TECHNICAL ADVISORY COMMITTEE 
ON PHYSICIAN SERVICES 

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Via Videoconference 
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Commencing at 10:04 a.m.

Shana W. Spencer, RPR, CRR 
Court Reporter
APPEARANCES

BOARD MEMBERS:

  William Thornbury, Jr., MD, Chair
  William McIntyre, MD, Vice Chair
  Ashima Gupta, MD
  Don Neel, MD
  Tuyen Tran, MD (not present)
DR. THORNBURY: I'd like to call this meeting to order. Can everyone hear me? (Yes.)

DR. THORNBURY: Thank you. I want to make certain my volume is okay. This is the July 2021 meeting of the Physician's Technical Advisory Committee. I believe we meet every Title XIX.

We have a pretty heavy agenda today, and I want to thank everybody, in particular Commissioner Lee, for joining us. As a privilege of the chair, I'm going to move the KenPAC issue up firstly. That's particularly engaging our commissioner.

If we could, would you like to set that up for us, somebody?

DR. GUPTA: Well, I asked that it be on it because Dr. Neel was telling me about it, and I thought it was a great idea. So, you know, this whole time -- I know all of us think about reimbursement -- I've been trying to brainstorm ways to try to increase the Medicaid budget that could also help keep good doctors in Kentucky. So Dr. Neel had agreed to tell us a little bit about it.
DR. NEEL: Sure. Would you like me to do that now?

DR. THORNBURY: Please.

DR. NEEL: Yes? Okay. I will have forgotten some of the years that were involved, but the point is KenPAC was created to try to provide a medical home and better access to care for our Medicaid children primarily.

And so the legislature agreed to a three-dollar per member per month and subsequently $4 per member per month for children or recipients to be assigned to a physician that would then provide a medical home so that Medicaid patients would not wander around trying to find a place to go and have a known home that they could.

For children, for example, it was to be sure that they had their immunizations, to be sure that they had their Well-Child checks, to be sure that they had a place they could go when they have illness. So that was the idea.

And so it was particularly for those of us that were out in smaller towns. I was in
Owensboro, which wasn't particularly a smaller town. But I had a large Medicaid practice. Like, 75 percent of my practice was Medicaid. In Louisville, for example, very few physicians even took Medicaid, pediatricians in particular.

This program, we thought, worked quite well. The problem was we were the first state, I believe -- and Lisa can correct me if she wants -- to really set up such a statewide program. It worked fairly well.

The problem was a fellow named Tom Badgett and I worked through about three different administrations trying to increase the value to the State and to the recipients of KenPAC in that we wanted to make sure that the physicians were earning that.

There were a lot of people in the legislature and others who thought that this was just extra payment to doctors that really wasn't necessary. A lot of us thought the opposite. And we tried to get in certain requirements, which were not really laid out in the legislation, that would make sure that those KenPAC physicians provided a better
quality care to those children and others.

When -- when the MCOs were being considered -- and Steve Beshear was governor at that time -- the governors were going to meetings that were showing -- and to make it, I think, kind of simple, if they could put Medicaid on budget and go to a Medicaid-managed care system, it would be much better than having the legislature have to consider each year how to increase the dollars for Medicaid.

I met with the governor at that time and tried to assure him that four dollars per member per month, which he didn't see as much money, when you multiplied that by several thousand that some of us had in patients, it was quite important as a way to keep our doors open. Because Medicaid reimbursement was just not enough, especially as EMRs and that sort of thing were starting to come to be the norm of practice, and they were very expensive.

So I was not able to convince him of that. And I think Eric Friedlander was part of the decision that was made, and he's
secretary now. And I could understand the thinking because they thought that as the MCOs took over, they would increase fees, I suppose, to primary care physicians. That didn't really happen except with WellCare.

And WellCare put together a number of us physicians, primary care, particularly pediatricians, in several groups particularly in western Kentucky. And we agreed to bump up the level of care for the patients we were taking care of.

And so WellCare actually continued to pay a number of physicians and groups a per member per month. They were able to do that on their own, and they thought that it was useful for providing better care. And I think they may, in fact, still be doing that in some small measure.

So, anyway, when MCOs took over, then KenPAC disappeared from Kentucky. It was kind of -- the idea was stolen by North Carolina, and they were given credit for being the first state, which they were not.

And for a number of years, they did a per member per month which worked quite well,
and I'm quite familiar with things that have
gone on there. It's become a bit of a
problem for North Carolina.

Another state or two has done something
similar. And in Florida, what they
decided -- where I've been recently working.
They decided that they would do it in a
different way, and what they did was they
bumped up pediatrics, family practice, and OB
to Medicare rates.

They did not do that for all the other
physicians, but they felt that that would
help access to care. So in a way, that's
kind of a KenPAC-type thing that they did.

So we thought that because practices
particularly in our small towns in Kentucky
are having difficulty financially, EMR is
costing a lot of money, they need some way to
provide access to care for our Medicaid
children in particular and to keep their
doors open. I couldn't have kept my doors
open in Owensboro had it not been for KenPAC.

So that's one reason we wanted to bring
it up, and I'd love for Lisa to comment
because she knew what was going on back then,
too. And I'll be glad to answer any
questions. Go ahead.

COMMISSIONER LEE: Thank you for
that history, Dr. Neel, and you're correct.
We did have a KenPAC model that started in
1986 in Kentucky. It was called KenPAC. It
was called Kentucky Patient Access to Care.
The whole idea behind KenPAC, as Dr. Neel
pointed out, was to ensure that individuals
had access to a primary care doctor. And we
did pay -- the department paid the providers
paid a per member per month for individuals.

And, again, the premise was that
individuals would have access to a primary
care doctor, and that additional funding,
that per member per month would be used to
help facilitate care management and ensure
quality of care.

And so -- and it worked very well for
those providers like Dr. Neel who really
took -- and take the Medicaid program
seriously and who believe in this program and
think that it makes a difference in the lives
of those we serve.

So it did work fairly well. However, we
did see a continual increase in the cost of providing care for Medicaid members. So from 1986 up to about 1997 -- 1997 was when managed care was first introduced into the state of Kentucky, and we had two regions. The state was broken up into eight regions, and the thought back was in 1997 was to get one managed care organization per region and let them manage the care of the Medicaid member.

So two MCOs came up. One, as we all know, was Passport in region three and then we had another region, region five. And I think that was -- Kentucky Health Select maybe was the name of it. And Kentucky Health Select in region five could not make it, so they bowed out and then we had Passport up until -- as the only MCO up until 2011.

And in 2011, the Department made a decision to go Medicaid managed care statewide, and part of that reason was budgetary. We could have that per member per month to the MCOs, and we would be able to have a predictable budget.
And when we did that, when we moved to managed care statewide full-time, there -- you know, CMS states that Medicaid -- the Department of Medicaid Services cannot pay providers for services that are included in the MCO array of services.

So the KenPAC program was eliminated. And as Dr. Neel said, providers can still work with the managed care organizations to get that per member per month and implement some quality measures and have some sort of goals that they have to meet in order to receive that per member per month.

So providers can contract with their MCOs and negotiate to get some of those per-member-per-month rates back in there. But, again, they would have quality measures or some sort of measurable activities, goals that the providers would have to meet.

And this is allowed under the contract. We have in the MCO contract that they can engage in or negotiate value-based purchasing contracts with their provider groups that they have. So there is an opportunity for providers to start doing that.
And I think, based on my perspective and where I sit, I don't know that we have any baseline data, for example. Where do we -- where do we want to move that healthcare needle? What do we see is the biggest issue in the healthcare delivery system right now as it relates to the Medicaid member? How can we engage our managed care organizations? And what do we need to measure, and how can we start reporting out?

And I think that that's what I would look to this group to do, is kind of help us. You know, Medicaid managed care has been statewide now -- this November, it will be ten years that Medicaid managed care has been in operation statewide in Kentucky. And I would like to have some sort of information, some sort of data to report out to say how we've moved the healthcare needle, if we have, in that ten years.

