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

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Via Videoconference
January 20, 2023
Commencing at 10:10 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

William Thornbury, Jr., MD, Chair

Ashima Gupta, MD

Don Neal, MD

Eric Lydon, MD (not present)

Tuyen Tran, MD

DR. THORNBURY: Good morning, everybody. I'm Dr. William Thornbury. This is the Physician's Technical Advisory Committee, January 20, 2023. I have ten after the hour.

Let the record show that we are meeting under auspice of XIX and that we have a quorum.

Is there any discussion, deletions, or additions with regard to the minutes of the previous meeting that was distributed?

(No response.)

DR. THORNBURY: There being none, I'm going to go ahead and accept the minutes as approved.

Cody, do we have any old business we need to address?

MR. HUNT: We do not.

DR. THORNBURY: Very good. Let's take our item to our new business.

Today, we've asked Dr. Lisa Watkins from the Milbank Memorial Fund to join us. I've very much anticipated this chat with her. The MMF works to improve population health and health equity by collaborating with

leaders and decision makers and connecting them to experience and sound evidence.

Today, we welcome, of course, Dr. Watkins. She's the director of one of the founding members of the Milbank Memorial Fund multi-payer primary care network. That's a consortium of 18 state and regional multi-payer programs designed to transform primary care.

Dr. Watkins is the chief operating -- is the chief of operations at -- was the chief operations at Vermont Blueprint For Health. She received her medical degree from Perelman School of Medicine at UPN and her undergraduate degree from City College of New York.

Dr. Watkins is going to provide us with a presentation this morning and highlight some of the efforts around the country to transform primary care and enhance those patient outcomes.

Dr. Watkins, we very much look forward to having you here. Thank you for making time in your schedule to be with us. The floor is yours, ma'am.

DR. WATKINS: Thank you so much, Dr. Thornbury. I really appreciate this opportunity. And I'm really delighted to see just the sheer number of people on the phone today because I really think this is an -- a topic near and dear to my heart, and I'm happy to share what I understand about it. And I'm eager to hear your thoughts as well. So with that, I will start my presentation.

So just briefly about the Milbank Memorial Fund, we are an old operating foundation. I believe we are 119 years old now. We aim to improve population health and health equity by collaborating with leaders and decision makers around the country and connecting them with experience and sound evidence.

It is a -- this was a -- it is a family fund, now a -- fully a nonprofit. We're based in New York City. I don't actually live in New York City. I live in the state of Vermont, and I've worked remotely since my time at the fund, which is now since 2014. And many of us work remotely now, as I'm sure many of you have been over the last few

years.

So just the three sort of primary areas where we do our work. We advance our mission by identifying, informing, and inspiring current and future state health policy leaders through multiple state leadership networks to enhance their effectiveness, both an Emerging Leaders Program as well as what we refer to as our Milbank Fellows Program, people who are further along in their careers but are nonetheless excited to be working on a new project and get something from working with their peers around the country.

We work with state health policy decision makers -- and that would be -- an opportunity to speak to you would be an excellent example of that -- to advance primary care transformation, sustainable health care costs, and healthy aging.

And as many of you may be aware, we have a pretty well-utilized platform for expanding access to information through our publication activities. We do have an evidence-based publication called the *Milbank Quarterly,* which is a peer-reviewed journal on

population health and health policy.

And then we publish a great deal through our program activities, often an evaluation of the programs that we have been involved in around the country. And as I -- as is obvious, my particular area is around primary care transformation, especially in the multi-payer space.

Any questions about the fund before we get started?

(No response.)

DR. WATKINS: Great.

DR. THORNBURY: Dr. Watkins.

DR. WATKINS: Yes.

DR. THORNBURY: I know you're pressed, but I would very much like to understand a little bit about the Milbank family or the benefactor of the fund. Did they have a vision? What was the reason for the development of this memoriam?

DR. WATKINS: Oh, sure. I'd be glad to describe that. So the fund was established by Elizabeth Milbank-Anderson. She -- I actually don't remember exactly where the money came from, but I'm pretty

sure it wasn't coal. I know that they -- this is a fund that she -- and very unusual for her time -- inherited the money of the fund. She was, I think, the sole family member. Although the other family members that were cousins, et cetera, insisted that she have a man help her -- a cousin help her with the administration of the monies.

But she was a very well-known philanthropist and established a number of founding hospitals in New York City really focused very much on hygiene and cleanliness, working on the establishment of clean water treatment, getting rid of the open sewers in lower Manhattan.

She also was able to establish physical locations for several of New York City's upper -- higher education establishments such as Barnard College, which was the women's college at Columbia University. And the work --

DR. THORNBURY: Thank you very much.

DR. WATKINS: Oh, absolutely. The work has been really -- has evolved over the

last century to very much focus on health policy and especially around our work with states, although we work in close partnership with the Federal Government, especially over the last decade, with this Center For Innovation at CMS.

So this is the agenda that -- in consultation with Cody and my boss, Chris Koller, the president of the fund -- we came up with. I just want to briefly go over the case for primary care support and looking at the National Academy's report from 2021, which has really served as a good roadmap for some of the recent work.

A bit of an overview of where Kentucky stands in the primary care world -- and I did this research myself, and I would really love to hear how accurate it sounds to you as I -- as I walk through it.

And then I'm going to talk about some various opportunities that maybe -- you may want to learn more about after this discussion, around how state government has led some primary care advancement strategies and then some more broad partnership advocacy

strategies that we're seeing around the country and then entertain questions.

So this is sort of like the pledge of allegiance, but it really has guided our work for many years. The NASEM Report, as I said, published in 2021, April of that year, defines "high-quality primary care as the provision of whole person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings," so recognizing that there needs to be coordination, "and through sustained relationships with patients, families, and communities."

So the patient is at the center, but the patient does not exist in a vacuum or alone. It recognizes that this is a -- this is a community and really needs to be addressed as such.

Just as a quick note, you'll see that there are quite a few references at the -- on the bottom part of the slides. All of these I hope to be live. And I know that I shared

this with Cody, so you should be able to get access to these to understand more.

So you have this Physician Technical Advisory Committee. I think it is a remarkable opportunity to increase the visibility and perhaps the support for primary care and really to make the case for it. So your role is to provide guidance and recommendations. It's broader than just primary care obviously, but today we are talking about primary care.

And these three points are things that have guided us in this, that we really know that primary care is the only part of the healthcare system that explicitly results in longer lives and lower disparity rates, according to recent studies.

The portion of the healthcare spending going to primary care as opposed to hospital services, specialty services, et cetera, is decreasing at a time of increasing inequity that we've certainly observed sadly in a very vivid way through the pandemic. And because of that, the resilience has really been shown to be poor.

And a primary care-oriented system is a less expensive one but not in the short term. Investments need to be made without an obvious one- to two-year return on those investments, which is a really hard sell no matter who you're talking to. But we are still convinced that is the case.

So I just wanted to talk a little bit about Kentucky and -- you know, since there have been some big changes in the last couple of years here. And you have seen, by far in your state, the nation's largest percentage increase in Medicaid enrollment since 2013, the time of the Affordable Care Act enactment, with enrollment up over 100 percent with the national average up 54 percent, which is still okay. But it's really remarkable what's happened in Kentucky.

And then further enhancements. Obviously, you're well aware of what your governor has been working on, extension of Medicaid coverage for areas that are not traditionally part of Medicaid in many states and really taking into account that people

need services in order to be able to work and be productive members of society and to really be able to support their families and themselves.

So what I did is I went through a couple of, you know, larger resources to try to understand where Kentucky sits in relation to the rest of the country. I want to make a big caveat here that when you say this is what is the case in a state, you are by definition glossing over the fact that you have a heterogenous place.

I mean, you have urban areas. You have rural areas. There are all kinds of challenges that are not necessarily going to be reflected in these numbers that are generated in the analysis of large datasets.

But I did want to call your attention to a couple of things and -- just so you can see where Kentucky sits. And, again, these are -- all of the sources for these slides are on the slides themselves.

So looking at Kentucky -- actually, just stepping back, this is looking at the primary healthcare health professional shortage

areas, so areas where there really is not enough primary care to serve the identified population. And then this is really looking at the percentage of the need that's actually being met, so this is the flip side. It's looking at the positive -- what is actually available in the states.

And Kentucky is in the highest quartile here, meaning that you have a lot of primary care providers, and I believe this is not just physicians. I believe this includes physician assistants and APRNs. And you can see this heterogeneity around the country with Kentucky in one of the top places.

I also just -- I put this in this morning. Cody, I apologize. This is yet another slide that I added to my deck just this morning.

But I wanted to just point out the primary care physicians per 100,000 -- so looking, you know, 100,000 people by state. And this is data from a couple of years ago. Again, you're seeing a wide -- wide variation with Kentucky only having 58 -- sorry, jumpy slides -- 58 per 100,000. Other states

having much larger numbers, quite a few states around the middle.

And I don't -- I don't really know if this means access to primary care. I'll very quickly point out Vermont, where I live and was in practice, has a very high number of primary care physicians per 100,000. But if you go to the town just south of me in Middlebury, Vermont, and you try to get -- to become a new patient in a primary care practice, you'll have a really hard time.

