The foregoing zoom meeting was held, pursuant to notice, on Friday, September 17, 2021, beginning at the hour of 10:00 a.m., Chairman Charles Thornbury, M.D., presiding.
PHYSICIAN TECHNICAL ADVISORY COMMITTEE MEMBERS

PRESENT:

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

DR. THORNBURY: I am going to call this meeting to order.

This is the Kentucky Physicians Technical Advisory Committee under the auspices of Title XIX. We have in attendance on the committee Dr. Neal, our emeritus chair and fortunate board member. We have Dr. McIntyre, our vice-chair, and myself which is a quorum.

I would like to see if it is possible -- I know we are working back to back -- and I will just say ahead of time that if we don't have anything next month, the next time, we won't call the meeting. I certainly wouldn't ask you guys to be here if I didn't want to review some of these articles.

But we don't meet just to meet. We meet to
try to work on things and I am meeting back to
back at this time because we had so much. We had
almost a year where we almost basically didn't
meet.

I want to try to do it this way. I would
like to see if we can keep ourselves to about 30
or 40 minutes today because a lot of you guys have
obligations beyond this. And several of these
issues kind of dovetail into one each other. So I
am going to use the Chairman's prerogative and
work on this item number 2 first.

Amber, can you hear me?

MS. LAFLIN: Yes, I can.

DR. THORNBURY: You want to take a swing at
this pitch and send us off with a -- just to
briefly touch on these issues that came up last
time.

MS. LAFLIN: Sure.

I think there was a lot of discussion at the
last meeting about coming up with some quality
measures for the MCOs and discussion about where
that different information is out there and
potential reports.

I think one of the questions that wasn't
addressed is what is being done currently. Are
there any type of quality measures, I guess, that
the DMS is currently using to evaluate the MCOs
and if they are actually changing health status in
the state as opposed to what are the measures, I
guess, at this point when they file their reports,
what is DMS looking at.

DR. THORNBURY: Thank you, Amber.

Dr. Neal, you have a lot of institutional
recollection on this. Do you want to chime in
here, sir?

DR. NEAL: Well, yes, I would be glad to.

As a matter of fact, we had a meeting among
the quality committee for Aetna and we met
yesterday. And they presented a pretty lengthy
report about the things that DMS is really looking
at and requiring.

And one of the particular things that came
up, of course because of the high rate of diabetes
and obesity in Kentucky particularly in children
also, they were looking at do the templates in our
EMRs show that and reflect that we are doing
appropriate studies like A1Cs, looking at history
of family, and all of that sort of thing.

So they have been given some marching orders.
And several of them I don't even remember from
yesterday because it was about a 40 page report as usual.

But those are some of the things DMS is looking at. Of course, all of that kind of pales with COVID obviously. But I do know that, for example, obesity, which was already a real problem in Kentucky, we had started to make a little inroads in decreasing the incidence of obesity.

But with COVID, it's gone back up again. So I can go further but let me stop right there and let somebody else chime in.

DR. THORNBURY: Well, if somebody would like to speak to this issue, I am very welcome to do it. The way, I think, that we would see it is let me look at it say from KMA's point of view.

If KMA, who is a major stakeholder here because they represent maybe 10,000 physicians, well, they don't have the resources to put together these quantity measures. And, you know, the resources there are with DMS and the MCOs. It is truly not with us. And so I don't think we need to do any more quality measures. I think we need to refine those. And our chief medical officers who are well experienced can help them with that.
And I just didn't want to go too far. I didn't want to leave that an open-ended piece of rope as something that we were responsible for when I really don't see that we have the resources to help you all with that.

If somebody would like to speak more to that, I am welcome to do it. But I would rather just go on. Is there somebody that would like to chime in about this or have a thought about it?

MS. PARKER: This is Angie Parker with Medicaid. And I know I am a few minutes late to the show.

But I am the director of program quality and outcomes. And I am assuming you are talking about number 2, DMS measures for MCOs.

DR. THORNBURY: Yes, Angie. Thank you for attending.

MS. PARKER: No problem.

And who -- what I am asking when I came in on it that, was it Anthem was talking with the providers about with the 40 page document?

DR. NEAL: No. This was Dr. Neal. I was reporting a meeting from Aetna, their quality.

MS. PARKER: Okay.

Well, as a little history, Medicaid has a
quality strategy which is a requirement of DMS which is a good requirement that we all need to make sure that we are all doing quality of care. And this was developed in 2019. So it is already, you know, when it was written, it was probably already too old. It was already needed to be updated. But the one before that was in 2012.

So with your conversation with Aetna, I can only assume that part of that is based on the DMS quality strategy which we are currently looking at and evaluating where we need to target specifically quality measures. And to the other physician -- I forgot. I didn't get your name -- yes, we can't rule the ocean. But we need to make sure that we are focusing on the certain things that we can try to move that needle. And we do need our providers' assistance in that in assuring that your patients are getting preventive care and doing their follow-ups and those types of things.

I think, and not being a part of the Aetna meeting, I think it is more of figuring out a partnership on how to get some of these quantity measures accomplished. And I don't know how familiar you are with HEDIS measures. But there are, I don't know, 33 HEDIS measures in their
quality measures. And some of those, you know, there is like 5 or 6 on diabetes. And whether or not they have had, you know, people have are gotten their hemoglobin A1C or not, and if it is above 9 or less than 7.

