The foregoing zoom meeting was held, pursuant to notice, on Friday, January 21, 2022, beginning at the hour of 10:00 a.m., Chairman William Thornbury, M.D., presiding.
PHYSICIAN TECHNICAL ADVISORY COMMITTEE MEMBERS

PRESENT:

William Thornbury, M.D., Chairman
Ashima Gupta, M.D.
Don Neal, M.D.

DR. THORNBURY: It is 9:02 central time, 10:02 eastern time. This is January 21, 2022. This is the physicians technical advisory committee meeting under the auspices of Title XIX. I am here today with a quorum. Let the minutes show that I am here joined by Dr. Gupta and Dr. Neal. That will give us a quorum today.

We have staff on board. In particular, we want to welcome Cody Hunt. Cody is working with us. And Cody spent a lot of time getting ready. Cody, I really appreciate your work getting ready for today. Thank you very much. You are welcome here.

We have a good attendance today. Let's call the meeting to order. And then our first item will be approval of minutes of the last meeting. Is there a motion to approve?

DR. NEAL: So moved. Dr. Neal.
DR. THORNBURY: Dr. Neal. Second?

DR. GUPTA: I second. Dr. Gupta.

DR. THORNBURY: Dr. Gupta. All in favor without objection.

GROUP: Aye.

DR. THORNBURY: The minutes are approved.

Item III, old business. We have one item for old business. That's the update on DMS Medicaid limits for complex E & M visits. Cody, can you set that up for us, please?

MR. HUNT: Sure. So just to quickly introduce myself. My name is Cody Hunt. And as of December, I am the new health policy manager of the Kentucky Medical Association. So I look forward to getting to know each of you and I look forward to working with you.

So to begin, this is an issue that predates my role here. And it is an issue that this committee has discussed in this space with DMS over the course of the past year and a half. Today the committee would really just like to get an update from DMS on where they are with any potential changes or any considerations that could be coming to the administrative regulation that governs this policy which again is 907 KAR 3:010.
And just to refresh everyone. The problematic portion of this administrative regulation that's been discussed in the past states, quote, except for chemotherapy administration to a recipient under the age of 19, reimbursement for an evaluation and management service with a corresponding CPT code of 929214 or 99215 shall be limited to 2 per recipient per provider per calendar year, end quote.

So during the interim under the direction of Dr. Thornbury, we have looked in to how our surrounding states' Medicaid programs treat complex E & M visits. And we found that the vast majority of them do not appear to have any limitation on these visits. So, of course, we would be happy to share this information with DMS if that would help further the conversation. And with that, I will turn it back over to you, Dr. Thornbury.

DR. THORNBURY: This is an issue that we have brought up a couple of times. And I think the concern here is that I admire when the -- when 10 years ago when this was set up, I admire the general shift of saying, well, we are going to try to limit to our down side if you are an MCO
provider or a partner of ours. But I think at this point what's happened is, particularly in Kentucky, it has become deleterious and it is having the opposite effect. It is demoralizing your primary care. And I am not talking about the maybe clinics out there. I am talking about the people that are doing the serious, the diabetes, the COPD, the hypertension. And that's your primary care workforce.

And what happens is these people come in. They have transportation difficulties getting in. When they do come in, they have literally a litany of things that they want to try to accomplish in one visit. In trying to do that, it may not make sense bureaucratically. So we will just schedule another visit. But when you do that, those things don't occur. These people don't come back. They can't come back. There are multiple problems.

So we end up dealing with multiple complex things in any one visit.

Now government asks us to code properly which is, in coding, when we take care of now with the current recommendation, the current guidelines, when we have 2 stable, chronic medical problems, let's say high blood pressure with thyroid disease
or cholesterol with diabetes. Well, if they are stable, that in and of itself is a 4. Well in my office, we hardly ever get that. I mean we get diabetes, hypertension, their shoulder hurts, and there is something on their skin and they want a refill on this. And that happens, I would say, 4 times before 9:00 o'clock in my office.

And I guess the greater point here is is when you are asking, you know, when you are asking your primary care workforce to shoulder the burden of this and you are not compensating them because of somebody slipped in a nice little modifier to a regulation, well, that, again, that deteriorates the morality of the work that they are doing. And everybody is in on the game and everybody understands this.

And I have heard this over and over again. I think we -- as Cody looked around at surrounding states, when Cody says that, well pretty much none of them are really doing this that means nobody else is doing this. You know, they pulled a fast one here in Kentucky is what it seems like.

Dr. Neal has a lot better perspective than I do. Our emeritus chair, Dr. Neal, can you lend us some wisdom here?
MS. HUGHES: Dr. Thornbury, this is Sharley. I think we have somebody on from DMS that may be able to give you an update from us if you would like.

DR. THORNBURY: I welcome that. If they are prepared, I will turn the floor over to them.

MS. HUGHES: Justin or Jonathan? Justin, did I see you coming on?

MR. DEARINGER: Good morning. My name is Justin Dearinger. I am the assistant director with the division of policy and operations for the Department for Medicaid Services.

And I don't have a concrete update today to give to you. I know that is probably not what you wanted to hear. I can tell you that we have been meeting about this topic, discussing this topic. And I think, I mean, we understand the issue and what the surrounding states are doing. And I think we should have something to come back with you very, very soon.