So this is -- I don't understand on some level why there's this disparity between this very, you know, generous-looking number and people who are not actually accepting new patients. So having a lot of physicians doesn't necessarily mean that you have access to care.

This is just for comparison. I just wanted you to see where Kentucky is in terms of primary care spending in Medicare. I realize we are talking about Medicaid today, but I just wanted to put this into the mix because I'm going to also show you the rates of payment comparing Medicaid to Medicare fee

schedules.

So Kentucky is -- this is primary care spending. This is the share of the total health care spending among Medicare beneficiaries who are 65 and older. So they weren't just looking -- they were just looking at patients who fall into Medicare because of age, not necessarily because of disability at a younger age.

This data came from CMS' limited dataset, and the commonwealth fund, I believe, published this. So you can see Kentucky is, once again, a top performing state.

This is a broader piece of data, just looking at percentage of physicians accepting payments for new patients by specialty and coverage type, older data from 2017. I could not find anything more recent that was usable.

Looking at just primary care specifically, you have 76 percent -- nearly 76 percent of primary care physicians are accepting new Medicaid patients, and you see a wide variation looking at the other

specialties.

Again, somewhat dated data. But I wanted to give you a sense of where Kentucky is relative to your neighboring states. And I literally looked at a map, and I, like, drew a circle. And that's sort of how I got this collection of states to compare Kentucky to.

So in Kentucky, 88.5 percent of physicians who accept new patients are accepting Medicaid as new patients. Again, you have some variation looking at other states but quite a -- you know, it's really -- it looks quite good. Private insurance, far more, but still, a number that could stand some improvement but is nonetheless something to be proud of.

And then the Medicaid-to-Medicare Fee Index Measures, data from 2019. So this was looking at Medicaid payments in the fee-for-service mechanism only, so not looking at Managed Care Organizations. So Medicaid payments as a percentage of Medicare payments.

And my boss, Chris Koller, says this is

where we show we're doing this on the cheap in Medicaid, that 65 cents on the dollar is -- makes it hard for people to serve -- appropriately serve their Medicaid populations.

Any questions before we get started on the -- some of the opportunities to address some of the disparities?

(No response.)

DR. WATKINS: So the next few slides are some examples from around the country of solutions or at least ongoing projects to work on some of the things that you saw highlighted is a problem nationally, not just in your state, obviously. And I'm going to walk through a couple of mechanisms that other states have used or are in the process of using.

Specifically, we're going to look at how to raise Medicaid reimbursement rates, which was a legislative process in Virginia; how to fashion Medicaid managed care contracts so that they reflect what the State would really like to see as benefits and opportunities in access for their Medicaid beneficiaries; some

statewide primary care transformation programs in a number of states; and then the opportunities that present themselves with 1115 waivers and some resources for investigating that further.

So years ago, more than a decade ago now, the Virginia Center For Health Innovation was established. It is truly a nonpartisan, multi-stakeholder public private partnership. And so they have been at work for quite a long time. It's a very strong and sustainable -- and sustained working partnership of many different disciplines in Virginia.

And in 2020, they created a specific primary care task force. And with a combination of advocacy -- I'm sure there was lobbying, really partnering with colleagues in the legislature as well as -- and during this time, there was a change in administration in the last year in Virginia and elected a new governor.

But the general assembly did approve a 10 percent increase in that rate that you saw, the percentage of the Medicaid fee as a

percentage of the Medicare fees. They actually almost got to 100. They had quite a bit of bipartisan support and then there was -- somehow, this particular language got caught as a political pawn and first was deep-sixed and then they managed to resurrect it and got from 70 to 80 percent.

And frankly, the physicians who were involved in this were delighted to get that -- even that increase. They would love to see more, but it made a big difference, I believe, for the energy moving forward.

So it was really a result of this task force recommendation, and they also are -- they are fully funding an annual preparation of primary care spending report. So you can't act on information that you don't have, so this actually has memorialized an opportunity to measure what the primary care investment actually is in the state of Virginia and will continue that work moving forward.

Their website is down here. There's a great deal of information. They have a very detailed report of the last several years'

activities in that paper.

Our colleagues in Tennessee have really worked to have their Managed Care Organizations' contracts reflect the priorities of TennCare. And so I -- we don't need to read all this language, but you can see that -- you know, that there are things -- these are really explicit things around primary care, looking at the role of how children are being treated as well, requiring all CoverKids members.

So there really is a -- again, memorialized in these contracts so that the entities that wish to serve as MCOs have to comply with this, or else they don't -- will not be awarded contracts. And this is a live link to all the documents. Their language is completely publicly available.

These are multi-payer models, and in each case, there is a standing legislation that requires participation -- actually, I shouldn't say in each case. These are multi-payer programs that have been led or at least very fully supported by state Medicaid agencies over the years.

And they're different from each other, but they all have some common components, one of which is a true patient-centered medical home approach. Sometimes they call them health homes. Sometimes they call -- you know, there are different sort of titles for them. But it's a sense that the money follows the patient, and that is -- it's a very specific approach to make sure that the patient and the patient's family are the focus of the care.

In Vermont, to which I'm most familiar, I was actually part of the development team for the Vermont Blueprint For Health when I worked for the Department of Health and then later for the state Medicaid agency in Vermont.

And this is a program that combined using -- well, legislation that mandated that commercial payers, if they wished to do business in the state of Vermont, they had to actually participate in this program, which did not mean that all payers were involved because, you know, you have ARISA issues. And you can't force self-insured payers to do

this.

But nonetheless -- and Vermont has very few commercial payers that are actually part of the mix. It's just a very small state. There are 600,000 people total. So I realize it's the exception rather than the rule, but it was a good experiment.

And this program, the Vermont Blueprint for Health, is still in existence and still enjoys the support of the state Medicaid agency, the commercial payers, and Medicare.

And the bottom line is that we -- you know, there still is fee for service, but there's an increasing value-based payment as part of the structure. And there's also a community health team structure, which is a care coordinating -- not necessarily brick and mortar but a free-standing group of people that provide services that are allied health professionals.

You have, you know, behavioral health and nutrition services, substance and abuse treatment, all kinds of things that really meet the needs of the community, and that's a service free to all patients. And it's

supported by the participating payers on a per-patient-per-month basis.

Oregon has a patient-centered primary care home program as well. They have their community care organizations, the CCOs. This has been very much focused on Medicaid, and that's where the management of the program is. But they've also had tremendous multi-payer participation, partly galvanized by the State's participation in the state -- the innovation center is CMS' patient -- the primary care models over the last decade or so.

And then in Washington, it looks like they just started it. Actually, that's not the case. This particular program is brand new from 2021. Washington has had a long history of working in the multi-payer space, but they actually solidified that with a Memorandum of Understanding that was signed by most of their major payers as well as their state Medicaid agency to commit to value-based payment transformation activities.

All of these -- there's ample

information on these websites about the programs. And, actually, if there's specific interest, I know people in each of these programs and the preceding slides. I'd be happy to introduce you if you're interested.

So 1115 waivers are not brand new, but there's a new opportunity that was just released, I think, a couple of weeks ago. And this -- this is specifically focused on addressing health-related social needs, or what were formerly referred to as the social determinants of health.

So this is an opportunity for any state, should it wish to pursue it, to work with the Federal Government to be able to modify the way the Medicaid dollars are spent in your state.

And in theory, this is easier to do now than it used to be. I mean, I'm not saying at all that any waiver with the Federal Government is easy. It's very complicated. I'm sure our colleagues on the line for Medicaid -- maybe they're all rolling their eyes. I can't see. But I think it is -- it's challenging.

But nonetheless, that -- acknowledging that this particular aspect, especially around looking for health-related social-needs opportunities for improvement is an extremely -- it's a positive step.

And then just the last thing I really would like to -- there are a couple of resources. This is one in particular from our colleagues at the Center For Health Care Strategies, which is a nonprofit that has a strong footprint in supporting state Medicaid agencies with a wide set of opportunities, whether there are webinars, publications, and some specific programs that states can apply for and be part of learning -- shared learning networks, et cetera.

This particular report includes a landscape scan of Medicaid value-based payment approaches and various strategies to put things into place. They did profiles of a couple of states but also list a wider variety of things.

And I would just encourage you to get -- take a look at the CHCS website, and they're extremely accessible people should you have

more questions.

And that's it for my formal presentation. I'm happy to answer questions or --

DR. PATEL: Hey, this is Chirag.

DR. WATKINS: -- if not answer them, I'll tell you that I'll get back to you.

DR. PATEL: Hey, this is Chirag. I'm the CMO at WellCare. Can you guys hear me okay? I have a couple of questions and maybe a comment.

DR. WATKINS: Sure.

DR. PATEL: Yeah. Hey, first of all, thank you so much for this presentation. It's very timely. It's probably on most of our minds in a lot of different ways.

And so I very appreciate that number about the primary care doctors per 100,000. I often wonder -- and I came from the ACO world. I'm from Georgia originally, and that's what most of my practice setting was. It does depend on where in these primary care physicians' career they are. Like, are they well-versed with EMR? Are they on the older

end or the back end of their practice career?

And that really determines if they're going to be willing to enter into a PCMH model, enter an ACO, going to a value-based payment model, do the extra things around -- you know, the softer things in clinical care. I don't like to call them softer but the SDoH things, things of having an embedded CM in the office. Like, those things are less likely in an older physician cohort setting.

