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PHYSICIAN SERVICES TECHNICAL ADVISORY COMMITTEE

SEPTEMBER 6, 2019 MEETING

TRANSCRIPT OF MEETING

SEPTEMBER 6, 2019

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The foregoing meeting was held, pursuant to notice, on Friday, September 6, 2019, beginning at the hour of 10:00 a.m., at the Cabinet for Health and Family Services, Public Health Conference Room C, 275 East Main Street, Frankfort, Franklin County, Kentucky, 40601, Vice Chairman William McIntyre, M.D., presiding.

1 DR. MCINTYRE: I was just appointed acting  
2 chair. So I was expecting just to sit back and  
3 listen but that isn't going to be the case. So I  
4 will wing it. So bear with me.

5 So let's do introductions first.

6 \* \* \*

7 SEE ATTACHED SIGN-IN SHEET

8 \* \* \*

9 DR. MCINTYRE: So I thought I was old. I am  
10 70 and a half and still practicing. And I was an  
11 infantryman in Vietnam. The gentleman next to me  
12 makes me feel like a youngster. He was old enough  
13 to be a doctor in Vietnam although he went to  
14 Germany instead.

15 First, status updates telehealth  
16 implementation. Is anybody here to speak to that?

17 MS. HUGHES: We are doing -- I mean we are  
18 doing the statement of consideration for the  
19 regulation, responding to all of the comments.  
20 That's being worked on. I believe Jonathan is  
21 just about through and will be ready to go back to  
22 LRC soon. But, I mean, it is implemented.  
23 Because we filed it as an emergency reg for  
24 July 1. So it is up and operational.

25 DR. MCINTYRE: So I am pretty ignorant on

1 telehealth issues. But I do know I got an email  
2 that the telehealth board was dissolved a couple  
3 of months ago.

4 What has replaced that?

5 MS. LADY: They are working on that. They  
6 are working on a different kind. It is not going  
7 to really be --

8 MR. GRAY: It is more like an advisory  
9 council. But we have folded the function of  
10 telehealth up underneath the Cabinet for Health  
11 and Family Services. And it is part of our office  
12 of data management. So it is fully part of the  
13 Cabinet now.

14 And that was dissolved. There was a piece of  
15 legislation that got passed, I think, in 2018 I  
16 think it was that dissolved the telehealth board  
17 as of June 30 of 2019. So we have been following  
18 that legislation. And I think with what we're  
19 doing with the KHIE, the Kentucky Health  
20 Information Exchange, and telehealth, all of this  
21 really is coming together very well in terms of  
22 the structure. And I think the state will benefit  
23 from what we are doing.

24 DR. MCINTYRE: And you mentioned an advisory  
25 council. Is there a separate advisory council

1 similar to this committee that advises the Cabinet  
2 on telehealth?

3 MR. GRAY: It is not a Medicaid TAC. So it  
4 would be, again, more of an advisory council. But  
5 it would not flow up through the MAC in terms of  
6 comments. But it would be more to advise the  
7 Cabinet with regard to the direction we need to  
8 take in the area of telehealth.

9 DR. MCINTYRE: Now, is that being set up or  
10 is that already --

11 MS. LADY: It is. And KMA and probably KPCA  
12 got like an email that asked us to suggest people  
13 that would be -- work on that advisory council.

14 MR. GRAY: September. I would think that  
15 probably would be together by the end of the year,  
16 that council.

17 DR. MCINTYRE: Okay. All right.

18 DR. NEEL: Wonder if we could have the MCOs  
19 talk a little about challenges that we see with  
20 telehealth? We passed the parity legislation. It  
21 seems like telehealth has become the better than  
22 sliced bread kind of thing, going to solve all of  
23 problems of access, the thing the urgent care  
24 centers were going to do years ago.

25 But there is a lot still to be talked about

1 as far as quality of care and that sort of thing.

2 Norton's is just getting involved in it. And  
3 we are starting to learn there are more challenges  
4 than we thought about that. I just wondered how  
5 the MCOs -- of course, payment is one of their  
6 things. Looking at the other, I just wondered how  
7 they view telehealth at this point.

8 DR. MCINTYRE: So the next item on the  
9 agenda, the MCO updates. So if you folks could  
10 speak briefly and give your thoughts on how  
11 telehealth is impacting your operations with your  
12 updates, that would be very helpful.

13 DR. NEEL: That's fine.

14 DR. HOUCHINS: So in terms of WellCare, I am  
15 not sure that I have any updates to share  
16 regarding telehealth. I mean I have my own  
17 personal opinions on telehealth. I think it  
18 certainly has a role. But it is not there to  
19 replace a face-to-face meeting between a patient  
20 and a provider. And that may just be the old  
21 school doctor in me.

22 But, you know, I personally would really like  
23 to see telehealth evolve into a consultative role  
24 or at least the consultative potential for  
25 telehealth to really take some fruition. So, for

1 example, in my primary specialty of child  
2 psychiatry, there aren't enough of us to go around  
3 and I think that consultations with FPs and  
4 pediatricians can be extraordinarily useful. But  
5 there is not always a mechanism by which to cover  
6 that type of service.

7 So, I mean, I could see expansion there.  
8 But, again, I am not sure that I have any specific  
9 updates to share from WellCare. Maybe Passport  
10 would have some.

11 DR. HOUGHLAND: I will be happy to offer some  
12 thoughts about telehealth; our experience, and  
13 maybe some, you know, opportunities and potential  
14 unintended consequences that we have to think our  
15 way through together. And then for other updates,  
16 I will look to Lucy to try to fill that out.

17 Again, I am sorry. Steve Houghland with  
18 Passport for our friend the court reporter.

19 So we have seen a little bit of an increase  
20 in telehealth services, primarily in behavioral  
21 health, and child psychiatry being one of the  
22 places where we have some increase. Last time I  
23 checked, we had somewhere around 7 -- between 15  
24 to 20 providers that were delivering telehealth  
25 services in behavioral health with about 1500 to

1 2000 encounters through the first half of the  
2 year. So not a huge number. A lot of those were  
3 through a couple of CMHCs providing services in  
4 more remote parts of the state, particularly for  
5 helping to fill some child psychiatry services.

6 There have also been some services rendered  
7 through the academic medical centers. I do see it  
8 as an opportunity similar to Tim here. I think  
9 finding the right niche on how to coordinate care  
10 is an opportunity and a challenge.

11 How is the communication between the 2? The  
12 physical health provider sometimes and the  
13 behavioral provider having more integrated care  
14 and communications is part of it or through other  
15 specialty back to a primary care provider. Where  
16 there are urgent care and care visits being  
17 provided, how do you connect that back to the  
18 provider if it is not the assigned PCP, for  
19 example?

20 And I think that is a part what we are trying  
21 to work our way through and part of the  
22 application under the regulation -- or the statute  
23 and I believe the regulation as I remember seeing  
24 it.

25 So how do you close the loop so to speak is,

1 I think, part of the still one of those questions.  
2 And, you know, what role can we play in trying to  
3 help close that loop?

4 One of the things that we have thought  
5 about -- and honestly, I don't think we have a  
6 great solution for it -- the parity piece really  
7 was not a concern for us. We already had that in  
8 place prior to any statute or regulation. So we  
9 were already paying equivalent whether it was  
10 face-to-face or something through telehealth.

11 The facility component and reimbursement for  
12 that under the traditional model was a challenge.  
13 Now, not having to be tied to bricks and mortar  
14 simplifies that a little bit potentially. But I  
15 think a piece that is still not completely clear  
16 to me, especially if we are looking at less than  
17 realtime delivery of services where a patient, a  
18 member, they receive multiple services same day  
19 and it kind of escalating at different sites of  
20 service by different providers.

21 There are certain billing rules that kind of  
22 exist in the world that may cause things to kick  
23 out. And so how do you coordinate that? And  
24 that's one of the questions I had about the cash  
25 encounter that what would happen to that if the

1 member has a service to render, there is not  
2 complete fulfillment of the service at the time.  
3 They end up seeing another sited service, going to  
4 see another specialist. The data service could  
5 still be the same but the billing dates would be  
6 different.

7 If you go back to the date of render, typical  
8 billing rules would kick out one of those  
9 encounters for the same service, same day. So  
10 those are some of the -- I think those are very  
11 logistic specific questions that will have to be  
12 worked through over time. But a lot of it depends  
13 on is it something that is rendered realtime? Or  
14 is it rendered and then fulfilled at a different  
15 time?

16 So kind of the storing forward process. How  
17 does that work within some of the generally  
18 accepted billing rules?

19 MR. HIBBS: I can echo what was just said.  
20 So not coming from the clinician background, where  
21 I come from is the network relations area at  
22 Anthem. Most of the questions that came a couple  
23 of months ago were primarily around behavioral  
24 health. So that's where it focused.

25 It seems on my end to have slowed down. I

1 would have to defer to our PP, provider solutions,  
2 to see if she has heard of anything. But to that  
3 end, we do have fall provider webinars that are  
4 going to be scheduled in November which presents a  
5 pretty good opportunity for providers to ask any  
6 questions about telehealth or anything that would  
7 be, you know, of concern around that area.

8 You know, also to visit this, it seems to be  
9 kind of a fairly new rollout that one of the  
10 updates that we always bring is that providers can  
11 always sign up on our website for provider  
12 communications and newsletters for pretty much  
13 every line of business. So, you know, I am sure  
14 down the line over the next few months, telehealth  
15 may have some articles or updates that will be  
16 useful.

17 And as far as that for telehealth, I don't  
18 have any general challenges or concerns that I  
19 have personally faced with it. I do know Anthem  
20 up to this point has put out some changes in their  
21 provider manual and updates to their policy and  
22 guidelines on our general website.

23 But that's pretty much it for telehealth.

24 And, do you know, are we still going around  
25 for just the other general updates for MCOs at

1 this time or do you want to keep going on  
2 telehealth?