We are -- the regulation is open. It hasn't been filed with LRC just yet. But the promulgation process has started. We have made some changes. And we will probably most likely --
so he could tell you exactly. But I would assume
that we would send the copy of that draft
regulation to you all to pre-review before we file
that with LRC. And so you all should be seeing
that very shortly.

That's the update that I have.

DR. THORNBURY: We appreciate that, Justin.

Thank you.

MR. DEARINGER: You are welcome.

DR. THORNBURY: I don't want to belabor the
topic. Does anybody else have any thoughts on
this?

DR. NEAL: Bill, am I on mute? Can you hear
me?

DR. THORNBURY: No, I can hear you, Dr. Neal.

DR. NEAL: Yeah. You know, we have debated
and debated this until we are out of breath with
it. And there is no sense in our wasting our time
until we find out if we are going to be happy with
what they are going to send us. Because we are so
far behind it. It is bigger than this because we
are underpaying at 214 levels. So we are ready to
move on with that. But we have got to get to
this. The new guidelines are that 213 should be
about 40 percent of visits. And 214, 60 percent
or vice versa. It keeps changing. And we know that that's gamesmanship that everybody is playing. And we have just got -- Justin, can you at least tell us if you think we are going to be happy with what you are going to advise?

Is he still here?

MR. DEARINGER: I am. I don't think I am really prepared to today. But I think it will be -- I think it will be good. I mean I don't know, you know, in the regulation, in the promulgation process, we have to come to a complete agreement within the department and then within the Cabinet level before we are able to share those because it is an administrative regulation.

If it was a policy change or something like that, it would be a lot easier to, you know, to change just based on conversations and we can do that at a division level.

But because it is a Kentucky administrative regulation, we have to get approval from all of our upper management before we are able to start sharing that with, you know, with our stakeholders.

But I think we are there. We are at that,
you know, we are at that level. We just haven't
got the final, all right, go ahead and send this
out yet. So that's coming very, very soon. And I
don't think there will be a ton of back and forth
on it. I think it will be good. But I really
can't speak a lot to it more than that.

    DR. NEAL: We understand your position.

    Is the Commissioner on with us today or
anybody that can speak to it that is -- anybody
got --

    MR. DEARINGER: I don't see the Commissioner
on today.

    DR. THERIOT: This is Dr. Theriot. And I
just wanted to let you guys know we hear you and
we understand. So Dr. Thornbury, Dr. Gupta, Dr.
Neal, we are, I think, pretty much on the same
page and we are working on it.

    DR. THORNBURY: Thank you, Judy. We really
appreciate that. And I saw you pop in.

    Well, I don't really want to beat this horse
any further. I think we are kind, at least in our
position, we are of like mind here. And, again, I
think we want a more efficient system.

    If it's okay, I would like to just move this
on to new business. Does anybody object to that?
DR. NEAL: No, that's fine.

DR. THORNBURY: Okay. Well, let's go on to new business. We have a couple of things. The first item I asked to bring up was just a presentation on the telehealth Medicaid program. And the only reason I am interested in talking about that, I am not interested in embarrassing anybody or putting anybody in a bad position. I just want DMS to understand that the physicians, in particular I, am committed to trying to lower our cost in Kentucky. And this whole program was designed to try to move us in that direction.

The reason that we brought telehealth in is because I saw that we are going to have to have a more efficient model of delivery. And that's only good if it is working. And if it is not working, then we have got to make some changes. And because 1 in 3 Kentuckians are in this program, it could go bad in a really big way if you go back quickly.

That's why I am interested in talking about this. I am really coming to the physicians, we want to try to help you and try to help understand, at least from our view, are we going in the right direction?
Cody, can you give us an update on this, please?

MR. DEARINGER: Sure.

So to kind of just frame it, provide a general overview going back to 2018, thanks to the leadership of Dr. Thornbury and Senator Alvarado, the General Assembly passed Senate Bill 112 which really enabled Kentucky to be the leader in telehealth policy as we all know. And then of course with the COVID-19 pandemic, we saw the great benefit of telemedicine. And due to this, thanks to the leadership of Representative Frazier and Representative Moser in the General Assembly, made further improvements to our state's telehealth laws by way of House Bill 140.

So today Dr. Thornbury just wanted to see if someone from DMS and CHFS would be able to present or provide an overview of the utilization report that was required by House Bill 140. And further speak to several specific data points about the telehealth program and Medicaid. And we thought that the House Bill 140 report would just be a good starting point for discussing the telehealth data that CHFS has collected.

And I believe the last time, there was a
discussion on telehealth data in this setting. It was nearly a year ago and the state really hadn't had time to truly compile our 2020 data and certainly not the 2021 data.

So with that, I will turn that back over to you, Dr. Thornbury, or Medicaid, whoever wants to chime in.

DR. THORNBURY: Well, thank you, Cody. Again I think the overlying philosophy -- and I received the information. I want to thank DMS for being very forward about that. And I looked through it. It is -- it's -- I don't know what to say about it.

What I am trying to accomplish is moving as much chronic disease care online as we can. I think that is the opportunity that we have for savings. I think trying to move acute care online can save a few dollars. It may save a few dollars. It may cost a few dollars. I just see that as a push.

But I see the real authority is keeping people out of the ER for chronic disease, keeping them out of the hospital for chronic disease, asking the families to obtain care earlier when things are not going well. And, again, there's a
transportation cost that is kind of -- it could be significant but it is kind of nebulous. And I appreciate the fact that we are still into this pretty early. But I want to just open up to our DMS colleagues and see if there is anything that they could do, do they have any guidance on this for us? Do they have any intuition on this? I'll open the floor up for discussion.