And the question that I always wonder: Does Kentucky have the right mix of where primary care physicians are in their trained career, and are they equitably dispersed across rural and urban settings? And if they're not, then it doesn't matter if we have enough physicians because we don't have the right mix of primary care physicians.

DR. WATKINS: That's such an important point, and that's why I only added that slide at the last moment. Because I don't think it's an accurate reflection. I think it doesn't necessarily tell you what you need to know.

I think that there are opportunities for

practices regardless of where they are in the continuum of the years of experience to be supported in using data, in being able to manage panels and populations in such a way. But it requires support and some investment on the part of whoever is hosting the opportunity, and that is expensive.

In -- I'll go back to Vermont just briefly, and I realize it's not necessarily applicable. But I can tell you where we spent a lot of money, which was that we actually had practice facilitators who literally went to the practices and sat down with staff and said this is how you understand these reports that are coming back to you about what -- what happens next.

Who has missed their every three-month visit for their diabetes? Who is not showing up for -- you know, for their foot checks for their diabetes? How do you make sure that people are engaged in the health system appropriately and that -- you know, the access to timely, updated, actionable data is key.

And so those investments, infrastructure

investments, whether at the practice or at the state level, if you're talking about a Health Information Exchange or an all-payer claims database, you know, all of that takes investment. And that would help level the playing field a little bit in terms of people's comfort with the technology.

I think the distribution in terms of rural and urban is also very important. I know it's really hard to be a provider in a rural place where you're isolated, and I think that that is increasingly difficult, especially as rural hospitals are threatened with closure. And, you know, there are a lot of issues that compound the access to care.

DR. PATEL: You know what I --

DR. THORNBURY: Dr. Watkins.

DR. PATEL: Go ahead.

DR. THORNBURY: Dr. Watkins?

DR. WATKINS: Uh-huh.

DR. THORNBURY: Yeah. This is Dr. Thornbury. If you don't mind, I'd like a swing at that pitch.

DR. WATKINS: Sure.

DR. THORNBURY: Well, I can tell

you that looking on the ground, I want to re-emphasize what Dr. Watkins just pointed out in an elegant way. But I want to take you from theoretical physics to the practical physics of what's going on in Kentucky.

The reason that we do not have younger primary care doctors is because this is not a place that they want to come. And to underscore that, I'm going to emphasize the fact that we have three medical schools training people, and those doctors are leaving.

You see, we're training people in Kentucky to go to somewhere else, and the reason there is, is because the environment is not adequate enough. They don't have enough mentors. There's not enough pay.

When you start -- when you start at 65 percent of Medicare, that means that every patient you're seeing is a loss. By definition, every case that you see with Medicaid is going to lose money.

And so because of those things, it's hard to ask -- and we've been saying this, I don't know, for five years that I can think

of that I've been on this committee. We've been saying that there's going to be a reckoning coming.

You see, the number that you alluded to firstly, the very generous primary care per 100,000 is not physicians. That's the number of physician assistants and physicians and APRNs. And unfortunately, due to the Hattiesburg data -- due to that data we just saw a month ago from the ERs saying that if you're investing in these extenders, you're going to pay more money.

And we -- we on the ground know that, but this is just the -- we're starting to see the data come back now. And so if you're saying, well, why is it that we don't have this maybe environment to move toward a -- what used to be the termed the patient-centered medical home, you know, that type of model. And that's because the environment here has not been generous enough to keep people coming into primary care.

DR. PATEL: I have a quick question for you guys because I'm new to the group. Is there any state-funded program where, if

you are a Kentucky citizen and you go to a Kentucky med school, will pay for you to join a practice incubator model or forego or forgive your medical school and undergraduate loans if you give us five years of service once you're done with residency and primary care? Are those programs like that available in Kentucky?

I know North Carolina, eastern Carolina has it. I know there are some places out in the western part of the U.S. that have it. But do we have that here?

DR. THORNBURY: Gerry Stover. Gerry, do you want to take a -- you want this one?

MR. STOVER: No, we don't. I think one of the challenges -- and we worked a little bit with the Kentucky Primary Care Association with this -- was the issue of how the Federal Government looks at the health professional shortage areas and reining those counties and areas so that you have a higher score to be -- to qualify for some of the federal loan repayment.

So I can't speak directly to some of the

activities at the state loan repayment office, but I know it's been a challenge because of that formula. And I know, in working with the former exec, David Bolt, you know, there were efforts that we were trying to make to get the feds to look at a different model and so on. And, unfortunately, that wasn't successful.

So as you pointed out, Doc, so eloquently, it's a struggle. And, unfortunately, the gap is being filled by other individuals that -- the PAs and the nurse practitioners that -- so...

DR. WATKINS: Can PAs and APRNs practice independently in Kentucky? Are they establishing their own practices, or do they have to have a cooperative agreement with a physician --

MR. STOVER: After four years, they can apply for independent status.

DR. WATKINS: Okay.

MR. STOVER: Most of -- probably a percentage of the activity is the rural health clinics and the federally qualified health centers. Because the ratio -- with

particularly rural health clinics, that model is focused on a higher number of PAs and nurse practitioners to physicians.

You do have to have a medical director at either of those models, but they typically are a higher number of mid-level providers in those particular models.

DR. WATKINS: Thank you.

DR. THORNBURY: Dr. Neal, do you have any thoughts on this?

DR. NEAL: Yes, I do, as a matter of fact. We could talk for hours.

Dr. Watkins covered certain states, but there are some others that are developing new models that may be helpful. Florida, for example, in 20 -- can you hear me, by the way?

DR. WATKINS: Yeah, we can.

DR. NEAL: Okay. In 2017, they instituted primary care increases up to the Medicare level for pediatricians and many of the other primary care, and they just renewed that this year.

Unfortunately -- and I can speak to that because I worked recently seven years in

Florida -- that did not prevent small practices and small group practices from being taken over by larger corporate practices and also hospitals. So I'm not sure that just throwing money at it is going to be the answer.

North Carolina has just come up with a new program that's going to add social determinants of health, if you would, by having not for profits in communities paid for helping out with access to care. And that's an interesting thing.

Rhode Island, I think, recently increased theirs up toward Medicare rates. And it was interesting that you talked about Virginia which increased a mighty ten percent. And that was based on saving money, is the only reason they seemed to do that.

So I don't -- I'm not sure throwing money at it is. We're so far behind in Kentucky, and as you just heard, we think in most of the rural areas -- and we can't even be able to determine that yet. Who is the delivering the primary care? It looks like it's primarily mid-level providers.

And so if we are going to talk our young residents and physicians coming out of training and to stay in Kentucky, we've got to have a huge paradigm change in the way we're treating Medicaid and those who see those patients.

We -- years ago -- and I want to take a few more seconds of your time -- is we had something called KenPAC. And we were actually one of the first states that ever did that, where we paid a per member per month. And I think that kept a lot of our doors open.

I was in a solo practice for 45 years in the fourth largest city in Kentucky and, still, I had -- 75 percent of my patients were Medicaid. And so that allowed me to keep the doors open. Now, that was before EMRs. I don't think I could have done it and paying for an EMR.

But I think that we're going to have to think of something like that. I think, because of the failure of the ACOs by paying a value-based payment and a return of a percent to physicians has not worked well,

and they're even looking at a per member per month. And I'd like to hear, Doctor, you talk a little bit more about that particular idea.

DR. WATKINS: I'm sorry. Specifically about the per-member-per-month payments or --

DR. NEAL: Yeah, per member per month. Because that way, a large -- a provider with a large Medicaid practice obviously benefits more by a per member per month.

DR. WATKINS: You're singing my tune, Doctor. No, really. It's very clear that fee for service is a -- I mean, it was so evident, just in the last couple of years, when you saw all these practices dependent on fee for service all around the country that nearly had to shut their doors. In some cases, they did, during the pandemic when they couldn't actually bring their patients in.

And the practices that were either capitated fully, partially, you know, had some sort of -- essentially, it was a

cushion, were able to weather the storm much more resiliently. I don't have any question about that.

And the absolute recommendation of the NASEM report that I mentioned earlier on the -- earlier in the hour is for that, moving away from fee for service, moving towards value-based care, assuming that there is -- you can trust the practice to deliver the services by paying at a specific level and supporting the infrastructure.

You know, it's really sad to hear the description of three medical schools, you know, pumping out physicians for other states. I think that's a very hard thing to hear.

I think also -- there's also, frankly, students in medical schools in the United States -- whether they're in state schools that are somewhat supported or in public -- private institutions, you know, there are more students -- last year at least, at one of the -- at Dartmouth, there were more students going into anesthesia than family medicine.

What are you supposed to do about that? I mean, these are students that owe huge amounts of money, and they're going to make decisions that will not necessarily benefit the public at large.

DR. THORNBURY: Well, Dr. Watkins --

DR. PATEL: Yeah. I echo your sentiment. You know, I trained at Eastern Carolina Brody School of Medicine. It's Vidant now. And they have one of the biggest primary care programs in the country back when I trained. I don't want to date myself now. But of my graduating class, 95 percent went into specialty training afterwards. None of them are in eastern Carolina anymore.