3 DR. MCINTYRE: Yes.

4 MR. HIBBS: So outside of telehealth, we  
5 rolled out our Medicaid and Medicare only dispute  
6 functionality on a daily. So hopefully that is  
7 going to make it a little bit easier for providers  
8 to go in and to give you another method of getting  
9 those bills or disputes for the government  
10 business done.

11 It is not for commercial at this time.  
12 Hopefully it will be soon. I want to make that  
13 clear. But that did go live on 7/29.

14 MS. LADY: It is for Medicare, too?

15 MR. HIBBS: It is for Medicare --

16 MS. LADY: And Medicaid?

17 MR. HIBBS: That's correct. And along the  
18 Medicaid lines, IngenioRx for Anthem did go  
19 effective 10/1. That was for Medicaid.

20 DR. MCINTYRE: I am sorry. I am bad with  
21 names. Tell me your name again and your role at  
22 Anthem.

23 MR. HIBBS: Yes. I am sorry. I am Matt  
24 Hibbs. I am the network relations consultant for  
25 Anthem. I primarily service the Lexington region.

1 We have some changes going on. So we have a  
2 couple open roles in the different territories.  
3 But Louisville, Lexington, we are kind of pitching  
4 in some help by filling those positions there.  
5 And I do a lot of the southern region by  
6 Tennessee.

7 DR. MCINTYRE: Thank you.

8 MS. BROWN: I don't have any MCO updates.

9 MS. HUGHES: WellCare or Aetna?

10 MS. ASHER: I am with Aetna. I can go ahead.  
11 I am Sammie Asher. And I am network relationship  
12 manager of Aetna.

13 Telehealth is working out really well for us.  
14 We have a lot of satisfied providers, especially  
15 in the underserved areas. They are taking full  
16 advantage of that.

17 There are questions that they are asking  
18 every day. And it is basic questions and we are,  
19 obviously, we are answering those. And the  
20 billing portion is going really well. They are  
21 learning how to bill with the appropriate  
22 modifiers. Behavioral health is getting huge in  
23 that scope and there is a lot of things we are  
24 working on for webinars in the fall to sort of  
25 touch on behavioral health and telehealth.

1           So it is looking good.

2           MS. LADY: Are there any exclusions on the  
3 behavioral health?

4           MS. ASHER: Not that I know of. Behavioral  
5 health is not my strong suit. I am more primary  
6 care and hospital driven. But we are learning  
7 more about that and that's why we are rolling out  
8 the webinars in the fall.

9           DR. TRAN: Can I ask you to look into whether  
10 or not you can conduct group sessions in  
11 telehealth? My understanding is that it is still  
12 prohibited. And it goes back to Medicare  
13 regulations and the statutes and what have you.

14          MS. ASHER: Okay.

15          DR. TRAN: Because I think I can think of  
16 many instances where people can take advantage of  
17 group sessions. If you are a nutritionist and you  
18 are --

19          MS. LADY: Diabetes.

20          DR. TRAN: -- and, you know, the patients  
21 don't necessarily have to leave their home. That  
22 would rapidly get care to those in the community  
23 that don't have access.

24          MS. ASHER: I understand.

25          MS. LADY: Or tobacco cessation. Those are

1 the 2 that have come up the most often.

2 DR. MCINTYRE: I wonder what HIPAA issues  
3 would arise in a group session?

4 DR. HOUGHLAND: Sign a release.

5 DR. TRAN: So the discussion that we have had  
6 at other scenarios is if you are talking to  
7 patient John Doe and it is in a group session and  
8 John Doe's brother, John Doe's wife walks into the  
9 room, you just broached and violated HIPAA because  
10 that person wasn't really part of that need to  
11 know.

12 So you would have to request that the patient  
13 or whoever is going to participate in the  
14 telehealth close the doors. But how would you  
15 ensure that they are going to keep that door  
16 locked?

17 MS. LADY: Do you all have a standard  
18 release, like, form that a patient would sign? Is  
19 it like what you would normally sign at a  
20 physician's office?

21 DR. HOUGHLAND: So we do. However, this  
22 would really be at the rendering site.

23 DR. TRAN: It would be the physicians.

24 DR. HOUGHLAND: Yeah. So it would be the  
25 providers that have to govern that.

1 MS. LADY: But if they have that on site,  
2 they could have the patient sign it.

3 DR. HOUGHLAND: They could. And, sorry, I  
4 don't mean to monopolize here. I guess I see a  
5 couple of scenarios there.

6 One is is that the group is still the group  
7 and then the facilitator is remote. And so to  
8 control a session is a little different then in  
9 controlling information. And privacy is one  
10 thing.

11 Now, the inverse is a completely different  
12 scenario, though, where the facilitator is here  
13 and everybody else is remote. Generally I think  
14 the technology, it still wouldn't completely  
15 support that through Skype or other HIPAA  
16 protected types of technology to support remote  
17 sessions, multiple sessions, at once with a  
18 central facilitator. But I don't exactly know how  
19 the provider would be comfortable with assuring  
20 that confidentiality is maintained.

21 Whenever we have remote staff that are  
22 involved in that, we actually check to make sure  
23 that they have a dedicated location for their  
24 equipment and that they have signed certain  
25 releases and attestations that they will make sure

1 that there is security for the equipment, et  
2 cetera, to be able to have any kind of session  
3 that is conducted where there may be protected  
4 health information even potentially disclosed.

5 On the side of delivering that to a patient,  
6 I don't know. If I were wearing the provider hat  
7 in that setting, I would be a little concerned  
8 about how to do that. And to me I think having  
9 the central location where the group is located  
10 and then the provider being remote, that has a lot  
11 more security built into it.

12 I think the other people -- it just depends  
13 on the risk tolerance of the members of the group  
14 and the risk tolerance of the provider. Because  
15 ultimately the provider is the one that is going  
16 to be responsible for that.

17 MR. GRAY: This is David Gray with the  
18 Cabinet.

19 So really the intent of the telehealth reg  
20 that we have currently put out is really to take  
21 the place of a face-to-face encounter. It really  
22 has not in terms of this group approach. And part  
23 of this is we have no budget for the telehealth  
24 endeavor. So we are doing this. And what it  
25 looks like in 2019 will look different than it

1 looks like in 2025 because this is very much  
2 evolving. You have got more secure HIPAA  
3 compliant technologies that are getting approved  
4 daily down to the iPhone or the Android.

5 So we really have to start with smaller  
6 steps. But this was the -- our attempt to --  
7 behavioral health certainly very important, being  
8 able to get access to, you know, child  
9 psychiatrists in just the dirt. And that is not  
10 going to change any time in the future. So being  
11 able to get those type of consults in place.

12 But it is really for right now it tends to be  
13 more in the place of a face-to-face, not so much a  
14 group setting application. And I think also  
15 that's an area that would, you know, we have got  
16 to kind of define the parameters for that.  
17 Because you talk about it being an advantage. It  
18 also could be taken advantage of. And I think we  
19 have got to be very careful about that, too.

20 DR. MCINTYRE: I think inevitably you would  
21 end up with group sessions on YouTube if it was  
22 done regularly. And I mean I can just imagine  
23 some guy saying, you know, I am divorced twice and  
24 I cheated on both of my wives and it coming out on  
25 YouTube.

1 MR. GRAY: Again, we are very early in this  
2 journey. So --

3 MS. LADY: Well, Dr. Tran, that is something  
4 we need to work on I guess.

5 DR. TRAN: It certainly can be done. And it,  
6 as he pointed out and articulated better than I  
7 did, there are 2 ways to approach the group  
8 sessions. One is to have a controlled group  
9 environment. That's easier. The current practice  
10 that we are trying to adopt now to maximize  
11 convenience for the patient is they could be at  
12 their cell phone remotely and everyone is remote  
13 but then you pull them together into a conference  
14 group session. And the obstacle now is how do we  
15 ensure that confidentiality. Because if the  
16 patient is sitting at home, brother Joe or wife  
17 Dana could walk in and now you have just violated  
18 everyone's confidential --

19 MS. LADY: It does make more sense like if it  
20 is controlled. That's how they do diabetes  
21 education now in an office is they bring in the  
22 people in a group in a closed room. And then  
23 usually a medical or nutritional therapist goes  
24 over what you are supposed to be eating, whether  
25 you do or not, you know, those kind of things.

1           So that is pretty controlled like that today.  
2           I can see that. But, yeah, when the patient's at  
3           home and their family is all walking around,  
4           different scenario.

5           DR. TRAN: The second question -- and as a  
6           member of KSAM, Kentucky Chapter of Society of  
7           Addiction Medicine, we were asked a question from  
8           the community in regards to prescription of  
9           scheduled medications while using telehealth.

10          And I don't know if you guys are familiar the  
11          Ryan Haight, H-A-I-G-H-T, Ryan Haight Act which  
12          spells out. And, I think in 2010 or 2011,  
13          something like that, there was an addendum added  
14          to specifically address that issue. And has  
15          anyone at the Medicaid level talked about how we  
16          are going to comply with the DEA, the Ryan Haight  
17          Act, so that providers who want to utilize the  
18          telehealth modality to deliver care can prescribe  
19          scheduled medications?

20          MS. BROWN: We haven't discussed that to my  
21          knowledge at this point but I have made a note.  
22          It is an interesting topic.

23          DR. MCINTYRE: Just going back for a minute  
24          to the idea of group sessions on the telemedicine.  
25          Steve was talking about within Passport

1           having group sessions on video conferencing. But  
2           these people are employed or are contractors and  
3           are accountable for whatever they do with that  
4           information. You know a patient on Medicaid, what  
5           can you possibly take away from them but their  
6           freedom? Are they even subject to the HIPAA law  
7           if they violate other people's protected health  
8           information? You know, it just -- there are lots  
9           of issues.