And they get a lot of this information. You probably in the spring have somebody from all the MCOs come into your office to get charts and look at them and see if some of these measures are being met.

So, with all of that little bit of history with that, I guess my question is -- because I did come in a little bit late to the conversation -- what's your concern?

DR. THORNBURY: Let me try to reiterate. We really don't have a concern here. That's why we are letting you know. In the last meeting I think with the commissioner, somehow there was an ethereal belief that somehow, at least in my understanding or from our side, we thought it was that we want you to come up with quality measures or designs.

And what we are saying is, well, that's not what we are going to do. We don't have that data. That's not our position. We want to make sure
that people like you, Angie, and our MCO partners can work on those things. And if you want -- you don't need my counsel. Sometimes they say in my business that, you know, a bit of advice that's not welcome is seen as, well, something that is not very good.

But I think that what we would say is if you have less quality measures that are more important, it might be more helpful to you all, it might be helpful to, for example, your primary care workforce. Because you can measure too many things and they become overwhelmed.

That's just a suggestion. But the only reason we brought it up was saying, listen, this a hot potato that we can't catch for you. But we are obviously partners with you and we want to work with you. We just don't want you to think that we are going to return something to you when this is kind of what you all do.

Does that make sense?

MS. PARKER: Yes.

And I think where the commissioner was coming from is, you know, part of some of the issues that you see day to day and in those areas of where we could or the MCOs could assist you in helping
improve the quality of care. So --

DR. THORNBURY: Yes, ma'am.

MS. PARKER: I think we understand that, you know, we don't expect you all to get together necessarily. I mean obviously via the TAC you all could potentially come up with things that you see most quite often and think that something that the MCOs and Medicaid could help assist on improving quality of care.

DR. THORNBURY: Thank you.

Dr. Theriot, you wanted to say something?

DR. THERIOT: I was just going to say one example, and it kind of gets to what Dr. Neal was saying with obesity, is the diabetes prevention programs. And when you look over the last several decades at the American health ratings, you know, Kentucky has basically stayed the same. We are not doing great on smoking and diabetes and all of those things.

But one thing that has come out is that they have done studies. And if a physician suggests, maybe not the first time or the second time but maybe the third time, that a patient attend a diabetes prevention program, that seems to be the key to get the patient to do that. And all that
is is, you know, people that have diabetes and you talk to them about it. And then they get nutrition and exercise counseling in an organized manner over about a 4 month or 6 month period.

But -- and so I think that's, you know, some of the studies that are coming out, it does show that the physician referrals make a really big difference. And I do know, I mean, that it is hard. You know, sometimes you suggest it. People say no and then you never go back to it because you have all of these other things you have to worry about.

But that's where the DMRs could come in. You know, if they can target, say, hey, this lady has gestational diabetes. Her BMI is 40. She doesn't have diabetes yet but, you know, she is a time bomb waiting to happen. Get her into one of these programs. If it can just kind of alert you to doing that instead of, you know, her coming in for the headache and then dealing with the headache or the sore foot. You know, just repeating those preventive medicine things.

Because basically the patients are afraid you are going to bring it up. You know, I am going in there for my sore throat. They are going to weigh
me and mention my weight. And then they leave. And so they don't want to mention their weight. So they leave. And when you don't mention it, they say, whew, I am so glad he didn't mention that.

But it is, you know, it is -- I don't know. That's where the physician can come and do -- being a little bit more -- trying to do more of that preventative stuff and referring stuff.

DR. THORNBURY: If I may, what I would like to try to do here is, I don't want this to get out of hand. But I do want to handle things in a logical manner.

So what I would like to try to do for the panel today is I want to open this up to talk about 1, 2 and 3 all at the same time. Because they are just different aspects of the same problem which is to say, if I am looking at the penny on one side I see heads, the other side tails, and on the side I see the side of it.

Let me try to couch this for the group.

Put that one minute article that I just now came across in my daily reading on physician primary care burnout. Now the reason I am mentioning this, because I guess what I am trying
to say from a physician's point of view, is we are trying to give DMS a fair warning on this one.

First of all, Kentucky is a beautiful state. I call it the Kauai of the east. But, you know, a lot of people don't want to live here. And I will be candid with you since I work on many of the workforce committees and on the board, our medical schools are not driving out a lot of primary care. We put out a lot of specialty care and we train doctors for every other state in the country. Just as soon as they get it, they leave here.

And you all need to hear that. And you all should know that. And what I am telling you here is you are having problems now. I think sometimes when you are not in the middle of it, you may have a different perception of what's going on here.

I can tell you in my office, I get a sore throat a couple of times a week. Because you know what. They come in. They don't come in with that. We handle that by phone with telemedicine. They come in with diabetes, hypertension, dyslipidemia, or shoulder surgery and they want to know what this is.

And, by the way, I want to add a couple of quality measures. Heck, I'll add 3 or 4 quality
measures. The answer to that is no. And it is not going to happen. If you all think it is going to happen, no offense here, but your neighbors are the Easter Bunny and Santa Claus. There is not enough time to do it. It is not going to happen.

And primary care, as far as I am concerned, this is physician time, not the extender time. Let me tell you what. This is not about traffic cop. We are not here to send somebody to the orthopedic surgeon. I am here to take care of that problem and that should be done 90 percent of the time. And I talking about we are the guys not in charge of putting the cath in. We are charged with making sure they don't go back to the cath lab, that their lipid studies are appropriate, that they are normotensive, that their proteins in their urines are properly addressed. They are on the ACE inhibitors and R renal. That's what we do.

And I think sometimes there is a disbelief or misunderstanding from DMS that we are like the cough and cold people. Well, that is absolutely not true.

And so if you are going to ask us to shoulder this, you all need to understand you are going to
have to -- my -- well, I am not here to tell you how pay for your services. But I think that you are seeing and what this article brings to bear is, the strain is beginning to crack. And what they say, in the next 5 years, 20 percent of your workforce is just gone and it is not coming back. And if you think about what is really happening, if you just step back for a second from the 30,000-foot point of view, we have telemedicine coming here from out of state providing care to us. Well, now, that's the way technology works. But now think about that. For every dollar you pay, how much is that coming back into Kentucky taxes or Kentucky reimbursement? I will bet you $.40 of every dollar that you pay out to a Kentucky provider somehow makes its way back into the economic cycle here. For every dollar you send out of state, well, they are not spending that money here. And what is happening is is those people can't take care of your chronic disease care. We would be fine if they could do that but they can't. They can certainly take care of all of your cough and cold and sprained ankles and UTIs and poison ivy which is 20 or 25 percent of the health dollar.
In Kentucky, we have people that are a lot sicker. And because of that, you are asking us to shoulder all the burden. And when you come back to number one and say, you know what, we are just going to write this regulation such that we are going pay you a level 4 twice a year. And the rest of that time, we are just going to keep the money.

Well, you can do that.

But, you know, there is going to be a consequence to that. Because all the people that I know never work for money when it comes to Medicaid. They work for service and for the glory of God. They work to help the patients in our Commonwealth. And they do it as a service.

But even then, they are losing money. And this is just some type of capricious thing that somebody snuck in. And, listen, I applaud you for getting it in there. But we have come to the point now where I am just telling you guys, your workforce is I breaking. And once it is broken, then you have really got a problem because you will probably never be able to fix it.

I don't know how you are going to ever recruit people to come back into the Commonwealth
and live here and raise their families here. And
I am telling you this so that you all can begin to
say, you know what, if we are going to add quality
measures, maybe we ought to pay for those quality
measures. Maybe we should pay a certain stipend
for primary care that's doing real primary care
and not urgent clinic work and maybe either as a
service fee for service part to that.

I don't know. These people have figured it
out all around the country. But I would hope that
you guys would know that. And all of these things
are related, this quality measures. Well, listen.
I am in an ACO and I can't tell you how many
quality measures I have. I mean I must have 20
quality measures I have to follow.

And you can hear the frustration in my voice.
And I guess we are trying to give ownership and a
voice to all of the thousands of doctors in
Kentucky that are trying to do this work for you
and are dealing -- they are becoming overwhelmed.
And if we don't call this to your attention, well,
what good are we going to do. And I guess the
business end of it -- and I will be quiet here --
if it gets too far and you have enough physicians
leave and you don't have enough new doctors coming
in, then your system will break. You will have people come in here but they won't be the best doctors in the country. They will be the people, well, nobody else really wanted that much. Or people that don't want to come in at all. And so, you know, we are just going to do telemedicine. And all of that other stuff, you just send it to the ER.

I mean I am just trying to say to you that I understand everybody has an interest here. I understand the MCOs are trying to make as much money as they can. I mean that's just what they do. That's their entity. They are a capitalistic organization. They have stockholders. I understand DMS has a small cover they are trying to pull it over everything and they can't get it covered. And the doctors are just trying to survive out there.

But if we don't lay ownership to this and try to tell you the existential crises that you are looking at in the next few years, well, we are not doing our job. And with that, I will certainly open it up to anybody that wants to comment and I will try to keep as quiet as I can.

MS. HUGHES: Dr. Thornbury, this is Sharley.
I don't think what the commissioner was asking was that she was necessarily intending to put quality measures on the providers. She was wanting you all to help come up with stuff that DMS could be looking at with the MCOs as far as, like Dr. Theriot said, the obesity or cancer and stuff, the items that we can look at, what reports can we get from the MCOs for us to see that they are making improvements in our --

DR. THORNBURY: I appreciate that. And thank you very much. I think that -- I guess we could provide those to you.

But, I mean, I think all of the ACOs here have quality measures from DMS that they have already narrowed down on. And DMS might just start with asking a couple of the ACOs, say what are your quality measures that you all measure. And just kind of see how the medical directors, you know, how they feel about that.

I mean we can provide those for you. But that's work that was done 10 years ago really.

MS. GUICE: This is Lee Guice with policy and operations in Medicaid.

DR. THORNBURY: Yes, ma'am.

MS. GUICE: And I would like to say I
appreciate your comments certainly. And comments
like that are what I believe the TAC is for and
those are the kinds of pieces of information,
certainly your deepest frustrations.

But we want to hear those. But what we would
also like to hear is what can we do to help with
that. Because it is certainly not our wish to
impose anything on providers that will further
break the system. It is -- Medicaid is for
provision of health care services to the most
vulnerable and everyone else in the state.

As the largest single payer in the state, we
are all about provision of services.

But we also understand that we can't provide
services if there are no providers. And so it is
a partnership.

DR. THORNBURY: Lee, I appreciate that.

My gentle suggestion -- and I don't do this
for a living -- I am not a policy wok. But my
gentle suggestion would be is I think that what
has happened not only in Kentucky but in the
country is you all compensate primary care like it
is a specialty. You come with a broken arm, we
are going to pay for the broken arm. You come in
with a sore throat, we are going to pay for the
sore throat.

But the primary care doesn't work like that.

You see, primary care doesn't just fix your broken arm or sore throat. You all said it yourself already, we are supposed to get them to quit smoking. We are supposed to get them, even though when they don't want to do it, we are supposed to get that colon scope and the obesity clinic. We are trying to solve a problem with people that don't have enough money. We are trying to get them on medications that are being denied. We are trying to get them tests.

You see there is so many other things that are occurring in primary care that are not compensated. And my gentle suggestion that there are probably -- I am not saying you should go out and buy a consultant -- but there is a lot of work in this. There is probably volumes and volumes of work in this thing, though. If your primary care workforce is going to do the things that you all want it to do, if you all want us to lower these risk factors and socioeconomic problems, you should pay it differently.

Because it is not the same as going to see one of our specialists for, say, a GI problem and
that's all they are going to talk about. The GI
guy is not going to worry about, you know, other
issues like their diabetes. We want to work with
our specialty partners. But paying them is a
different manner of paying primary care because
you are asking to do a lot of things. And I would
say DMS should probably investigate all of the
work that has been done and say, well, you know,
who else pays primary care differently and how
successful are they. That's work that I might
suggest that somebody in DMS knows something about
it because I am sure you all go to meetings and
they talk about this kind of thing.

MS. GUICE: You mean back when we did go to
meetings?

DR. THORNbury: Well, that was kind of a faux
pas.

MS. GUICE: No. No. I was just trying to
insert just a little bit of levity into the
conversation.

DR. THORNbury: This is not an easy problem
to solve. And I am going to tell you that if
anybody solved it really well, I am not aware of
it. But there is more and more work to say -- I
am not saying that primary care needs more money.
I am not saying that. What I am trying to say is it just needs to be paid differently because it works differently and you are asking it to do things.

I mean if you think about how many quality measures actually fall on the shoulders of specialists. Well, hardly any. I mean really. And then we have, like I said, in my MCO, we must have 30, you know, that aside from all the work you want me to do, on top of all of that, I have to make sure that all of this other stuff is accomplished. And this other stuff is not small stuff because it is what is actually saving the Commonwealth money.

And so when we came to you a few years ago and said we think telemedicine is a good idea. Well, again, it would allow us a way to try to say, well, we are going to have to work more efficiently. Well, I am going to suggest to you that if you pay primary care like the way you pay specialists, you are probably going to get what you get. You are just going to get little small specialists. They are going to handle each problem as it comes in and they are not going to worry about the quality measures because they
don't have time to do it.

They are not making a lot of money on these cases. They are businesses. They have to look at it like that. It is not that they want to give them any less. There is just so much time they can give them.

And so I think, again, if you all were sophisticated enough to go say, well, how are other people, how are some of these larger states or more successful states with primary care, who does that really well. Let's look at how they are doing it. That might give you guys some insight into how to work with us. And we can, from there we can try to open a dialogue to try to give you some insight.

Dr. Neal, Dr. Theriot, Dr. McIntyre, do you have any thoughts here?

DR. NEAL: I have got a lot of thoughts. If any of them want to speak, then I am going to back you up. Because we are in crises mode as far as I am concerned.

Medicaid has gone from being the safety net to being the primary insurance for more than half of the people in this state. And I can tell you that -- and I won't talk about reimbursement --
but I will talk about being able to keep doors open. I was a solo pediatrician for 45 years. And over the last 20 years, I could not have kept my doors open had it not been for KenPAC. Now some people don't want to talk about pay for performance or monthly payment as an extra. But that's what kept our doors open.

When we went to the MCOs, it was decided not to have KenPAC. And I brought this up before or a monthly payment. Some, at least one of the MCOs and I will say it, WellCare, actually kept that in force for a number of us who have large Medicaid practices because it is the only way that we could make it. We could not make it with the Medicaid payments. And that gets into the limits on complex care, et cetera.

But that kept a lot of us open.

We are to the point now where most of the private pediatric -- and I will only speak to pediatrics -- and, Bill, I think it is worse in the family practice -- most of the private groups have capitulated and joined hospital groups or larger corporate groups because they absolutely -- they could not make it.

And one of the major problems there was
electronic medical records. There was no way that I could have afforded electronic medical records under those circumstances because of software issues and the problems with that that come along.

The other thing that came up there is that I couldn't become a patient-centered medical home because I did not have an electronic medical record.

So those are just a few of the things that chipped away. And I can tell you now that it is felt that fee for service is outmoded and now we need to go with ways of payment for quality care which implies that we weren't giving quality care. And the only way we could keep the doors open was to see more patients. And that was actually true.

We are in this situation now where a good pediatrician on a good day can probably only see somewhere between high 20s and low 30s of patients a day. And with reimbursement as it is now, there is no way that they can keep the doors open.

So what it looks like to me is that the larger systems that employ pediatric groups are making up that loss by income from Medicare patients, that sort of thing. So I will stop there and see if somebody else wants to jump in.
DR. THORNBURY: Anybody, please.

DR. MCINTYRE: Yeah. This is Dr. McIntyre.

Just a couple of thoughts. One of them is that, as Dr. Thornbury was saying, doctors can go elsewhere to do better. Kentucky borders 7 other states. So for a large proportion of the physician population, they don't even have to move to practice in another state. For example, in Jenkins where I live, I am 2 miles from the Virginia state line and can practice in Virginia almost as easily as I can practice in Kentucky.

On telemedicine, that's one of the few good things that have come out of the COVID crises, is that telemedicine has become accepted and is being used on a widespread basis. But I keep reading about things, proposals to restrict telemedicine payments as we come out of this crises which I think would be a bad thing.

DR. THORNBURY: Dr. Theriot, do you have anything? Judy?

DR. THERIOT: I mean I agree with actually what everyone has said. And what I am thinking, what is going through my head, is more of a value-based payment which, you know, type of opportunity. I know some of the MCOs have started
some of that this year. But it is not very widespread.

I also agree that limiting the level 4s and 5 office visits needs to change. Because it is true that, you know, if you have a couple of chronic illnesses, which most adults have, then you are doing a level 4 and 5 all the time every time they come in.

So I mean that will be one way to change or, you know, improve the payment for what you guys are doing in the office. But, yeah, I think it is a big problem. I mean it resonates with me. I have maybe a few days in my life reached 30 patients a day and I pride myself on being fast. But that's about it. You know, most of the time, I am around 25. And then you go home and you do your notes.

So you are not really finished after the 10 or 11 hours. And I truly am one of the fast ones. But I mean -- so I hear what you guys are saying. And I do think it is going to get worse. I also think that, even in our pediatric residency program where we are primary care, most of our graduates are going into a sub-specialty at U of L. So they are going into the NICU or an ER or
pulmonary or GI. They are not going into primary care pediatrics.

And I think there is a lot of reasons for that because I am not sure they actually realized the payment options or -- at the time that they are finishing their residency. But they know primary care works really hard and they see other things out there. And they have a huge amount of student loans. And I think that when they are logical about it and see how they can pay off those student loans working as a primary care pediatrician.

So we do have a lot of problems.

DR. THORNBURY: Well, I think that -- I think that this kind of all moves back to our first principles of, say, Barbara Starfield, speaking of pediatricians, you know Dr. Starfield's work several decades ago also basically stated on every level, whether it was a city or town, a state or a county, Commonwealth, or even a nation-based level, systems that have good primary care have better outcomes and lower costs every single time. It has never been disproven, ever.

And I think what we are trying to do is I don't think -- I don't want our voice today to
come across as chiding anyone. We are all equal partners. But the thing of it is, I mean, for example, if I am the head of an MCO, I mean I can't really come and do business in Kentucky and make money unless I have got somebody out there that is willing to do that work. And the people that are doing the heavy work are your primary care workforce. But yet the medical schools are not driving -- they are not driving primary care people. Again, we are training people. They are just leaving. And they are not coming to primary care. They are coming to neurology or pediatrics. You know, they are just going into different areas.

So why would they -- we have to give them a reason to stay. Now, the reason is not just money. But on the other hand, how do you ask them to say, well, for example, I am sure a lot of people on the call never worked with an EMR. Well the EMR might cost you 60 or $100,000. They might as well give it to you for free because it is 2 or 3 or $4,000 a month that they get you on. And if you don't keep it up, you know what, when it breaks or there is an update, well all of those records that you had in there are worthless.
So it is not just an annuity. It is an annuity that they have you by the short hairs. They can any time decide what they want to do and you are going to have to play ball their way. And it is not just that. Now they have telemedicine systems that works just the same way. I have all my patients on telemedicine. Well, now, I get mad at that company. I go to another company. Now I have got to get my patients to all go into another company.

You see how -- and at the same time they come in and you say, well, Kentucky has 30 or 35 percent, you know, COVID vaccination. Well, who is the person that is really going to get that accomplished? Do you think some ad is going to do it? Well, it might get their attention. But that happens on a one on one gradual basis. Every time they have an interaction with the health system, we have to be there to counsel them.

But that takes time. Either I am going to take care of their diabetes or I am going to take care of the COVID. There is only so many hours. I think Judy kind of said this and Dr. Neal has pointed out. There is only so many minutes in the day that we can accomplish these things. And so
if you have asked us on these quality measures saying, well, we want these quality measures. You know, by golly, we do, too.

The quality measures really started with us. But we don't have the time to do it because when we do make the time to do it, there is just not enough compensation to keep your doors open. If I take care of this, I got to tell some person I can't see them today. And what we are saying is if you are using a more sophisticated way for primary care so say, well, we want you to fix the broken arm. We want you to do their diabetes and their high blood pressure and cholesterol all in one visit. Okay. But can you spend some time on smoking cessation with them.

It might not work the 3rd or 4th time, but the 5th time, you know, they might bite on it. And a lot of my patients do. Or when they maybe go to the diabetes counseling about how to prepare their foods and shop properly, well, again, if you pay for that, I think we are going to get better outcomes moving forward. And we hope you will be able to see that.

And, again, that's why I brought all of these together, the limits on E & M. Well, there is
sometimes, again, I don't want to monopolize the conversation, but I have diabetics, I have a lot of them in Kentucky. They come in. And every time they come in for that visit, we are talking about their blood pressure because they have hypertension. We are talking about their diabetes and the amendments that have to be made. We are talking about their lipids. And that's the minimum. Because a lot of these people have either vascular disease, smoking or something on top of that. And then, of course, I am trying to adjudicate some other quality measure. Or they say, well, I have this other problem and I can't get down here next week. I can't reschedule. I don't have a way down here, would you take care of this, too? And, you know, and that's for free, right? I mean once we are at 2 problems. That's at 4. So anything we do on top of that is for free. And you know what? We do it anyway because that's what we are here to do.

But we want you all to understand what is going on. Because if we don't tell you this, you know, you have no idea of how this is working so that you can't solve these problems for us. And we are hoping that you can work with our MCO
partners and say, you know, in Kentucky we have a lot of sick people. We have a lot of chronic disease.

If we are going to ask them to do this for us, if we are going to try to come and make a profit, we need people that are going to do something about that. And there is no better -- there is no better -- well, that's not true. I think prescription generic drugs actually give you a better return on investment than primary care.

But in the health care system, it is number 2. Primary care, good primary care, is the number 2 cost savings measure to the entire health system. And I hope that you will consider investing in that.

MS. GUICE: One of the things I would like to ask you is you were talking about, and as Dr. Theriot was talking about, the 99214s and 215s. Is there some other criteria that we could place on like maybe a diagnosis code that we could place on having every office visit be a 215 or a 214?

DR. THORNBURY: Well, Lee, it is a great question. And the short answer is, it kind of came up last time, is kind of no.

We are responsible by law and by medical
obligation to say candidly this is what we have
done for you all and we need to code it properly.
And when we do that, it comes out the way it comes
out. Now almost -- and primary care with the kind
of care we have in Kentucky, I am not going to
talk about urgent care for cough and cold stuff
and poison ivy. But real primary care which is
what we are dealing with, almost always they come
in -- it is very uncommon somebody walks out of my
office with a 4. Because if they do, they
probably don't need to be there or I handle it by
phone. I just give it to them.

And so there is no such thing as what's a CPT
code for that. Well, there is no CPT code for
that. We just have to tell you what we have done.

And that's why a lot of people, and I think
Dr. Neal suggested, you know, in these -- people
that are providing primary care, real primary
care, for you, if you can identify those, you
should say that, well, maybe we should see a
system of who has worked this over the last couple
of decades on is there an extra stipend for those
people for taking care of our patients.

You know, we are just not going to give you
the money. We are going to make sure that certain
quality measures are intact. And that's where Judy would come in. And I would expect Angie would say, well, we want these quality measures. If we are going to give you this extra money, we want these quality measures addressed. And that's a good quid pro quo. That's what we want to do. We want to show you that we are doing these quality measures. But on the other hand in order to be able to do that, we have to make the time to do it.

That's how I would solve the problem.

But now there is smarter people than I am and people that make their living doing this. And they have done it for decades. I just don't know how they do it.

DR. NEAL: Well, very soon we are going to have to have a serious discussion on this 99213, '14, '15. They had talked about blending it. And actually a year and half or so ago it was supposed to take effect.

Well, we spoke against that or decided that wasn't what should be done. But we are going to have to do that. Because right now, if you look at the studies, somewhere between 40 and 60 percent of every pediatric's visit properly
coded would be a 99214. And it is way below that because most of us older pediatricians didn't code it above because we didn't get paid if it was more than 2.

So I think DMS has to look at that very quickly. And with the discussion of how we change that.

The other problem with value-based care, the way I have -- I have read everything I can find on value-based care. And it involves pediatricians and family practice doctors assuming risk. And the MCOs, that's what they do is calculate risk into their premiums and all of that. We can't calculate risk into what we charge. And I think that is something that needs to be thought about more.

We don't have time to even think about risk. The risk to us is providing good care to our patients. And I think that DMS, somebody needs to call some of us to discuss it somewhere along the way. I will stop there.

MR. GUICE: I thought that's what we were doing is discussing it.

DR. NEAL: Well, we are now. Yes. Is that Lee?
MR. GULICE: Yes, sir.

DR. NEAL: Lee, I have known you for years. And you all have always been very fair with us. But we are still strapped by what the people above us have said we can do. And so I think that we need to have discussion. The Medicaid Advisory Counsel, which I served on a long time, needs to discuss that. Because there are a lot of stakeholders involved; home health, optometry, you know, pharmacy. Everybody is kind of tied to the physician because that's where all of these services start.

And so we have got to look at all of that. And we've got to do it pretty quickly. Because as Bill says, we are approaching the edge of the cliff pretty quickly in my opinion.

DR. THERIOT: I mean they changed the coding guidelines January 1, 2021. So before that, the vast majority of the, at least in pediatric offices, the codes that people coded were the 99213s. And now they have switched that to better show what people are doing, you know, the time and effort that you are putting into the visit.

So now probably 60 percent would be, or more, might be a 99214. And so I think that does have
to change. Because if you are coding properly, you are going to be coding for a 99214. And then it is not going to be reimbursed after the second one.

DR. THORNBURY: Well, Judy, I think you are right. And I think, again, I want this to be a very positive discussion. I think what as physicians we are trying to do is I think we are trying to bring to your attention that there is an eminently impending crises. And I think that at that point, we have to leave it with the -- with the department to decide how you in the administration think is the wisest way to manage this and to work with the commissioner on that.

I think some of the things that we suggested, you know, is it time to get together a group of people and sit down and begin to have conversations about, maybe in Kentucky, do we, like in Kentucky in 2018, '17, we saw a new vision for health care delivery here. And lot of people in the country shared that.

Well, should we look at a new vision of the way we are going to have to work with primary care providers, at least in our state, to make this work and is it time for that? Well, only you all
can decide that because you are the referee here. The MCOs, God love them. They are like children, man. I mean they are going to do whatever they can get away with. If they can get away with saying, we are going to pay for two 99214s a year, they are going to do it.

But at this point, does it serve your interest? Does it really serve the Commonwealth's interest if all of a sudden the infrastructure implodes? Well, I don't know. But you all have got to decide that. All we can try to do is say, we will be partners with you. We are calling your attention to this. And if we can help you, we will.

But, again, this is not our expertise. There are companies, I am sure, and very large states that have worked with this for many years. And I don't know what their outcomes are because I don't do that for a living. But in my opinion, you might want to consider is it time to decide either internally that we need to have, in the next few years, we have got to solve this problem because it is not going to go away.

If you do think that, maybe you can have other round tables. I don't think this small
committee, you know, which is a subset of a larger committee, I don't think that committeeing it to death is going to solve that problem. But I think we are trying to tell you in a very direct way there is a major problems here. It is not getting better. And it is getting worse. And I really don't know.

When I saw that article, and that article is the tip of the iceberg, it is worse in Kentucky, I can tell you, because I am on these workforce committees. It really is worse.

I don't know how long it is going to go until it does break. When it does, it will be a problem. I guess it is just like an iceberg. It sits there and sits there and sits there and finally it snaps. And when it goes, it will be too late to fix it. Because it will take several years, in my opinion, for this to be corrected.

Judy, do you have any last thoughts? I saw you trying to chime in there for a second.

DR. THERIOT: No. I do think COVID has made things worse and made the burnout worse. And people are just tired. And it might, I mean it might be the straw that breaks the camel's back and you see people leaving the workforce even
sooner because they just can't keep up the pace.

    It is just too hard.

DR. THORNBURY: Well, I think we beat this
horse enough. And I appreciate the gentle ears of
everyone here. And, again, I am sorry I am so
passionate about this. I guess when you have
lived this for 20 years, or with respect to Dr.
Neal and Dr. McIntyre, maybe a bit longer. You
know, I love this state. I love my Commonwealth.
I want to see great things for it. I don't want
to see bad things for us.

    And I hope that we can do it a better way.
And I hope that we have great leaders in our
physicians. And with not only DMS but also our
MCO partners, they can help us solve these
problems that everybody can win and nobody gets
the short end of the stick.

    Because if we don't have anything to -- if it
finally does break, it will be, you know, just
become catastrophic. Businesses won't want to
move in here. People won't want to stay. You
will just become a welfare state.

    But if I could, I am going a close that down
and just -- Ashima wanted to work on a topic for
contact lenses. That will be our last topic
today.

   Ashima, can you help us out with that?

   DR. GUPTA: Sure.

   We recently had a board meeting, the Kentucky Academy of Eye Physicians and Surgeons, Monday night. And it was brought up that, you know, Medicaid covers specialty contact lenses through the age of 20 or 21, I believe. And then, of course, after that age they are treated as an adult and contact lenses are no longer covered.

   So this is just specifically a specialty contact lenses for specific eye conditions like Keratoconus corneal deformities where patients can actually improve their vision with a specialty contact lens and they can avoid surgery.

   So what happens is that after the age of 21, these contact lenses are no longer covered but, of course, the surgery is covered and so they, you know, they don't have the money to pay for these contact lenses which can be several hundred dollars. But instead the much more expensive surgery will be covered. And, of course, there can always be complications from that surgery. So that actually costs the health care system more money by having these patients choose surgery over
something that could, you know, clearly be taken
care of with a contact lens.

So that's just one example.

There are several other eye conditions that
also can be taken care of with specialty contact
lenses. So I know it is a long road but I wanted
to bring it up and I would like it to be brought
up. I would love to make a recommendation that
Medicaid cover specialty contact lenses for
specific reasons throughout a patient's lifetime
rather than cutting of it off at the age of 21.

And I am sure the optometry TAC will be very
much for this as well because they see a lot of
these patients requiring contact lenses. So
that's what I wanted to bring up.

DR. THORNBURY: Would anybody like to discuss
Dr. Gupta's point?

DR. MCINTYRE: I would like to second her
recommendation. There is Dr. McIntyre.

DR. THORNBURY: Thank you, Dr. McIntyre.

So we have a motion there. Before we vote on
it, would anybody like to discuss this from any of
our partners, the MCOs or for DMS?

There has been a motion brought to the floor.

All those in favor say aye.
GROUP: Aye.

DR. THORBURY: Any opposed? No opposition. Motion carries. We will forward that to the MAC.

MS. GUICE: Excuse me for interrupting.

But, Dr. Gupta, would you mind very much to forward some of your research on the specialty contact lenses? That would certainly, since apparently you have already done some or there is some out there, if you could send that to us, that would help us. We are doing a review of our adult vision benefits now. So that would be very helpful to us and I would certainly appreciate it.

DR. GUPTA: Should I send that to --

MS. GUICE: You can send it to Sharley and she will get it to me.

DR. GUPTA: Okay. Okay.

DR. THORBURY: Thank you, Lee. Is there any more business before the committee today?

DR. MCINTYRE: I would just like to request -- McIntyre again -- Dr. Gupta, that for the MAC meeting that she present this rather than me because she can answer questions and is much more knowledgeable about this as a pediatric ophthalmologist. I certainly am not, as an ER doctor.
DR. GUPTA: I would be happy to.

DR. MCINTYRE: Thank you.

DR. NEAL: Bill, when is the next MAC meeting?

DR. GUPTA: Thursday.

DR. THORNBURY: Thursday.

MS. HUGHES: Dr. Thornbury, since you do have a quorum, can you approve the minutes from your last meeting? You are on mute, sir.

DR. THORNBURY: Sharley, I am so sorry. It must have slipped my mind.

MS. HUGHES: You are fine.

DR. THORNBURY: Are there any additions or deletions to the minutes from the last meeting? If there are none, can we accept them by acclamation? All in favor?

GROUP: Yes.

DR. THORNBURY: We will file the minutes. Thank you. Thank you, Sharley. I am a bad boy.

MS. HUGHES: No you are not. You are fine.

DR. THORNBURY: Our next meeting is scheduled for November 12. However, if there is not a substantial calendar, I am not going to bring our group back unless we have some real work to do. If we do, of course we will let everybody know.
And, again, thank you for your morning. I really appreciate it. Enjoy your weekend everybody.

This meeting is adjourned.

DR. NEAL: Bill, he had something he wanted to say.

DR. THORNBURY: Yes. Go ahead.

DR. MCINTYRE: We had planned to have an in person meeting in November. Do we want to move that plan forward until March?

DR. THORNBURY: It is so far ahead considering the amount of COVID and the way these new variants are acting, I think that it might be best to work with DMS and the governor on that when we get closer.

I mean we would always want to be a person. I think that's not a bad thing at all a few times a year. But I think at this point, I really can't see that far ahead.

Would the committee like to meet in person if we could in November? Would that be good? Would everybody be agreeable to that? We would be, I guess, in Frankfort wouldn't we?

DR. GUPTA: I would prefer not to given the increasing rates of COVID.

DR. THORNBURY: What was that, Ashima? I
couldn't hear you.

    DR. GUPTA: I said I would prefer not to
given the increasing rates of COVID right now.

    DR. THORNBURY: Okay. Well, let's see where
we are. Again, this is, you know, we are in the
middle of September here. It is just a long way
away considering the way the virus is acting. So
when we get closer I think we will have a clearer
picture. Okay? But we will keep everybody
informed.

    DR. NEAL: Bill, Don Neal. Quickly.

        Did we have any MCOs in attendance today? I
couldn't see. I saw Tom James was on but I am not
sure exactly. Nobody spoke up.

    DR. THORNBURY: Dr. Cantor is in. I see her.

    DR. NEAL: Okay. All right.

        Because it is very important to have their
input into this. And that's why I like the in
person meeting so I know who is there. But also I
think that they are so important to us at this
point. We need to know that.

    DR. BRUNNER: Dan Brunner and Peter Thurman
are here from Anthem as well.

    DR. THORNBURY: Thank you guys for coming.

    DR. NEAL: Yes, thank you.
DR. THORNBURY:  Dr. Brunner, I see you here, too. I didn't see that on my screen. I see you, too, as well. I am so sorry.

DR. BRUNNER:  That's okay.

DR. THORNBURY:  Thank you very much.

MS. HUGHES:  Dr. Neal, click on the participants button on your computer screen. It will show you all -- everybody that's in the meeting so you can see. If you know who the person is you are looking for, you will see them.

DR. NEAL:  That's the problem. Only one of them, two say who they are with. Otherwise it is just listed by name.

MS. HUGHES:  Right.

DR. GALLOWAY:  Lisa Galloway and Cathy Steven are here from Humana, too.

DR. THORNBURY:  Hi, Lisa. How are you?

DR. GALLOWAY:  I'm good.

DR. THORNBURY:  Thank you for coming. Well, do we have anything else to do, you guys?

DR. NEAL:  Thank you, Bill. You did a great job.

DR. THORNBURY:  Well, thank you, guys. Judy, it is great to see you as always. Thank you, Sharley for helping us.
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 PHYSICIANS TAC, 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 24th day of September, 2021.

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

My Commission Expires: 7/15/2023