DR. WATKINS: Right. Well, it's hard. I think, you know, we -- we've been at this for so many years and trying to say: How do we make this a more feasible lifestyle for people? How do you create that?

I think that in partnership with mid-levels and with community health workers and with community health teams and having the support so that your day -- the

physician's day is not inappropriately eaten up by things that really should be better handled by other members of their teams. But that requires planning and infrastructure and, you know, creation of a new structure that really isn't -- it's not an instantaneous thing.

But it has been done in other parts, and thank you for sharing that information about the other programs in Florida and North Carolina, et cetera. It's helpful to hear those.

MR. STOVER: I'm trying to raise my hand because I have a question, Dr. Thornbury, for our presenter. This is Gerry Stover with the Kentucky Academy.

I've got Dr. Swiney on who is one of our direct primary care physicians, and I wanted to see if our speaker has looked at that. I know from talking with Mr. Kol- -- or former Secretary Koller -- which that's an interesting model there in itself when you speak about the fact that Rhode Island separated out health insurance commissioner from the overall commissioner's office.

DR. WATKINS: Right.

MR. STOVER: But the thing I wanted to ask you about is that with Rhode Island's initiative to get to six percent, and as we -- I think we know they plateaued at about four percent because the money wasn't getting to the physician. It was staying within the health system, and maybe even part of that could have been the way the health plans were recording -- or reporting out on the data.

But anyhow, I think one of the elements that came out of that was the fact that the money wasn't actually getting to the primary care physician to incentivize them more to be more aggressive with some of the higher-end chronic care disease aspects.

With direct primary care, you eliminate obviously people like me, an administrative kind of position. Are you seeing any data on that that could represent some positive move off of that plateau number?

DR. WATKINS: So I would describe that as data that needs to be collected and analyzed. And we actually are -- we're working on getting some funding for a study

looking at both Oregon and Rhode Island and their now decade of experience with -- with targets being set for primary care investment.

But your point -- and I completely -- I don't have a solution for this at all. But I just want to underscore that for practices that are part of a larger health system, whether that's a health organization, you know, multispecialty organization or part of a hospital system or part of a, you know, pharmacy chain -- I mean, I think the individual practitioner is not necessarily going to ever have any awareness of the return to them, as it were, of their efforts.

And I think that's a -- that's a travesty, you know, that if you are putting all the work in there, it should be evident to you. It's not necessarily that people want extra dollars in their pocket, although certainly that would be helpful.

But, you know, are they actually -- are there better services for their patients? Is there a team that they can depend on in terms of getting their patients the mental health

services that they need? Are there other things that their patients benefit from as being part of that type of an enhanced program? And I think those questions remain to be answered.

We have published some information about perception of quality on the part of the physician community specifically in Ohio as part of the comprehensive primary care plus program, which actually included some northern counties in Kentucky as part of the Ohio region.

And that -- that appears to have been very well received, and the practices felt that they were getting better -- they felt they were delivering better care to their patients and had better access to services that they needed to get ahold of in order to better serve their practices.

So I'd direct you to the Milbank Memorial Fund website. There's a primary care page, and there are probably a dozen reports that we've published over the last five or six years looking at some of the participants in CMS' primary care models.

So there is some data, but it's not overwhelming. And your point about what happens when you're in a large system is a very important one.

DR. SWINEY: Hi. This is -- this is Dr. Patty Swiney. Since I got mentioned, I guess I'll speak up.

I am also the advocacy chair for the Kentucky Academy of Family Physicians so just a couple of comments. The American Academy of Family Physicians, we have an ongoing project to increase primary care investment in all of our states, and we're using some of these other states that have gone through.

So we are in the process of trying to come up with a plan, and we do need to work on that with other folks and getting our stakeholders all in align and to do that. I know that there is a bill before the legislature this time about creating an all-payer claims database that will really help some of that information and the data we need.

One of the comments was that it seems like rural health care is being provided by

mid-level providers, and I'm going to say that that's probably not true. When we look at some of the locations, nurse practitioners and PAs are usually in areas where there are primary care physicians, family physicians.

And we have had a tremendous problem getting the data from the Kentucky Board of Nursing to get that data, who is practicing independently where. But it seems like they are not going from the national model -- they are not going rural. They are staying more in the specialties, also.

There are a few that do, and I'm not going to say never. But I will take exception to that point. I do think that it's not necessarily with mid-levels out in the physician -- or out in the rural areas.

The other thing is PAs here do not have independent practice. It's only the nurse practitioners, after four years, that can have independent practice.

And then I have a question for you. How do you see direct primary care working? We -- we actually kind of do our own case management and everything. We work with

those social determinants of health every day in our patients.

A lot of them don't have insurance. So we keep our costs down, and that's how it works. But how would this work with that? So those are my questions, and I look forward to looking at some of this data.

DR. WATKINS: So I will tell you I am actually not as well-versed as I'd like to be at all around direct primary care, but it seems a viable alternative, especially in the face of the challenges that have been described by so many of you here today.

So it's something that I would certainly encourage you to pursue, and I would be happy to partner with you, Dr. Swiney, to try to get more information from areas that have had perhaps more experience. So we can -- we can talk offline about that. I'd be happy to try to address that with you.

And thank you for the -- just the specific information about the range and mechanisms of practice of the mid-levels. Yeah. I think that you're right. The same forces exist for APRNs and PAs to work in

psychiatry or in plastic surgery or, you know, to have a more reasonable lifestyle than in primary care which is just, by definition, very challenging.

Can I ask you about the work with the AAFP? So this -- my understanding is that there's a nationwide opportunity. It's a big learning community coming from AAFP nationally with, I think, the Friedman Foundation's -- well, Friedman -- not a foundation, the Friedman Health Services Research Organization --

DR. SWINEY: Right.

DR. WATKINS: -- is actually furnishing that. Yeah. So I'm actually very interested in learning how that's working.

My understanding is that there will be legislation -- legislative language, sort of model legislative language that would be available to anyone interested in that as well as the opportunity for collaborating with peers in other states which I -- obviously, you can tell by the way Milbank does its work, you know, that's something we consider to be extremely valuable. So --

DR. SWINEY: Right. Actually -- I'm sorry. I didn't mean to interrupt.

DR. WATKINS: No. Go ahead. Please. Please. Go ahead.

DR. SWINEY: So, actually, we meet about once a month. We've -- this is our fourth month, and just getting information from other states, brainstorming, lots of data collection, how to collect that data. And then the goal is that after these six months, we will have a -- sorry. We will have a toolkit put together by the AAFP of how to do this.

Primary care investment has been a huge topic at all of our state legislative conferences and our advocacy summits. It's just the right thing to do. It increases the quality of health care, so it's really been a very exciting time for us to see what other states are doing and how Kentucky specifically can increase that. It's just going to increase the quality of health care for our -- for our patients.

DR. WATKINS: Right. Right. Completely agree. But I feel like I might be

preaching to the choir here so got that.

There are a couple of other opportunities for national involvement should you be interested, or perhaps you've already explored this. But the Primary Care Collaborative, which used to be called the PCPCC, actually has a quarterly primary care investment workgroup. They just were meeting in February, I believe.

But it's -- I believe it's really open to any organization or state that's interested in participating, and it offers the opportunity of hearing from various states, at least every few months, and seeing what kind of progress is being made.

And I think there will be future opportunities in terms of primary care investment, learning collaboratives moving forward similar to what you're working with with the AAFP. So I'm glad to hear that's been positive so far.

DR. THORNBURY: Dr. Watkins?

DR. WATKINS: Yes. Dr. Tran has raised his hand. I thought maybe we should --

DR. TRAN: Hi. This is Tuyen Tran. I've been studying this for quite some time as well from an economic standpoint. And one of the issues that I just wanted to see if people thought about it and then dismissed it because it wasn't effective.

But it seems to me that without doubt, the social determinants impact health care, and our primary care doctors are experiencing an increasing burden of preventive tasks and whatnot. And it just seems like the social determinants have also been thrown onto their shoulders.

Is there ever an interest perhaps in sorting and teasing out these social determinants and treating it and separating it from the actual health care itself? And perhaps by doing that, we could address each issue more effectively instead of combining it into one.

DR. WATKINS: That's a really good question. I mean, I think the -- part of that -- what appears to be a pretty tight linkage around social determinants of health and primary care is that primary care is

where things might get identified fairly readily. So there are ways of collecting that information and getting referrals appropriately outside of the primary care practice but, nonetheless, so that the primary care practice knows that it's happening.

And there's -- actually, there's a very innovative program that's now statewide in Oklahoma where it's essentially using text messaging to answer a series of questions while the patient is in the waiting room at a primary care office. And it's a very simple screening, very quickly. You know, the patient has to consent to whether they want to talk about this issue or not.

But it's been extremely effective in terms of like on the spot, at the moment, sure, let's get you -- let's get you this referral while you're here. Not necessarily deal with the underlying issue but -- on the part of the primary care practice, whoever that is in that practice, but getting that person correctly referred and follow-up to know whether anything actually happened, if

the patient was able to get services and if there's any additional actions that have to happen.

So there are models around the country, and especially the one in Oklahoma is very interesting through MyHealth Access. So I'd be glad to send that on, too. I hope someone is taking notes here of things that I can provide links to.