10           DR. HOUGHLAND: Well, I don't believe they  
11           are subject to HIPAA. Although, I guess,  
12           depending on what type of informed consent was or  
13           was not obtained in that, there could be some  
14           additional -- and I am not an attorney. I will  
15           disclose that.

16           But I would think that there is something  
17           potentially around liable, slander, and other  
18           types of personal harm that could come about as a  
19           result of posting something publicly that they  
20           were not supposed to. I think some of it comes  
21           back to what is communicated, what's the informed  
22           consent, what is all of the structure of  
23           regulation and other governing kind of documents  
24           and rules exist for protection.

25           And I am way beyond my capacity to be able to

1 understand.

2 MS. LADY: I wonder how they get around that.  
3 So now they must have something like that already  
4 in place when they do those. Because group  
5 counseling goes on with diabetes management and  
6 even with tobacco cessation.

7 So it is happening today. So there must be  
8 some way to do that.

9 DR. HOUGHLAND: Yeah. I think the difference  
10 is unless somebody is videotaping a face-to-face,  
11 you know, a group session that is occurring in  
12 realtime, the ability for it to go viral is so  
13 much less. Yeah, there is potential harm in a 1  
14 to 1 conversation. 1 to 10,000 in 5 seconds, I  
15 mean, it is just a completely different scale that  
16 we are not -- I am not really accustomed to.

17 MS. HUGHES: I am thinking if you are a  
18 diabetic or you are smoking and you are in a group  
19 of similar people, there probably are some  
20 releases. I don't know that Cooper Clayton  
21 necessarily has releases but you are not  
22 disclosing stuff, I wouldn't think, like you would  
23 be disclosing if were you a mental health provider  
24 and you had 6 people in 6 different locations.

25 I am thinking of myself. If I was one of

1           those patients, I wouldn't want to be 6 different  
2           locations entrusting that that other patient is  
3           not going to let somebody else come in the room.  
4           But that's just personally on that part of it.

5           MS. LADY: We can probably table this. I  
6           talked to David. We will come back to it because  
7           I think there is a lot to discuss there. But I  
8           think it is doable. You just have to figure it  
9           out.

10          DR. MCINTYRE: Steve was mentioning civil  
11          remedies. And, of course, I am not an attorney  
12          either. But civil remedies are meaningless if you  
13          don't have any assets.

14          DR. HOUGHLAND: Some of those may be even  
15          more than civil, too, though.

16          DR. MCINTYRE: Yeah.

17          MR. GRAY: This may be something that we can  
18          do. But for financial and budgetary reasons, we  
19          won't be able to. I just don't --

20          MS. HUGHES: Well, I was kind of looking down  
21          through the regs to see if there was anything in  
22          the regulation -- and trying to read it on this is  
23          impossible to see -- but mention anything about  
24          group therapies in the regulation. And I don't  
25          know that.

1 MS. LADY: The regulation is really broad  
2 because that is why it, in my opinion, why it is  
3 such a good regulation. Because it just says  
4 face-to-face. And, of course, you can do group  
5 counseling face-to-face. It is done today. It is  
6 just you are doing face-to-face to a whole bunch  
7 of people basically.

8 That's my interpretation. I am not an  
9 attorney either. So I don't know. I just think  
10 there is more work to be done here. So we will  
11 work with the Cabinet and Dr. Tran and anybody  
12 else who is interested in it. I guess this could  
13 be an issue that the new council talks about, too,  
14 the advisory group.

15 MR. GRAY: Well, and also the final reg. We  
16 have an e-reg. Then you have got all of the  
17 comments that came in on the e-reg. So the final  
18 reg wouldn't necessarily completely mirror the  
19 e-reg. So it will have a different look and feel  
20 to it.

21 MS. LADY: That's true. I am guessing you  
22 all got a bunch of comments, too.

23 MS. HUGHES: I don't know that.

24 MS. LADY: Yeah. I am going to say you did.

25 DR. MCINTYRE: I will share my own

1 experiences with telehealth as an ER doctor.

2 In Flemingsburg, we don't have that  
3 capability. I worked previously in Columbia where  
4 we used telehealth with Vanderbilt with doctors  
5 who were licensed in Kentucky for stroke  
6 referrals. And at the present time, I work  
7 part-time. I work full-time in Flemingsburg,  
8 Kentucky and part-time in Hot Springs, Virginia.  
9 And we do have telehealth there.

10 And within the last month, I have used it  
11 both on stroke patients and also on psyche  
12 patients. The place I work is way up in the  
13 mountains and no one wants to -- no mental health  
14 provider from another county wants to come there  
15 because it is at least an hour drive.

16 So within the last 2 weeks, I was involved in  
17 doing telehealth with a psychotic patient getting  
18 the mental health people from a neighboring county  
19 to arrange a transfer to a state mental hospital.

20 And it works very well for stroke care. I  
21 mean they want to know -- from Flemingsburg, we  
22 have to figure out what the NIH Stroke Scale is  
23 before we transfer. In Hot Springs, we just put  
24 the stroke doctor on telehealth with the patient  
25 and they figure out the NIH Stroke Scale.

1           And the last one I had, I was told this  
2 patient is not a candidate for clot removal based  
3 on the telehealth evaluation. So it works pretty  
4 nicely.

5           Public health trends. I think --

6           MS. LADY: I think we still have Humana and  
7 Passport.

8           MR. DAY: I am Beth Day. I am with Humana  
9 CareSource. I don't have a lot of feedback on  
10 telehealth. I am in the Louisville area so I am  
11 not in an underserved area by any means. We are  
12 up to our necks in physicians thankfully.

13           I can take that back and reach out to some of  
14 the reps that I have out in the some of the  
15 eastern and western parts of the state where there  
16 is not that availability for patients to readily  
17 get perhaps the treatment they need or the  
18 evaluation that they need as to what their  
19 experience has been. But I have not really had a  
20 lot of feedback that the providers are utilizing  
21 it at this time.

22           I do know that we are reimbursing for it. I  
23 know that is something that KPCA mentions on the  
24 monthly meetings. But that's really the only  
25 impact that I have had on that is speaking with

1 David Bolt making sure that that is on the fee  
2 schedule that we are reimbursing for it.

3 Our biggest update is going to be is  
4 ever-present on the horizon. And we are going to  
5 just become Humana, no longer Humana CareSource.  
6 And our goal is, of course, to make sure that that  
7 transition is as seamless as possible further out  
8 to the provider base. We are going to be at the  
9 Medicaid forums with a lot of good information to  
10 help you guys walk with us through this transition  
11 so that you know who to contact for prior  
12 authorization, where claims are going to go, what  
13 things are changing, what things are not changing.

14 We will have fliers so that you can have  
15 those at your front desk with pictures of what it  
16 might be looking like. We don't want any kind of  
17 patient impact. We certainly don't want any kind  
18 of abrasion for you guys as we go through this  
19 process of change.

20 Definitely excited about it. I think it is  
21 going to be a great change.

22 DR. MCINTYRE: Thank you.

23 MS. HOWARD: And with Passport. I don't have  
24 much. This only thing is Avesis became our vendor  
25 for vision, routine and medical, September 1.

1 Other authorizations we have brought in-house;  
2 pain management, therapy. Oncology and cardiology  
3 authorizations are going to New Century Health as  
4 of October 1. And that transition went very well.  
5 And that's all I have.

6 DR. MCINTYRE: And Avesis is strictly  
7 vision-related.

8 MS. HOWARD: They do our dental, also. But  
9 they are taking over our vision.

10 MS. LADY: What's the same of the second  
11 contract you all are working with, Lucy?

12 MS. HOWARD: For oncology and cardiology?  
13 New Century Health.

14 MS. LADY: But the pain management is done by  
15 staff at Passport, right?

16 MS. HOWARD: Yes.

17 DR. GUPTA: Since Avesis is -- I do have a  
18 question about how Avesis is going to -- is it  
19 going to be any different with Passport versus how  
20 it currently is with WellCare and Aetna?

21 MS. SANDLIN: Not to my knowledge. The  
22 claims will go to the same address. The plan is  
23 just a little different for adult members than it  
24 is for WellCare and Aetna, adult members. But we  
25 sent out those plans.

1 DR. GUPTA: Okay.

2 DR. MCINTYRE: Any other comments under  
3 updates? Moving on. Public health trends.  
4 Anybody here to speak on that?

5 MS. LADY: I just threw that out there for  
6 the MCOs in case they have some new public health  
7 initiative that they are doing at their specific  
8 MCO like on tobacco or flu or anything like that.

9 DR. TRAN: We talked several sessions ago, we  
10 had a nice discussion regarding the diabetes  
11 management and focus. Whatever happened to that?  
12 Is that --

13 MS. LADY: I am not sure on the MCO. But KMA  
14 was going to make that their focus. That changed  
15 because the Foundation for Healthy Kentucky  
16 approached us to work with us once again. And  
17 they decided to -- with that bill that got passed  
18 the very last minute at last year's session about  
19 the smoke-free schools. So we have partnered with  
20 them and got the signage, those kind of press  
21 releases. So instead of shifting to diabetes, KMA  
22 is, once again, going to focus on smoke-free for  
23 another year.

24 And it seems like it is going well. And so  
25 since they have had -- they had -- there was a map

1 of the schools. And the press release was really  
2 kind of fun to watch because they had 2 students  
3 that were part of that. And they were advocates  
4 for not using tobacco. And they did a very nice  
5 presentation. I was like, wow, it was impressive.

6 So since that press release rolled out, there  
7 has been other schools that have already requested  
8 that signage. And the director from the Board of  
9 Education, one of questions is always about  
10 enforcement. And she said they will enforce that  
11 rule. So if it is smoke-free, you are not allowed  
12 to smoke. Parents. You are not allowed to smoke  
13 combustible or vaping at any -- like it could be a  
14 football game, basketball game. It doesn't matter  
15 where it is once they have opted in if you will.