MR. DEARINGER: I would like to -- I am going to try to share a screen here. (Ms. Hughes setting up screen share.) All right.

So getting started, this is just a brief presentation on telehealth that we have put together. I want you all to know before we get started that we have quite a bit of other data that we are reviewing that we are looking at specifically in cost savings and cost comparison ratios that we will be able to share at a little bit later date that's not necessarily available today. But we will get started with this.

This is a trend. If you will look at a percent of increase and you will see the 2 data points for dates is March of 2022, August of 2021. And you can see the behavioral or the billing type, provider type. Of course, that's the way we
break things down here in DMS is by provider type. As far as billing goes, and you can see the percentage increase based on that provider type for the telehealth trend. Now this is for fee for service only. It doesn't include MCO data. It means CRBHSOs with the highest percentage increase followed by multi-therapy agencies definitely the top 2. And you can kind of see how it goes down. Even there toward the end, our certified nurse practitioners with 144 percent increase in telehealth usage.

To put that in a just a graph form for visualization, you can see the increase there. Quite a bit of increase and usage.

The next part here was the MCO trend. As you can see with the MCOs, a little different story. Still broken down by billing provider type; individual physicians followed by physician assistants were definitely the top 2 increase percentage-wise. Those are huge increases in the use of telehealth which were good and individual physicians definitely taking advantage of that. So those are some of the trends on who was using telehealth the most, which provider types, which groups, and how big of a percentage increase those
were since 2020.

Again, here is a chart to kind of visualize that just a little bit more. And some different areas showing the increases and growth for different provider types throughout the different data ranges on dates.

We can look at the -- some takeaways; fee for service versus MCO trends. We see for fee for service, the BHSOs are the primary -- had the primary increase in telehealth usage. However, all provider types with fee for service and MCOs both had significant increases in telehealth uses during that time period. For MCOs, individual physicians definitely had the greatest increase in telehealth usage. And we look at for fee for service for the behavioral health organizations, using telehealth to be able to reach individuals that sometimes may not be able to be reached, they may not be able to make it into the office. That was definitely a key takeaway and benefit for their usage in telehealth as it increased throughout that time period.

And that is that presentation.

I also have -- and we will start again with fee for service here. This is a member count,
amount paid and claim amount. And that's just a small graph to kind of show you the fee for service trends during the data ranges. You can kind of see when telehealth started and when the COVID surge hit the hardest, those telehealth numbers, of course, peaked telehealth usage and it has kind of dropped back down. (Ms. Hughes assisting with share screen.)

So, again, just a visualization, a chart, to see the surge in usage, amount paid, claim amount during the COVID surge. And then kind of a drop back down to more baseline I think when individuals started coming back into the offices. This is fee for service.

And I don't know if you all have this information. But if you don't, I will send it to you after this meeting. We break it down by service month on this one. And it has the member count, claim amount, and amount paid. We start March of 2019. We end with November of 2021. And you are able to kind of see from that how the trends went and for fee for service.

We did the same thing with the MCOs. You can see the graph shows a similar story for MCOs. A little higher usage rate continuing. Then fee for
service. Fee for service dropped down a little more than we kind of expected. So you can see that the peak is around the same with the surge in COVID-19. But then we seem to, after that, kind of leveled out, plateaued out, with the usage and claim amount for telehealth with the MCO data compared to the fee for service data which seemed to drop down quite a bit more.

Again, same data points and the data ranges as far as dates there on those slides. So those are 2 of the pieces of information we pulled for fee for service. Also for MCOs.

Again, we have more data that we are reviewing as far as cost savings and comparison on how much money was actually saved on the state side and also on the physicians' side or provider type side. And we will be getting that to you all very shortly.

DR. THORNBURY: Thank you, Justin. I thought that the last slide was particularly good.

I think the 2 things that my takeaway -- what my takeaway was -- firstly with the passage of 112, I don't think anyone -- I can't believe anyone foresaw COVID. And that really put everybody into the bucket. So all of the
providers I think that are out there in Kentucky
now have some type of way to conduct telemedicine.
And we wanted that. We just kind of got thrown
into the deep end of the pool very quickly. So I
think we have been successful in implementing it
much sooner than we thought it would happen.

But the second slide, you know, it looks to
me like now the last 6 months that those claims
have come off, if I recall, maybe there is 50,000
claims. You know, because it has kind of settled
in a little bit different. Maybe the providers in
Kentucky are seeing the role for them that the
virtual clinic is going to provide. You know, it
is not going to solve all of their problems. It
is going to solve some of the problems. We just
wanted to solve it in a way where it is going to
save money.

So I appreciate that. Ashima, Dr. Neal, do
you all have some thoughts on this?

DR. NEAL: Ashima, go ahead. Then I will
speak.

DR. GUPTA: I am here. Yes.

I mean in my personal practice,
ophthalmology, it is very difficult for us to do
telemedicine. We did during the 6 weeks close out
on the beginning of the pandemic for certain cases. But, otherwise, I mean I see very high value in telemedicine. I think that, you know, I totally agree with everything that you are saying.

DR. THORNBURY: Bill?

DR. NEAL: Yes. Well, of course, Bill, you and I have been doing telemedicine for ever since we have been in practice as long as there has been a telephone. And we just didn't -- weren't able to see our patients at that point. So dermatology has come into play there quite a bit.