DR. THORNBURY: Dr. Watkins?

DR. WATKINS: Yes.

DR. THORNBURY: I'd like to jump in on that. This is Dr. Thornbury. I think what we've asked for for the last year or so is for the Commonwealth to consider engaging the major stakeholders to try to come to understand what we see is the crisis that is really kind of imminent to us.

Barbara Starfield did her work, I'm guessing -- she published a book in '92, so she must have done it 35 years ago. And when her work was published, the great majority of primary care was almost always provided by physicians.

And what we're seeing today is a little

different. What -- and I'm married to a nurse practitioner. I've trained them. I've worked with them. I've worked with physician assistants.

What I see as the dichotomy is if you ask those people to do what they do well, our system works very, very well. Particularly when we work in teams, it's extremely efficient.

What I'm seeing is when I put those people independently is I'm getting kind of double-paying, where you come in to see them for the problem and then they send it to someone else. And that's really more triage or -- we call it traffic hopping.

And that's different from comprehensive medicine, which is what we're trying to -- what we're trying to accomplish here in Kentucky. You see, for every one person working in Kentucky, Dr. Watkins, we basically have one person that's on Medicaid, and that's just not sustainable. I don't know -- there's no logic that is going to be sustainable for that.

And what we're asking these primary care

practices to do is we want you to do minor and moderate acute care. We want you to do the overwhelming 85 or 90 percent of the chronic disease care, and which Kentucky is not the healthiest.

We are asking them to do all the preventive medicine. We're asking them to access and coordinate the care. So if someone comes in, well, do they see neurosurgery or neurology. We're asking them where in the care system are they going to fit most efficiently. We're asking them to address social determinants of health.

And the problem that I get is my first patient has diabetes, hypertension, dyslipidemia, which I think they're there for. Their shoulder hurts. They want to know what this thing on their arm is, and their A1C is 9 percent because they can't afford the medicine, or there's some other issue. And I'm being held accountable for that.

And so that is the -- that's the overwhelming burden that you're asking these people to do. It's not like, well, if you go

to the nephrologist, well, there's just so many kidney diseases. There's -- the cardiologist, so many heart diseases. And you go, and you get paid for that.

And that brings me to my -- the point I really want to make, which is in Kentucky, my grave concern is the way our system, as I understand it -- I could be wrong here. But the way I understand the system is set up, we -- there's an old saying in management. If you can't measure it, you can't administrate it.

I don't think in Kentucky we can determine who the primary care providers are because we can't see them. Like, we see 99213, 99214, but we have no idea who that is. And there's no coding, so we not only have no idea who the primary care people are. We have no idea who the primary care physicians are.

We have no -- I don't know that we -- I don't even know how you would even come up with an accurate spend on primary care, how you could measure that if you don't know who your physicians are.

And so we have kind of an existential problem because what I see coming, and I think what a lot of us in this committee see coming, is there's going to be a day where we've gotten so far that the health burden and the chronic disease burden is so much that we can never get back from it. There's no way to catch up. It takes decades to solve those problems.

And because we have so few people that want to stay and the physician -- the Commonwealth has become so poor in retaining these doctors, that there's no way that they want to come back here.

And now we're in this crisis of how long is it going to be until it's just so bad even the MCOs won't stay, that, you know, even they'll say, well, there's no money to be made here. It's just too much. We have to go somewhere else. And we don't see a solution to that.

DR. WATKINS: It sounds extraordinarily difficult, and I guess my one comment would be that there is opportunity to answer some of the information gaps, to

understand better what your workforce really looks like, and to tease out who's actually taking care of patients. And then other things that are admittedly smaller, there's no major overhaul but -- that could answer all of those problems certainly in a current financial structure and setting.

But I do think there are ways to support pieces of the system, and I think that would probably be -- you know, thinking about what Dr. Swiney was talking about. Like, if we can, you know, look at actually getting an all-payer claims database so that you have a trusted, accessible resource of information and, you know, making -- making moves towards increasing primary care investment to potentially cushion the fall for the medical student who decides to stay in the state for a variety of reasons.

But what you're describing sounds very difficult, and you're not alone. I mean, so many states are facing so much of this. They're on variations but, nonetheless, there's a common theme for any state.

DR. THORNBURY: Do we have more

questions for Dr. Watkins this afternoon -- this morning?

DR. TRAN: Dr. Thornbury, this is Tuyen Tran again. I do have --

DR. THORNBURY: Yes, sir.

DR. TRAN: -- one last question. And in one of the slide decks -- one of the slides, you had -- your group had suggested that the MCOs, Medicaid strongly look at enhancing the reimbursement rate to be more compatible with Medicare.

If I was an MCO -- if I was a Medicaid provider, administrator, how do I accomplish that without hurting my organization? So if I'm WellCare and I really want to help my physicians, and, you know, I set the reimbursement based on what I can afford to do.

So what are some ways that your group has looked at to help the MCOs deliver that?

DR. WATKINS: So we haven't actually done that directly, so I will be forced to demure and not -- not answer your question.

I do think there are ways to leverage

quality metrics to reward practices, to reward practitioners, and to have -- I mean, there are pieces -- you know, and shifting perhaps to more a value-based payment that gives the practitioners more freedom to do what they need to do because they have a set amount of money that they know they can -- they can use as opposed to relying on the fee-for-service schedules. But it's a -- it's a quandary, and I don't know the answer.

Well, I want to thank you all for allowing me this opportunity to spend this time with you and to share what I understand and reveal what I don't, because there's a lot. And I really want to hear more as this journey continues for all of you, and I wish you the best.

And we are a resource to you. Email me. Ask questions. I'd be glad to connect you with people in other states that are doing analogous work. There's a lot to be said for stealing shamelessly from others in terms of strategy and trying out opportunities.

DR. THORNBURY: Dr. Watkins, we greatly appreciate your time and your

expertise, and thank you very much for making it to join us this morning; okay?

DR. WATKINS: It's been my pleasure. Thank you very much.

DR. THORNBURY: We'll say one mutually shared, then.

I want to advance us to the next item on our new business, which is opening a little bit of a discussion on the CMS initiative to advance interoperability and improving the primary -- prior access process through the proposed rule.

As many know, CMS' newly proposed rule on advancing interoperability and improving primary -- prior authorization access is part of a Biden/Harris administration's ongoing effort to commit to increasing Health Data Exchange and investing in this interoperability. CMS issued this proposed rule, and it seeks to improve these initiatives.

Our discussion today would be turning this to our MCO partners, to DMS to see if they have any insight into their thoughts on the prior authorization access. We've

discussed this for a few years. Any discussion on the interoperability position to this?

This is a new -- there's a timely matter here because this is a rather new initiative, and I don't know how they feel about this, what work they've done. I don't know if they have any insight, but we're very open to discussing these things as a way to try to make our system more efficient so that we can work as partners to get a better outcome and lower cost.

I'd open up the floor to anyone that would like to speak on this issue.

DR. NEAL: We're not standing in line. Dr. Thornbury, in what -- are you talking about the initiative that's going to go before the Kentucky legislature? What are you searching for there?

DR. THORNBURY: Okay. Cody, why don't you step in here. Let me -- let me get Cody to offer a little bit of insight and help throw a magnifying glass to the areas that we're looking at in particular, Dr. Neal.

DR. NEAL: Okay.

MR. HUNT: Sure. So this is regarding the new rule that CMS has proposed at the federal level. It largely is going to impact Medicare, Medicare Advantage Plans, but it also has some spillover to the state Medicaid programs.

And it makes some adjustments that require new implementation around electronic prior authorization process, shortens time frames for certain payers to respond to prior authorization requests, and establishes some policies to make the prior authorization process overall more transparent.

And so I think really, just kind of curious -- and this is all still, you know, very early in the stage of its rollout, and it's -- the public comment period is still open till March. Nothing is even close to being finalized yet.

But I think we're just kind of curious if the state Medicaid folks had any insight or any thoughts on what the state program might anticipate as a result of this proposed rule.

DR. NEAL: Dr. Neal again. In a meeting yesterday with Aetna quality committee, we discussed prior authorizations. And I tried to get from them -- this all started as a matter of quality. Prior authorizations really started -- was to try to increase quality of care. But what I got yesterday was no, really, it's fraud and abuse that we're really looking at.

And, also, we are having -- each state is different that the plans work in as far as what they require as far as prior authorization. So what I got back from them is it's not all us doing prior authorizations. The State is requiring.

And so that's going to be one of our first questions to state Medicaid, is: What are you requiring as far as prior authorizations? And is fraud and abuse really something that we're dealing with here? Because we were told it was quality of care issue.

So I've got more questions than answers after that discussion with Aetna yesterday.

MS. PARKER: Hi. This is Angie

Parker with Medicaid. In doing utilization management -- and prior authorizations is part of that -- it's multi-faceted really. Yes. Fraud, waste, and abuse is part of that. It's ensuring that the right care at the right time is -- and the right place is occurring.

It's also early identification of people with social determinants of health particularly as well. And it's multi- -- like I said, it's multi-faceted. It's, you know, does this person need case management? Are they already in case management?