I think it's very important for us to sit back and evaluate what the department is doing as far as moving the healthcare needle in the state, and I don't think that's something we've done a lot of. So I would
look to the physicians TAC to kind of help us
design some sort of reports that we can start
saying how we're moving the healthcare
needle. You know, what are we doing that is
positively impacting? What sort of
interventions could we do that may assist us
in furthering our objective of improving the
lives of those we serve?

And I think that that's where the
Department historically has been lacking, is
identifying that information and measuring
and reporting out. And, of course, I think
that the physicians on this TAC have the
expertise in deciding and helping us prepare
some sort of report.

What should we look at? What would we
want to look at ten years ago versus today to
see if we've made an improvement, and do we
have some long-term goals and some short-term
goals that we can reach?

And it's not only us measuring. It's
what can we hold our MCOs accountable for.
What can we ask them to do and that -- again,
that's measurable that we can hold them
accountable. And I think that that's where
I'm coming from, is I think that we all are here for the same reason, and that's, again, to improve the lives of those we serve. But unless we start documenting and measuring, we don't know how well we're doing it.

So I think I'll stop there and open it up for some discussion about, you know, maybe some ideas -- we're not going to solve everything right now today and have a really big reporting format. But if we can start designing those reports and how we measure -- and, you know, Medicaid serves almost 1.6 million individuals right now.

And we have historical data that we can even go back in and look and say, here's what was happening in 2010. Here's our baseline data, you know, number of people who inappropriately used the ER, for example. And here as to medications, are they actually filling their medications?

And we now have the Kentucky Health Information Exchange, so we have access to additional information that we can pull in related to our Medicaid members.

So I think, you know -- again, I'll stop
and open it up for a discussion on that

   topic.

   DR. THORNBURY: Dr. Neel, do you

   have a retort?

   DR. NEEL: Well, no. That was an

   excellent presentation by Lisa, and I am so

   excited to hear that they would like to

   participate with us or whoever to do that.

   I sit on the Quality Care Committee for

   Aetna, and have for several years, for the

   MCO that they have. And they have volumes of

   data related to quality of care, because I

   never -- I know every month, we get reports

   that are 50 pages. It's like drinking from a

   firehose, trying to assimilate all of that,

   and I wonder if we could work with them. I

   don't know how much of that information is

   proprietary. I hope not.

   And I wonder, Lisa, if we could work

   with them. I guess they report some of that

   data to you. But the KMA and the TAC

   committee wouldn't be able to do it without

   help from somebody.

   COMMISSIONER LEE: So the MCOs do

   report -- I think they have about 73 reports
that they send to the Department For Medicaid Services. Some of it does have proprietary information, but most of it is not.

    I think a starting point would be to see what reports the MCOs are submitting to the Department now that may be useful for this TAC to review. And we can also design our own report based on our claims data because we have all the encounter claims from every MCO. We have the pharmacy data.

    And then we could have -- at this presentation, it may be good to have a presentation from KHIE, Kentucky Health Information Exchange, to see what sort of data is in there that we could pull into Medicaid to start designing those reports.

    For example, I know that KHIE does contain discharge data from hospitals, so we would be able to get that information and kind of start looking at, you know, how do we get a really good picture of the Medicaid member and their health status now -- or in 2010, now, and what do we want to see that health status going forward.

    So I think a couple of options again are
looking at the reports that the MCOs give us
to find out which ones would be useful for
this TAC, design our own reports for this TAC
to kind of start measuring and starting out
small so that we can kind of figure out where
we need to dig into that data.

And we can also start looking at, you
know, regional differences. What does the
health status look like in eastern Kentucky
versus western Kentucky? I think we might
find some vast differences.

So it could be that as we move forward
and we talk about improving the health
status, that we look at very specific
regional differences and maybe interventions
in one region versus different interventions
in another region so --

DR. THORNBURY: In moving toward
these Q/A measures, one consideration,
Commissioner Lee and Dr. Neel, might be to
try to align these things with what CMS is
already doing. I know that our practice
works with an ACO, and we're a primary care
practice. So there are just an innumerable
amount of things you can look at, as you can
appreciate, Dr. Neel.

But if we can align -- I mean, the Government has done a lot of this work. And, again, I don't want to try to reinvent the wheel here. But if we could try to put some -- what we might say would be in Kentucky very critical things. Like, you know, we're No. 1 in colon cancer, so our patients getting colon scopes. We're No. 1 in lung cancer, smoking cessation, you know, diabetes.

There might be four or five measures that we could very easily start with that might be helpful to the Commonwealth and then helpful to the physicians to try to help us. That's just a suggestion there as we move through that.

Would that be -- what do you all think about that idea?

DR. NEEL: I think that --

COMMISSIONER LEE: I agree with you. There's no sense in inventing (sic) the wheel. Whatever we have access out there to that we can get that will help us go forward. But, yeah, I think that the -- at the very --
you know, defining that baseline and where we want to move from there is going to be critical, and I don't know that that's out there.

I know that we have -- you know, that we are -- as you said, we have a high incident rate of colon cancer, lung cancer. So getting that baseline in the Medicaid population, how many of those individuals, and then moving forward from there.

DR. THORNBURY: Amber, perhaps, since we're all on the same page here, would we be able to kind of have you help us work with our DMS colleagues and maybe some of the medical directors to see if we can put together a short list of, say, you know, maybe five things or a few more and bring it back to the meeting and see if we can all kind of come to terms on it so that everybody could be agreeable and then we'll try to work through our -- via desk colleagues, to try to work through them and decide if we can implement these things.

What do you think about that? Would that be doable for you, Amber?
MS. LAFLIN: Sure. I may not have -- I am new to this role, so I may not have all the appropriate contacts right now. But I can certainly hopefully reach out to someone in the commissioner's officer and try to see who we need to get involved. And then also, of course, with -- if there are certain things you do want to look at, if you want to provide that input as well.

DR. THORNBURY: Well, I do think if you have access in your position to some of the ACOs in Kentucky, if we have a phone call we could make to them. Because their quality committees have already -- they've tightened these things up over a few years. That might give us a jumping place to start off of.

And then again, we would want our chief medical officers in each of these MCOs to kind of chime in to say, well, these are special issues to us. And then I think the last word really is -- comes from DMS here to say, well, in the Commonwealth, we're looking out for our interests, and this is what the Commonwealth's interests are. And then just boil that down to something we can begin from.
and then take that -- take that forward, if
that's okay, Amber.

It's going to be a lot of phone calls
between now and our next meeting in
September, but I think that might be the way
to start the conversation.

Dr. Neel, would that be agreeable to
you, sir?

DR. NEEL: I think that would be
great. I'm worried particularly, and always
have been, about access to specialty care.
And that -- the way they report it, the MCOs,
it looks like they have good access to care.
But when you start to drill down, you find
out they don't.

And I wonder if some of our problems
with, you know, people getting checked for
colon cancer, et cetera, have to do with
access to care. And, Lisa, we've talked
about that forever. Those were questions
that kept coming up 20 years ago. And I
think that we need to work -- and that's one
of the things we need to chip away at.

DR. THORNBURY: Well, I don't want
to foreshadow our next topic, and that's
going to come right into there.

Commissioner Lee, would that -- would our initial plan, would that be agreeable to you?

COMMISSIONER LEE: Yes. I think it would, Dr. Thornbury. And, again, I think getting the information and the data and start reporting that out so we can all see it. And then -- I think you mentioned the medical directors of the MCOs. I do know that Dr. Terry O here in the department also meets with the medical directors. And I think how do we get this group aligned with that group so that we all agree going forward, you know, making those recommendations and agreeing on what we need to do. I think it's a good plan.

MR. THORNBURY: Yes, ma'am. I think we'll have to work with Dr. Terry O to help us. In this particular problem, we're going to have a common vision. And since everybody is an equal stakeholder, I think that if we can help him help us work together -- because we're going to have our ideas.
But, Amber, you may have to kind of be the catalyst between all of that; okay?

Commissioner Lee, I know you have a tight schedule, so I'm going to move us along. Our next topic really dovetails into this. And I know if you can't stay, I understand that.

Is there -- can I move us on here for the --

COMMISSIONER LEE: Absolutely. You can move us on, and I'll stay for a few more minutes and interject as I can.

DR. THORNBURY: Well, our -- I want to bring us to our first item, Item I on the agenda, which was the Medicaid limits on E&M office visits and chronic care, which was 907 -- the administrative regulations that are in front of you there.

I guess this has been going on since '07-'08. And Dr. Neel kind of foreshadowed the difficulty, that we've come to a position in our community here where, based on the new coding standards, the -- in a lot of the primary care fields, the 99214 has become much more prominent to be compliant with
correct coding.

And I guess distilling it down to something very simple for the physician's point of view, it's kind of like going to the gas station the first couple times a year, and you pay full price. And then every time that you go after that, you just expect a discount. You know, I can get a full tank of gas, but you're going to give it to me at less.

And the problem, I think, we're having here in Kentucky is after this devastating COVID epidemic, is we have a lot of practices, particularly primary care practices, that are struggling to stay afloat.

And I think, if I understand this correct, what the CMS' intent on changing the coding was to support the work that primary care -- because the way coding -- the way CPT codes were billed, it really doesn't reflect all the work that primary care does. It really reflects more specialty work.

So I want to walk this forward a little bit, with Dr. Neel pointing out that what's
happened in my community and others, as I understand it, when you pay substantially less for these Medicaid patients, what happens is the specialists won't see them. And that means that the primary care is not only doing their work, but now they're doing the work of the specialist. And commensurate with that extra work is an extra liability.

And what we are seeing in our practice is we just can't get approval, for example, say, for imaging. If you want us to do the work of some type of -- the specialist would do -- I'm going to give you an example. Say, a headache, and they have a chronic headache. So you have to do some type of imaging.

Well, we can't get approval for that imaging, so now we're taking liability. And we're not being paid the same and then our specialists won't see these patients. You can kind of see the problem.

We could -- physicians are always going to whine about money. I get that. But the problem here now is an equity issue, and so let me make my case. The case here is that now we have populations in a rural area. We
have populations specifically of color that now do not have access. They don't have equal access, not only to primary care. They don't have equal access, we believe, now to specialists.

And because of these -- I can only describe these -- I don't mean to be too harsh here, but they're just capricious. I mean, this is -- these things don't make any sense for our point of view, and now we -- it kind of works its way down the line. We can't -- we don't have the income to staff properly. We don't have staff. That means we can't take these patients in.

You can see the innumerable effects, and I don't want to opine too much on that. And I'll open the floor up. But I guess what we're saying is we've kind of come to the end of this, and we've gone as far as really we can -- we cannot go any further.

We're going to have to have this changed, and we're going to have to use this committee to forward our ideas to the MAC to say, listen, this is -- this is just not tenable.
Am I -- I'll ask my physician colleagues. Am I summarizing this correctly? Or, Amber, do you have a thought here?

MS. LAFLIN: No. I think we hear about this a lot, about this limitation. It's questioned, I think, kind of just where did this come from. What's the justification for this? And, you know, a lot of questions. Like you said, a lot of chronic care. It has a lot of chronic care management implications.

You know, we're hearing more and more that the cases that a lot of the primary care physicians are dealing with are not simple. They are complex. They're multiple problems, a lot of behavioral health problems included.

So this -- we are getting a lot of questions on kind of the genesis of this, why it exists. And, you know, it is a limitation for physicians trying to provide that high level of care throughout the year.

DR. NEEL: Don Neel. I would like to say, it's obvious where this came from. This was to save money, and I understand in the beginning. But the game has changed
since then. And most studies now report that for sick visits, 99214s should be about 40 percent of the visits, and 60 percent would be 99213s.

And so in the old days, they didn't reduce it to a 99213. They just didn't pay it. Medicaid didn't pay it. So most of the pediatricians in Kentucky just quit trying to code the 99214, so the older ones got out of the habit of doing that. But now it's changed.

And, Lisa, it seems to me this is going to require, I guess, a statutory change. Do we have a chance of getting that done?

COMMISSIONER LEE: I understand what you're saying. I understand that Medicaid members, many of them are more complex. And I think if you look in there in that very first statement, except for chemotherapy administration. So we understand that there should be some exceptions. And I think, again, what does our data tell us? Where -- are there other -- for example, besides chemotherapy, other diagnosis codes that we should consider
Dr. Neel, you mentioned some national studies and documents that have been done on this. What are we seeing? What does the data tell us? What's been done at the national level? Do other states limit these codes? Is it just Kentucky?

And in Medicaid, I wish we could -- you know, I had somebody that could sit and just focus on this one little topic, but we have -- you know, our bandwidth is not that large, so anything that this TAC can do to help us.

We've outlined the issue, which is we believe that the limitations on 99214 and 99215 should be lifted. So now we need to lay out our argument. Why is that? Is it for everybody? Is it just for some specific diagnosis codes, and how do we ensure that we -- that the providers are coding correctly?

I know that, Dr. Thornbury, you had mentioned, you know, correct coding. How do we ensure that our providers continue to code and don't just up-code in order to get the
rates? I'm not saying that every provider is
going to do that, but we know that there may
be one or two out there that are -- that may
do that.

But I think that our ultimate goal is to
do what is best for our member. You all know
my philosophy is the Medicaid program was
created for the Medicaid member. We can't
take care of our providers -- our members if
we don't take care of our providers.

So let's just kind of -- let's kind of
look and see what we can do and how we can
start chipping away at this so that we do
build a healthcare system that is actually
treating our members at the right time and
the right place and that our providers can
accurately code what they're doing.

So, again, I think, looking at -- first
of all, looking at specific diagnosis codes.
Maybe should we have the -- we have an
exception in there. Does it make sense for
us to have more exceptions right now rather
than just kind of lift the limit altogether,
or what do we propose? And I think that I
look to this body of experts to kind of help
guide that policy. That's why you're here, is to make those recommendations. Let us look at it. Look at the impact on the program and our members and providers and go forth and do good, as I say.

So does it sound like -- and it sounds like to me that, yes, Dr. Neel, it will require a statute change. But what documentation and support do we have that will help us get that statute changed and within the constraints that we have, that we're operating with today.

DR. NEEL: Okay. Are the MCOs now allowed to pay more? Even though this is in the statute, are they allowed to make that change or not?

COMMISSIONER LEE: Well, you know, I think that the MCOs could pay, but based on the way -- and I know enough about all this just to be a little bit dangerous. I'm up here at this high level. But I think -- I think that what would happen is the MCOs could pay. They absolutely could.

But I think what would happen is that where we look at their medical loss ratio,
when we're looking at the way they operate
their program, for those codes that are over
the limit and that they paid more money
for -- in the 99214, 99215, those that are
over the limit, we, then, in calculating
their medical loss ratio, would look at them
as a 99213. I believe that's the way that
would happen. So, again --

DR. NEEL: They would then want
more per-member-per-month money?

COMMISSIONER LEE: Yes.

DR. NEEL: Okay. I got it.

COMMISSIONER LEE: So that's the
way that would work. But, again, what are
other states or -- and what does Medicare do?
I mean, are there limitations, and why is
this in here? Is it just arbitrary and
capricious, as Dr. Thornbury said? In
Medicaid, are other states doing that?

But what argument do we make, and how do
we -- again, what sort of parameters could we
put in place to ensure that providers don't
up-code just to get more money.

DR. THORNBURY: Let me -- let me
try to chime in here and do a little bit of
education. So seeing your very high level of looking at how we provide care to the Commonwealth, from a primary care -- from a more granular level, this is generally what we see.

In primary care in Kentucky, they don't come in with a specific generally diagnosis. With our offices, what we see with adult primary care is they come for their diabetes, their hypertension, dyslipidemia. And a lot of times, we're handling their gout and thyroid. So we really have four and five diagnoses at a time.

Now, the current coding standards say if you have two chronic diseases and they're stable, well, that's your four right there. So what this means is in my office, well, I mean, about every patient that comes in is a four, essentially. It's almost a hundred percent. I mean, you would -- you would have to go out of your way to try to down-code.

And you said: What happens to the 99213s? Well, they can't even come in. We can't even get them in because the people are so sick. They come in with -- you know,
we -- I mean, I don't want to be too -- we use an IV therapy system at the hospital to basically run a semi-ER. The people that are coming in, they're so ill now.

And then the acuity is so high that I think that what CMS has said is they understand that the primary care force across the country has been devastated. And these coding standards were never designed for primary care because primary care does a lot of things. They're providing prior authorization. They're doing social work. There's just a number of things, as I know you are well aware of.

The problem has been is they're trying to say, well, this is one way that we can try to compensate the work that is not actually being presented. When you go to see a gastroenterologist, you're seeing one particular CPT code. It may or may not be stable.

Well, that's a highly unusual thing in my office. I mean, again, there are three, four, five, six, seven -- they will -- it's like going to Walmart with ten dollars.
They're going to try to get as much as they can even if they can't remember it all.

And to answer your point, if I'm not mistaken, I mean, we have auditors in our office all the time that -- and I assume the MCOs do the same thing with everybody else, that they're reviewing our coding.

But, I mean, in primary care now, our acuity in Kentucky has become so difficult. It's not a specific CPT code. It's -- they come in with multiple codes. And then -- and, again, just to try to be compliant with correct coding, these things are very heavily weighted.

And I guess what we're trying to communicate to you is the back of your primary care workforce has just been broken. I mean, they can -- they're just not -- it's just not tenable anymore. The question is: How many more practices are we going to lose? That's not clear to us.

But there's just no way that we -- that I can see -- again, I think we've gone -- I think we're telling you we've gone really further than we probably should have gone.
And the question is: What are going to be the implications? Because they're going to be difficult. We're already having difficulty getting specialists to see the patients, and so we're now taking all that speciality care on.

As complicated as that has become, we've become -- primary care in Kentucky, to me, is no longer cough and cold. Have you gotten your tetanus shot? It might be that, too. But it's become -- it's basically become chronic diseased care management.

And, again, I want to be very respectful here, but I want you to try to understand what you -- what we've asked the primary care workforce to do.

I was here ten years ago when it looked a lot differently, when there were just single entities that came in for the earache and the cough and the cold, and I sprained my ankle. You know, that kind of stuff we just really don't see in private practice anymore. You see that, but they're there for something else, too, almost certainly.

Does somebody else want to chime in
here? I don't want to monopolize our time here on this.

   DR. MCINTYRE: This is Dr. McIntyre. I've got a couple of questions. The next MAC meeting is next week. Do we want to make a specific recommendation to the MAC on this?

   And my second question is on this limitation of using 99214 and 99215. Is that a Kentucky Medicaid regulation that does that? Is that a state law, or is that a federal law?

   COMMISSIONER LEE: Yeah. The information we're looking at right now on the agenda, the 907 KAR 3:010, is a specific Kentucky Medicaid regulation.

   DR. NEEL: Well, why don't we bring that as a recommendation? Because that needs to be looked at very quickly.

   Lisa, one thing before you go that has to do with this is, you know, we got very close to having blended codes. They were going to do away with 213 and 14s, and we were going to have blended codes. But everybody screamed so loud about that, that
it didn't happen. And so is that still in the books out there somewhere?

COMMISSIONER LEE: I'm not sure. I couldn't speak to that. But I do appreciate this conversation. I am going to have to hop off here in just a minute.

DR. NEEL: Okay.

COMMISSIONER LEE: But one thing I would like to say, too, is the -- as we move forward with this and we talk about the complexity of the Medicaid members, you know, we had a huge increase in the use of telehealth services. I'm not sure how many of you use the telehealth services. And we do have parity, payment parity from our telehealth in our regulations.

So is it appropriate, too, for -- when we talk about complexity, would it be appropriate, too, for these codes to be done via telehealth, or would it be more -- since they are more complex, in the office? And is there any other parameters we should put around the use of telehealth for these codes? I'm just asking you, I mean, for your professional opinion here on those -- on that
topic.

DR. THORNBURY: What we've done, Commissioner, in our offices, we've had to move many of these chronic care visits online. So for people that are stable and have the ability to understand what we're trying to accomplish -- and that's a great majority of our patients -- we moved these 99214s, these we're going to adjust medicines for your diabetes, your high blood pressure, your cholesterol and, again, maybe your thyroid, we're going to do that online. And so those people that used to be in the office, we're moving as many as we can online to try to accommodate what's coming into the office.

Because as these practices are closing, these patients again -- or people are leaving the workforce. Physicians are just giving up. And so what we're getting is -- we get four, five, six requests every day in our practice to become (sic) a physician. We haven't taken new patients in several years.

So to answer your question succinctly, is we moved those people online as much as
can be. Now, there are some people that

don't have the technology. There's a few of

those. There are some people that you just
can't talk to them online. It needs to be
done in person because you can't accomplish
it safely.

But the acuity has now gone from, again,
cough and cold and I sprained my ankle or
I've got poison ivy to, you know, we're
adjusting these chronic disease states, your
diabetes, your hypertension, your COPD.

And that's -- we're hoping -- and we're
coming to that here in our agenda in a few
minutes. We're hoping to work with the
Commonwealth to try to lower the burden of
the chronic disease care. So we're
getting -- we're hoping that the data will
begin to show us that people are seeking care
earlier instead of ending up in the ER or the
hospital, and we're beginning to try to
implement that.

DR. MCINTYRE: What specifically
are we going to -- should we recommend to the
MAC? To increase the number of allowable

214, 215 visits from two a year to, say, four
a year or to eliminate --

DR. THORNBURY: Well, it's got to reflect correct coding standards, you know. If you're going to ask your workforce, your physician workforce, to bear the risk and responsibility of the chronic disease care, the higher acuity visits, the ability that we give out to specialists, then, you know, that has a liability respectful to that. You can't say we're going to go from two to four. You have to say you have to respect -- you know, CMS put these guidelines out, this coding to say this is the work that's being done, and it should be compensated that way.

And so my suggestion to the MAC would be to say with regard to equity of service for our members, for our beneficiaries, that we have to have these standards, you know, lifted.

Again, this -- I mean, I understand this came in, and I think it's been a great run for the MCOs. But the downside has been it has begun to devastate our workforce, and I suggest that -- Ashima, that we kind of give you enough information to try to take our
recommendation up to the MAC. Dr. Neel?

DR. NEEL: Yes. I completely agree. No. Setting a new limit wouldn't do it, Bill, I don't think, at all. I think before you joined, we talked a bit about that.

We just need to make our case that that needs to be removed, and we're going to have to work with the MCO because it's going to cost some money there, but it's proper money with proper coding. So let's take that idea, I think, there, that it be removed.

DR. GUPTA: This is Ashima Gupta. So, you know, all that, I think, partly comes down to the Medicaid budget and properly reimbursing the physicians. And I know the budget is a difficult part.

But just to let you know, for some hard data, Kentucky ranks eighth highest in diabetes prevalence. In 2017, it had the fifth highest death rate in the nation due to diabetes and was a third leading cause of death in African-Americans. In 2017, diabetes cost Kentucky 5.16 billion dollars in total medical expenditures, lost work, and
wages in 2017. And that was taken from Kentucky.gov.

So, you know, as Dr. Thornbury is saying, the chronic diseases is just -- it's getting out of hand. And to try to combat that, it has to be first prevention and then properly reimbursing the doctors so we don't lose these practices and lose these doctors.

And I know maybe a couple, one or two doctors, may abuse the system. But those doctors could just be flagged and then counseled. We don't have to, you know, penalize every single doctor just based on a couple -- the practices of a couple physicians that may abuse the system.

So, I mean, I totally agree. I think that that should be -- you know, that statute should be removed. The limitation should be removed. And then if, you know, DMS finds some practices overusing the codes, then they could just be counseled and, you know, looked at what is going on over there.

DR. MCINTYRE: In terms of taking a recommendation to the MAC, I would be happy, and I think it would be very equitable to
remove these limitations. But I think the more we ask for, the less we're likely to get with a department that's severely limited in what they can spend. So I'd just throw that into the mix.

But if the vote of the committee is to eliminate -- to recommend elimination of this restriction, I would be happy to take that to the MAC.

DR. GUPTA: What about just lifting the limitation on 99214, Dr. Thornbury?
You're on mute.

DR. THORNBURY: Well, I don't take issue with these specifics, but then again, what you're going to run up against is the correct coding standards.

DR. NEEL: Exactly.

DR. THORNBURY: You know, that's what you run up against. You can't ask your physicians to be compliant with correct coding standards, which is a federal mandate, and then on the other hand say, well, by the way, we're just going to ignore the 215s that come in.

And so I think CMS, their intent was to
take care of these chronic disease patients. And in Kentucky, we are highly burdened with that. And I'm sure that we -- we report information to CMS, and in order for them to have the adequate information, we have to code correctly.

And that coding isn't about offering a discount. It's discounted enough. The correct coding is to say, well, can these practices remain viable. And I think that's the whole reason the coding changes came about. So I don't see how you -- intellectually, I don't know how you get away from that.

I think what you're going to say is, you know, based on the health equity needs of the beneficiary, that -- and to remain compliant with correct coding, that we've asked for these standards to be removed.

I don't see how you -- I don't see -- just intellectually, I don't know how you get out of that. And I'm open to any rational argument, but I just don't know how that occurs.

DR. MCINTYRE: I've listened to the
dental TAC do their presentation and their
discussion on how -- how poorly reimbursed
they are, the result of which a lot of
Medicaid members can't get dental care.

And I was struck by one of the things
they said. This gentleman doing the
presentation said that they're reimbursed for
a root canal at $34 which, if you think about
that, is mind-boggling. He said if they
doubled Medicaid reimbursement to the
dentists, they would still be taking a loss
on every patient they saw.

So, I mean, that doesn't directly impact
what we're talking about, but it does show
that what this is about really is limitation
on reimbursement and that this limitation on
reimbursement is clearly a global problem.

But all that being said, I'm
comfortable -- whatever we vote on, I'm
comfortable taking it to the MAC.

DR. THORNBURY: So I understand
there's a motion on the floor. Dr. Neel, is
that right?

DR. NEEL: Yes. I would so move
that we do that. And, you know, it would be
okay to put into that that we're recommending -- and Lisa said let's look at what other states are doing. Let's have some ammunition when we get into the war.

DR. THORNBURY: Well, I think that's a position for the MAC, but we need to get our information out to them. So could we -- is there a second to take a vote on this?

DR. MCINTYRE: Second.

DR. THORNBURY: Okay. Are there all in favor?

(Aye.)

DR. THORNBURY: Any opposed?

(No response.)

DR. THORNBURY: None opposed. Then we'll move that -- Ashima, we'll write that up and move that up to the MAC this coming week; is that correct?

MS. LAFLIN: Do we have specific language? I think I need to turn that in.

DR. THORNBURY: Yeah. We'll probably have Amber help us out with that, if that's agreeable to you, unless Sharley takes an issue with it. We just have such a heavy
agenda, I hate to try to iron that out now.

MS. HUGHES: Well, not that I take an issue with it. But state open records or open meeting laws require that anything you vote on, the language has to be defined as to what you vote on. So you have to clearly make your recommendation during the open meeting and vote on that language.

DR. THORNBURY: Okay. I think --

MS. HUGHES: So if the recommendation is that you want to remove the limits, then you all just come up with the language that you want to remove the limits on 99214 and 99215. That's your recommendation.

DR. THORNBURY: Yes, ma'am.

DR. NEEL: Yes. Exactly.

DR. THORNBURY: Yes, ma'am.

DR. MCINTYRE: Yeah. We could do that in a single sentence, I think.

DR. THORNBURY: And then it'll get up to the MAC, and they can hammer out the particulars there. That's probably the better place for it. But that would be the simple wordage. Would that be okay with you,
Sharley? Is that agreeable?

MS. HUGHES: Yes. That's fine.

DR. THORNBURY: All right. Is that agreeable to all the members of the TAC?

DR. GUPTA: Yes.

DR. NEEL: Yes.

DR. THORNBURY: Commissioner Lee, thank you for your valuable time. It's great to see you again.

COMMISSIONER LEE: It's good to see you. I had my hand raised. I didn't want to jump into that great conversation.

DR. THORNBURY: Oh, I'm sorry.

COMMISSIONER LEE: That's okay. This is a really important discussion and topic, and I so appreciate everybody's participation on this TAC. I know that you take time -- precious time out of your day to do this.

And I also appreciate all the hard work and your advocacy for the Medicaid members and the providers that serve them. I do think that we are a team, and we are here to improve the lives of those we serve.

I think, you know, Dr. Gupta made some
really good comments about prevention and reimbursement. And I do think,
Dr. Thornbury, as you said, COVID has
definitely put a spotlight on some of the
issues that we’re facing and, particularly,
our primary care providers and more work that
has been done on them.

And I think as we go together and move
forward getting the information, getting the
data to make our case, I think that we can
build a healthcare system that is -- that
improves the health care of those that we
serve.

We do have some budgetary limitations.
But, again, Medicaid is -- you know, we cover
one out of every three lives. We are the
biggest payer of healthcare services in this
state. And I think, as such, we should be a
leader in the healthcare policy arena. I
think that we use our data, and we move
forth.

And what we do in Medicaid to improve
this program should have an effect on even in
the commercial world. Because we do --
again, we serve more members in the state
than any other insurance carrier, and we pay
for more than anybody else in the state. So,
again, we should be that leader in healthcare
policy.

And I thank every one of you for your
participation, and hopefully I can join some
future meetings.

DR. THORNBURY: Thank you again,
Commissioner Lee.

DR. NEEL: Thank you.

DR. THORNBURY: I'm going to move
us -- if it's okay with the committee, I'm
going to move us to Item No. 5, which kind of
dovetails into our work to this point, the
Medicaid physician fee schedule.

Is there any other discussion on that,
or have we answered our questions and move
forward? Does somebody have any thoughts on
that one?

DR. GUPTA: On the fee schedule?

DR. THORNBURY: Yes, ma'am.

DR. GUPTA: I -- really, I just --
I did all that last night, and what I
found -- are you able to pull that up,
Sharley?
MS. HUGHES: Yes. Hold on just a second. Let me --

DR. GUPTA: This was -- from what Amber gave me, I was able to compare Kentucky, West Virginia, Ohio, and Indiana and then I added the national CMS values.

So, overall, I'd say Ohio is probably the worst. Kentucky is kind of middle of the row, and Indiana and West Virginia probably have -- overall, looking at everything, maybe a little bit better reimbursement rates. But they're all pretty terrible compared to the national CMS values.

So this is just for our own education looking at, you know, reimbursement. And, actually, I don't really know what the difference is between facility and nonfacility, but I went ahead and just highlighted the nonfacility reimbursement rates just so you could more easily compare.

MS. GUICE: This is Lee Guice. If you'd like for me to, I can chime in on the facility versus nonfacility.

DR. GUPTA: Yes, please.

MS. GUICE: So that would be in a
hospital or outside of a hospital or in a -- usually, it's a hospital, inpatient versus outpatient.

DR. GUPTA: Okay. So nonfacility is outpatient; facility is hospital.

MS. GUICE: Right.

DR. GUPTA: Thank you. Yeah. So most of us, I guess, would -- in general, primary care, specialty practice is nonfacility codes. And I just picked the fee codes that I personally use.

Sorry, Dr. Neel. I didn't get your email until this morning, so I wasn't able to incorporate those.

DR. NEEL: That's all right.

DR. GUPTA: Just to show you that we're all severely underpaid. That was the point of it, as we already know, but here's some hard data on that. We're always looking for data. And this is not comparing to any of the MCOs, so I did not have that -- did not enter any of that information.

DR. THORNBURY: Well, I think -- do you have a recommendation, Ashima? Do you want to move this forward to your --
DR. GUPTA: Really, I don't have a recommendation. I think whatever we've already discussed, this is just more for our education. I know that if I make a recommendation to try to increase the reimbursement, I know it's not going to happen, you know, especially compared -- if we were significantly below our surrounding states, then maybe I could make a recommendation.

DR. THORNBURY: I circled back to this a couple times, but I think -- again, it's one thing to have a -- you know, I've never met a person who felt like they were actually paid for the work that they did. I've just never met that person yet.

But I think what's happening here is this has now come to the position where -- I don't know what we lost, three percent of practices last year because of COVID. It was moving toward six percent. I don't know if we ever hit that or not.

But as these practices are beginning to close, it's affecting our Commonwealth more substantially because we just have a greater
burden of chronic disease and a greater burden of poor than many -- many other states in the United States. And what -- that's made things even worse. It's accelerated the problem.

Because what physicians and practices are left are now overwhelmed, and they -- you know, it's just like anything else. They have to make a profit to promulgate their mission.

Well, it's like what I'm seeing with my specialists. I try to get somebody into neurology or orthopedic surgery. They just won't take the patients. They say, we don't take any of these. Or try psychiatry. You know, they -- it just doesn't exist.

And so, you know, I think that there's going to have to be some way that our Commonwealth is going to have to work with the Government and our MCO partners to try to sustain the healthcare that we have.

And this is, again, part of a larger conversation. But I think we're coming to the position now where we've kind of talked about this for a few years. Really, for a
decade, we've just kind of moved back and forth on it. But now I think that the system is beginning to break, and it will take some real leadership amongst that to try to figure out how we're going to survive this.

Because I don't see that you can hire some cheap telemedicine company to solve your problems. If you're talking a cough or cold and you can do it at a discount, well, I think that's wonderful. But, you know, the great -- that's not what's breaking our back in Kentucky. What's breaking our back is the burden of chronic disease care. And, really, that's going to have to be done in person.

I mean, sooner or later, you can't be changing somebody's insulin or thyroid medication or lipid treatment or cardiovascular treatment. They're going to have to come in. You know, you just can't do that on telemedicine all the time unless you have a relationship, at least in my mind. That was the way our telemedicine system was set up.

DR. GUPTA: Well, one thing is, is that -- so I'm a subspecialist. I'm a
pediatric ophthalmologist. And, you know, in the last -- when I moved back here eight years ago, there were eight pediatric ophthalmologists. We are now four. And two are in their 70s and then there's two of us that are a bit younger.

And that's all there is in Louisville. There's no one at the university. They just lost their pediatric ophthalmologist. And the person who's seeing all the kids there is the pediatric optometrist.

You know, Norton is trying to hire a pediatric ophthalmologist, and they can't because it's so hard. That -- they need to properly reimburse that person.

And I'm in private practice, and I can't -- I don't see -- I only see kids 50 percent of the time because I -- there's no way I could survive on just seeing kids with the reimbursements. I mean, I have to do 50-percent adult general ophthalmology in order to survive.

So this is becoming -- I'm seeing it in my subspecialty how much of an issue it is, and the only other pediatric ophthalmologists...
in the state are in Lexington. So it's
becoming a severe problem for these children.

So that's why I wanted to go into all
this and just, you know, point out -- again,
reiterate how bad the reimbursement is.
So -- but I don't have a recommendation,
unless you have one.

DR. THORNbury: Dr. Neel, do you
have any thoughts on this?

DR. Neel: Well, I tell you, we've
been fighting this for so long, you know, a
philosophical question comes up. Kentucky is
such a poor, unhealthy state. And healthcare
costs more than sick care, and that sick care
is what we're giving now. And it -- you have
to look down the road.

And the legislature, when they look at
their budget, they're not looking down to the
next generation of healthier Kentuckians. So
we've got to continue to fight that battle
somehow.

But I -- we've just got to nibble away
at this, as Ashima says. We just can't go in
asking for a complete increase in fees.
We've just got to show that there are places
where we can whittle away at it. That's my feeling.

DR. THORNBURY: I think the best thing for us to do is to sit on our position of releasing the 214s and 215s. And I think that, in and of itself, will be -- it may add a measure of stop gaps and sustainability for the practices. I just think that's the best way to do it because that's the most appropriate.

And, again, if you're going to follow federal regulations on coding, that's the best arm we have right now. And we've already made that recommendation, so I don't think we need to go forward any more.

DR. NEEL: I agree.

DR. THORNBURY: Is that okay with you, Ashima?

DR. GUPTA: No. I mean, you look here. The 213 code is $42, you know.

DR. THORNBURY: Yeah.

DR. GUPTA: The 214 code is $67. $42, that's, like, nothing so --

DR. NEEL: Well, you were talking about states around. Look at West Virginia,
a state poor like Kentucky. But they're paying $60 for a 213 and 85 for a 214. And are they limiting? We don't know. That's one of the things that Lisa has given us the charge to find out, and that's what we can do easily.

DR. GUPTA: We could just focus on these three states and find out what they're doing with their limitation. That might help Amber, to make it a little bit simpler.

DR. MCINTYRE: I'd be interested to see what Virginia is doing. Virginia actually borders Kentucky. A lot of people don't know that. I've been working in Virginia off and on for years. And it would be interesting to see what a more prosperous state is doing, what their fees are.

DR. THORNBURY: Well, then, let's leave it there, then; okay? Is that okay with everybody?

DR. NEEL: Yes.

DR. GUPTA: Yes.

DR. THORNBURY: Okay. Let's move -- let's kind of dovetail into our work with telehealth. And trying to do that --
again, the reason I've asked this to be added to our agenda is because this was really our solution from physicians to try to help our Commonwealth solve some of these problems.

The problem that we felt like was coming was just -- there's just -- people are aging. There's too much chronic disease care. It's expensive care, and the only way that we see intellectually to try to gun the future to try to minimize this is to try to get the care in sooner, to try to take care of it more efficiently. And we felt telemedicine would do that.

Now, the benefit of that -- I don't know if you all are aware of this, but they just had the AMA meeting. We received accolades from around the country of the work that we've done. And many states have actually asked for our legislation, which is a model, to help them model how to handle this.

And, of course, before COVID came, we were -- already set it in place. And I would just commend the work of our -- of DMS, legislature, and our executive leadership in accomplishing that. And that's, again,
across all party lines and across all generational gaps.

That being said, what we want to try to do is if -- we want to try to communicate to DMS is -- if we have the ability to look at data with them or share that, what we're trying to do is to see what we can do to try to bend the cost curve down. I don't know if this data is even available, but I want you to know that we're interested in this and trying to partner to help work with you all to lower our costs.

Do we have any data available, is my question today, on the work of telemedicine treatment over the last year or two?

MS. GUICE: I'm not sure -- I think I can respond a little bit to that. This is Lee Guice again.

DR. THORNBURY: Hey, Lee.

MS. GUICE: The -- we are excited actually to have a year's worth of telehealth data available to us at this point in time. However, I mean, that's the only positive thing that I've figured out so far from the year of COVID, is that the increase in the
use of telehealth allows us to have enough
data to do some analysis on the efficacy of
telehealth, on the use of telehealth. Did it
improve health? Did it hurt health?

Are there limitations that -- because we
do have -- we have had a few limitations in
place in our regulations that maybe can be
changed now that we have the opportunity to
take a look. However, when I say the
opportunity to take a look, I mean we have
the data. Have we had the opportunity to
take a look? Not just yet.

So it's on the list of items that we
anticipate being able to work on as the
pandemic, if it does continue to lessen in
severity, and we're able to respond more to
these sorts of policy changes and policy
attributes that we want to make sure we move
forward with in a positive way.

You heard doc -- I mean -- doctor. You
heard Commissioner Lee talk about her vision
of Medicaid, and that's certainly where we're
going now, is to make sure that we're
providing good, quality services to all of
our members.
So we have it. We have not started any analysis at this point, but we anticipate that to be in one of the top-tier priorities for us going forward.

DR. THORNBURY: Lee, thank you for joining us today and thank you for kind of letting us understand where we are. I feel some extra burden, having helped Dr. Alvarado and Representative Riley write those -- that legislation. This is the way, I think, intellectually this is likely to go.

I think what really happened was is we had a few swimming classes. Then we got thrown into the deep end of the pool. That was COVID, and so that's not altogether bad. Really, what it did was it forced everybody in the Commonwealth, all the health systems, to implement it, which could have taken years, and it really happened overnight.

And so as you begin to look at the data, what I suspect you may see is, is at first, Lee, there will just be -- it'll just be a smashing of everything is out there. But once people have begun to use this, what we want to begin to see is -- I want very
closely to see is, are we getting our chronic disease cases on there. Instead of cough and cold and poison ivy, are we getting our thyroid, our diabetes, our hypertension, our COPD. Those are the cases that we feel that we're going to have our chance to lower the cost.

And then once those are on there, you know, can we do this efficiently? And I guess that's what we're going to be looking at down the road. Are we seeing less ER visits for this? Are we seeing less hospitalization visits because of these chronic diseases?

So that's the -- that's the wager that we have placed in using this technology, this delivery model. So when you all begin to look at it under that critical eye, I hope that you'll kind of see it the same way that we do, that -- again, that's my expectation.

MS. GUICE: Certainly. I anticipate a collaborative effort on the analysis. You know, because Medicaid has it, you know, we'll have to do some initial gathering, et cetera. But what you just
talked about, Dr. Thornbury, is, I think, what the commissioner was also referring to when she talked about thinking about what parameters to put around the analysis, what kind of criteria would be appropriate to look at.

And so we have the data. You know, we have folks who can pull it and put it in some pie charts and formatting and perhaps even do some trending analysis. But what we would rely on our clinical partners to do and experts is, you know, how. How do you look at it? What would be appropriate? So those are the kinds of things that certainly we're interested in, and we're interested in working with the TAC on.

DR. THORNBURY: Well, thank you again, Lee. Again, to your colleagues in the data division, if they can -- the thing that we're going to be interested in is how much can they discern, if they can, how much has gone to chronic disease care over time. That's going to be a very important issue for us.

I'll move us along, then, to -- we have
two items left. Let's move to Item 3, maternal-fetal mortality. Who'd like to set that one up for us?

DR. GUPTA: I put that on the schedule just because of something that came up right before the last MAC meeting. Amber, I mean, do you think we need to make any statement regarding this, or we can just move past it now?

MS. LAFLIN: Oh, no. I didn't know what the intention was on this, so yeah. I mean, I don't think so.

DR. GUPTA: Okay. I just -- I didn't know if we needed to make any kind of statement that, you know, in regards to birthing centers, that, you know, we just want to make sure that the quality of care -- our main concern is quality of care and patient safety. But if we don't need to, we can just move past it.

DR. THORNBURY: Well, I mean, we have a few minutes. Is there anything -- what brought this to your attention, Ashima?

DR. GUPTA: Amber, are you frozen? It was just -- I think it was a
discussion between the commissioner and Dr. Parton. Right before our last MAC meeting, they met with some of the legislature.

And there was some discussion that hadn't really been -- they were kind of just moving past what we had already -- what we had not, in our own TACs, been able or had time to discuss.

So -- but I think everything has been fine, so I just didn't know, Amber, if we needed to have any kind of statement or anything.

MS. LAFLIN: No. I wasn't -- I think this was kind of addressed by the commissioner in the last -- I think the question was really around how the TACs are making recommendations and those are going to the MAC. I think we're supposed to be getting some clarification on those recommendations, so those haven't come out yet. But I think that was really the issue. There were some things that were presented as recommendations of the MAC that it didn't really -- I think there were some questions
about how that happened.

So I think that was honestly more of a process question, and I think at the last MAC meeting, the commissioner did address that. And we were supposed to be getting some new guidelines on how to make recommendations.

DR. NEEL: Well, this is a tough one because it goes along with the other things that Kentucky is noted for: Smoking, obesity, drugs. And so maternal-fetal mortality, we've been struggling to get that rate down in Kentucky.

And I still have mothers that come in to me with a newborn baby, and they're smoking already. And I said, did you quit while you were -- well, no. The obstetrician never mentioned it to me, you know. Or they start up immediately after a baby is born.

We've got all kinds of things that are Kentucky problems that we've got to work with. So moving that arrow is going to be kind of difficult.

DR. THORNBURY: We can certainly keep a topic like this open, Dr. Neel and Dr. Gupta. And, you know, we could add to
this in a future meeting if you'd like. Would that be okay?

DR. NEEL: Yes. For me, it would.

DR. THORNBURY: Ashima, is that okay with you?

DR. GUPTA: Yeah. That's fine. I think all -- maybe we could put it under a category of prevention because I think all our problems could be prevented.

DR. THORNBURY: Well, it indirectly dovetails into the work we're doing which is -- I can tell you in the primary care field, trying to get to prevention unfortunately is becoming more and more difficult because we're just overwhelmed with doing the work of the specialists.

And so I think that we -- you know, this is where it kind of shows up, is maternal-fetal mortality. At some point, these numbers are going to show up, with more cancers, more whatever. But I think, again, I think the point -- we kind of hammered that home a few times today.

DR. GUPTA: Right.

DR. THORNBURY: Let's -- we'll keep
an eye on this; okay?

DR. GUPTA: Sounds good.

DR. THORNBURY: Our last item is Item 4, the soda tax. Who would like to discuss that for us?

DR. GUPTA: That's me again.

DR. THORNBURY: Ashima, you're a famous person today.

DR. GUPTA: I was on a roll. So this came -- actually, Dr. Bobrowski, he is the MAC rep for dental. And he made a recommendation at the last MAC meeting to pass a soda tax which actually can't be passed. I mean, that can't happen through the MAC. But it brought a lot of awareness.

And this is something that actually my brother and I -- he's an ophthalmologist, also. He had brought the soda tax to the KMA several years ago, and it was turned down at that time.

And I'm actually presenting -- I just got a -- I revised it, and I'm getting it -- it has been passed through our Greater Louisville Medical Society and then it will be presented at the KMA this year.
But this is a way to increase the Medicaid budget. And so I just want to just bring it up here from -- just tell you a little bit about my research on it. That there are several states that have implemented something like this, at least 11 regions, and Tennessee and West Virginia are included in that. They have some form of sugar tax or soda tax.

And Arkansas, in particular, when they implemented it in the early 1990s, their first year, they raised 13 million dollars. And all the funds from that soda tax directly went into a specific trust fund that's called a Medicaid trust fund. And by 2013, it had raised over 167 million dollars. So all that money -- you know, that money basically supports Medicaid and is not used for anything else.

Now, they're having some pushback now to try to end it because of the soda companies who -- you know, of course, there's competition from the surrounding states, that people will go across the border or whatever like that. But in general, it has
significantly increased the Medicaid budget.  

    Now, will it -- will it deter consumers from purchasing soda? It probably won't. Because, unfortunately, you can use SNAP dollars to buy soda. And a study in 2016 by the United -- the USDA found that sugary -- more money was spent on sugary drinks in both SNAP and non-SNAP households. And it was actually, I think, the No. 1 and No. 2 most-purchased commodity in SNAP households.

    So this probably won't deter consumers. It might make them think a little bit about it, whether to purchase it or not. But at least it would help increase the budget so we can take care of those patients.

    I think, ultimately, what needs to happen -- because with the cigarette tax, that has definitely helped decrease purchases, but you're not allowed to purchase cigarettes using SNAP dollars. So I think, in the end, which will be a very long battle, is to not have soda on the list of things being able to purchase with SNAP dollars.

    So I know we can't really make a recommendation, but I was thinking maybe we
could just go ahead and do it anyways even though -- just to make our voice heard even though we -- we know that it can't be -- we know that this is not a problem that can be -- or the soda tax can't be -- it has to go through legislation.

DR. THORNBURY: Yeah. I think that when you talk about an excise tax, that's going to have to come under KRS just like the tobacco tax. Probably the format might be either working through, say, the Kentucky Medical Association with a resolution toward legislation more to the foundation of the -- for health in Kentucky. That would be another arm to try to do that.

The problem is it does end up informationally in our position because the related health consequences are quite problematic, particularly in our Commonwealth. But I agree with you that the PTAC, per se, I don't know is the direct arm that we're going to be able to really do anything.

You could put it on your MAC agenda, but I'm not sure what -- you know, aside from
taking up time on the agenda, what they can
really do about that. If we asked DMS to do
something, well, I'm not really sure. What
can DMS do or what --

DR. GUPTA: Well, they can't do
anything.

DR. THORNBURY: Yeah.

DR. GUPTA: After that meeting,
I'll let you know that there definitely was
support from nursing by Dr. Beth Parton and
the dentist, Garth Bobrowski, and the
podiatrist. So, you know, the four of us did
reach out to each other afterwards, and they
agreed to bring it back to their own, you
know, associations and see if, like -- you
know, if we can go through our own
associations like the KMA and then bring it
to the legislation.

I mean, I don't know if, like, maybe --
if Dr. McIntyre could just even say we
discussed the soda tax and we support it, but
we don't have a recommendation. We know it's
not something that can be -- or we can just
leave it.

DR. THORNBURY: I don't take issue
with supporting that. Amber, I can't remember. Do you remember off your head if we have policy on this? I've seen it come up in the house of delegates a few times with regard to a resolution, but do you know if we have a policy on the sugar/soda tax?

MS. LAFLIN: No. KMA does not. As Dr. Gupta mentioned, the last time it came up, it did not pass House. So no, KMA does not have existing policy on a soda tax.

DR. THORNBURY: Well, Ashima, one thing you could do is resolutions are -- it's going to be a virtual meeting this year. You could present that to KMA, and I'm sure Amber can help us with that.

DR. GUPTA: I am going to present it because it's already been passed through our Greater Louisville Medical Society.

DR. THORNBURY: Yes, ma'am. Maybe GLMS can go ahead and forward that again. I would -- I believe that would be a nice thing to do. Do you want a straw vote today? Would that help? Would you want to forward a motion for a straw vote from the committee to support it?
DR. GUPTA: Sure.

DR. THORNBURY: Okay. Is there a second?

DR. MCINTYRE: Second.

DR. THORNBURY: Okay. All in favor?

(Aye.)

DR. THORNBURY: Any opposed?

(No response.)

DR. THORNBURY: None opposed.

Well, do we have any other work to do today? Anybody have anything else or anything for a future meeting that we need to include?

MS. LAFLIN: I think we needed to discuss -- I'm sorry. Go ahead, Dr. McIntyre.

DR. MCINTYRE: Oh, I notice Item 8, method for future meetings, Zoom or in person.

DR. THORNBURY: Oh, yeah. Excuse me. Thank you. Well, let's talk about that. Do we want to be in person -- I mean, if it's possible, do we want to be in person in Frankfort, or do we want to be on Zoom? What's the best -- what does the committee
think?

   DR. GUPTA: Zoom.

   DR. THORNBURY: Bill, what do you think? Dr. Neel?

   DR. NEEL: I like personal meetings in that we have been having MCOs attend sometimes in the past. Did we have any on today listening? I don't know who else was out there.

   MS. HUGHES: Dr. Neel --

   DR. GUPTA: There are lots of people on the meeting.

   MS. HUGHES: Yeah. All the MCOs are invited to attend even the Zoom meetings. I think most of them -- now, they don't all have their name and their -- their organization and their name when they're signing in. But I know a couple have, and I'm recognizing some of the names as being from the MCOs. So I believe probably all of our MCOs are represented at most every TAC meeting now, even the Zoom ones.

   MS. THERIOT: And, Dr. Thornbury, the medical directors from the MCOs, many of them are on this call.
DR. THORNBURY: Yes.

DR. NEEL: Great. Okay. I didn't recognize all the names. But sometimes if we know they're there, we can ask their opinions on various things and get a lot more information. As long as we have that, I don't have any problem with the Zoom meeting.

DR. THORNBURY: Well, I did notice that, and I do appreciate my physician colleagues joining us from the MCOs. We are partnered with them. And we'll all either succeed together, or we'll fail together.

My thought on this might be to -- you know, I think this -- we've found over the last year, this is a very effective format for a lot of us that are busy. However, there is another side to that. There's just nothing like being in person at least a little bit.

And I might just wonder if -- you know, if once a year, we can get together in person in Frankfort, you know, that's not a bad thing. And maybe the other meetings we could take online so that we can involve as many people and respect their schedules. As
pressed as these are -- all these people are
busy people that are aligning with us.

But that'll be my thought. Maybe try to
have one meeting a year in person and one
meeting -- and the rest of our meetings
online. But I'll open it up to the committee
to see whatever is best. I serve you guys.

**DR. MCINTYRE:** I'd make a motion to
have our November meeting in person.

**DR. THORNBURY:** Don, do you
think -- is that okay with you?

**DR. NEEL:** I'll second that.

**DR. THORNBURY:** Okay. Ashima, do
you have any thought there?

**DR. GUPTA:** I'm good with having
one meeting in person and the rest on Zoom.

**DR. THORNBURY:** Okay. Well, then,
let's -- the motion is that we'll have one
meeting a year at least. That'll be our
protocol. And the next meeting will be in
November, and we'll try -- if we could get
everybody in person, that would really be
nice, particularly to put a face with a lot
of the names. And the senior leadership that
we're meeting, it's very hard to work with
them if I don't really know who they are.

All in favor?

(Aye.)

DR. THORNBURY: Any opposed?

(No response.)

DR. THORNBURY: None opposed.

Well, then, our next meeting will be

September 17, 2021. We'll try to make that

in person if we're not under an emergency

order.

MS. HUGHES: I thought you were doing the November --


meeting. Thank you, Sharley. Almost messed that one up.

So our next meeting is September 17th.

However, the plan will be to have the

November meeting in person. Thank you,

Sharley.

MS. HUGHES: Well, the reason I say that is because we're in the process of

trying to purchase some sound equipment and

so forth for our conference rooms, and I'm not real sure we'll have it by September.
So --

DR. THORNBURY: Well, the motion was for November, and I missed that. I've had too many meetings this week. I'm so sorry.

MS. HUGHES: You're fine. You're fine.

DR. THORNBURY: If there isn't anything else, I want to thank everybody for coming, particularly Commissioner Lee. Sharley, we want to thank you and your effort and your team. I want to thank my MCO colleagues. And then, Shana, thank you for helping us with this; okay? Thank you, everybody. If there isn't any objection, we'll adjourn.

MS. HUGHES: Thank you. Y'all have a good weekend.

(Meeting concluded at 11:27 a.m.)
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CERTIFICATE

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 22nd day of July, 2021.

/s/ Shana W. Spencer
Shana Spencer, RPR, CRR