16 So we went with that which is going to be a  
17 really good program and probably pretty  
18 successful. But that knocked diabetes out. But I  
19 bet some of the MCOs do something on diabetes.

20 DR. HOUGHLAND: So I will address this a  
21 couple of ways. And I apologize up front on part  
22 of it.

23 So future activities, I know enough to be  
24 dangerous but I have to be pretty careful right  
25 now because we are in process of responding to a

1 solicitation and there are certain rules that --

2 MS. HUGHES: Can we not talk about future?

3 DR. HOUGHLAND: So I want to --

4 MR. GRAY: We would rather you talk about  
5 current stats.

6 DR. HOUGHLAND: I just wanted to make sure  
7 that everybody understood. And so a place I feel  
8 confident in having a conversation about is kind  
9 of follow up to the diabetes prevention program  
10 which I think you were referring to earlier,  
11 Dr. Tran, which was discussed in this committee  
12 earlier.

13 And in that there is still work that is  
14 ongoing with that. I think all of us, all of the  
15 MCOs, are in the process of collecting more  
16 information to provide back to the department as  
17 part of the joint senate resolution to assess the  
18 feasibility of adding that as a benefit to  
19 members. It is currently not.

20 And so we are still in the investigative  
21 phase and data collection phase I would say. But  
22 that is ongoing.

23 Some other activities, you know, we continue  
24 to promote preventative services which I think  
25 certainly falls within public health related

1 activities. Immunizations for our members being  
2 extremely important. You know, campaigns around  
3 flu are starting to pick up around the  
4 communities. And certainly that's something that  
5 we -- that we have historically supported and  
6 would continue to do that through a number of  
7 engagement techniques for members.

8 So beyond kind of current, I feel like I  
9 could get myself into trouble pretty quickly.

10 MS. HUGHES: And us.

11 DR. HOUGHLAND: I think I am the one that  
12 would end up getting in trouble.

13 DR. TRAN: Thank you.

14 MS. ASHER: For the past few months, our  
15 community outreach folks have really got involved  
16 in diabetes education. So we are currently doing,  
17 in the community, diabetic cooking classes to show  
18 the folks what is healthy and what is not.  
19 Because, you know, potatoes are not healthy even  
20 though they come out of the ground. So we are  
21 getting huge numbers of folks coming out with  
22 those.

23 MS. LADY: Are they all over the state?

24 MS. ASHER: Yes. Our community outreach  
25 folks are all over the state and they are setting

1 up these little cooking instructional things. The  
2 members are involved. They are actually coming up  
3 and doing --

4 MS. LADY: How do you advertise that? We'll  
5 help you with that.

6 MS. ASHER: We advertise a lot in the  
7 community health centers. And we have case  
8 managers for our diabetes patients that reach out  
9 with information. And we contact them through  
10 that.

11 So I was really shocked because, see, they  
12 are really getting a good turnout. And I think  
13 that's great. Because in eastern Kentucky, they  
14 eat what they want. You ain't going to tell them  
15 what they are going to eat. And they are focusing  
16 out there really heavily because it is an  
17 epidemic. And they are getting really a lot of  
18 outreach from western Kentucky.

19 MS. BROWN: I would like to make a  
20 suggestion.

21 You know, in every county, you have  
22 departments of public health and we have county  
23 extension offices. And I have wondered if it  
24 wouldn't be good to do some of those outreach  
25 activities in those offices, in those county

1 extension offices. Because then it is something  
2 that the community is already familiar with and it  
3 is not like they are going to the Aetna, Humana,  
4 Passport cooking class. They are going to the  
5 community extension office, county extension  
6 office cooking class.

7 I just wondered if there could be more use of  
8 those facilities in some of our more remote areas  
9 for this kind of effort.

10 MS. ASHER: And those are the perfect  
11 facilities because I have done things at the  
12 extension office before. And, yes, the community  
13 loves those places.

14 MS. BROWN: And they have everything you  
15 need.

16 MS. HUGHES: Are the classes available for  
17 everybody in the community or only Medicaid?

18 MS. ASHER: No. Everyone can come.  
19 Obviously anyone can come. It is diabetes  
20 education. But anyone can come. So it is not  
21 just our members. But we are getting a lot of,  
22 you know, comments and reaction from our members  
23 that we can actually follow.

24 MS. HUGHES: Every UK -- what did you just  
25 say they were called?

1 MS. BROWN: The county extension offices.

2 MS. HUGHES: The extension offices that I  
3 have been in has full kitchens, plenty of room and  
4 everything. And as long as it is an educational  
5 reason that you are asking to use their  
6 facilities, it is completely free.

7 MS. BROWN: And then coordinate it with the  
8 department of public health. They will be happy  
9 to have that extra support for the things they are  
10 trying to promote as public health officials.

11 MS. LADY: You could work with AX, too.

12 MS. HUGHES: I know the Franklin County  
13 Health Department does diabetic stuff.

14 DR. MCINTYRE: I have a special interest in  
15 diabetes being a type 2 diabetic.

16 One of the things that bothers me is there is  
17 really 2 tiers of care for diabetes. There is the  
18 Medicaid tier. And there is the people who make  
19 incomes like doctors make tier.

20 So I am on a GLP-1 agonist list. I think  
21 that is GLP-2. I have a FreeStyle Libre. I have  
22 a little device that my wife inserted into my arm  
23 that gets changed every 2 weeks. And my blood  
24 sugar is 158. More importantly, I am not a -- it  
25 gives me a reading -- it not only tells me what my

1 blood sugar is, it gives me a realtime plot of my  
2 blood sugar as long as I check it every 8 hours.  
3 So it tells me minute to minute what my blood  
4 sugar has done, which is good for me because I am  
5 not a very compliant patient. And last night with  
6 some Italian food downtown here, I had a piece of  
7 cake. And it shows what my blood sugar did. It  
8 went up to 312. It shows me that my blood sugar  
9 was --

10 MS. HUGHES: I bet it was good.

11 DR. MCINTYRE: It showed me that my blood  
12 sugar was out of range for 8 hours.

13 And then I have the SGLT2 inhibitor. I had  
14 to use the bathroom several times during the  
15 night. It actually made me dehydrated. I drank 2  
16 bottles of water. But, you know, it just gave me  
17 the impression that the cake wasn't worth it. It  
18 was just too much hassle. And it --

19 MS. LADY: But the pasta was worth it, wasn't  
20 it?

21 DR. MCINTYRE: The pasta was. But clearly  
22 this is -- there was a nurse in Flemingsburg who  
23 came down to the ER to have another nurse insert  
24 the thing into her arm. And it takes like 30  
25 seconds. You have got just little filaments in

1 your arm. And her reason for doing it is her A1C  
2 went up over 11 and she was wearing out her  
3 fingers doing finger sticks. And it was worth the  
4 \$73 a month to her to pay out of her pocket. I  
5 don't think any insurance covers it. My wife's  
6 federal Blue Cross doesn't cover it.

7 MS. LADY: So the out of pocket cost is \$73  
8 each month?

9 DR. MCINTYRE: Yeah. Plus about \$400 for the  
10 SGLT1 and SGLT2 inhibitor and the GLP-1 analog.  
11 But it is worth it. I like my eyesight. I like  
12 my limbs. I like my kidneys.

13 MS. LADY: You are attached to your limbs.

14 DR. TRAN: To be fair, I think we generalize  
15 the Medicaids, the MCOs I think do a decent job in  
16 terms of selecting appropriate medications that  
17 are available to the clients with the  
18 consideration of contained budgets. I get that.  
19 The only thing -- and I think that's where you are  
20 coming from -- is that our Medicaid clients don't  
21 often get the wide selection that others do.

22 But I would argue that in most cases, they do  
23 get a fair number of choices and options. So I  
24 wanted to go ahead and say I think that they are  
25 reasonable in that regard.

1           There are situations where it is frustrating  
2           from a provider standpoint where you are  
3           instructed, no, we are only going to pay for this  
4           high intensity statin and that's it. Well, if we  
5           have 2 high intensity statins, unless there is an  
6           outrageous price difference, maybe we should give  
7           some of that control back to the doc. I don't  
8           have any interest or I don't really care which  
9           statin. But if the patient likes this one better  
10          than the other, that's the one he or she should  
11          get.

12           That's the only thing I ask is as the MCOs  
13          look at what's on their formulary, be somewhat  
14          considerate. Because I don't want to have to  
15          follow a PA every time.

16           DR. HOUGHLAND: If I could respond to that?

17           I think that makes complete sense. And it is  
18          something that we do try to do as we are looking  
19          at our preferred drug list.

20           It is a completely different scenario for a  
21          hospital, for example, in managing their formulary  
22          where for too long I was the chairman of the P&T  
23          committee for a hospital and where you are trying  
24          to manage stock and the net side. So, you know,  
25          the priority of your formulary is there you end up

1 having a lot of outlay and a lot of waste.

2 Our side is a completely different  
3 phenomenon. And, admittedly, when I first  
4 started, I was kind of operating under the idea,  
5 and by role I was still operating under the idea,  
6 of managing stock. And don't have to do that now.  
7 But it does come down to really safety efficacy  
8 and the final decider is cost.

9 So always looking at what is the most cost  
10 effective. And, unfortunately, a lot of times it  
11 does come down to the way things are positioned on  
12 your formulary ends up and what the market share  
13 is for your membership has a significant impact on  
14 what the cost to our system ends up being. And  
15 so, you know, on one hand it is a, well, why can't  
16 we have all generics. Well, generally you can.  
17 Although now, as an example, generics sometimes  
18 are more expensive than the brand. So whenever  
19 you take into account some of the rebates that  
20 exist, and we had to actually change our policies  
21 where before whenever something became generic, it  
22 automatically became preferred.

23 Industry figured that out. And so they  
24 started positioning things where the generic came  
25 in higher than what their brand product was. So

1 we had to change that auto rule. But, you know,  
2 managing so that we have enough options but not  
3 get into a place where it ends up increasing costs  
4 because we are losing some of the purchasing power  
5 of volume that ends up having an impact for all of  
6 us.

7 And, yes, I am going not going to deny the  
8 fact that it has more of an immediate impact to us  
9 from a medical expense and managing budget. But  
10 ultimately that does get passed through and has an  
11 impact everywhere. So I think finding that right  
12 balance. Are we perfect? No. But, I think, you  
13 know, we do try to listen to input and feedback  
14 and take that back.

15 DR. TRAN: And I know that we were talking  
16 about diabetes. For example, in my personal role,  
17 this is where it impacts me. In our addiction  
18 clinic, there is a medication that's approved,  
19 Buprenorphine, and there are multiple different  
20 possible combinations. You can have the Suboxone.  
21 You can have the Zubsolv. It is all kind of the  
22 same. And shopping around, I realize the prices  
23 are fairly similar. But what amazes me is every  
24 few months we get an update where we are changing  
25 to this formulary. And now our patients have to

1 jump from one to the other. And it really makes  
2 no difference. But, yet, it is disruptive to  
3 them.

4 And so all I think, to say what he was  
5 asking, I think that we should be fair. But by  
6 the same token, I would like to have our  
7 physicians have some of that ability as ours. I  
8 don't want to prescribe a medicine that is \$300  
9 when a \$10 medicine would work just as well.

10 DR. HOUGHLAND: I appreciate that. And I  
11 think that's one of the things that I think we are  
12 learning better about is how to help people  
13 understand why whenever we feel like there is a  
14 reason. That's part of what we do present to our  
15 pharmacy and therapeutics committee that is really  
16 approving and driving some of these  
17 recommendations and changes. But really  
18 explaining why on a broader format of that.

19 The list price is one thing. And that's  
20 what's published. But what we end up finding out,  
21 and generally it is through rebates that is  
22 available. So something that the sticker price  
23 looks very similar but it ends up being 50 percent  
24 less because of a rebate that we all are able to  
25 take advantage of. Well, all. The health plan,

1 the Commonwealth directly and indirectly because  
2 of decreased cost. But they also get rebates off  
3 of that as well. And then the, you know, if we  
4 can do a better job of improving quality of care  
5 and decreasing the overall cost, then I think  
6 ultimately it can help the providers.

7 But it is a more circuitous route.

8 And so tying that back and helping the people  
9 on the front lines understand how this is  
10 ultimately a benefit to them, decreasing pressures  
11 in other places so that ultimately they don't feel  
12 the pressure in direct reimbursement, for example.  
13 I think we can do a much better job of that.

14 DR. MCINTYRE: I sat on the P&T committee for  
15 Medicaid. Been on it since 2015. It's been a  
16 real eye-opener. Every drug that has been  
17 involved in participating in the rebate program,  
18 which it in itself is inexplicably complicated,  
19 has to be approved. We are not allowed to  
20 disapprove any medication. We make  
21 recommendations to the commissioner as to whether  
22 it is preferred or non-preferred. And what we  
23 get, Magellan Health coordinates -- basically runs  
24 the meeting. We approve their recommendations.  
25 They are the contractor for the state on managing

1 medications. And I assume, Steve, that you are  
2 involved with Magellan Health in the same way.

3 DR. HOUGHLAND: No, we actually are not. No.  
4 We had been before. We see the output of the  
5 state's P&T committee and consider all of those  
6 things. But we are not actively engaged with it.

7 DR. MCINTYRE: Well, what Magellan gives us  
8 in the meeting is we will have a meeting in 2  
9 weeks. And we will go over several classes of  
10 medications. Statins may be one of them. And  
11 they will give us a list of medications. You  
12 know, we will go to statin page. There will be a  
13 list of however many statins there are. And the  
14 cheapest one is at the top. And it has a dollar  
15 sign. And then below it in order of price are the  
16 other competing medications. And what boggles my  
17 mind, it isn't anything like, well, this one is  
18 30 percent more or this one is 15 percent more.

19 It is this one is 5 times as much. This one  
20 is 34 times as much. This one is 75 times as  
21 much. Dr. Tran spoke about Buprenorphine or  
22 really about medication assisted treatment. We  
23 have speakers that they are only allowed 3  
24 minutes. They come and speak to us about the  
25 medications that they are pushing.

1           One of them was pushing a medication for  
2 medication assisted treatment that -- and I  
3 happened to google it while he was speaking and  
4 asked him a question afterwards. The headline of  
5 the google thing that came up was that this  
6 medication costs 7500 times as much as Clonidine.  
7 And still he was trying to get that a preferred  
8 medication which, of course, was a futile effort.  
9 This medication, new medication, 7,500 times  
10 before Clonidine.

11           DR. TRAN: That's ridiculous, yes.

12           DR. MCINTYRE: On the other hand, Magellan  
13 has had some successes. The medications for  
14 Hepatitis C are advertised as between \$85,000 or  
15 \$100,000 for a 6 week course of treatment.  
16 Magellan has gotten that price down to the point  
17 that Medicaid recipients, at least in the fee for  
18 service program, have access to the medications,  
19 even patients who have been cured, gotten into the  
20 drug scene again and relapsed, have access to the  
21 medication a second time.

22           And my understanding is that the state pays a  
23 fixed amount for an unlimited supply of the drug.  
24 Those are my random thoughts.

25           We are pretty close to winding this up. TAC

1 recommendations. Is there anything?

2 MS. LADY: I didn't get any from  
3 Dr. Thornbury. Do you all have any ideas? Do you  
4 have anything? We had some previously that we  
5 submitted. But I will leave that to you.

6 If you think of something, send it to me. We  
7 will format it and get it to Sharley before.  
8 Because the MAC meeting is coming up really fast,  
9 isn't it?

10 MS. HUGHES: Yeah. But the recommendations  
11 would need to be voted on here. You can't do the  
12 TAC business via email. You have to do TAC  
13 business --

14 MS. LADY: Can you vote via phone, though?

15 MS. HUGHES: Everything TAC business-related  
16 has to be done in open so the public can see it.

17 MS. LADY: Okay. So we will have to think  
18 about it and then you guys bring to the next  
19 meeting.

20 DR. MCINTYRE: Do it in a bathroom.

21 MS. LADY: That's good to know, actually.

22 MS. HUGHES: That's one of the reasons I was  
23 going to talk a little bit about the open meetings  
24 thing that I sent out is we have got to really --  
25 we are discovering some things are going on. And

1 not just one TAC, several TACs. But the business  
2 of the TAC, I mean even the statute even goes so  
3 far as to say if there is a majority of you 5 on  
4 this TAC at a church function and you start  
5 talking about business of the TAC, you are  
6 breaking the open meetings laws. Because, you  
7 know, that's not to say that all 5 of you can't be  
8 at a church function at the same time. But if you  
9 start discussing the business of the Physicians  
10 TAC, then there is where you are breaking the law.

11 So you can't conduct business by email  
12 because the public is not actually able to see and  
13 be a part of that. So the recommendation, the  
14 things would have to be voted on here.

15 MS. LADY: So we would have to do it at our  
16 next meeting.

17 I do have a question on that, though. What  
18 typically happens, and it is not really TAC. It  
19 is more Medicaid.

20 DR. TRAN: Well, we have to do some  
21 preparatory work as a group. And we will send  
22 emails so that the group will have some sort of  
23 idea of what the agenda, talking points, that sort  
24 of thing.

25 MS. LADY: And that's usually based on

1 feedback from patient and claim denials.

2 DR. TRAN: Could we get some legal person to  
3 help interpret that?

4 MS. HUGHES: We already have.

5 DR. TRAN: Because otherwise, it would make a  
6 very difficult meeting.

7 MS. HUGHES: The information that I sent out  
8 in that presentation was reviewed by our legal  
9 staff as being accurate.

10 DR. TRAN: Yeah. I read that.

11 MS. HUGHES: And what I sent out actually  
12 came from a material that the Attorney General  
13 actually distributed. And I would be happy to  
14 send that to you all.

15 DR. TRAN: So the email discussions that  
16 we're having is illegal?

17 MS. HUGHES: If you are discussing business  
18 of the TAC, yes.

19 MS. LADY: But how do you get your agenda set  
20 without -- this is my dilemma.

21 MS. HUGHES: As far as the agenda, you know,  
22 suggesting items, that is something you are  
23 suggesting. I would say everybody does it, you  
24 know. The statute very plainly says you can't do  
25 it by email. But, you know, you cannot vote. You

1 cannot --

2 MS. LADY: That part I understand.

3 MS. HUGHES: You cannot say this is a  
4 recommendation we want to give via email. So you  
5 have to be very careful. And that's, like I said,  
6 we had one TAC that came up with a sub-committee.  
7 And those sub-committees -- that sub-committee met  
8 and did not make those meetings public.

9 MS. LADY: Do sub-committees have to be  
10 public?

11 MS. HUGHES: Yes.

12 MS. LADY: I guess it is good we don't have a  
13 sub-committee. I didn't realize that. I didn't  
14 know that the sub-committee was -- I thought that  
15 was just like a group of people to help these  
16 guys.

17 MS. HUGHES: No.

18 You all are a subcommittee of the MAC. So,  
19 therefore, this is already a sub-committee.

20 DR. HOUGHLAND: I am not sure you actually  
21 have the authority to make a sub-committee to be  
22 honest.

23 MS. LADY: See, we thought that at first,  
24 too. But at a MAC like 2 or 3 years ago, they  
25 said go for it.

1 DR. HOUGHLAND: I don't know. I acknowledge  
2 I am not a member of this committee. Just maybe  
3 have a couple of thoughts to try to help with some  
4 of the logistics.

5 One is generally there are certain, in most  
6 meetings that occur under a certain frequency,  
7 there are certain items that tend to carry over  
8 that becomes kind of the framework for the bulk of  
9 the agenda. And not having seen the AG's guidance  
10 on this, I wonder if the chair could have  
11 individual conversations, either verbally or with  
12 individual email conversations, with individuals  
13 of the committee not all at the same time to try  
14 to adhere to the letter as well as --

15 MS. HUGHES: Well, they actually -- it is  
16 funny that you bring that up. Because as an  
17 example that the Attorney General's Office  
18 provides is that you cannot get around the  
19 requirements of the quorum and the open meetings  
20 by 2 of you getting together and saying I think we  
21 need to talk about this. And Dr. Tran saying,  
22 okay, well, I will get with Dr. McIntyre. You get  
23 with Dr. Neel. And then you all go have these  
24 conversations one-on-one. They actually gave that  
25 as an example of what you cannot do.

1 MS. LADY: That makes sense. We understand  
2 the quorum and we understand the -- we get that.  
3 I don't think the Physicians TAC is the problem.

4 DR. GUPTA: I think like in general --

5 MS. LADY: I've been to other TACs --

6 MS. HUGHES: Well, like, for example, of the  
7 Physicians TAC. At the meeting where you all had  
8 the last recommendations, they did not come up  
9 with all of the wording and vote on the exact  
10 wording of the TAC.

11 MS. LADY: We had to wordsmith it.

12 MS. HUGHES: But that did not give the TAC  
13 and the public the ability to vote and the public  
14 to see and so forth. So the department has been a  
15 little lax. And so I am just -- I didn't want you  
16 all to go back and vote on recommendations that  
17 were not presented at this meeting.

18 DR. TRAN: This is painful. What we will  
19 have to do is we are going to have to come 30  
20 minutes early before the meeting. And that's  
21 illegal, too.

22 MS. HUGHES: That's illegal, too.

23 MS. LADY: See, I don't know, Sharley.

24 MS. HUGHES: Your agenda items are -- you are  
25 fine of emailing agenda items. I just want to

1 caution you on actually not making recommendations  
2 via email and that type of stuff.

3 MS. LADY: I don't know. You know --

4 MS. HUGHES: This is not us saying that.  
5 This is in the Kentucky Revised Statutes.

6 MS. LADY: I guess we will just leave this  
7 alone for now.

8 DR. TRAN: I do have one agenda item that I  
9 would like to bring forth to all the MCOs and  
10 Medicaid as a whole. This was just recently  
11 brought to my attention so that's why I couldn't  
12 figure out how to -- and I had reached out to  
13 Medicaid offices to get this resolved.

14 One of the issues that we are having to deal  
15 with is there are -- the opioid epidemic is not  
16 gone. It is still rampant. Many of these people  
17 tend to require intensive counseling. One of the  
18 modalities that was proposed recently was the  
19 introduction of peer counseling.

20 You know, if we are going to stabilize these  
21 people and integrate them back into society as  
22 productive citizens, we need to start with giving  
23 them some opportunity to be gainfully employed.  
24 Otherwise, they continue down that vicious cycle.

25 Having said that, we took one of the first

1 few steps and we hired 3 peer counselors just to  
2 see how we can incorporate these people. And you  
3 know what, other patients loved them. They could  
4 relate. They had street credibility. It was  
5 wonderful. All was fine and dandy.

6 So we reached out to Medicaid and said, how  
7 can we use these folks to provide that counseling?  
8 Oh, yeah, they can do this. They can do this and  
9 that. Okay. Then my people have come back to me  
10 recently with, well, you know they have these  
11 things called units of work. And they have 120  
12 units of work per week.

13 So I did some quick analysis on my  
14 spreadsheet before I came. And it was very  
15 difficult. Let me give you an example.

16 So most of these people are better off doing  
17 group sessions because they don't really have the  
18 expertise to provide that psychotherapeutic  
19 counseling. I mean the blind leading the blind to  
20 me is not effective. It is just not good. I  
21 don't really want to hear from another person who  
22 is having the same problem. But I can understand  
23 that group session, that support that they can  
24 offer. If I have a peer counselor and that person  
25 is conducting a group session, they are allowed 8

1 maximum people in that group. And the units, if I  
2 am not mistaken, are billed in 15 minute  
3 intervals. So if you do the math, that's 4 times  
4 4 per hour times 8. That's 32. And if they do 3  
5 sessions, 3 hours of work, that's whatever 32  
6 times 3 is, they don't have many hours left for  
7 the rest of the week.

8 DR. MCINTYRE: 96.

9 DR. TRAN: Yes.

10 So if I am going to pay somebody, they have a  
11 maximum of 120. So 120 minus 96. 24. They don't  
12 have much else to do for the rest of the week. As  
13 a financial person doing the math, I am struggling  
14 with how do I pay for somebody for the whole 40  
15 hour week when they just provided me with only 3  
16 hours of labor? If that makes sense to you math  
17 people.

18 DR. HOUGHLAND: I don't know the nuances of  
19 the -- kind of the structure of the billing scheme  
20 for that. I would have to go back and look at it.  
21 It sounds like it was almost built off the  
22 non-group, that it was a per unit, per hour, per  
23 40 hour workweek which is still short of 120 but  
24 that would allow some documentation time and some  
25 other things.

1           So that would be my guess.

2           So I wasn't envisioning -- now some of those  
3 things are not completely under my control. We  
4 have will have to go back and get some very good  
5 conversation collaboratively in figuring out of  
6 this.

7           MS. LEWIS: Dr. Tran, I am Molly Lewis with  
8 the Kentucky Primary Care Association. And we  
9 would love to talk to you more about that. We are  
10 currently participating in the effort with a  
11 contract with behavioral health and have funding  
12 and a relationship with Betty Ford Hazelden to  
13 help encourage the use of peer support specialists  
14 and help promote their utilization to help make  
15 opioid addiction treatment more sustainable for  
16 the clinics once the funding runs out so this  
17 employment or workforce can be folded into  
18 everyday services.

19           We are also working on the transportation  
20 aspect. And so -- and that's what our funding is  
21 currently geared towards. Actually our clinics  
22 that we are starting with are the ones that have  
23 pediatricians and prenatal care, obstetricians to  
24 help blend it into women who are pregnant.

25           But our clinics primarily are paid on a PSS

1 rate. And peer support specialists do not qualify  
2 for a face-to-face encounter. Something that we  
3 are struggling with is how to put a modifier with  
4 them so that can be billed and create some sort of  
5 sustainability, clearly recognizing that they are  
6 not health care providers that would earn a  
7 face-to-face encounter rate.

8 DR. TRAN: At the end of the day, they have  
9 make it worth our while. I mean we want to be  
10 good citizens but we still have a business to run.  
11 So we need to make sure that these peer counselors  
12 that we bring into employment can help us pay the  
13 light bills at the end of the day.

14 I can't give them 3 hours of the work and  
15 then have to, you know, fetch the other  
16 30-something hours out of my back pocket. That's  
17 not a good sound business model. So I am reaching  
18 out to you to help us perhaps compromise or figure  
19 out a solution that works. Because I think the  
20 intention of bringing these people and integrating  
21 them back into the workforce, that has got to be a  
22 win for all, right.

23 UNIDENTIFIED SPEAKER: Maybe if we all --  
24 could you help us get a discussion going on about  
25 how to make peer support sustainable?

1 MS. BROWN: I will look into it, yeah.

2 UNIDENTIFIED SPEAKER: Yeah.

3 DR. MCINTYRE: Going back to this open  
4 meeting act thing.

5 Well, the pharmacy and therapeutics  
6 committee -- I have been on it since 2015. I  
7 don't know when the open meetings act was passed  
8 but I am sure it was far before 2015. When we act  
9 on personnel matters, you know, voting for Vice  
10 Chair, et cetera, we go into executive session and  
11 we excuse the public.

12 MS. HUGHES: There are reasons for going into  
13 executive session.

14 DR. MCINTYRE: Well, regardless. I got an  
15 agenda for the next P&T committee from Magellan.  
16 I mean, if I was to read and follow to the letter  
17 this Attorney General's opinion, I guess Magellan  
18 would be going to jail. Dr. Tran whispered to me  
19 10 minutes ago, you know, I have an additional  
20 item. Are we both going to jail or is it just  
21 him?

22 MS. HUGHES: If you are in the meeting --

23 DR. MCINTYRE: Well, nobody else could hear  
24 it. Public members couldn't hear it. So is he  
25 guilty of a felony or a misdemeanor? If we do

1 that, is the Franklin County Commonwealth  
2 Attorney's Office going to be able to do anything  
3 besides prosecuting TAC members for this  
4 violation? I mean, you cannot have a meeting like  
5 this or like the P&T committee and not have  
6 communication between the members. It just can't  
7 happened.

8 MS. BROWN: Could I just suggest something?

9 I have been involved in federal advisory  
10 committees where the agenda for the next meeting  
11 is set at the current meeting. And it's phrased  
12 in a very general way. And there is always a  
13 category, other business items that may arise.  
14 And what you need to do -- I haven't read the  
15 Kentucky Attorney General's opinion yet -- but  
16 what this committee needs to do is talk about what  
17 you want to talk about at the MAC here in general  
18 terms because you won't have your specifics in  
19 mind yet. But you need to set your agenda here in  
20 public and leave a general enough category for  
21 other business items that may arise between now  
22 and then. And then leave your discussions for the  
23 next meeting.

24 DR. MCINTYRE: But it sounds like we can't  
25 even talk to each other about new business items

1 that come up during the next few months.

2 MS. BROWN: I haven't read the details of  
3 that opinion. But I do think it is important not  
4 to conduct TAC business anywhere outside the  
5 meetings. Yes?

6 DR. GUPTA: I have a comment.

7 MS. HUGHES: If you were going to call Lindy  
8 about an issue that is happening in your practice  
9 that you are having issues with an MCO and you  
10 want to talk to her about it, that's -- and if  
11 that -- if based upon that issue because you are  
12 bringing it under new business, you want to bring  
13 it up at the TAC, that's fine. But that's your  
14 practice that you are talking to Lindy about.

15 MS. LADY: And see that's where it gets  
16 confusing, Sharley, because we were told  
17 specifically not to do that. So what we were told  
18 pretty emphatically because I had to take up once  
19 again for the Physician TAC because I feel like  
20 our agenda is very broad and very general. And we  
21 haven't brought in all these little individual  
22 claim issues. We were told not to do that, that  
23 you shouldn't bring in claim denials and talk  
24 about --

25 MS. HUGHES: No, I don't mean that. I mean

1 if he is seeing that, for instance, that a couple  
2 of these --

3 DR. MCINTYRE: The telehealth port being  
4 dissolved, that is something --

5 MS. LADY: That is broad and it is public  
6 information and it is relative to --

7 DR. MCINTYRE: And I could have emailed  
8 everybody and Lindy or could have emailed Lindy  
9 and copied everybody and say, hey, the telehealth  
10 port has been dissolved. What do you think? Or  
11 the telehealth board has been dissolved. We need  
12 to talk about that at the next meeting.

13 And, I mean, if we can't do stuff like that,  
14 we might as well all go home and stay home.

15 DR. GUPTA: I think whatever we have been  
16 doing since I have been on this committee has been  
17 in compliance, honestly. Because whenever you let  
18 us know about we have our TAC meeting, does  
19 anybody have anything to put on the agenda, we are  
20 not having a group discussion. I say, Lindy, I  
21 want to talk about this. This has been brought to  
22 my attention. Let's put this on the --

23 And I mean that is totally fine.

24 MS. LADY: How are we going to do an agenda  
25 with --

1 DR. GUPTA: I don't think Sharley is saying  
2 we can't do that.

3 MS. HUGHES: I think you all are getting hung  
4 up on it. It's not that big of a deal. What I am  
5 saying to you, the reason I brought it up was that  
6 you said if you all have any recommendations, you  
7 can send them to me and I will write them up.

8 You cannot do that.

9 MS. LADY: And that makes sense I have to  
10 say.

11 MS. HUGHES: You are making recommendations,  
12 TAC recommendations. You are not conducting in  
13 the room of the TAC meeting.

14 DR. GUPTA: We have never held a discussion  
15 over email. We never have.

16 MS. LADY: That's because it is too  
17 difficult.

18 MRS. HUGHES: In this day and time, I don't  
19 perceive -- now, I am not an attorney. Sometimes  
20 I may have to play one. But I am not.

21 I don't think an email of saying, Lindy, we  
22 need to add this to our agenda. I am seeing this  
23 in, you said Flemingsburg, I am seeing this around  
24 Flemingsburg happening with Medicaid recipients  
25 and this problem coming up. I think we need to

1 bring it up on the TAC. I don't think that's  
2 going to be an issue.

3 But, again, I am not an attorney. But it's  
4 when you start actually discussing different  
5 recommendations.

6 MS. LADY: I got you. So we will just follow  
7 that. That's not a problem and that makes sense.

8 Usually I contact him. I guess I feel  
9 sensitive towards this because I have been to  
10 other TAC meetings and I think we have a good TAC.  
11 But, anyway, they are very good about giving me  
12 issues. I am good about going to him first or him  
13 at Passport or Aetna and getting those resolved  
14 before we ever get here.

15 MS. HUGHES: And that's the way it should be.

16 MS. LADY: And I think so, too. And I think  
17 that's what's worked for our members because we  
18 are usually able to resolve it. So you will  
19 notice most of our agendas are very same kind of  
20 big ticket issues that everyone is talking about  
21 like telehealth, and giving the opportunity for  
22 the MCOs to provide updates. It is very sort of  
23 basic.

24 And to Dr. Gupta's point, I think that's why  
25 we do it and I think it is in compliance. We will

1 take care of the TAC, though. So if we have any  
2 recommendations that have to be made here, we have  
3 got to hammer out all of the writing here.

4 That makes sense to me.

5 DR. TRAN: I would like to propose, because I  
6 am trying to summarize what has been said. I  
7 think it is probably a good plan of action and I  
8 would like to motion for everyone to consider is,  
9 perhaps what we can do as the last item on the  
10 agenda is to walk around the room and request are  
11 there pertinent items that we would like to  
12 discuss at the next meeting? And when we all get  
13 the minutes, that will give us all the opportunity  
14 to do our own individual research so that at the  
15 next meeting we are prepared to discuss it and we  
16 can have that discussion here.

17 MS. LADY: So we will --

18 DR. TRAN: And then everyone present may have  
19 the opportunity to have brought up that. And I  
20 think that might help us with the agenda  
21 development. And we still have a topic, a section  
22 here called new business. So that still gives  
23 everyone the opportunity to throw in new business  
24 at the very last second. But having the ability  
25 to have this planned out gives us all -- and it

1           might make the meetings more fruitful if we have  
2           all had an opportunity to research ahead of time  
3           before the next meeting.

4           So I would I would like to propose that as --

5           MS. LADY: That makes sense.

6           MS. HUGHES: And I will ask our general  
7           counsel to get a clarification. Because I don't  
8           want Dr. McIntyre to be concerned he is going to  
9           end up in the Franklin County Jail. I haven't  
10          been there but I have heard it is not great.

11          But I don't think just coming up with agenda  
12          items is going to be a concern. But mine was, you  
13          can't -- like the recommendation. I will ask our  
14          general counsel for some legal advice on that  
15          because I am sure it would be the same question at  
16          every one of the TACs.

17          But I don't think this TAC is doing anything  
18          wrong. And especially with Dr. Tran leaning over  
19          to you and saying I have one more item. Because  
20          it is under new business. And nobody else may not  
21          have heard it, but you are going to bring it up.

22          So that's not an issue. I am not going to be  
23          the reporter that goes to the people and have you  
24          prosecuted for something.

25          DR. TRAN: Do we have to vote on that last

1 motion?

2 DR. MCINTYRE: Yeah.

3 DR. GUPTA: I second.

4 DR. MCINTYRE: So the motion is, at the end  
5 of each Physician TAC meeting that we discuss any  
6 changes from this template. This is really a  
7 template for every TAC meeting. That we discuss  
8 any changes from this template for the next TAC  
9 meeting and vote on them if necessary.

10 All in favor?

11 GROUP: Aye. (Vote unanimous.)

12 MS. LADY: Thank you very much. And thank  
13 you all.

14 DR. MCINTYRE: As you know, I am the  
15 representative to the MAC. And I have only once  
16 taken recommendations to the MAC. And those were  
17 voted on here in this meeting. And I will  
18 continue to not make any new recommendations to  
19 the MAC. And Ashima will keep me honest because  
20 she is our voting member of the MAC.

21 MS. HUGHES: I really am not worried about  
22 you all. I just want -- we have several TACs that  
23 actually asked us to put together -- you all are  
24 not government employees so you are not going to  
25 know, be familiar with our open meeting laws. So

1 that's why some of them wanted --

2 DR. TRAN: I am a government employee.

3 MS. HUGHES: Well, okay. You might be. The  
4 rest of them probably aren't. I forget that you  
5 are with VA, right?

6 MS. LADY: Dr. McIntyre.

7 DR. TRAN: I took this day off so I am  
8 technically a free person today.

9 DR. MCINTYRE: Okay. The last item, wrap up,  
10 round table meeting and event reminder. Lindy,  
11 are there any event reminders?

12 MS. LADY: Well, I think the MCOs may have  
13 some. We have our annual meeting coming up. So  
14 that's coming up the 19th through the 23rd. But  
15 you all probably already know that.

16 But if any of you all have any events coming  
17 up, we work with David a lot and actually Sharley  
18 sent out something that we had already gotten.  
19 Whenever there is webinars from Medicaid, we  
20 always publish those on our event calendar so our  
21 members -- so if the MCOs have anything like  
22 cooking classes, we have already kind of discussed  
23 that, then you can send me those. And we are  
24 happy to put it on our event calendar to remind  
25 our members what's going on so they can take

1 advantage of anything that you would want them to  
2 know.

3 DR. MCINTYRE: Okay.

4 Now, does anybody have any suggested addition  
5 to changes to this template for the November  
6 meeting, to this template for the agenda?

7 DR. TRAN: Well, I wasn't suggesting changes  
8 to the template. I am just saying as a last  
9 agenda item, we just simply walk around the room  
10 to see if there are topics that we would like to  
11 discuss for next meeting's agenda. Then it can be  
12 documented in the minutes so that we can be  
13 prepared to discuss it next time and we don't  
14 violate any rules.

15 DR. MCINTYRE: We want to keep you out of  
16 jail.

17 Does anybody have any anything to add to this  
18 agenda for the next meeting?

19 MS. LADY: The only thing I have is we want  
20 to invite the new medical director for Medicaid.  
21 So I didn't -- so I wasn't able to do that this  
22 time. But we would love to have her at our next  
23 meeting.

24 MS. HUGHES: If I could take just a few  
25 minutes on that.

1           Lindy and I talked about this a little bit  
2 before the meeting. And that Dr. Theriot does not  
3 work for Medicaid on Fridays. So that creates a  
4 problem with her attending. Because this year,  
5 all of your meeting have been held on Friday. And  
6 the one that is set for November is scheduled for  
7 a Friday.

8           So that's why she's not been able to attend  
9 is because she is actually back practicing at the  
10 University of Louisville on Fridays. So -- and I  
11 do agree. I think it would be great for her to be  
12 able to attend.