But, anyway, I think telemedicine probably kept some doors open that couldn't have kept open during COVID because people couldn't come to the office, wouldn't come to the office. And that's still an issue. We still have mothers afraid to bring their children into the office or even their teenagers unless they have to. And it is a real special problem for us because we really can't do much telemedicine for a well child under about age 3 because there is so many things we have to check for.

And the Academy of Pediatrics has come up with guidelines which said if they can come to the office, they need to. They don't need to do
telemedicine. And then a note needs to be made onto the chart when you do telemedicine on a well child, that there were certain things that couldn't be done that need to be followed up in the office. And I am sure Bill understands all of that.

So that's been a real concern. And I just don't want telemedicine to get out of hand. Certainly we are seeing a lot of teenage mental health problems now with COVID, depression and that sort of thing. And telehealth is helping that no doubt. I see there is a bill before the legislature now that has to do with kids missing school because of mental issues. And most of that is going to be a telehealth visit I think.

So there is just a myriad of things that we need to discuss. But we've got to be careful and not let it take the place of the in person visit.

I would love to hear your thoughts on that, Bill.

DR. THORNBURY: My hope is that it won't take the place of the in person visit. My hope, and the way that we worked with this is again more the way Toyota would work with mean systems. They will take the more complicated things that have to
be in the office and place them in the office.
The things that don't need to be in the office
that would just take time and structuring and
logistics, we are going to move those online so
that we can take care the people that need to be
there.

I think if you were a patient, the way that
you would see it was when you called, you could
come in to see the patient or the physician or the
provider today. You wouldn't get put off a couple
of days or a couple of weeks. It would just say,
well, we have room for you.

And that would be the gold standard. And I
think the people that do that work better than
anybody is probably Kaiser out there in
California. KP has done a lot of work in this
area. And about 50 percent of their interactions
are online, at least in primary care that is.

And so if you, over several years if we
mature to that, that would tell me the kinds of
things that need to be seen in the office can be
done in the office.

I don't want to go too far before I say,
Sharley, I do not know what we are going to do
without you. You know, I am just saying. I know
that you will enjoy your retirement. But we are really going to be in a bad spot here.

MS. HUGHES: Well, I appreciate that. But I am sure they will have someone who will probably even do a better job.

DR. THORNBURY: I don't see how, Sharley. I don't see it.

MS. HUGHES: I appreciate that very much.

DR. THORNBURY: Well, you are very welcome.

Cody, you and I have spoken off line a week or so ago about just some things that I would look at intellectually. And these are not things that I think our committee is requesting. I think -- I just want to put this out there for people like Justin in his position so that he can see things the way we see it.

Do you have a few things that I would follow if I was looking at the data as it came in that you would just mention out there just in case they might want to use this?

MR. HUNT: Sure.

One of the metrics that has been discussed in recent publications was success rates of telehealth visits looking specifically at socio-demographic factors, how those are
influencing visits. And then one of the other ones was, we have a way of gauging or a metric to look at the percentage of chronic disease care that's going online.

And then, finally, really just looking at the encounter rate for enrollees, is it going up or down? And then is the cost per enrollee going up or down as it relates to their utilization of telehealth?

DR. THORNBURY: And, Justin, I am sure -- I don't want to step on your toes here -- but that's really what you guys do. And I think what Dr. Neal pointed out earlier is, you know for example, are we seeing more visits just to see more visits? You know, is the average encounter staying about the same or are we able to actually reduce that?

You know, is the average cost -- you know, I am sure we know this -- there are people there that know it to the penny. But is the average cost per encounter, is it over time going down or is it coming up by more than expected?

And so those are kinds of things that we would look at. Again, the last thing is I don't know if you can parse the data. But it would really be important to me if I was on that end to
say, are our chronic disease care encounters as a percentage, are they going up online? Because that would be a good thing.

That would be the fact that the physicians and other health professionals understand it. They have taught this to the families. The families understand how to use it. That would be a very mature way to understand if telemedicine was actually working properly in a place like Kentucky where there is a lot of chronic disease burden.

So we thought we would just pitch those things out there to you in your work to see if that is some type of -- makes some type of sense to you guys. It would be make a lot of sense to me to understand those kind of numbers from year to year.

MR. DEARINGER: No, absolutely. And those are some of the things that are taking just a little bit longer to kind of piece out and put together. But that kind of information, that kind of data is data that we can piece together from claims and other information that we gather. And so putting in a viewable, accessible source to be able to track trends and see what is actually
going on with the cost and who, you know, are chronic patients taking advantage of those type things, what percentages of which types of patients are using these services. All of that information is, you know, we see that as being extremely beneficial data for you all and for us as well. And so we are working on those things.

Those are some of the things, like I said earlier, where we are working on them, just not completely ready to share just yet. But we will be very soon. And so I think those will be very interesting but they will also be very helpful and beneficial for us in creating policy and looking toward a future and I am sure for you all as well.

DR. THORNBURY: Well, we want to keep our commitment to you and to DMS and the administration that, that as we move through this, we are going to try to be equal partners for you to help solve this problem and give you as much insight from our position as we can.

Again, our goal is to try to make this an affordable program for the Commonwealth and sustainable. And I think that not only will you have the interest of us, I think you might have the interest of a lot of people around the
country. Because if we are able to solve this, a lot of different states are going to come in and ask how we did it and what was our secret sauce.

Well, is there anything else on this topic? It sounds like we are at least getting the ball moving. Anything else before we move on?