So as far as that is concerned, utilization management, prior authorization is -- and it's also based on what the population and the data is showing. They should be basing their prior authorization lists on all those factors.

And what they're seeing, it could be abused, or people are going to more expensive areas for treatment that could potentially be occurring in another facility.

So -- and as far as the interoperability part, all MCOs are required to offer a portal

for providers to request prior authorization for whatever is on their prior authorization list.

Does that help from a DMS perspective?

DR. NEAL: Yes.

DR. THORNBURY: Angie, thank you very much.

DR. NEAL: Yes. Thank you.

You know, I'm a pediatrician, and the only way prior authorization really affects me is prescribing of medications. That's the only place that it's really a problem. And those prior authorizations are so often based upon brand name versus generic. They're based on the rebates that Medicaid gets.

It's a lot of things other than what the clinician is facing. He just wants the child to get the ADHD medication. And it's driving the drugstores crazy because they're having to carry two -- two sets of generic and brand-name medications. And that may be just a small part of the total picture, but I can tell you that that's not what's affecting us.

Now, I will say that with some mid-level practitioners, I review about probably 500

nurse practitioner charts a week for the group I work for in Florida, and I can tell you that the amount of referrals to specialists for things that they couldn't handle that we physicians could handle are just incredible.

And that's one thing that you just mentioned. Is it the right kind of care in the right place at the right time? And I think that's something we're going to have to look at as there's more mid-levels practicing.

DR. THORNBURY: Dr. Neal, let me step in. And, again, Angie, thank you very much for commenting.

I'm empathetic to the other side of this, which is -- candidly, I feel like that there are people out there, particularly -- and I hate to -- the poor mid-levels are really taking some heat here in this particular venue.

But in all fairness, what I'm seeing when I do the reviews is a lot of these people really just have kind of no idea of really why they're ordering what they're

ordering. And I see -- you know, we don't want to be spending money -- and this is our money we're talking about. We don't want to be spending our money inappropriately where it's not going to offer a value.

But there's another side to it, and the other side to it is more anecdotal. I'll just give you in my private practice. So I've got a lady who does our checkout. Well, she's also the same lady that does the prior authorizations, which means the entire day, she is on the phone trying to do two jobs. And there's nobody that pays to do that job because it's a hidden cost in health care.

And it's not just the medicines which, you know, we try to use -- in my practice, we have a moral obligation. We try to use every and all, you know, nonmedication alternatives. We try to use generic medicines when and if they can. When we started using brand-name meds, we try to use the most effective or the least costful. So we kind of a stepped tier.

The same way with imaging. I mean, we don't order imagining willy-nilly. When they

finally need something, they're going to have to have it.

And, actually, the sad irony in my practice is we are trying to help these companies, and even they can't see it. The systems are that they can't see it. Like, we have somebody, well, you're going to have to get a CT scan today. They're like, well, we'll give you three days. Well, this person is just going to end up in the ER.

Now you're going to pay me, and you're going to pay somebody over there. And the same thing that happens is the -- the study is going to get accomplished. The question is how -- are you going to pay two people to do it? And that's what I'm seeing over and over again, which is there's just no way.

When I get candidly -- and I apologize for being so direct. But when we ask for a Medicaid prior authorization, my -- the girls just look at me. They give me the eye roll, and we just know that they're going to have to go somewhere else. That means to a -- like an ER somewhere. We just can't get what we need to try to save them money.

If somebody is going to have to have something to rule out a DVT, they have to have something to rule out a DVT. If somebody has fever and abdominal pain, man, they have to have a CT scan. That's just medical liability. You're going to have to have something like that.

And so the problem that I see is -- again, on the other side is somebody is paying for these prior authorizations. It looks to me like the commonwealth and the MCOs, every time there's a prior authorization, they're paying some company to do that prior authorization. And that's not an inexpensive fee.

It really is difficult to do the work, and it's just one more thing. It's not just about the money that you're offering the primary care workforce. It's the quality of life.

It's every -- every single person that's coming in almost is getting some type of phone call, and that phone call is taking, you know, 15, 20 minutes. We've had people -- very commonly, it's two or three

times a day, they're on hold for 40, 45 minutes before they can get to a decision.

And I just want maybe the MCOs -- maybe they know this. Maybe they don't know this. I don't know. But this is the reality of the world that we're trying to work in.

And I think you're -- that's why you're seeing legislation maybe not only nationally but you're seeing it in Kentucky to say, well, if you have a group of people that have proven that they're doing a very good job and trying to ethically work to help the system and save you money, can you not work with them to make their lives a little easier and to try to make the system more efficient.

Because, again, all these processes take time, and they all take money. And some of it is hidden, and that's what I think, is I think sometimes it doesn't show up exactly on your books.

How do you measure when somebody was seen at the primary care office for one thing but then has to go over to the ER to get the imaging study, and it renders that extra cost? And where does that show up on an

accounting fee?

Well, I don't know, but that's exactly what's happening, I'm sorry to say.

Dr. Neal, am I -- can you help me out here?

DR. NEAL: Well, you're exactly right in what you're saying, and that's why we're seeing so much burnout, I think. And just throwing money at primary care is not going to be the answer when -- you know, when they used to see 40 patients a day and now they're struggling to see 25 and working through lunch and dealing with EMRs like Epic that are very difficult for them.

And I just -- I don't know. I think that's why we've all got together -- got to get together and talk about this really soon and see if we can come up with some answers.

DR. THORNBURY: Well, I think just what you were pointing out earlier. We had a very senior executive say, well, you know, in Kentucky, your workforce might be older. They're primary care doctors. Maybe they don't have EMRs. Well, why is that?

Well, think about it for just a second. If every case that I'm seeing for Medicaid is

losing money by definition and the EMR's cost -- it's not the purchase price. It might be -- maybe get it for free. Maybe it's 65,000. It's irrelevant. Because it's two, three, four, five thousand dollars every month to maintain the EMR. And if you choose not to do that, when they update it and it doesn't work, well, now, you're in really big trouble.

And you see why these people can't afford to do it. They're like, well, we just can't afford -- there's no way to do it. I'm going to have to sell out to the hospital. I'm going to have to sell out to this group. Well, you don't sell out. You just go work for them. You just take a financial hit. But I think that's why you're seeing so few people trying to work independently.

DR. NEAL: Right.

DR. THORNBURY: Well, it's a lot to unpack. It's a lot to unpack, and I think that -- I think -- and try to summarize this, I think in today's meeting, what we're trying to say is -- I guess we're trying to reiterate again the great difficulties we see

with the primary care process in Kentucky and how that's not only causing problems today, but we see -- that's one issue. But the problems tomorrow are really what worry me, is how this is going to go.

It's, I guess, analogous to I have a child in elementary and they get 10 to 15 minutes of recess every day. And it's almost like I'm purposely teaching them to be fat and lazy. I mean, you know, I'm teaching them to say, well, we don't really need you outside. It's not an important part of your life when every single person I know that's an adult makes exercise an important part of their life.

And so it's the same thing here. We're teaching our people to say, well, can we just -- can we invest in a workforce that maybe won't be as qualified and is going to spend more money for us? Or are we going to invest in a comprehensive workforce that might save us money, but it may be money down the road? But that money down the road is not going to go away. These people are still going to live here. They're probably not

going to move away.

And it's going to really be difficult. It's going to be difficult to make money if you're an MCO. It's going to be difficult to manage this if you're a politician. If you're a legislator, you're going to have a problem -- if you think the pension problem is a big problem, this is going to overtake that, in my opinion.

DR. NEAL: Amen.

DR. THORNBURY: I just don't see -- I think even our expert -- our national expert came in, and she was completely stumped. It was like, well, how do you solve this problem? She's like, well, I don't know how you've got to solve it.

But I think this might be the chance where leadership can come together and say we need to get -- it's time to get the senior leaders back at the table to decide what the future for the commonwealth is going to be. Are we going to be a poor, rural state that's going to be at 49 or 50th in every single thing, or are we going to try to make our state a healthier state, a place where we

want to live, where people want to move in?

Now that they can live anywhere. When Starlink comes on board, you're not going to need this internet through the ground. You're going to have it through the sky. You can live anywhere and do your work.

You know, we have water in Kentucky. We have great resources. This is a -- this is the Kauai of the east. You know, we have wonderful things in our commonwealth. Can we make our health care ability to match that? Can we bring it in so that businesses can come in to the commonwealth and afford to work here instead of maybe saying, well, you can come in. You can't work here because you're going to be taxed. Your health care is too expensive.

We're trying to solve these problems, and we're asking for help by calling attention to it. Does anybody else have any thoughts on the matter?

DR. TRAN: Dr. Thornbury, I think Daniel had a hand up.

DR. THORNBURY: Yes, sir. I can't see anything. My Zoom on this is completely

terrible. This is -- I apologize to the group. I usually have a great Zoom experience. I'm having nothing. I can do nothing with my mic. I can't see attendees. I've got nothing for you guys. I'm sorry.

MR. ESQUIBEL: No worries. Thank you all for recognizing me. My name is Daniel Esquibel. I'm with Humana in our public policy team, and my Humana colleagues asked me to join for today's conversation as a resource, if that's helpful.

So, really, I can provide a very high-level overview of the CMS proposed rule and speak to some of the initial concerns that have been raised, if that's helpful, and happy to try to field any questions from there.