13           DR. TRAN: Who makes the decision as to what  
14 day of the week we meet?

15           MS. LADY: You all do.

16           DR. TRAN: We did?

17           MS. LADY: Yes.

18           DR. NEEL: Can we change that now for the  
19 November meeting?

20           MS. HUGHES: You can make a change for  
21 November.

22           MS. LADY: You can do whatever you want to  
23 but Dr. Gupta may have some --

24           DR. GUPTA: I know Dr. Thornbury and I  
25 have -- Fridays is our preferred date. Because I

1 don't work on most Fridays. And I think for him  
2 also because his practice, I think he has --  
3 Fridays is better for him. If it is like a one  
4 time deal not on a Friday, I can make that work.  
5 But, otherwise, I would not be able to come to  
6 these meetings regularly if it is not on a Friday.

7 DR. MCINTYRE: And just for your information,  
8 we set the dates at the beginning of the year for  
9 the whole year. And we will do that again at our  
10 March meeting.

11 DR. GUPTA: Maybe if we could like for 2020,  
12 we could schedule one of these TAC meetings on a  
13 day that we have a MAC meeting, you know, then we  
14 are already here. I just take a whole day off  
15 from work.

16 DR. MCINTYRE: Unless we meet at 8 in the  
17 morning, we wouldn't be able to do this meeting  
18 before.

19 DR. GUPTA: Right. I know. But I mean if it  
20 is like a one time.

21 MS. LADY: It would be an early meeting.

22 DR. GUPTA: Or we could do an afternoon. I  
23 mean I know we wouldn't be able to make a  
24 recommendation.

25 MS. LADY: But we can still do one after the

1           MAC.  Whatever you all want to do is fine with me.  
2           I will make it work.

3           DR. GUPTA:  Why don't we put it down on the  
4           agenda for the next meeting?

5           DR. NEEL:  You can only come on Fridays  
6           unless it is a MAC meeting which is not on a  
7           Friday.

8           DR. GUPTA:  Well, because I have to come to  
9           that.  I already have that scheduled out.  So I do  
10          work on Thursdays.  Fridays, I work 2 Fridays a  
11          month but I am able to, you know, coordinate those  
12          Fridays with this meeting.

13          But if it was like a regular thing where I am  
14          taking all of these Thursdays off, it wouldn't  
15          work for me.

16          MS. LADY:  All of them are still practicing  
17          medicine.  And doctor --

18          DR. TRAN:  And I have 2 jobs.

19          MS. LADY:  Yeah.  So it is tough.  But you  
20          all think about it.  We can make that work doing  
21          that.

22          MS. HUGHES:  Now, I don't know if this will  
23          help.  But you do have the option now of the video  
24          teleconference.  So I don't know where you live.  
25          Are you in Lexington or Louisville?

1 DR. GUPTA: I am in Louisville. Can we have  
2 these meeting in Louisville now?

3 MS. HUGHES: Well, I mean obviously we would  
4 prefer your meeting be here. Because if you are  
5 having them out of Frankfort, Medicaid wouldn't  
6 probably be able to attend. But I am saying if  
7 they chose to have a meeting on a day other than a  
8 Friday, would you be able to take a couple of  
9 hours to attend via the video teleconference  
10 rather than taking 4 or 5 hours to come?

11 DR. GUPTA: Well, I mean if it was on a  
12 regular basis, I still face the same kind of  
13 issue. I lose a whole session of work basically.  
14 I mean I don't want to just make this about me.  
15 But I mean if that's what the group wants, then I  
16 mean I will definitely try to make that work.  
17 But, I mean, that would be -- that is a nice  
18 alternative than me losing 2 hours driving.

19 DR. MCINTYRE: And Dr. Thornbury comes from  
20 Glasgow. So actually this is an hour -- almost an  
21 further for him than the Louisville meetings were.  
22 And, I mean, he makes the point repeatedly that he  
23 has to close his practice for a day to come to  
24 these meetings.

25 MS. LADY: Sharley, so if we came to

1 Frankfort, would you have the teleconference like  
2 at other meetings? Would you all do that here?

3 MS. HUGHES: You all would have to do it. We  
4 have sent out a thing that we can't. There is a  
5 screen here, but that's all I can guarantee.

6 MS. LADY: So but we do use our Go-Life here.  
7 We could use whatever feature we wanted to. But  
8 you would still want us to do it --

9 DR. TRAN: They would have to still host it.

10 MS. HUGHES: You would have to be able to  
11 have the ability at your host location for any TAC  
12 member that attends via video conference to be  
13 able to be seen and heard at all times by  
14 everybody in the room. So if you have to --

15 DR. TRAN: For it to work, the host has to be  
16 here and everyone else gets dialed in.

17 MS. HUGHES: Yes. So if you have the ability  
18 to somehow put everyone, 3 or 4 TAC members, up on  
19 that screen for people to see them, that's fine.  
20 But we do still have to have a public location.

21 MS. LADY: Okay.

22 DR. TRAN: So going back, I do agree with  
23 Lindy.

24 At some point in time if we could put a  
25 request that Dr. Theriot -- that Dr. Theriot at

1 least attend one of our sessions. And if we have  
2 to, maybe we can accommodate her schedule and make  
3 it on a day that she is available. However that  
4 works out, if you could have that discussion with  
5 her.

6 MS. LADY: So maybe we do it at a MAC meeting  
7 where -- because those are on Thursdays and she is  
8 probably at the MAC meetings.

9 MS. HUGHES: She is, yes.

10 MS. LADY: Yes. So if we did it, that might  
11 be an option.

12 DR. TRAN: Because I think it's important for  
13 to her to actually be present at one of our  
14 meetings.

15 DR. GUPTA: Or if you wanted to, because our  
16 next TAC meeting after November is not until  
17 March, right. If we wanted to have that TAC  
18 meeting, that March TAC meeting, on a Thursday,  
19 then I could teleconference in.

20 MS. LADY: So we have --

21 DR. GUPTA: We would still have 4 people.

22 MS. LADY: So a MAC meeting is coming up the  
23 26th, I think, of this month. I think that's  
24 right.

25 MS. HUGHES: It is the fourth Thursday.

1 MS. LADY: And then there will be another.  
2 So we won't have anything in October. And then  
3 there will be November. So do you want to try to  
4 shoot for November?

5 DR. GUPTA: Can we change our TAC meeting in  
6 November?

7 MS. HUGHES: You can change it. As long as  
8 we have a date. And this would be plenty of  
9 notice for us to change it if you wanted to change  
10 it.

11 DR. MCINTYRE: So if we change it to the date  
12 of the MAC meeting, do we want to do it after the  
13 MAC meeting or do we want to do it before the MAC  
14 meeting?

15 MS. LADY: Whatever works for you guys.

16 DR. MCINTYRE: Do it before the MAC meeting  
17 would basically be an 8 o'clock meeting. Plus we  
18 need time to get down to the Capitol Annex.

19 MS. LADY: Or we could --

20 MS. HUGHES: Now the November MAC is going to  
21 be early. Because every other month, they meet  
22 the fourth. So the meeting will actually be on  
23 the 21st of November.

24 DR. TRAN: My calendar says November 15th is  
25 the next MAC meeting, is that correct?

1 MS. HUGHES: Now, I can see if I could get  
2 you all a room at the Annex if you wanted to do an  
3 8. Either way, you would have to have a room at  
4 the Annex. You wouldn't want to come here and  
5 then go to the MAC and come here.

6 DR. MCINTYRE: I am going to make the motion  
7 that we do the next meeting to facilitate the  
8 medical director being present, that we change our  
9 TAC meeting to -- what did you say it was -- the  
10 21st at 8 a.m.?

11 MS. HUGHES: The 21st.

12 DR. MCINTYRE: At the Capitol Annex. And  
13 we'll ask Sharley to get us a room.

14 DR. TRAN: Is that November 21st?

15 DR. NEEL: 21st. After would be bad because  
16 the last MAC meeting went way over.

17 MS. HUGHES: What?

18 DR. NEEL: The last MAC meeting went long.

19 MS. HUGHES: That was only because of the  
20 fact that there was 3 MCOs --

21 DR. NEEL: Right. But trust me, it went  
22 long. So we wouldn't want to be after because --

23 MS. HUGHES: Typically the MAC meeting is  
24 either early or by 12:30. It rarely goes over.

25 DR. NEEL: I have been there for years and

1 years.

2 MS. HUGHES: I understand. We gave them more  
3 time.

4 MS. LADY: If we met at 8, is that the motion  
5 on the table, 11/21/19 at 8 a.m. and Sharley is  
6 going to see if she can get us a room?

7 DR. MCINTYRE: So let's do a vote on that.  
8 In favor of that?

9 GROUP: Aye.

10 MS. LADY: Instead of the 15th.

11 MS. HUGHES: Having said that, I cannot  
12 guarantee the ability to video teleconference at  
13 the Annex. I have not seen any meetings rooms --

14 MS. LADY: We are going to do it in person  
15 right. Is that right?

16 DR. NEEL: We still don't know if she can  
17 attend because she has to come from Louisville.

18 MS. HUGHES: Who? Dr. Theriot will be here  
19 working that day.

20 DR. TRAN: She will be working that day.

21 MS. LADY: She will already be in Frankfort.

22 DR. NEEL: Does she get here at 8 o'clock?

23 MS. HUGHES: She is usually here right at 8.

24 DR. GUPTA: Does Dr. Thornbury needs to be  
25 hopefully --

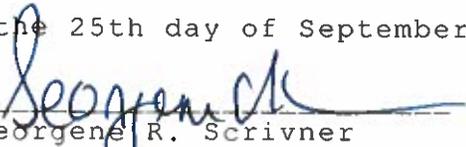
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CERTIFICATE

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 meeting of the TECHNICAL ADVISORY COMMITTEE ON PHYSICIAN SERVICES, taken at the time and place and for the purposes set out in the caption hereof; that said meeting was taken down by me in stenotype and afterwards transcribed by me; that the appearances were as set out in the caption hereof; and that no request was made by counsel for any party that the transcript be submitted for reading and signature.

Given under my hand as notary public aforesaid, this the 25th day of September, 2019.

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

My Commission Expires: 7/15/2023