DR. NEAL: No. I just want to make one quick point.

DR. THORNBURY: Yes, sir.

DR. NEAL: We primary care docs have always been accused of we want to see more patients just to make more money. Well, that's almost laughable because we are just trying to keep our doors open. And it is just a joke. Because just the advent of the electronic medical record took the pediatrician from seeing 40 to 50 patients a day down to 25 or 30 a day.

And though telemedicine has just helped, it doesn't even pay for the electronic medical record cost we are dealing with right now. So this is a really complex thing that we are talking about. So I just want to make that point before we move on. Because, yes, Bill, you said we want to be equal partners with DMS. But we want them to know, I think somebody said, that the physician
component of the Medicaid budget is like 3 percent, some ridiculously small.

Justin, can you give us an answer to that?

MR. DEARINGER: I do not have those numbers in front of me right now but we can get you those.

DR. NEAL: Okay. By the way, I just want you to know with the light behind you, you look like one of the 12 disciples and the light from heaven is coming down behind you. So --

MR. DEARINGER: That was intentional. So --

DR. NEAL: Okay. All right.

MR. DEARINGER: I apologize.

DR. NEAL: We need that light from above right now, believe me.

Okay. We are just feeling in our town of Owensboro we are fighting to try to get primary care providers. And I hate to use that word. Clinicians I will say. Because our access to care is deteriorating. People with COVID, for example, can't even get in to be given the okay to get the antibodies, you know, that sort of thing. It is just really bad.

So you need to know what's happening. And I am in the fourth largest city in the state. What's happening out there in the rural areas?
Bill, you might speak to that a few minutes before we move along. I think it is important.

DR. THORNBURY: Well, I want to respect what we are trying to accomplish. And I don't want to -- I don't want the conversation to seem like we are trying to injure our work partner which is DMS.

DR. NEAL: Oh, I understand.

DR. THORNBURY: Short of generic medications, if I am not mistaken, I think Barbara Starfield's model of, you know, of thorough primary care has never been disproven in 30 years that I have been working. And that would be, the more primary care you had, whether it is on a local level, a regional level, or a state-based level, those health systems are the most -- they are the most economic, which means they provide better outcomes at lower cost and it's never been disproven.

In Kentucky, again, if we are spending 3 percent of our resources on the primary care workforce, the way I would look at that is, we have a real opportunity to try to improve that. Because as you improve that number, you are going to get better outcomes. And I wish I had some hard data for you.
The last time I remember, somebody up in New Jersey did work on this. Jerry Stover with the KAFP, Jerry would know something like this. But those people that did that work showed that for the investment that they put in primary care, they were getting substantial investment down the road as in lower costs and better outcomes. And that's kind of what we want.

It really is laughable to try to think that physicians or other providers are trying to see more patients to generate more money. It is actually the opposite of that. I think we are trying to keep people away from the health system for a number of reasons. And that kind of -- I mean, again, without going to far on this discussion -- it really kind of brings us right into the next step which is how can we help these people do their job because these guys are saving us money.

If I was DMS, that's the way I would look at them. Like these primary care people, they are saving us a bunch of money. What can we do to make their life better? That would be one of my take homes.

I will take us, if it is okay, I will walk us
into our next business item which really dovetails into this which is prior authorizations. Is that okay with everything if we move on here?

DR. NEAL: Yes. Fine.

DR. THORNBURY: So prior authorizations, I woke up this morning and I thought I would just kind of give you a little bit of an example instead of an ethereal, well, you know, yapping about some type of problem that we are having. I want to tell you about a case that really happened yesterday and last night.

So we had a lady come in. And this lady is a beneficiary. And she says -- she tells us she has had like 20 falls in the last week. And when you hear that, she was initially scheduled for something else but she goes I want to talk about this. And we go, well, we want to talk about this, too. And unfortunately this lady has an underlying really serious metabolic problem where she is going to be required to be on some anti-coagulation. And so when those kind of people fall, what you need to understand is, they are at risk for like these serious internal bleeding or bleeding, subdural bleeding from the brain. And that gets to be a very serious issue.
Well, that being said, the first thing we want to try to do was we wanted to say, well, can we get this lady imaged? We are going to have to figure out why she is falling. Looks like she is having some weakness. Maybe she's bleeding in her low back. Maybe it's putting some pressure on the spine. Maybe she's becoming ataxic. She is going to need a CT scan.

And in doing that, you know, we are trying to get a CT scan and some imaging of her low back so that we can keep her out of the ER. Now we can send her to the ER. But they are just going to have to redo the work again. I mean they know the same thing I know. I have done that job. And so they are just going to have to do -- they are going to have to go through this whole thing again. And now we are talking about another fee.

And so there is this thing in my office we call the look. So when I asked my ladies to get this thing scheduled, I get the look back. The look is, well, this is a patient who has Medicaid. You are not going to get anything approved.

And so I said, well, can you do your very best. Can you give it just a shot and we will spend 15 or 20 or 30 minutes on there and say, you
know what, we can't do it. So where do you think
it goes? Well, eventually we have to call the
lady back. Eventually this lady has got to go to
the ER. And now we are into that again.

And so that is the specific. But let me give
the moral of the story. The moral of the story I
think is something like this. I think there are
people in that -- that believe that when you all
put prior authorizations on there, that that's
going to save you money. I thing that in your
heart, you really do believe that. But that's
just a lie that I think you are telling yourself
because that is not what happens at all. You just
pay more for it.