I would say overall, this is a -- probably not going to alleviate concerns about the reliance on electronic health records. But this proposed rule is continuing to build off of what are called Application Programming Interfaces, APIs.

So really emphasizing the continued electronic exchange of health information

with an intent of that happening through the EHR workflow. So this is really going to introduce another conversation for many of you with your EHR and technology vendors on how they're going to enable that exchange.

One of the provisions here that is intended to make things a bit easier, whether in primary care or in other specialty areas, is something called the Provider Access API that's intended to help make -- or deliver direct access to your patients' electronic health information even when you don't have the complete longitudinal record. So this is the intent behind these procedures.

And then really intending -- this dataset will also include information about existing or previous prior authorization requests, so you have more of that view as well. And just something to be conscious of as you think about the prior authorization requirements here as well as we build on -- excuse me, or as CMS proposes to expand use of electronic prior authorization, they're also proposing to measure provider's use of these electronic prior authorization

processes as part of the various quality reporting measures, whether in MIPS for Medicare or in hospitals as well, as part of the promoting interoperability program.

I hope that was helpful. I will turn it back over to the broader conversation now.

DR. THORNBURY: Thank you, Daniel. And we welcome Humana as not only a leader in the commonwealth but a leader nationally in health care. And it doesn't go unnoticed that you've elected to make your national headquarters here which the commonwealth appreciates.

How do you all -- Daniel, how do you all view prior authorization, for example, to get into that particular aspect? How do you see that as something that you all have to work through? Because every -- again, every PA case is going to cost you guys money. How does that -- what's the calculus on that in working with your primary care teams?

MR. ESQUIBEL: So that is definitely an area that we're evaluating and really looking at how this can be made as streamlined as possible, getting the

necessary information but also not wanting to put any hurdles in front of people unnecessarily, really recognizing that anything that can be done on the electronic prior auth front is likely to advantage everyone in the system. I think we're generally supportive of that.

I know there are others from the business on the phone from Humana, or on the call, so I would certainly defer to their comments as they know the business particulars in greater detail than I do.

DR. GALLOWAY: Yeah. This is Dr. Galloway. I'm one of the medical directors at Humana. I work with our utilization management team.

You know, Humana has been working to do some -- I actually have a couple of slides to share on our PA process. I don't know if this is the appropriate time or not.

But we have been working to make our PA process more automated. We've enabled some artificial intelligence to be able to, one, when providers send the clinical information, to be able to search and annotate it, you

know, to be able to share the information among the reviewers more appropriately.

A pilot that Humana corporate has been doing and with the Epic payer platform -- they collaborated with Epic to work on being able to do the prior authorizations directly from the Epic platform.

It's a very small pilot right now. We've seen some good success with that where -- in the Epic platform that will help recognize codes that are on the PAL, to pull them out when the provider -- and to be able to pull the clinical information related to those codes, you know, so that you don't have to go into a separate system to do your prior authorization requests.

And one of the other things we've done is questionnaires, where it's through -- when they go into Availity, providers have the option on some of our higher volume procedures and auth requests where there's just a series of questions they would ask, so they can get, you know, real-time approval.

That has been rolled out more extensively in our Medicare and commercial.

But the end of this past year, we started putting some questionnaires in place for the Medicaid, and our goal this next year is to add several more additional ones of those on some of our DME requests, genetic requests, some of the outpatient surgeries, and behavioral health services.

DR. THORNBURY: Thank you, Dr. Galloway. That was -- that was quite informative.

Do we have any other of our MCO partners -- would they like to speak to this issue?

MS. BICKERS: And, Dr. Galloway, I dropped my email in the chat. This is Erin with the Department of Medicaid. If you'd like to just email those over to me, I'm happy to share that information with the TAC.

DR. GALLOWAY: Yeah. We will send over the slide deck. Happy to do that.

DR. THORNBURY: Thank you, Erin.

DR. BRUNNER: This is Dan from Anthem, Dan Brunner from Anthem. We're also exploring artificial intelligence for seamless prior auths as well, where a

provider, through EMR access and whatnot, could enter data in real-time, get an auth in real-time for those criteria that meet prior auths. So we are also exploring those as Dr. -- similar to what Dr. Galloway mentioned.

DR. THORNBURY: Well, having some experience and part of my career spent in AI, in technology, I would tell you I think that's a very -- I think it's a wonderful opportunity for the -- what we have probably now, the fourth generation of AI coming out, to help all of us work together. I would -- I would really support your efforts in that. I think that it's quite obvious it's a way for us to work more efficiently together, particularly on your side.

Commensurate with that, I would say that I would hope that you all would have -- that your prior authorization teams would have the clinical maturity to understand that all prior authorizations are not equal. I mean, again, I would suggest that if you have these very mature, comprehensive practices that are working out there trying to ethically save

you money, that you may want to try to identify them and make it to their advantage to work more efficiently with you guys so that they can take -- so they can really begin to recruit people.

That's what we would do if, say, we had a particular insurer that made it easier for us, well, we would -- we would start telling our people what we want them to do. We'd say, when it comes time, we want you to get this insurance because it's going to make it easier.

But I would just say globally, the easier it is to work with us or these other -- or these primary care practices that are trying to -- again, they're trying to save the system money. They're trying to save the MCO, the commonwealth. They're trying to save the patient time and do the right thing for the patient. I hope that you'll look at those different from just the vast swath of people just asking for something from you all every single minute of every single day.

DR. BRUNNER: That's a great point,

Bill. Thank you.

DR. TRAN: Dr. Thornbury, may I ask a question?

DR. THORNBURY: Yes, Dr. Tran. Yes.

DR. TRAN: Yes. I'd like to ask two points to the Medicaid MCOs, and I know that this -- regarding the proposed rule, one of the issues that I have concern about in developing these APIs, for the last decade plus, we have been trying to get all of the software companies to talk to each other. We have multiple EHRs, and our attempts to get these EHRs to communicate effectively so that we can have decent exchange of information has not been terribly successful.

And so my concern is: Are we all going to be indirectly forced to choose one or the other type of EHRs that will be compatible? Because some of our EHRs may not be compatible yet, and how are we going to achieve PAs? So that's question No. 1.

Question No. 2 is we have somewhat been hearing a lot of discussion about some of the barriers from the physician side, from the

practice side. And I think Dr. Thornbury expressed the most important one, and that is, you know, nobody takes into account those hidden costs, both on our side and on your side.

But I'm particularly interested in hearing from you guys. No. 1, I know that this is a multi-faceted requirement, to do the prior authorizations. But would it be easier for you to identify situations, scenarios that would trigger concern to do the prior authorizations instead of forcing everyone to go through the prior authorizations?

MR. ESQUIBEL: I'm happy to take the first part of your question, Dr. Tran. With regard to access to the data and interoperability among various EHR systems, the rules specify a specific data standard. It's called the FHIR standard, F-H-I-R.

So that is intended to work sort of agnostic of the EHR system you're working through. That is the regulatory intent. How that is implemented and how that moves forward in the real world, of course, is

going to be a bit of living by the experience.

DR. TRAN: And what was the last one called? Was it H7 that everyone was supposed to transition to so that we could have this --

MR. ESQUIBEL: Yes. HL7.

DR. TRAN: Yeah. How did that go? Not so -- I even tried to learn HL7, to program it, and that was extremely difficult. So I am somewhat familiar with the FHIR.

But, again, that's my concern, is if I'm one of these EH -- if I have one of these EHRs and, for whatever reason, my vendor is just incapable of making it compatible, what am I going to do, for my patients that is?

MR. ESQUIBEL: So from a regulatory standpoint, just quickly, CMS sort of learning that lesson has come back with the ONC, the Office of the National Coordinator, for health IT, and they have put -- modified the conditions of certification for the EHR vendors so that if they do not support this standard now, they will not be certified going forward.

DR. THORNBURY: Dr. Tran, can you hear me?

DR. TRAN: Yes. Thank you, Daniel. That was helpful. And the only -- again, as a small clinic practice, my concern is, well, darn it. Now I've got to change an EHR if it's not going to be compatible, you know, and that's quite an expense for small clinics.

DR. THORNBURY: Well, I'll tell you the practical part of this, Dr. Tran. Can you hear me? This is Dr. Thornbury.

DR. TRAN: Yes, sir.

DR. THORNBURY: Well, I think the practical part of this is -- at least from my small seat is I don't see this ever getting solved on this level. I think the discouraging thing was, of all the things the Government is actually into, the thing is they should have come back from the very early -- on the very front of this and set those standards.

I mean, when you buy a television, basically, you plug it in, put the wire in, and it kinda works. It doesn't matter where

you plug the TV in, which TV you buy. They all kind of have this standard.

And I think the problem that we had here was when the cat got out of the bag, it got out of the bag so far, there was no interest in the EMR companies having you ever switch. It's more like the tobacco companies. Maybe that's a poor analogy. Maybe it's not. But there really isn't.

I've seen a solution more with -- as technology advances -- and we alluded to it earlier. Things like these AI mechanisms that are working now are going to work on a little bit different level. And they -- there will be an opportunity to move medical information in that way, albeit, it would be -- the security, it's going to be a little challenging in that aspect. I don't know how they're going to do it otherwise.

