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PHYSICIAN SERVICES TECHNICAL ADVISORY COMMITTEE  
MAY 17, 2019 MEETING

TRANSCRIPT OF MEETING

MAY 17, 2019

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The foregoing meeting was held, pursuant to notice, on Friday, May 17, 2019, beginning at the hour of 10:00 a.m., at the Cabinet for Health and Family Services, Thompson Conference Room, Second Floor, 275 East Main Street, Frankfort, Franklin County, Kentucky, 40601, Vice Chairman William McIntyre, M.D., presiding.

1           VICE CHAIRMAN MCINTYRE: The meeting of the  
2           Physician Technical Advisory Committee is now in  
3           session. And we are just talking among ourselves.  
4           I don't think we will make a formal TAC  
5           recommendation. But between us and Lindy, if we  
6           could get this room on a regular basis as opposed  
7           to wandering all the way through the building to  
8           the other end on the first floor, that would be  
9           wonderful.

10           So the first item is approval of minutes from  
11           the last meeting. Do we have minutes from the  
12           last meeting to approve?

13           MS. LADY: Yes. I don't know that I sent  
14           them out to you all, though. They are on the  
15           website. They are on the Medicaid website. But I  
16           think I forgot to remind you all that they are out  
17           there.

18           VICE CHAIRMAN MCINTYRE: Okay.

19           DR. TRAN: Motion to approve it.

20           MS. LADY: Dr. Tran reviewed them. So --

21           DR. TRAN: There were a lot of misspellings.  
22           But that's okay.

23           VICE CHAIRMAN MCINTYRE: Moving right along.

24           The provider enrollment. Is there somebody  
25           from the department?

1 MS. BATES: Are we going to do introductions  
2 so everyone knows who is in the room?

3 VICE CHAIRMAN MCINTYRE: We can do that. I  
4 am Dr. McIntyre. Dr. Thornbury isn't here today.  
5 And I am vice-chairman so I am conducting the  
6 meeting. This is Dr. Ashima Gupta and Dr. Tran.  
7 So we have a quorum.

8 \* \* \*

9 AUDIENCE INTRODUCING THEMSELVES

10 \* \* \*

11 VICE CHAIRMAN MCINTYRE: Okay.

12 MS. BATES: So what's the question about the  
13 provider portal?

14 DR. MCINTYRE: Just what the status is  
15 currently.

16 MS. BATES: So the provider portal is up and  
17 running but there is also alongside with House  
18 Bill 69 last year, we have to do the CVO, the one  
19 CVO. So that is going to go out soon -- I don't  
20 know when -- but as an RFP to develop that system.  
21 And so the portal will kind of go alongside that  
22 system.

23 So there are some pilot sites that are our  
24 pilot providers that are using the portal right  
25 now. And I think it will go all the way live

1 obviously when we get the other system set up. So  
2 that's all I know.

3 VICE CHAIRMAN MCINTYRE: Has the RFP been  
4 sent out?

5 MS. BATES: No.

6 DR. TRAN: May I make a request? I assume  
7 that the portal will be public so that providers  
8 can check the status of their application on the  
9 portal?

10 MS. BATES: It should be. If you have  
11 questions about the portal, because I don't do  
12 provider enrollment necessarily. I just know  
13 enough to be dangerous. But you can submit those  
14 specific questions. We will be happy to have that  
15 team answer them. I am pretty sure that that  
16 answer is yes. But I don't want to answer the  
17 wrong way for you.

18 DR. TRAN: Thank you.

19 VICE CHAIRMAN MCINTYRE: Do we have any idea  
20 when the RFP is going to be sent out?

21 MS. BATES: I do not. It has been written.  
22 I know that.

23 VICE CHAIRMAN MCINTYRE: Okay. Any questions  
24 from anyone else?

25 DR. TRAN: Your best estimation of when it

1 will be live for the rest of us?

2 MS. BATES: I have no estimate.

3 DR. TRAN: July? No estimate?

4 MS. BATES: Huh, uh. July of this year? No.

5 VICE CHAIRMAN MCINTYRE: All right.

6 Telehealth implementation?

7 MS. BATES: So we are still on track to  
8 implement the new telehealth changes on July 1.  
9 The regulation had been filed before. We received  
10 comments back. We made changes to the reg. And  
11 we have to file that again as an e-reg, as an  
12 emergency reg and an ordinary reg. The main  
13 difference that everybody would be interested in  
14 is that we are going to raise the reimbursement  
15 back up to 100 percent.

16 VICE CHAIRMAN MCINTYRE: Oh, excellent.

17 DR. TRAN: I have a question.

18 Whose responsibility is it to ensure that the  
19 modality chosen will comply with HIPAA? For  
20 example, is that something that Medicaid will look  
21 into? Is that something that HIPAA itself looks  
22 into? Is that the provider's responsibility? How  
23 will we ensure that HIPAA is not going to be  
24 violated?

25 MS. BATES: I don't remember what the

1 regulation says specifically right now. But  
 2 before, that was a function of the telehealth  
 3 board. And so I don't know. I will get back with  
 4 you on that. They are still -- the telehealth  
 5 board is still active. And they are going to, I  
 6 think, have their last meeting next month.

7 MS. LADY: In June.

8 MS. BATES: Is it next month? So I'll get  
 9 with them on that. They know a lot more about  
 10 that. Because they were kind of responsible for  
 11 the transition over for everybody; Medicaid and  
 12 commercial. So let me ask them about that.

13 From the Medicaid perspective, not privacy  
 14 but I do want to mention this. We are getting  
 15 ready to send out a provider letter to our  
 16 providers that kind of lets the providers know  
 17 what we are going to expect to see on claims as  
 18 far as denoting the telehealth service and the  
 19 place where the --

20 MS. LADY: Oh, good. So when will that come  
 21 out, Stephanie?

22 MS. BATES: When we finish figuring out the  
 23 dental piece. Because they have a different claim  
 24 form. And we want to make sure we are getting it  
 25 right.

1 MS. LADY: So but that's in the works and it  
2 will come out probably soon?

3 MS. BATES: We have it already written. We  
4 just want to make sure that claims and counters  
5 pass correctly for the dental side.

6 MS. LADY: Okay.

7 DR. TRAN: If I heard you correctly, the  
8 reimbursement will be 100 percent comparable to  
9 face-to-face?

10 MS. BATES: Correct.

11 DR. TRAN: That is wonderful.

12 VICE CHAIRMAN MCINTYRE: That will be through  
13 --

14 DR. GUPTA: Do we have --

15 MS. BATES: Unless you all -- I am sorry.  
16 Sorry. Unless the contract, you know, an MCO can  
17 always pay you more. So it just depends on. I am  
18 sure that they all --

19 VICE CHAIRMAN MCINTYRE: But that's the  
20 floor?

21 MS. BATES: Right.

22 DR. GUPTA: I was just going to say, was our  
23 recommendation -- did we hear back?

24 MS. LADY: We have not heard back. It ties  
25 into what Stephanie --

1           So the Physician TAC made some recommendation  
2 about billing and like identifying not just  
3 whether it is a telehealth service but if it is an  
4 acute service or is a chronic service. And we  
5 thought --

6           MS. BATES: So we are not going to do that.  
7 What we are going to do -- and I will tell you  
8 what we are going to do.

9           So we are going to use the 02 place of  
10 service which is the telehealth. But we wanted  
11 to -- that alone wasn't going to tell us where the  
12 patient is. And we are going to want to know  
13 that, right. And so we are going to use modifiers  
14 to denote like if it is at the home or the school  
15 or the office or wherever.

16           MS. LADY: So you will use place of service  
17 modifiers to --

18           MS. BATES: So place of service is different  
19 than a modifier. So place of service is going to  
20 be 02. The modifiers are going to tell us where  
21 the person is. The problem is the dental form is  
22 different. And so we are trying to figure out how  
23 to do that so that way we don't mess up the dental  
24 claims obviously.

25           DR. TRAN: Will the 02 impact the

1 reimbursement?

2 MS. BATES: No.

3 DR. TRAN: Why are we collecting the place  
4 where the patient is at?

5 MS. BATES: Why? So in one year, wouldn't  
6 you want to know how many people Medicaid served  
7 through telehealth while they were at the home or  
8 at the school? So we are forward-thinking because  
9 we are going to be asked those questions. So we  
10 have to know that.

11 DR. TRAN: Well, I am only asking because in  
12 the VA we did go through that same learning curve.  
13 We started out with CVT, clinical video  
14 telehealth, to VA locations. Remote provider.  
15 Remote patient. But it was always within a VA  
16 structure. And now we are pushing towards VVC  
17 where the patient may reside at the home. The  
18 patient may use his or her own device. The  
19 patient could be driving on the road -- don't  
20 drive -- but he could be a passenger in the car.

21 So we have now removed that. And you are  
22 right. It is nice to have that data to see.  
23 Because in the future, we really don't need the  
24 restraint of you must be at a certain location.  
25 You can be -- we can access you or you can access

1 health care anywhere.

2 MS. BATES: Yeah.

3 MS. LADY: So you will denote the telehealth  
4 by place of service. And then if they do the E&M,  
5 they would use an 11 for the office -- if they did  
6 it in the office. And then you will use the  
7 diagnostic codes. You can probably figure out who  
8 is chronic. And that was kind of the -- you are  
9 not going to --

10 MS. BATES: We are not doing anything  
11 different for telehealth than what we would do for  
12 physical health or for -- sorry, you know what I  
13 am saying. But face-to-face.

14 MS. LADY: Face-to-face visits.

15 DR. TRAN: And it actually makes it easier.

16 MS. BATES: So we don't do that now. When  
17 you -- it makes for --

18 MS. LADY: It makes the billing simpler.

19 MS. BATES: So we are just not going to do  
20 that.

21 MS. LADY: I think the TAC was trying to get  
22 at how many acute patients. But that could be  
23 later down the road I suppose. I do like that you  
24 are keeping it easy.

25 MS. BATES: Yeah. So we are not going to add

1 modifiers and do things on claims just to, you  
2 know, that is data analytics that can happen  
3 within an MCO or within Medicaid. We are not  
4 going to use a claim form or add something else,  
5 to have a provider add something else to a claim  
6 form just to know chronic versus acute.

7 MS. LADY: So it will keep it easy then.  
8 Whatever place the service -- the service is  
9 rendered in is the place of service you will use.  
10 And the 02 is telehealth and then everything else  
11 stays the same; hospital or office. Okay?

12 VICE CHAIRMAN MCINTYRE: I think one of the  
13 drivers of our recommendation was the 85 percent  
14 reimbursement.

15 MS. LADY: So that's changed.

16 VICE CHAIRMAN MCINTYRE: Whether that would  
17 work in terms of getting physicians to sign up,  
18 particularly for complicated things like chronic  
19 care. If it is 100 percent, I don't think you  
20 will see much push back from -- at least from this  
21 group.

22 MS. LADY: So that's actually helpful, the  
23 100 percent reimbursement. That will probably at  
24 least get -- that was the driver. Because there  
25 was a thought that at 85 percent, nobody is going

1 to do it. There is no incentive to use  
2 telehealth.

3 DR. TRAN: In my experience with even though  
4 most of patients are billed as chronic, but these  
5 people get acute exacerbations of their chronic  
6 entities. And we just take care of them and  
7 prevent that from becoming a hospitalization. And  
8 so there is value. And I think we get more  
9 touches instead of the face-to-face.

10 MS. LADY: It would be -- at some point I  
11 mean I guess further down the road there has to be  
12 a data analysis part for telehealth. But maybe we  
13 are not there yet. Because you probably would  
14 want to know how many people using telehealth that  
15 you kept out of the hospital if your treatment --

16 MS. BATES: It goes without saying that we  
17 will do data analytics on everything, not just  
18 telehealth, but everything.

19 DR. TRAN: But there is VA data that already  
20 substantiates what you just stated. Through the  
21 use of telehealth, the reduction -- and I can't  
22 remember whether it was absolute reduction or  
23 relative -- but there is a substantial reduction  
24 in hospitalizations.

25 MS. LADY: Thank you very much, Stephanie.

1 MS. BATES: You are welcome.

2 VICE CHAIRMAN MCINTYRE: Any questions?

3 Next item is managed care organization  
4 updates. Steve, you or anyone else have anything  
5 new to tell us?

6 MS. HOWARD: Updates? We do have some  
7 realignment in provider reps. So that's about the  
8 only thing that's going on with provider  
9 relations.

10 VICE CHAIRMAN MCINTYRE: And I am sorry.  
11 Tell me again which group you are with?

12 DR. HOUGHLAND: Passport.

13 MS. HOWARD: Passport.

14 MR. HIBBS: And just for Anthem, we do just  
15 have a couple of quick things similar along those  
16 lines of provider realignment.

17 So we are having the territories still  
18 reviewed by the state. We are hoping to have the  
19 new official maps out within the next 30 days.  
20 And then also the second update, the last one we  
21 had, was that on 6/1 we are going to start,  
22 providers will now be able to file claims disputes  
23 and appeals on-line with ALD.

24 So hopefully that will help enhance  
25 visibility, track-ability and things along those

1 lines.

2 MS. LADY: That's available now?

3 MR. HIBBS: We are shooting for 6/1. And  
4 there will be -- over the next few weeks, there  
5 will be some webinars to come that will show how  
6 to use it, provide the updates and things like  
7 that.

8 MS. CAHOON: Medicaid and Medicare, only,  
9 though.

10 MR. HIBBS: I am sorry. Yes. Medicaid,  
11 only. I apologize. Thank you, Lorrie.

12 VICE CHAIRMAN MCINTYRE: Okay. Next item is  
13 -- moving pretty quickly through this. I am  
14 sorry.

15 DR. HOUCHIN: So my name is Tim Houchin,  
16 again. I am from WellCare. Dr. Munir resigned  
17 for family reasons. And Howard Shaps will be the  
18 interim CMO. And I will be a main point of  
19 contact as well.

20 DR. PAYNE: Good morning. Aetna. So we are  
21 a well-oiled machine. So I guess something that  
22 will, I guess, probably be impactful for you will  
23 be we are taking a close look at our prior  
24 authorization list and trying to find things that  
25 we all agree that probably doesn't need prior

1 authorization. It is a burden for you and us  
2 both. And that is going to be something that we  
3 will look for in the future.

4 DR. TRAN: I think that's an issue that many  
5 of the KMA members are very concerned about. Just  
6 at the last meeting, I think those things --

7 DR. PAYNE: I have been at both meetings.

8 DR. TRAN: I think we all expressed concern.  
9 We want to be fair to everyone involved. If you  
10 need information, I think we want to share that  
11 with you. But we don't want to do that just for  
12 the sake of doing it.

13 DR. PAYNE: And it is a burden for everyone  
14 involved. If it is a list or there is a topic or  
15 an item or a procedure or whatever that we approve  
16 95 percent of the time or something like that,  
17 what's the purpose for anybody.

18 VICE CHAIRMAN MCINTYRE: I just had a  
19 question for my information.

20 I attended the -- I am a member of the  
21 pharmacy and therapeutics committee for future  
22 service and attended their meeting yesterday. And  
23 all we do in that meeting really is go over which  
24 medications require prior authorization, which  
25 ones don't.

1 Do the managed care organizations get  
2 involved in that?

3 DR. PAYNE: So I used to sit on that  
4 particular committee and I recall those days  
5 fondly. But so the answer is, yes. We have a  
6 very robust committee structure that we look at  
7 carefully. Now we, in terms of fee for service,  
8 we obviously don't interact with that. That's a  
9 different --

10 MS. BATES: You each have one, don't you?

11 DR. PAYNE: We each have our own committee,  
12 yeah.

13 VICE CHAIRMAN MCINTYRE: All right.

14 MS. BATES: Did Humana CareSource have  
15 anything?

16 MS. WHEELER: We don't have anything.

17 DR. GUPTA: On that same note, isn't there  
18 new legislation that says that once a drug has  
19 received prior authorization, that prior  
20 authorization is valid for a full year now?

21 MS. LADY: Yes.

22 MR. GRAY: Senate Bill 54.

23 MS. LADY: Senate Bill 54.

24 DR. PAYNE: 54.

25 DR. GUPTA: When is that going into effect,

1 do you know?

2 MR. GRAY: Sometime in July. Well, it may be  
3 lagging until January. I think that one actually  
4 has an effective date of January 1 of '20.  
5 Because of the timing of that.

6 DR. GUPTA: Okay.

7 MR. GRAY: And, again, those are for chronic  
8 medication.

9 DR. GUPTA: Right. Right.

10 VICE CHAIRMAN MCINTYRE: Anyone else?

11 Okay. Next item is public health trends.

12 MS. LADY: I am sorry. I have a question for  
13 the -- I already talked to Anthem.

14 But WellCare is doing like a summit in  
15 Louisville I think next week. Does anybody else  
16 have anything like that that they are offering for  
17 providers, either through webinar and in person?  
18 Because we will put it on our events calendar so  
19 our members can see it and sign up.

20 MS. HOWARD: Right now, no.

21 MS. LADY: If you have any webinars or  
22 anything like that that would be helpful, please  
23 send it to me. We will get it on the events  
24 calendar and share it in our e-news and stuff so  
25 we will get the word out.

1 MS. CAHOON: We will have.

2 MS. LADY: Thank you. Sorry, Dr. McIntyre.

3 VICE CHAIRMAN MCINTYRE: Public health  
4 trends? I know in the past we have had some  
5 discussions about immunization, that sort of  
6 thing.

7 DR. TRAN: I do have one question or actually  
8 it is more of like a begging proposal.

9 At the KMA, we had a very robust discussion  
10 where various organizations were wanting to  
11 collaborate to improve our community health and  
12 look at it in terms of an investment. And the  
13 topic is pre-diabetes or diabetes prevention or  
14 diabetes, period. And I believe at the last  
15 meeting, many of you were very much interested in  
16 developing a campaign of some sort to mitigate the  
17 natural progression of pre-diabetes to diabetes.

18 And I think that the savings would be  
19 tremendous if we can accomplish it.

20 And now that many societies are becoming  
21 active, I don't know if the group has an interest  
22 in joining this campaign. Because I think the  
23 more of us join forces to do one thing, it allows  
24 us to focus. It helps the community stay focused.  
25 And it is an epidemic. We never called it such

1 but it is an epidemic. One-third of our  
2 population has this horrible disease.

3 And so I wonder if that interest is still  
4 there or if you guys are still working on it.

5 MS. BATES: I was going to say -- but then  
6 you all can speak if you don't mind.

7 DR. HOUGHLAND: Sure.

8 MS. BATES: So back I guess in this past --  
9 it was signed on March 19 -- there is a senate  
10 joint resolution number 7 -- is that what you were  
11 going to bring up? Yeah. So basically asked us,  
12 Medicaid, to come up with -- to do a study on this  
13 very thing.

14 So what we did from our, from Medicaid, is  
15 ask the MCOs to come up with a proposal. And so  
16 go ahead and speak to that. But I just wanted to  
17 bring that up. If I are doing it --

18 DR. HOUGHLAND: I just wanted to say, it's  
19 time that you should bring this up. I think we  
20 have all issued a proposal of how we would look at  
21 our own membership and work with the Cabinet and  
22 the department to provide more information to  
23 inform this process to see if what is the  
24 absolute -- what do we expect the outcome to be  
25 based on the Medicaid population in Kentucky

1 drawing on experience from our own Kentuckians as  
2 part of the Kentucky Health employee benefit.  
3 Seeing if we can extrapolate that across the  
4 entire population starting with a smaller group  
5 internally.

6 I think that work is just being begun by all  
7 of us. There is some national information. When  
8 I looked at this before, it is only in the last  
9 few years where it really has been coming forth in  
10 Medicaid. And a lot of it was in commercial  
11 insured and some other sectors where there is  
12 different levers and different motivators that are  
13 able to be employed. I think we have to figure  
14 out how can we do that within the rules that we  
15 operate under from our state climate, et cetera,  
16 et cetera.

17 I think there is a lot of interest there.  
18 And doing it together seems to be something that  
19 makes a lot more sense that each one of us sitting  
20 out and trying -- each one of us trying to  
21 recreate something that is already there probably.

22 MS. BATES: And I don't think anybody  
23 disagrees in this room that diabetes prevention is  
24 important and that we should be doing this. So  
25 the barrier up to this point really has been how

1 to make it fit into the Medicaid space. Because  
2 in the Medicaid space, you have to have -- you  
3 have provider types and you can only pay certain  
4 licensed providers to do certain things. And so  
5 it's been kind of -- we try to look at what other  
6 states, the very few that even do it, have done.  
7 And then you can only pay for medically necessary  
8 services.

9 And so then there is that part.

10 So that's what we are doing now is we are  
11 kind of exploring how do we make that work and  
12 still get our federal match from the Feds.  
13 Because we won't if they don't agree with it. So  
14 that's where we are.

15 DR. TRAN: And I am glad you brought that up.  
16 Because as a provider, sometimes I don't really  
17 quite understand the regulatory issues that you  
18 have to deal with. And I think that when our  
19 providers and KMA -- what is it -- Kentucky  
20 Foundation for Health or -- there are many people  
21 and we don't understand what each of us do. And I  
22 think it is very important, you know, maybe a  
23 summit or something where all the minds can come  
24 together and here is our bubble, here is our  
25 bubble, and see where the intersection allows and

1 let's collaborate. It makes more sense than if we  
2 individually siloed, developed something that may  
3 contradict. That is going to get the wrong  
4 message out to the community.

5 MS. BATES: And so recently, also, we put out  
6 there is the diabetes report. I don't know if you  
7 saw it, but the newest Kentucky diabetes report.  
8 So that is legislatively ordered. And I think  
9 this is the fourth one maybe, third or fourth one.