For example, when I want something, well, I
am going to get it done. Now you may not give me
permission to do it but I am going to send them
over to the neurosurgeon and then they are going
to do it. Well, I am going to send them over to
the neurologist and they are going to do it. Or I
am going to have to send them to the ER and they
are going to do it.

And this happens several times a week. I
mean it happens almost on a daily basis. I have
to call the ER and tell them why I am sending them
my patient. I am sending you this patient because I cannot get imaging. You have got to do this. This is why. And invariably, you know, we are of like mind. They have to do the same thing.

And so to me, there is this giant hidden cost that nobody kind of -- I bet you don't even have a handle on it how many times people have to see a primary care person. Then they have to go to another person to get a consultation or an evaluation and then get the same test to get the answer to begin with.

And so not only is it frustrating, again, it is demoralizing and it's costing us money. Now fortunately I think this year in Kentucky that we have kind of come to a position where a lot of other states have come where this, if I am not mistaken, there is a gold card bill out there, something where if 90 percent of your requests are reasonable and appropriate, then we will let you have those things. And I hope that we can come to some type of working position that way again for the whole system.

Don, Ashima, surely you have had some work with this? Can you all comment on your experience please?
DR. NEAL: Ashima, go ahead.

DR. GUPTA: So with my Medicaid patients, I think because I am a specialist, I usually don't have an issue getting the -- like I usually order MRIs for the kids. I don't have a lot of issues. But I see exactly where you are going. And it is so true. And I was just thinking about this month we have had so many staff out sick. And, you know, across the country the staff shortages, it just causes more of a problem. Because, Dr. Thornbury, you are absolutely right. If we want something, we are going to get it one way or the other.

And I don't remember one time when I finally did a peer to peer with an insurance company that it was denied. It is always going to be approved if I have the staff to go through that process and then me, myself, making that extra time sitting at the end of the day to do that peer to peer. It is always approved. And it is just such a pain to have to go through that process and then totally agree, in the end if I can't get it done, that patient is going to the emergency room to get it done.

DR. THORNBURY: Don?
DR. NEAL: Yes.

I spent at least 2 hours reading everything I could online about prior authorization just for this morning. And it would appear that simply prior-authorizations came about in the first place to be sure that we were showing the best clinical judgment, that we were treating patients in the most efficient way that we could, and the best thing for everybody.

But it last morphed now into something where it is costing more to deal with prior authorizations. Big office groups have people that do nothing but get prior authorizations. And it has become a money saving thing, whether we like it or not, on the insurance side. And for those people who have risk contracts, maybe on the physicians' side.

But it looks like we have come to the point where we need to decide are prior authorizations worth it at this point? Because in several of the studies I read last night, it is now costing more to police it than it is to do it. And that's why I don't really see that the gold card idea -- I think we are past that sort of thing. And as Ashima says, she eventually gets all of them done
and that is going to happen.

So I just think a discussion of just forgetting prior authorization. We need the insurance companies to have -- we need to have a big discussion on this I think. That's what I have to say.

DR. THORNBURY: Well, and it kind of depends on where you are sitting. For example, if you are sitting in a position where you are responsible for budgets and you can't stretch the bed sheet around everywhere, you are trying to figure out where you are going to try to save money.

I understand the discussion from a fiscal point of view. But when you get in the trenches, again like Ashima says, well, before that they get to the ophthalmologist, I want to try to have the imaging that is going to allow her to do her work. And how would I know this? Because I have worked with this lady for 15 years. I mean I understand what they are going to want. Or I have spoken to them beforehand. For example, if a patient has got a neurosurgical issue and we are going to consider surgery or not, they are going to want that MRI of the lumbar spine before they walk in. Because if they don't, they are going to say how
are you doing, go get that MRI and come here in a
month and we will talk about it.

So the things are going to get -- it is not
that they are not going to get accomplished. They
are. Now, can you split the hairs in saying,
well, can you go to these baby clinics. Should
the baby clinics be ordering -- should they be
ordering stuff. Well, I don't know about that,
you know. How can we talk about traditional bread
and butter primary care where -- again, these
people are committed. These are like the lifelong
people that are committed to say, any institution,
say since -- saying even DMS. You have people
that are there lifelong. And they work there
every day and they are there year after year. And
they kind of understand the way the system works
and what's going to be efficient.

Where your primary care work force, again,
they are committed in the long term. They are
committed to these communities, these patients.
And I think you are going to -- at some point it
is going to be like CMS. You are going to have to
trust them to either do their job or they can't do
their job.

And, you know, with CMS or traditional CMS, I
don't have trouble getting things. And, you know, when I look at my reports every year it doesn't look to us like, you know, we are overspending or doing things -- anything inappropriate. There is just a certain amount of things that have to be accomplished.

So I guess -- I want to get away from the whining on this. I just want to, you know, help you guys understand what the problem is is that we can't do our work. Again Dr. Neal pointed out, we have somebody in our office that we are paying, nobody is paying for this. When you do a prior authorization, you don't get to bill for that time. They are on the phone or they are on the computer trying to get something approved that we already know is going to have to be approved.

And the question is is how long are we willing to go with that? Are we willing to go 5 minutes, 20 minutes, an hour? And several of these things take -- it takes a long time.