I mean, you know, you're in China -- or say you're in Japan. You use your Visa card. Within three seconds, everybody in the world knows what you've done. The banking system is completely under control. Our system just isn't.

And they've tried this -- I think for ten years, they've been trying to get these systems to work -- get vendors to work, and they slide at it one way. They -- I don't know. I mean, I think they help write -- I think they help write the legislation, is what I think.

Because whatever the loophole is, they seem to find a way to do it. We're into this at least ten years, and I've never seen, you know, being able to go from -- if you wanted to go from Epic or Cerner or Cerner to, you know, some other system, I've never seen that really capably possible.

And maybe it will happen. I -- you know, he's correct. We have FHIR now. They've had FHIR for, I guess, seven, eight, nine years now, maybe more than that, when we started working with it. But before that, you know, it was HL7. But I didn't see that that really made anything any different.

That just -- I hate to be such a pessimist today on that -- at least on that Epic -- on that topic, but I don't see how they solve it. I haven't seen it solved --

even close to being solved in the time that I've ever been practicing, and that's -- we've been doing this now 25 years, you know. It's been really serious EMR for 25 plus years.

Well, does anybody else -- does anybody else have any -- moving on to, say, general discussion, does anybody else have any topics, particularly our MCOs, that they have concerns about that we're not delivering on or that we're not talking about, or we need to investigate on our end?

Do you have any -- do we have any of our partners that want to bring something to the table that we can chat about today -- we have about 10 or 15 minutes -- or that we can look up and bring up at our next meeting?

MS. BICKERS: Dr. Gupta had her hand raised. I'm not sure if she still has questions or not.

DR. THORNBURY: Dr. Gupta, you'll just have to -- I can't see anything. I just see a big blank, black screen here. So I'm sorry. You'll have to just nudge me.

DR. GUPTA: That's okay. Good

morning, everyone. This goes back to when we were talking about the physician reimbursement and the whole primary care, you know, crisis.

And if I remember correctly -- and Dr. Neal, you might remember. At our last MAC meeting, there was -- I believe there was a presentation on the budget of DMS. And I remember there being a pie chart on the provider reimbursement, and it was such a small sliver of the overall budget. I was really surprised.

And it just makes no sense to me that we have all agreed to accept 65 percent of what Medicare reimburses. I mean, we're just going in saying that we -- yeah. We're going to see all these patients for, you know, significantly less amount of money, and we -- I mean, there's no reason why -- and I know this is, you know, far-reaching hope but that we -- Medicaid should reimburse at the level of Medicare.

I mean, that would solve so many problems. That would keep physicians in Kentucky. That would improve the health care

of everyone, and I know what I'm going to hear, is that we don't have the budget to reimburse at that level. But, you know, there's got to be a way to do that. I mean, that -- that would just be the simplest thing to do, so I don't know.

Dr. Neal, do you remember anything about that?

DR. NEAL: Yes.

DR. GUPTA: I might be remembering it incorrectly.

DR. NEAL: No. You did. Actually, it's about three percent of the total budget, is to primary care. That may seem simplistic, but that's what it is. Other things that you might look at is, for example, children only cost about $2,400 a year -- this was another chart that was up, for care in a year. Whereas, adults, it's about $3,500 a year. And for the elderly, it's somewhere up in $4,500 a year. So those are things we look at.

But I think it's too simplistic to say that if we went to Medicare rates, all of a sudden, all the primary care doctors would be

happy and not leave the state. Because there's just too many other issues that we've got to deal with.

And that's why I just -- you know, and I'll just say one last thing as far as I'm concerned. I am so tired of hearing about prior authorizations. It's taken all the oxygen out of the room at this point. Now, we finally got on EMRs, but we spent most of the time on prior authorization.

And the AMA Physician Recovery Plan is based upon getting rid or reducing the burden of prior authorizations. The KMA's legislative agenda is based upon that. And I almost wish we could just blow the whistle and call a timeout for a year on prior authorizations and see what would happen to us when we come out the other end.

Do -- are we all doing fraud and abuse? Are we not practicing quality care? But think about that. I know that's not going to happen. But I just wonder where we would be if we -- if we absolutely didn't discuss that for one year. Anyway, that's all I have to say.

DR. THORNBURY: Well, Dr. Neal, to your point, I think we're trying to look at that. Cody, you can -- you can help me out here. But I think we're trying to go back and decide: Well, when we had this COVID emergency and there wasn't a prior authorization, did we actually spend more money during that period of time?

I mean, I want to grant that there's one or two percent of doctors that are just going to -- no matter what system you set up, they're going to try to get around it. They're just -- and it's not just them. It's in every single field.

But, you know, does that one or two percent -- is it such -- is it such a -- or are we invest -- the other question might be intellectually is: Is that not the one problem? Is it not the one or two percent that are trying to defraud you? What it is is it's the people that are really not qualified to be making the decisions that you've put in there.

See, you've brought this cost upon yourself. You say, well, we're going to

invest in physician assistants, and we're going to invest in nurse practitioners. Well, you can ask Kaiser Permanente how that worked out. That almost bankrupted them, you know, and they went away from that.

But, you know, if that's who you're investing in and they're making the decisions, well, no wonder you're going to get bad outcomes. And that will never be solved. That's just not going to be solved.

But, now, Cody, am I wrong on this? Are we trying to not get the data to contrast that with the times when we were having to use prior authorization?

MR. HUNT: Yes. The PTAC did request that data several months ago from Medicaid regarding what the utilization -- when the utilization of prior authorization was removed for the Medicaid program back during the, I guess, mid to early stages of COVID. And we still await receipt of that data.

But DMS did present on it last year, but it was strictly regarding the utilization of prior -- what the utilization of behavioral

health services was when the prior auth was removed for those services. But the PTAC was specifically interested in the total utilization for all physician services.

DR. THORNBURY: Angie, Erin, do you guys have any insight into where we are on that?

MS. BICKERS: Cody, is that the information that you asked the commissioner for that I followed up on recently?

MR. HUNT: Yes.

MS. BICKERS: Okay. I have not heard back. I believe they're reviewing all of that, and the commissioner is out of office this week for personal reasons. So I will follow up with her. I'll make a note to follow up with her again on that when she's in office on Monday.

MR. HUNT: Okay. Thank you.

DR. THORNBURY: And thanks, Erin. Does anybody have anything else to add before we close it out today? We just have a few more minutes, but we have time for a few more questions.

MS. PARKER: I do want to add to

that a little bit, that we also -- you know, obviously, when we get the data, there were less people that were getting services, too. So you have to take that into consideration, but yes, I do know that they are looking at this. And behavioral health, we did see a significant increase.

DR. THORNBURY: Well, I think in fairness to your point, we recognize that up front. Of course, it's the only data that we have, and we think that even though we do see behavioral health increasing then, I think you're going to -- I think you're beginning to see -- in our practice, we're beginning to see more of it now.

It's been more of a delayed effect, and it's concerned us. It was much worse than I thought it would be. I thought we had this problem last year, and it was -- but it looks like it seems to be worsening to us.

And I would say, putting my KBML hat on, that we're seeing it with physicians, too. We're beginning to see a movement of more difficulty with physicians and their ability to cope.

Well, if there's nothing else today, then I'm going to remind everybody -- first, I want to thank everybody for attending. It was a very robust attendance. We had a wonderful speaker. Dr. Watkins was one of the national leaders in this area. We appreciate the very senior leadership that has attended.

Hopefully -- for as many problems as we've brought forward, we hope that we can devise even more solutions. And that's really what we're here to try to do, is even though the point was a little shrill today, we're trying to make that because we do have grave concerns.

And maybe -- again, to close out, maybe this is a time for us to get very senior leadership together to decide: What is the philosophy going to be in Kentucky moving forward? We would like those people to consider it.

And, again, thank you very much for your attendance today. Thank the members of the PTAC as well.

Our next meeting is 17 March, 2023. And

at this time, we'll call the meeting adjourned. Thank you, everybody.

MS. BICKERS: Dr. Thornbury, before we end really quick.

DR. THORNBURY: Yes, ma'am.

MS. BICKERS: This is Erin with Medicaid. I just wanted to give you guys a friendly reminder. I will not be with you in your March meeting. Kelli Sheets --

DR. THORNBURY: Oh, no.

MS. BICKERS: I will be on maternity leave so --

DR. THORNBURY: Oh, congratulations.

MS. BICKERS: Thank you. You're in very good hands with Kelli, but I just wanted to let you guys know that I will not be with you guys next meeting so that you know that Kelli is running everything. And I will make sure to copy her on all the emails that I send you guys with the presentation, so you have her contact information.

DR. THORNBURY: Well, congratulations. When we do come back, we're going to expect some actual photos for the

PTAC; okay?

MS. BICKERS: Absolutely.

DR. THORNBURY: Well, absolutely.

MS. BICKERS: Dr. Schuster with the behavioral health has already asked me to make sure Kelli gives her an update in their March meeting so absolutely.

DR. THORNBURY: Well, we want it. Absolutely. Thank you again, everybody, for such a wonderful meeting; okay? We'll see you in a few months.

(Meeting concluded at 11:57 a.m.)

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C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 2nd day of February, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR