR. McINTYRE: William McIntyre, I'm Vice Chair.

DR. THORNBURY: And, of course, I'm Dr. William Thornbury. Welcome. They snuck in.

MR. GROVES: Ken Groves, Anthem Medical Relations.

MS. GREENWELL: Paige Greenwell, Humana Caresource.

MR. HALEY: My name is Adam Haley, and I'm the Director of Public Policy for the Kentucky Academy of Audiology

DR. THORNBURY: Well, welcome everyone. Well, let's get to work. Do we have any other housekeeping issues before we jump into the agenda?

Can you guys hear us on the phone? Maybe you could just kind of let us know who's there.

MR. DOUGLASS: Charles Douglass with the Department of Medicaid Services.

DR. THORNBURY: Welcome, Charles.

MR. WALDIE: This is Matt Waldie with the National Area Health Alliance, here on behalf of the Kentucky Medical Group Management Association.

DR. THORNBURY: Okay, welcome.

MS. HACKETT: Kate Hackett with Medicaid Provider Enrollment.

DR. THORNBURY: Very good. Well, if there's no one else, I guess we'll jump in and I guess --

DR. HOUGHLAND: I'm here.

DR. THORNBURY: Go ahead.

DR. HOUGHLAND: Dr. Thornbury, it's Steve Houghland with Passport. I'm on my way to Frankfort this morning. I don't know, it may just be my connection, but I was having a very difficult time hearing anyone other than yourself in the room. I think there's a little difficulty here on the phone.

Charles and others from the department, I don't know if you have the same issue or not.

DR. THORNBURY: Dr. Houghland, welcome, safe driving, and we'll do our best. The phone is right beside me. So, I'm sorry if you-all can't hear us, we'll do our best to speak up. I would encourage you just to chime in and say that we just didn't catch that if we go by.

Well, welcome everybody. The first item on the agenda is provider enrollment. We'll look to our Medicaid staff to discuss that. Who's going to speak to that, Jeana?

MS. JOLLY: Kate is on the phone.

DR. THORNBURY: Kate, is that you?

MS. HACKETT: Yes, sir, it is. So the specific agenda item here is the online portal that I would like to speak to quickly. I want to let everyone know that we are moving into an extended pilot, where we will be bringing on eight provider types over the next three -- from November to the beginning of January, to extend the use of the online system.

With the online system we took into consideration the feedback from the five major -- five large hospitals that have been piloting with us. And specifically the delegate system enhancement, which we will be piloting with this new group. And so the provider types that we will be bringing on are chiropractors, optometrists, dentists, and then behavioral health provider types. And we have them in a staggered onboarding.

And beginning in October we will be doing a series of webinars for providers and credentialing agents within those provider types to help them begin to onboard in the system. To let you know how we have been getting in touch with them already, we've been working with the TAC, the Technical Advisory Committee, as well as the licensing board and the other associations across the state for each of the provider types.

The other thing that we'll be doing is bringing on two medium size hospitals at the beginning of January. And we are going to be working with Ephraim McDowell and King's Daughter Medical Center. And we're excited

about that because they are smaller than the university hospitals. And so we're looking forward to their feedback based on a different kind of use of the system, because they have smaller credentialing and enrollment departments. So, they will be using the system a little bit differently than the five -- than the UK, U of L, Children's, Vanderbilt did, so we're excited about that.

That's the staggered approach that we're going to be using to bring these different provider types. And based on the pilot experience from November until January, and then January to February with the two smaller hospitals, we will be, you know, taking into consideration mandated use by those provider types. Again, pilot means testing. We want these provider types to give us some feedback that we weren't able to get from the five university hospitals. And so those will come -- that feedback will come into play on the mandate consideration, to make -- because we need to make sure that the system is prepared.

Along with the webinar and those

pieces that we will be doing we also have -- and then the reaching out to the different associations, and licensing boards and stuff, we've also created some materials that will be on our web page that we're really excited about. These are very short, two to three minute videos on different pieces of partner portal, as well as job aids. Job aids are anywhere from one page to three to five pages. That helps people at a specific juncture of the Medicaid partner portal application.

They don't have to go through a whole manual to get what they want, they don't have to go through a whole video series to get what they want, they can just click on a particular video or a particular function that they're trying to maneuver through. So in terms of the portal, I know that that was a very quick overview, but that's where we are with the online piece. Does anybody have any questions about this?

DR. THORNBURY: Any questions here?

No, there are no questions here. Do you have more for us?

MS. HACKETT: Please?

DR. THORNBURY: Do you have more for us? There are no questions here.

MS. HACKETT: Okay. So, I don't have anything more. I just wanted to do this overview. And I really appreciate your time in letting me do this.

DR. THORNBURY: Well, we'd like to thank you for your report. I think the TAC's encouraged by the leadership that DMS has demonstrated here. This is a rather herculean task that we've been working on now for several years. It's finally coming to fruition with this being a pilot.

Again, anybody have any comments on this end? Lindy?

MS. LADY: I just want to know if Kate knew anything about the credentialing, like the RFP process for that one credentialing source.

DR. THORNBURY: Kate, can you hear, did you hear Lindy's question?

MS. HACKETT: I vaguely heard it. Would you -- Doctor, would you mind repeating it for me?

DR. THORNBURY: We're going to ask

you specific about the credentialing and where we are with RFP.

MS. HACKETT: Okay, so -- please?

DR. THORNBURY: Well, what we would like to know is more specifically, if you have any information for us right now on the RFP for the credentialing aspect, as we see that as a really key component of this process.

MS. HACKETT: Right, it is. So at this point the department is pulling together everything for the RFP. That's really all I can speak to. I've been in some of the meetings, in terms of ensuring that, you know, we understand how something -- as well as the new legislation that was just put in place as a result of the house bill. That is still being written.

MS. LADY: Do we have an ETA on when the RFP -- we don't.

MS. PARKER: We do not have an ETA yet. I can provide that information.

MS. LADY: Okay. That's what we wanted to know.

MS. HACKETT: Was that Angie?

DR. THORNBURY: Yeah, that was Angie

down there. We were querying if there's a date for the RFP. So what we hope is that as we move forward, that you'll give us regular updates. Would that be okay?

MS. HACKETT: Yes, sir, as I will be able to, yes, I would be happy to.

DR. THORNBURY: Again, we want to thank you and the team at DMS for driving this forward. We look forward to seeing how this comes about in the first quarter.

Does anybody else have anything on this topic? Anybody on the phone have anything on this topic?

I would like to move, if we don't, into our second topic, which is telemed update. Jeana.

MS. JOLLY: I spoke with Charles yesterday. And he said that they are meeting and they are currently working on updates to the regulations. And, Charles, if you would like to add anything to that.

DR. THORNBURY: Charles, can you hear us?

MR. DOUGLASS: Yes. There's been a task force, we've been working together for --

oh, since last spring when the house bill was passed to dissolve the telehealth board and move, basically, the telehealth approval process, who can do what and when, directly to Medicaid. We've been working on that. It's not due to be actually implemented till July 1 of 2019.

Right now we're working on drafting the regulation to take out the archaic part of it that has been there since probably the early 2000s, and make it more streamlined, to allow more opportunities for different providers to be able to perform telehealth, as well as different locations where it can be done. We're looking towards home and other types of places of service.

And so we've been working on that over the last six months. And, hopefully, by the first of the year we'll have that draft done so it can be looked at and approved by LRC, and then put into implementation soon thereafter.

DR. THORNBURY: Thank you, Charles.

Jeana, do you have anything else?

MS. JOLLY: No, I have nothing else.

DR. THORNBURY: Well, many of us, particularly some of the people in this room, are serving on some of the subcommittees. I serve on one. I've had five or six meetings. Lindy, I know you've been at all those. And there are three different groups for those, for me with this process. In short, our Senate 212 -- 112, Senate 112 basically stipulated that we're going to relook at how we're going to provide virtual care in the Commonwealth.

And part of this affects people in this room, that is the Department of Medicaid Services. But a much larger part will probably affect the private economy. And the legislation was intended to discuss both, but we only have input into one of those. The intent, I think, was not only we can provide more efficient care for the minor, acute things that most of us think about telemedicine, a cough, a cold, a rash, that type of thing, but more importantly, we feel that the savings are going to be delivered through our primary care providers in chronic disease care. Both with transportation and less admissions, less re-admissions, less morbidity because of better

access.

For all those things to happen there are -- indeed Charles is correct, there are a lot of moving parts, both with the regulatory side, as well as just the provider side that have to occur between now and July 1. The things that I think that we want to try as your Physician TAC to try to communicate to the department are things that sometimes may not be intuitive.

In my work over the last decade in telemedicine and mobile health, the first thing that we want to understand is that the great savings that we feel that are going to come through this are going to come through your primary care providers. So these are going to be established relationships. It's not that we exclude vendors from outside the Commonwealth to work in the Commonwealth, we certainly encourage that.

But in order for us to really provide these savings, we have to make sure that each party that's a provider, whether they're physician services, hospitals, rehab services, we have a number of health providers that this

is going to contribute to, they all have to have reviewed the technology, they have to purchase the technology, they have to train their staffs on the technology. When we begin there will be a very, very large, probably 18 month is my estimation, upgrade to train the patients and their families how to use the technology. So, we're going to see some delayed savings with this.

One of the things that might also be helpful with updating our regulations is to have the vision that we will provide our leadership in DMS, is that in these times of austerity, one of the things to consider is the initial reimbursement for telemedicine. If the initial reimbursement for these large health system providers is not equal to what they can see having them come in, then of course they're going to defer to having them come in. It will be much easier for them not to initially invest, to wait and delay that. And that's all well and good, however the Commonwealth will be getting another six months, year, two years, three years delay in having those savings.

Again, I think it's incumbent upon us

as your physicians to try to serve DMS and our MCO health providers well to understand, again, the people that are going to be training the patients will be these health providers. And there will be no real reimbursement for that. I can tell you having done this, that there are going to be people calling, they're going to be walking through this not once, but twice with staffs.

However, I think that on the back end, what the provider group hopes is if we can train these patients properly, it's been my personal experience, and the experience of many of my colleagues around the country with whom I've spoken, that once we change -- help these families understand where the cheese is, that once they understand how to use this properly, just like you can order pizza on your iPhone, once you've done that a couple times, when it's Friday night and the children are hungry, you can knock that thing down pretty quickly. Well, we hope to do that the same.

And, again, if we can move chronic disease care online, much less acute care, I think it's wonderful to move acute care. And,

again, I think the more people we have, the more competition we have, the more opportunity we have for savings. I've heard it bandied about, although I do not have the particulars, Dr. Alvarado said that the Commonwealth saved about 2 and a half million dollars for their state employees, the ones that elected to do that, and the ones -- these are minor, acute problems.

So what I'm thinking is, I'm not trying to save a couple million dollars, I'm trying to save a couple, 3, 4 hundred million dollars. And, again, in travel, I'm trying to save that -- and, again, these are -- we're not Vermont, you know, we're not Iowa, we have a lot of chronic disease care, but that gives us a lot of opportunity here in the Commonwealth.

And if we can get this off -- again, there's been a big, big, heavy lift by people inside Medicaid. So unbeknownst to many people here, again, there's been a number of meetings, a number of efforts to move our policy forward, so I think -- does anybody else have anything besides my experience to contribute to this dialogue?

MS. LADY: There is going to be a big stakeholder meeting in Frankfort on October 12th on this subject. And we're going to mostly talk about coverage, coding, reimbursement, but I'm sure many other things will be discussed.

DR. THORNBURY: You know, I appreciate that. I didn't chime in on that, but, Charles, just for your education to push this up the line, Angie, the biggest thing that we want to do is I think -- well, the second biggest thing I want to do is, aside from understanding how initial reimbursement might have to be played to get people to participate, is how are we going to make sense of all this data.

And we discussed this in our subcommittee. And for us to have a common language -- for the analysts to make sense of how much we're saving, where the savings is coming from, how is that different from what we're already doing, there has to be for the health providers, the common language here is going to be the coding language.

And the coding language is -- our

communication from the TAC to you guys is this is going to have to be something very similar to what we're already doing. So what the Commonwealth and what we need to see, what the analysts need to see, is if we're already conducting work and dealing in a certain way, you have data on that. For example, a 99213 for hypothyroidism. Well, what we want to know is, was that taken care of in the office or online.

So, we need to understand, again, not only what the level was, was it an equivalent level, but what the diagnosis was. And then again, is there a simple modifier to add whether you're conducting hypothyroidism in the office versus hypothyroidism online, so that we can see what we've moved online and how that's progressing. And then we can make speculation or extrapolation from there how this is being affected or what trajectory we're going on.

The more complicated this becomes, the more complicated the coding becomes, the more difficult it becomes for the analysts and for the providers to comply. And if that occurs, then we'll be in a real problem.

Because then we'll be into a margin issue and we won't be able to understand what we're doing, there will be no benchmarks. And if we begin to change things a year, or two, or three down the road, that's going to be a real problem.

So, Lindy, thank you for calling my attention to that. That October 12th meeting, it will be a very, very significant meeting.

MS. LADY: And so if anybody wants to attend, I think anyone can actually attend, you don't have to be part of the workgroup, let me know and I will send you the location, time, et cetera.

DR. THORNBURY: Does anybody have anything else there? Angie? Charles, do you have anything that you want to chime in on this before we move on?

MR. DOUGLASS: Yes. Medicare came out with a place of service change for -- specifically for telehealth. In the past we used the modifier GT to indicate it was performed via telehealth. And Medicare just this year came out with the place of service 02, which we didn't have before, which will

make it much more clear as to how it is being done. And that will be placed on any of the codes that are billed.

DR. THORNBURY: Charles, again, we'll really look and lean on your leadership on this. This will be a really important -- it seems like a very small thing, it will end up being a very, very large thing, particularly for the people that are in our strategic planners, to help them understand in the future what's going on.

MR. DOUGLASS: Certainly.

DR. THORNBURY: Thank you very much. Lindy, thanks for helping me on that.

Let's move on to our third item we have here, Kentucky Academy of Audiology, services for Medicaid recipients over the age of 21. Who would like to lead that?

MS. ROOF: I can start. Thank you all for listening today. So what I want to talk about is the benefits of expanding coverage for Medicaid recipients that are over age 21. Right now Medicaid only covers services birth to 21, and then they turn and then they have no audiologic care after that

point. So at this point we could -- if we expanded coverage over age 21, there's a potential long-term cost savings for the state.

If you look at all the links to untreated hearing loss and untreated balance disorders, there's a link of cognitive decline with untreated hearing loss. There's a link with poor quality of life, so higher instance of depression. And, also, the big one, if we're looking at cost savings in particular, with untreated vestibular disorders and fall risks.

So let's say you take someone who is an independent liver and let's say they have a fall. And they weren't diagnosed -- let's say they had a problem, but did not have access to care by an audiologist, and then they fell. Well, that's an immediate cost to the Medicaid system, where they have to go to the hospital. Or maybe they broke their leg, maybe then they have to go to a nursing home, they never get back to that independent care.

But if we gave them access to that care, which can be diagnosed and effectively managed by an audiologist, that could really,

potentially, save a lot of money for the state down the road. So just asking that you look at those links, and then we try to expand that coverage.

DR. GUPTA: Right now do you-all provide those services in your department?

MS. ROOF: So, I'm part of the University, so we do. But if you're looking at a private practice audiologist -- and there's audiologists all over the state in different departments. And so those patients -- for instance, one of my colleagues had an ear, nose and throat doctor call her at home and say, hey, there's a patient that's presented to the ER, he's got sudden hearing loss and he needs a hearing test. She said, well, okay, I'm happy to see him, what's his insurance? Medicaid.

Well, he has to pay over a hundred dollars out of pocket. They can't do that, so that patient was lost to follow-up. So, he actually never saw the ENT, because the ENT needs an audiogram to make their treatment decisions and they weren't able to get that. So that patient is lost to follow-up. So a lot of situations, that's what we run into a lot,

so --

MS. LADY: Should that be a recommendation of the TAC or --

DR. GUPTA: That's what I was wondering, if we could vote on it or make that recommendation.

DR. THORNBURY: I would entertain a motion. What do you have in mind, Dr. Gupta?

DR. GUPTA: I mean, I move that this audiological services, age 21 and over, is a covered service under Medicaid.

DR. THORNBURY: Being rather new this year to my position, would it be more appropriate -- what's the most appropriate way to handle this? Is it to move for an action or do we ask DMS to evaluate this to see if there's a cost savings for that?

MS. LADY: I think you probably have that information, so you could make that part of the recommendation. You've got a majority here, so --

DR. THORNBURY: Okay.

MS. LADY: So, we can recommend it at the next MAC meeting, as soon as that.

DR. THORNBURY: Okay.

MS. LADY: I may need to get with you to get some more background from you. And then I'll write the recommendation up, and then you review it and approve it.

DR. McIntyre: And I'll second the motion.

MS. LADY: There you go.

DR. GUPTA: I do have one comment. I know the whole 1115 waiver, I know that's on -- not the back burner, but it has been postponed a little bit. I just, I feel like one comment from Medicaid might be, if that's going to push forward, that they might want to push this service under, you know, those kinds of benefits under dental.

MS. LADY: If we get to maintain most of the waiver.

DR. GUPTA: Right, right. I just bring that up just for thought, but, I mean, I think it should be covered.

DR. THORNBURY: I can tell you in my private practice, I have to admit to being less educated in this area than I would prefer to be. When we generally have cases like that, it might be what's an acoustic neuroma versus what is peripheral vestibulitis or BPPV. Generally,

as a rule, is if we fail in our -- say we provide a Semont maneuver in the office or we fail, we might initially move them say to rehab.

Well, rehab would generally be a -- usually an organization in a rural area like ours or a hospital-based system, but I was unaware that audiology was driving this. Usually it's one of the -- I'm guessing it's physical therapy, that had been through some type of training with vestibular rehab, and so we check the vestibular rehab box.

MS. ROOF: Right.

DR. THORNBURY: And I thought I was rather well informed in this area and, to my chagrin, I'm really not. I would encourage your organization, the parent organization, to do maybe a little more outreach to people like myself, rehab directors and health systems, to help us understand how these patients can properly benefit.

Because really what we're trying to do is we're trying to prevent falls, we're trying to prevent, again, more costly problems down the road.

MS. ROOF: Right.

DR. THORNBURY: So I think that -- I would be open to that. That's just a suggestion.

MS. ROOF: Absolutely, thank you.

DR. THORNBURY: Is there any more discussion? I don't want to press this too far, but -- then we'll take up the motion.

DR. GUPTA: I just have one question.

DR. THORNBURY: Yes, ma'am.

DR. GUPTA: If Medicaid does not accept this, do you think that this is something that audiology could propose as one of the KMA proposals next year?

DR. THORNBURY: I think it would really be a nice -- it's a really important point. I think the -- again, what we want is, for the Commonwealth goal, is we want better health. And in better health, if we have professionals that provide cost savings on the back end, then I think we have to look to DMS and our MCO partners to decide what's the wisest way to move forward.

I think we can help, I think that we can help with that. You know, we can

facilitate that.

MS. LADY: You can talk to the Public Health Commission and they kind of set the health priorities for the --

DR. THORNBURY: Dr. Howard?

MS. LADY: So, Dr. John Johnstone is the KMA Chair of the Public Health Commission, but Dr. Howard is on that commission. So if you wanted to in 2019, if you made it a MAC recommendation and they accepted it. But you're right, with the 1115 waiver kind of in limbo, really, right now, who knows what will happen.

But you could come and address the Public Health Commission, they would welcome that. So if you would also like to consider doing that, they're a very enthusiastic group of physicians, so that would be another option.

DR. THORNBURY: I don't like to tell DMS what to do. I think that if we -- if we make our position known, I think that they have -- they're an organization, they have a way to process this.

I think we should give them every opportunity to try to handle it. That's what I

would say from TAC's point of view. We want to be courteous to the person we're dancing with and, you know, I want to show that lady every courtesy. And then I think that's a -- this is a private or business issue for you-all. I think you need to handle that in the best way you feel appropriate. But from our point of view, I think we need to just make our recommendations known and let us work forward and see where we are down the road. That would be my suggestion there.

MS. LADY: And many times the recommendations are accepted, and they move and they implement them without any kind of legislative process. Not always, but probably three-fourths of the recommendations, because they're kind of reasonable. Now, this is a little different, because it's kind of something new that's not been offered before. But I agree, Dr. Thornbury, usually -- that's kind of how the TAC -- they just do it through that process

DR. THORNBURY: And somebody will -- there will be some people from both sides. I assume that they'll put the numbers to paper.

Once they have -- we're kind of glossing over that now at the strategic level. But once they kind of do that, then I think they can see what the weight of it is. It's much easier to weigh. At that point I guess it would end up in front of your-all's committee.

DR. HOUGHLAND: Dr. Thornbury.

DR. THORNBURY: Yes, sir.

DR. HOUGHLAND: I'm sorry to interrupt.

DR. THORNBURY: No, you're not interrupting.

DR. HOUGHLAND: I, I hate to admit this, but I will publicly, I'm trying to remember how the transaction actually occurs under 21, and then the applicable -- how that's applicable going forward. So, I guess, you know, looking at this, is it a benefit limitation based on age or is there also an issue around the provider type designation.

And so, again, things can be administered under special services sometimes a little differently for children than they can be for the broader Medicaid benefit. And I guess for clarification, I was looking to see

if there was a feeling that there was a provider type recognition portion of the issue for adults, or if it really was just the way the state plan has described what the benefit is for adults. I don't know if that makes sense.

DR. THORNBURY: It does, it's a point well made here. Do we have an answer for that?

MS. ROOF: If I'm understanding correctly, all these services are actually offered by physicians, but they are not offered by the audiologists that actually do the testing. Is that what you mean?

DR. THORNBURY: We're just broadening the --

MS. ROOF: Right, yeah, the scope of providers.

DR. HOUGHLAND: I was wondering if audiology was actually a provider type that was recognized and billed directly. I thought it was a provider under physicians, but -- so there could be two components to consider over time, but --

MS. ROOF: Well, we definitely want direct access to care, because that would

contradict what Medicare says is appropriate. In 2008, with Transmittal 84, they said that audiologists should bill with their MPI, not under -- not incident to the physician. So if this does go forward, we definitely want to have direct access to care.

DR. HOUGHLAND: Right, sure.

MS. ROOF: Because if we're wanting to eliminate the, you know, extra cost, then a physician would have to oversee this, which would kind of eliminate some of the cost savings.

DR. THORNBURY: This is going to end up in front of them. Thank you, very well made point. It kind of hones to the point where if we move our recommendation forward, really what we want them to do is -- at some point somebody is going to have to sit down in the room and we're going to have to ferret all these particulars out.

MS. LADY: I'll get with you-all.

MS. ROOF: Sure, sure.

MS. LADY: We'll work this out through e-mail and we'll do some more research.

DR. THORNBURY: So does that change

our -- the motion here at all?

MS. LADY: We can still make a -- we just need to know what we're --

DR. THORNBURY: Okay.

MS. LADY: We need to do a little background.

DR. THORNBURY: We want to highlight the topic, consider that they evaluate this, how about that. We can soften that a little bit, it allows them to work with it. Because, again, really what we can do is if it's one or two changes, maybe that's something that's not only minimal, but it's helpful for everybody and everybody can get what they want.

Yes, sir.

DR. McINTYRE: One thing I would wonder is how many patients does it affect; in other words, the patient you're describing, is that an outlier? Is that something that happens 4 times a year, is that something that happens 250 times a year? If it happens 250 times a year, of course it would be more costly to make the change, but also it would show there's a real need for it.

DR. THORNBURY: I think Dr. McIntyre

is, again, just to put a third underline here, I think what we're doing is we want to bring this position where DMS sees it as something that's on their radar. Then they can perhaps call you-all in, and you can have a more salient discussion about this and open up a dialogue where something can be accomplished. We just can't accomplish it at the strategic level.

MS. ROOF: Sure.

DR. THORNBURY: But I think we can probably agree that we do need to at least move this forward, wouldn't you think. So if that's it, I'm going to end the discussion here.

Can we call for a vote then? Do we all agree on that?

(Board Members agree.)

DR. THORNBURY: We unanimously move forward. Okay.

Thank you very much for the helpful discussion there. And thank you-all to our guests.

That will move us up to our fourth item, which is the 1115 Medicaid waiver update. Who's got that one, Jeana?

MS. JOLLY: Currently we don't have any updates. We're waiting on CMS to get back with us on that. And I believe the plan may be that if they do get back with us, that it would start on 1-1 of '19. But, again, they have to get back with us first, so --

DR. THORNBURY: So, really, we're kind of caught in the middle of -- well, there's a couple things. We're talking about care and how the Commonwealth and its leadership want to provide care. Well, there are also very stringent regular federal policies about these issues. And then there's a political discussion about what -- how people feel that this should be provided. And all this sometimes ends up in a litigation.

Some of these topics are larger than us. And right now it looks like the topic actually is a little bit bigger than where we are. We really have no say at this and we're just going to -- we're at the football game, we'll just see what happens. It's an exciting game, I can say that much. But, again, I think that the -- to not make light of that, the other side of that is we're talking about very

real care here, and so I guess, again, we'll just have to be patient.

DR. LIU: Can I chime in for a minute?

DR. THORNBURY: We would welcome that, please.

DR. LIU: Yeah, I did want to share a few more specifics. So my understanding is this week the Department For Medicaid Services and Cabinet leadership presented a document to CMS in response to the open comments that were submitted. There was a fair amount of kind of misperceptions around the Kentucky Health program. And I hope that that documentation soon will be available on the Kentucky Health website. But the general message is, you know, we have been really assertive in trying to communicate with CMS as they kind of, you know, were asked to re-review our proposal.

The other comment I would make, which, also, you know, you're going to need to be patient before we give you really like specific and detailed information, but we have been tracking the submission of attestation forms for identifying those who are medically

frail. Just a plea to the committee members that that's an active process underway. We have seen kind of a preliminary pattern that's concerning, where many of the forms don't have complete information.

And, you know, I bear a lot of responsibility in designing that form. I know it's a very arduous process, with a pretty heavy administrative burden, but my expectation and hope is that the MCOs are being very, very supportive and proactive in engaging providers to really do a strong job of submitting documentation and really helping us make sure every Medicaid member has appropriate benefit.

The last comment is, you know, we do have a significant amount of content related to substance abuse disorder and the opioid epidemic included in our 1115 application. Van Ingram, who leads our office of drug control policy, has, again, been very assertively talking with CMS to hopefully get that kind of approved as quick as possible. A lot of that really would open doors for providers, because it would allow them to use 1115 enhanced federal financial participation to support

things like expanding access to medication-assisted therapy. So those are a few more updates related to Kentucky Health.

MS. LADY: Thank you, Dr. Liu.

DR. THORNBURY: Thank you, Dr. Liu.

Well, does anybody else have anything they would like to add? Lindy? Last chance.

MS. LADY: No.

DR. THORNBURY: Well, again, I think, again, at this point we'll kind of wait and see. But we'll keep that on the agenda.

The last item I have is number 5, new business, Administrative Improvements in Medicine, also known as the AIM initiative. Lindy, can you help us with that, can you lead that for us?

MS. LADY: I can. We need a better phone system. I'm not sure I've talked about the AIM initiative at the TAC meeting with the TAC committee, but KMA started the Administrative Improvements in Medicine initiative some time ago. And the AIM initiative really focuses on several health priorities that were set by the Public Health Commission, but they're, really, Medicaid's

health priorities and most insurers.

It's about improving health in smoking reduction, it's about diabetes, and this week we rolled out our focus on flu campaign, which we partnered with the Foundation For a Healthy Kentucky and we rolled it out at the capitol, and Dr. Howard was there. And we wanted to focus on the flu, because last year in Kentucky we lost 325 Kentuckians. And I think they said 5 of them, one of the doctors did, that 5 were children.

So, we rolled out the Focus on Flu Campaign, and partnered with some really good organizations, and got a lot of very good press. And the Cabinet was so great. They came out and all got their flu shots in the rotunda. That was really nice. And then next week, the 26th is our statewide flu shot day. So, we're really encouraging and trying to work on kind of disrupting all those myths around getting your flu shot, to try to get people actively engaged and really get them out there to sort of protect theirself, their family and the rest of us.

So the flu -- last year it was

tobacco cessation, or I guess 2017 we focused on that. Then we actually took a regulation to change that. Many of our priorities we look at the administrative burden. It doesn't take a legislative change, sometimes it can just be a public awareness campaign, sometimes it can be a recommendation by a committee or commission. So, we're going to continue to work on the AIM initiative.

And we have a portal where we're getting more information than we ever thought we would about different things. And then we're going to work on them in different ways and partner up. We'll, of course, stay partnered with DMS and work through that. But I just wanted to make you aware of that.

The other priorities, and one of the things that Dr. Liu touched on is, drug abuse, so that's one of the health priorities. Diabetes is probably what we're going to be working on in the next -- after we do our flu shot day. Because the AMA is rolling out a new program on diabetes that is pretty good, so we're going to partner with them and some other folks on that. So just kind of keeping out on

that, because a lot of this will touch Medicaid and I just kind of wanted to give you an overview of it.

And I do want to take the time to thank the Cabinet for all their help with the flu. That was the most fun I've ever had in Frankfort. You're never going to probably hear me say that again, but it was a great day, so thank you all.

MS. PARKER: Is the new program AMA is rolling out, the diabetes prevention program?

MS. LADY: It is. And it's looking really good. They've got a nice portal and resources.

MS. PARKER: We're looking at that as potentially one of our focus studies in quality.

MS. LADY: Yeah. So, I'll talk to you more.

MS. PARKER: Yes, please.

DR. THORNBURY: Anybody else have anything on this topic? If not, then we're really doing rather well.

MS. LADY: Don't jinx us.

DR. THORNBURY: And I don't mean to be such a tough task master and drive you with a whip, but we do have a lot of people's time and a lot of people made an effort to be here. Since we have this time, are there other topics that we would want to delve into, since we have a little bit of extra time today? Certainly, we have a two-hour bundled meeting, but we're still inside the first hour.

MS. LADY: I would like to circle back around to what Charles suggested on the place of service on the telemedicine, because we agree with that comment, not everybody agrees with that. So, CMS developed that new place of service 02. And if you use that place of service it's a telehealth service. But some people, some insurers and actually some in health care think that you still need to use the GT modifier. We think the place of service really does take care of that problem, so --

DR. THORNBURY: I'll chime in there. I didn't mean to cut you off there, I'm sorry.

MS. LADY: No, that was --

DR. THORNBURY: Well, I can tell you the practical part of it is the gold standard

used to be the health provider, I'm going to say physician, since this is a PTAC committee we're in, but the physician in the room with their patient, that was the gold standard of medicine. And I think the gold standard of medicine in my opinion, and I've written about this, will change to be the physician in the clinic with their patient, whether that clinic is virtual or in person.

And the reason is, is I think what Barbara Starfield taught us, and it's never been disproven, is when you have that relationship between a health provider or physician and their patient, that that relationship is really what allows us to drive better quality. It allows us to drive cost savings, because it drives better care. And physicians know -- and for almost a hundred years physicians have been using telephones to drive care in the ICU.

Telemedicine is a colloquial term that we're using now, but it's just medicine. It's just another way we're going to provide medicine with different technologies. What most people view telemedicine, again, the lay

public sees a common cold or some minor problem and they're going to call Amazon and get the Amazon doctor. Again, there's good data that says that that is safe and effective for certain constituents. The sparsity of data is the fact can we drive chronic disease care with modern -- with non-place care. And our data in Kentucky over 30 months says, yes, we can do that. If we can begin to do that, those are things that really cost us money.

What doesn't really cost us money, a lot of money, is going from the primary care doctor, for example, to the urgent clinic. I mean, there's a cost there, like I said, and I respect that. But really what costs us is the person with heart failure that's not getting care, that ends up with a one week admission, that is, you know, 20, 30, 40 thousand dollars. And when we can save that, it will take care of a thousand of these patients over here.

So, I think if we could -- if the 02 modifier is what we eventually can settle on, then that makes it easier for providers. They can -- we're in a state where we have mobile health now. What's the next generation, we

don't know. And that's what 112 was built on, because we don't know what the technology is going to be. So, we don't want to get in front of technology. We're going to let the different business interests, again, whether they're a competing interest from a third-party carrier, we'll let them provide their own care. Let this health system over here, let this private doctor, let some other company from outside Kentucky that's boarded in Kentucky come in and provide that. I mean, not that I'm a free market capitalist, I think the better, more assertive market we have, the better it will be for the Commonwealth and for our patients.

But never forget the fact that the big savings isn't coming from these acute care. The reason that we as a Commonwealth moved this forward wasn't to provide more acute care, we want to do -- if we can provide better access, that's great, we want to drive chronic disease care along. Because that's where our hundreds of millions of dollars of savings, if and when it comes, that's where it's going to come from. Then it's got to be done -- the only people

that can do that are people that have a building that are parked here in Kentucky. At some point you're going to have to see these patients face to face.

And it's a critical lesson we have to understand. Again, to make that all happen, to make that vision happen, and now we have the best -- there's no better legislation in the country than what we have here. We are on equal par with any other state in the country. And if we do well with the population we have, everybody in the country is going to come here, they're going to look at us and say how did you guys do it, we want to see exactly what you've done. And that 02 modifier is going to make it possible.

Because Deming always said a person with data -- a person without data is just another person with an opinion, you know. And if you have data that we can say that this is what we've done, and we can measure it, and not only can we measure it, we can demonstrate it and replicate it. And I'll tell you the best day to me is when our governor can go around the country -- they have a meeting once a year

when all the governors come in and they say what we do and what we did best. If they can come in and say this is what we did in Kentucky, everybody else is going to come here and say we want to see how you did it.

It's a really big goal. But to me this is one of the most important pieces of health policy that we've had in the last 30 years. It is going to be critical. It was quietly introduced, it went quietly through, but it is going to affect everything. It's going to affect every health provider. Every health provider is going to have to be onboard. If payment is secured for this, every -- we'll put every health provider onboard with every patient in Kentucky. And in three years we will be doing this just like it's how we get up and go to work every day. It will be -- and then we'll see what the data says.

So, I didn't mean to belabor that point. Do we have anything else?

MS. LADY: I do not.

DR. McINTYRE: I have something I'd like to bring up.

DR. THORNBURY: Sure, go ahead.

DR. McINTYRE: It's sort of off topic, because we don't discuss individual medications in this committee. I kind of had a personal experience with a number of -- experiment with a number of patients, being one me. I'm a type II diabetic. I draw disability from the VA for it, because I supposedly acquired it from Agent Orange exposure in Vietnam. But I've been on two of the medicines normally I think. Just one of them is prescribed because of clots, but I'm on both. Victoza, which is a GLP-1 agonist, and Invokana, which is an SGL-T2 inhibitor. And actually I've gotten my cost of Invokana cut by two-thirds by getting the 300 milligram tablets, cut them in thirds.

But on those medicines -- I mean, my diet is horrible, I'm a terrible diabetic patient. I should weigh 250 pounds. On those medicines, with no effort at all, I've lost 30 pounds in the last year. And my A1c is 7.3, which isn't fantastic, but -- yesterday in the Pharmacy and Therapeutic Committee they said something that I've never heard before in that committee. There was a medicine called Savella

for neuropathic pain, and Magellan, which is the benefits manager, said they wanted to add that onto the -- onto the --

MS. PARKER: Formulary?

DR. McINTYRE: Yeah, under the formulary as a preferred drug, because the cost has come down so much. And you hear all this about the outrageous cost of pharmaceuticals, and they are outrageous, but to hear the market forces working and prices coming down, that was my favorite thing in three years on the Pharmacy and Therapeutics Committee. That's all.

DR. THORNBURY: Well, I can say that the federal leadership under FDA has made a move to not only increase the number of generics onboarding, but also the amount of brand names. So say we don't just have in any GLP-1 class, there's not just three, but there might be now six. And that's just simple market forces, that the more competition you have, it offers more for PBNs to negotiate.

It's a very complex market, because it's not exactly a free market, it's a rather closed market as you might expect. And, for

example, the federal government in and of itself is not allowed to negotiate certain drug prices.

But I think a larger topic I would like to add, Lindy, for our next meeting, just to give fair warning for those people that -- I'd like to just bring back up again the discussion of administrative tasks that we have in medicine. This kind of falls into that genre.

MS. LADY: Okay.

DR. THORNBURY: Can we -- really, can we work with our MCO partners to find out, you know, who are the good eggs, and can we make it easier for those people to take care of the patients they need to take care of, because we just don't have enough health providers in Kentucky, as opposed to putting, you know, inordinate roadblocks in front of people. You know, this happens every day and it's causing a lot of angst.

I don't want to get into that pot today. But I still think it's something for us to see, can we find -- instead of bickering back and forth and throwing stones at each

other, can we find a way to work where the MCOs kind of get what they need. What the MCOs want, I would hope, would be to provide efficient, economic care so that they can be profitable for them and their stockholders. And the Commonwealth gets what it wants, where it gets the patients to get care at an affordable price and access efficiently. The people that get caught in the middle of that are the health providers. And so can we find a way to work together. Again, I think that's a topic for next time, but I'd like to at least -- AMA is working on this.

MS. LADY: Right.

DR. THORNBURY: And I've certainly been to a few meetings where there are I don't know how many, 70 some organizations tied into this. But I do think that going forward, you know, can we help solve these problems here.

MS. LADY: What we can do is share, I mean, there's no reason, the data that we've collected so far, which is quite a bit, and then you could probably -- the insurance could probably provide insight. Because sometimes some of the issues that are important, it's

difficult to tell is it a true burden, or is it something that happened to that individual or group because of A, B or C. Sometimes I can tell that, sometimes you have to really research it to figure it out. But we'd be happy to share that, I think we could do that.

DR. THORNBURY: I think if we're fortunate enough to have enough time next time, and depending on --

MS. LADY: We can print it out and hand it out, we can do that.

DR. THORNBURY: That would be really nice.

MS. LADY: Okay.

DR. THORNBURY: Well, we're at the end of our first hour, and I would rather you say nice things about us than not. So if there aren't -- are there any other new items of business? Anything else that we'd like to chat about today?

Then I'd like to thank everybody for coming. Tammy in particular, thank you very much for your hard work. We'll call the meeting adjourned. Thank you.

(The meeting adjourned at 11:02 a.m.)

STATE OF KENTUCKY)
) SS:
COUNTY OF JEFFERSON)

I, TAMARA DUVALL-McCLAIN, a Notary Public within and for the State at Large, my commission as such expiring on February 13, 2020, do hereby certify that the foregoing meeting of the Technical Advisory Committee on Physician Services was taken before me at the time and place and for the purpose stated; that the meeting was reduced by me to shorthand writing and transcribed by me with the aid of a computer; and that the foregoing is a full, true and correct transcript of the said meeting.

WITNESS my hand this the 5th day of October, 2018.

_____
TAMARA DUVALL-McCLAIN, CCR, RPR
Kentucky CCR No. 20042A138
Notary Public, State at Large
Kentucky Notary ID No. 549592