So I think eventually we just get demoralized and we give up like everybody else does and we either send them to the ER or we send them to -- a lot of specialists won't even take them without the imaging. Like, you can't do that. Or we
explain to them or there is a hidden agenda like we say, well, we know you want the imaging but we can't get it. You are going to have to order the imaging. And they do. They go to Ashima or somebody like Ashima and they get the imaging and then they come back and do another appointment.

So I want you to understand from our point of view, when it comes to prior authorization, how difficult that is making our job so that when this comes before you, because at some point when this legislation works its way through, someone from your end is going to have to contribute some information to this process. And I don't think, unless you sit in our shoes for a mile, you would really understand that.

Again, I don't want this to be a -- I don't believe in whining sessions. I don't think they accomplish anything. But I hope that you can understand the frustration that we're having in trying to solve the problems you have asked us to solve. You have asked us to solve these problems and we don't have the tools to do it.

I will just open the floor up at this point. I think we have kind of made our presentation. If anybody wants to chime in or has an idea.
DR. GUPTA: I can make one comment.

I was just thinking it would be interesting to do maybe a study, you know, if DMS agreed to get rid of the prior authorizations for like 5 years and compare the data. That's just a philosophical statement.

DR. NEAL: We have got some MCOs on the zoom right now. I see Aetna. I see Anthem. Could we have them give us a little bit of their perspective? They must be having internal discussions of prior authorizations. They must be dedicating a lot of time and money just to -- dealing with it. And one of them speak up.

MR. GROVES: Ken Groves with Anthem.

I will tell you I do hear the concerns that have been raised. But what we have done with Anthem is that we try to make the process a little bit smoother by presenting on our digital tools doing authorization via ability to speed the process whereby the providers do not have to spend so much time over the phone to make it more digital.

So that's what we have done to enable them to ease some of the burden, you mentioned the burden, for the providers.
DR. CANTOR: This is Dr. Cantor with United Health Care.

Along the same lines, we have a similar portal available online where the clinical information is entered and the decision can be rendered right then and there if it is an approval. If it becomes a denial, then that would go through the typical process. But that has been -- it is available. And if you need more information about that, I am happy to share that.

The other aspect of this is managing populations which is what we are tasked with is when we look at it from a population health perspective, there is enormous variation in clinical decision-making whether you look at allergists or obstetricians and anybody in between. There are not, unfortunately, appropriate standards of care that is met consistently by physician to physician to physician. And therein has been the rub in that because there are such variations, it is because physicians, and I will include myself as one, have not been policing ourselves well enough it's created this managed care opportunity, and we can
go down this whole historical vent which I am really not trying to do.

But my point is that unfortunately there are physicians who do not practice to the highest levels of standards of care. And that's part of the process of having a PA.

Thank you.

MR. GROVES: This is Ken Groves again from Anthem. Second, the sentiment, second, (Zoom audio difficulty) on our end when a member or patient needs certain tests that do not have that, cannot have that done and end up in the emergency department when the ER provider, I would like to get this test done, I would like if it's an outpatient like the doctor wanted and you hit a road block to get the prior-auth that way. I think my advice is, you know, when dealing with claims prior-auth, a lot of times things go undocumented as far as what the guideline require (Zoom audio difficulty). And my advice is to clearly document those things to speed the process.

We are always available. Obviously we are peer to peers and, where appropriate, overturn things. But I think part of the PA process was
designed to cut down on the waste. The vast majority of physicians are not wasting. They are not in that category. But there is a percentage that are kind of. And better care, lower costs is part of the process.

DR. THORNBURY: I would like to thank our MCO colleagues for their insight. My takeaway on this is, unfortunately, that I think what might be happening is you are letting the exception make the rule. I think there are a great many people that do follow the choosing wisely campaign and do take their work very seriously and are trying to work with not only you guys but the entire system to make this not only efficient but sustainable.

I think there are some people that may not be fully competent in the roles that they are in. I think they may not be competent in the literature. But I think unfortunately I think what happened is, my gut is having worked in this field now for about 25 years, is that those people are now making the entire rule for everyone. And it is causing -- it is become to -- it is, again, I know that you all believe that you are saving money. But you know what I would like? If I was in that job, you know what I would like to do? For every
denial, I would like to go back and find out when
I had a denial, I would like to go down and look
say 3 months later, well, did that patient
eventually end up having it done and how many
people did they have to go to get that thing done.

Because I would bet you, again much like
Ashima, when we want something accomplished, it is
going to get accomplish. It is going to take more
money and it is going to be more problems. It is
not going to be as convenient. But it is going to
get accomplished. If we have to have imaging, it
is going to have to be done by a specialist and
then we will have to have another appointment to
discuss it. Or just going to have to go over to
the ER because we can't get it today or tomorrow
or may have, whatever it is, 72 hours to decide.

So I think it is unfortunate. And then
hence, I think that's why we are talking about
statute today. That's why we have something in
front of the legislature because we can't work
this out ourselves. If we could, I guess we would
have already worked it out.

Are there any other comments before we finish
up? I don't see that talking about this any
further is going to accomplish anything.
MS. PARKER: If I may, this is Angie Parker with Medicaid. I just wanted to say that, you know, in the past 2 years during COVID, we have waived prior authorization on a lot of services. And currently it is still waived on behavioral health.

So we have been looking at that. I don't have all of the data in front of me as far as what that's looked at so far. But we are looking at the data of where we have waived PAs and should have more information on that at some point.

But generally, we have seen an increase in services without the PA. But, again, I don't have all of those specifics here to provide you. But it is being evaluated by Medicaid.

DR. THORNBURY: Thank you, Angie.

And I want to go on the record here to say that people that don't understand the imaging that they are ordering, that don't understand this, are not competent, I don't think they should be doing that. I am just going to say that up front. You know, I don't think that people should just be able to order whatever you want, whenever you want, whomever you want. I am not saying that.

What I am saying is is we need to try to find
a system to allow the people that are doing the
work for you guys to do their work and do it in a
way that it still addresses the principles of
population health and accomplishes the work on the
front end so that people like us can try to help
you guys.

Don, Ashima, do you have anything else before
we close it up here?

DR. GUPTA: Not about this. But --

DR. THORNBURY: Yeah. We still have another
item, don't we?

DR. GUPTA: Yeah. It is not on this agenda.

DR. THORNBURY: Yes. We do. We do have the
item. And that would be item 3.

Cody, do you have that for us? It didn't
make this but we did approve it.

MR. HURT: Yes. So as Dr. Gupta wanted to
discuss the Medicaid coverage of serum tears.

DR. GUPTA: Yes. Thank you.

So actually the Kentucky Academy of Eye
Physicians and Surgeons reached out to me last
week because I guess apparently CMTRs are not
currently paid for my Medicaid. And I asked them
some follow-up questions and unfortunately still
have not received that feedback. But just to give
a little education about that.

The CMTRs are basically using a patient's own blood. And it is just spun down and made into a tear slum, teardrop form, and used in severe dry eye, especially in patients who may have certain autoimmunities and have failed all other dry eye treatment. It is kind of like the last resort type of treatment. And it can be very successful.

So I asked them, you know, I don't know how much the out-of-pocket cost of that for a patient and I am still waiting to hear back on that. And I guess we could table this until the next meeting. But if you have -- anyone from DMS have any other questions that I could pose back to that group just so I can, you know, better give a recommendation at the next meeting, that would be great.

MS. HUGHES: Dr. Gupta, this is Sharley. And I definitely don't have questions because I am not familiar at all with this.

But since this is a question regarding coverage of procedure and stuff, if you could provide me with that information once you get it from the association, we can go ahead and start working on looking into this and maybe have you an
answer by the next meeting before that instead of you waiting until the next meeting to give us the information. So --

        DR. GUPTA: Okay. That would be better.

        MS. HUGHES: Yeah. If you could get all of that to me, then I could get it to the policy folks, and one of those would be Justin, and we can start looking into it and maybe them give you a heads-up even before the next meeting.

        DR. GUPTA: Okay. That would be great.

Thank you, Sharley.

        MS. HUGHES: You are more than welcome.

        DR. GUPTA: That's all I have.

        DR. THORNBURY: Very good, Ashima. Is there any new business today then? No new business.

So let's take a look here. I don't think we need to do any recommendations for the prior authorizations because I think we have something before the legislature this time. I certainly want to appreciate our DMS colleagues working with us on the telehealth program. There is nothing there. Do we not have -- Cody, does anybody recall if we have something before the MAC? Ashima, do we have something before the MAC on complex E & M? I thought we already did.
DR. GUPTA: I think we did I feel like 2 meetings ago, one or two meetings ago.

DR. THORNBURY: I think so. And with the department kind of working on that already, I don't really want to press that button any further. I appreciate them helping us.

So I think -- I don't -- I am not going to recommend any recommendations at this point. Our next meeting is, let's see, is that correct, Friday, March 18, 2022. Is that the right date?

MS. HUGHES: I am looking here just to verify.

DR. THORNBURY: I think so. I didn't check it before I got on, though.

DR. GUPTA: Dr. Thornbury?

DR. THORNBURY: Yes, ma'am.

DR. GUPTA: I am sorry. I think we did at the last MAC meeting, I think we did make a recommendation about the contact lens coverage for adult patients. I am not sure if we heard anything back from DMS yet. So I just ask if they could follow up on that.

DR. THORNBURY: Well, yeah. I think what we will do is we will just kind of, Cody, just kind of bring that in as old business so we can just
kind of -- just do a quick catch-up when we have our next meeting on item number 1 which is the complex E & M. And that way we can see where those -- where our colleagues are at. Okay?

MR. HUNT: Okay.

DR. THORNBURY: Okay. If there is nothing else, I'll ask for a motion to adjourn.

DR. GUPTA: So moved. Dr. Gupta.

DR. THORNBURY: Dr. Neal, I can't hear you. I think you are muted.

DR. NEAL: Can you hear me now?

DR. THORNBURY: I can hear you now.

DR. NEAL: Okay. Sorry. Somebody muted me. It wasn't my wife. I don't know who it was. When is the next MAC meeting and is it real or virtual?

MS. HUGHES: The next MAC is next Thursday the 27th. And it is virtual, yes.

DR. NEAL: It is virtual? Okay. Perfect.

MS. HUGHES: Yes. I think they voted to do their January and March meetings virtual and they would look at March whether they would do their May in person or virtual.

DR. NEAL: Okay. That's fine. So I would then move we adjourn if that's what you would like, Mr. Chair.
DR. THORNBURY: I think so. Thank you everybody and enjoy your weekend, okay.
CERTIFICATE

STATE OF KENTUCKY
COUNTY OF FRANKLIN

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

Given under my hand as notary public aforesaid, this the 26th day of January, 2022.

_______________________________
Georgene R. Scrivner
Notary Public - ID 625481
State of Kentucky at Large
CCR#20042109

My Commission Expires: 7/15/2023