10 Anyway, so that's when certain agencies  
11 within the Cabinet for Health and Family Services  
12 collaborate on the state of diabetes in Kentucky.  
13 And so this is the fourth one. And it is  
14 interesting to see how we have progressed since  
15 this began. So there is that. And you can always  
16 go out there and look at those and look at the old  
17 ones.

18 But it goes without saying that I think there  
19 has been a lot more collaboration in the past  
20 couple of years about this. We are, just in the  
21 next month, we, Medicaid, we are speaking at I  
22 think it is the Kentucky Diabetes -- I can't  
23 remember. But anyway, just to get that kind of  
24 education out. Because Medicaid is a foreign  
25 language to most people. And it is to Medicaid,

1 also. And we understand that. And we get kind of  
2 stuck in our government where we are worried about  
3 this and following this.

4 And so I completely agree with you.

5 But we did get proposals from the MCOs. We  
6 have to turn in our final report by November 1.  
7 We work within a budget. We don't have anything  
8 budgeted for that program right now. But next  
9 year is a budget session. So that doesn't mean  
10 that we can't in the future have a reg.

11 DR. TRAN: And, again, this is purely an  
12 anecdotal perspective. I see -- I go to various  
13 meetings, various commissions. And I see everyone  
14 coming up with very similar ideas and I start to  
15 worry that we are all in our little silo. And I  
16 just want to make sure that, hey, these guys are  
17 doing it here so that we do establish connections.

18 MS. BATES: For this particular service, I  
19 think where we are now is we all think that we  
20 should cover it. We just are trying to figure out  
21 how to make it happen.

22 DR. TRAN: Thank you.

23 DR. GUPTA: First of all, does Medicaid and  
24 MCOs cover a patient or reimburse for a patient  
25 seeing, like a diabetic patient, seeing a

1 nutritionist?

2 MS. BATES: So we cover diabetes  
3 self-management education for physicians in the  
4 hospital, right? But there are certain barriers.  
5 I am going to get this wrong.

6 MS. WHEELER: I don't believe they reimburse.  
7 Registered dieticians are not a recommended  
8 provider type.

9 MS. BATES: And that comes back to the  
10 provider type issue.

11 DR. HOUGHLAND: As is often the case, it  
12 depends. So if it is provided under the auspices  
13 of a physician in the office and billed as that is  
14 the place of service under the rendering, then it  
15 is reimbursable. But an independent registered  
16 dietician that is not attached to the physician or  
17 a facility, it is not reimbursed.

18 DR. GUPTA: So like if an endocrinologist  
19 employs a nutritionist, then that endocrinologist  
20 can get reimbursed?

21 DR. HOUGHLAND: That can be reimbursed, yes.

22 DR. GUPTA: Okay. So that's very good.

23 You know my feeling is that this all starts  
24 when the baby is born, right. And a lot of --  
25 unfortunately a lot of these patients -- well, it

1 happens to everybody. But we may tend to see it  
2 more in the underprivileged patient, right. So  
3 those patients tend to be on food stamps. And I  
4 feel like this all has to start with what food  
5 stamps cover. And I know we have no control over  
6 this. I know it is federal. But I just wish that  
7 the food stamps could be revolutionized, that it  
8 would not cover things in the middle of the  
9 grocery store. It would cover things on the edges  
10 of the grocery store. You know, potato chips, all  
11 the cheap stuff. It covers -- I mean I think they  
12 can get cigarettes, tobacco things. These are all  
13 things that are leading to diabetes and cancer and  
14 all of these things.

15 So I feel like it really needs to start with  
16 as soon as that baby is born.

17 MS. LADY: And that's where those medical  
18 nutritional therapy services need to start, too,  
19 because a lot of people can't -- this sounds  
20 terrible but I think there is truth in it and I  
21 have learned -- no one really cooks. That's kind  
22 of becoming a lost art. I know that sounds  
23 ridiculous. But that's been -- I volunteer for  
24 this through a church where we actually help  
25 people learn to cook nutritional meals. They have

1 no clue.

2 DR. GUPTA: Right.

3 DR. NEEL: It is called home ec.

4 MS. LADY: You are right. It was called home  
5 ec. And that's not offered any more much like  
6 physical education is optional and all those  
7 things. But you are right.

8 But that's where the MNT could come in.  
9 Because that therapy, and you are right,  
10 Stephanie, it confuses members. Because like on  
11 the Medicare side, they will pay a registered  
12 dietician. Medicaid won't. Some commercial  
13 payers may even pay that to a registered  
14 dietician. But if they get that service that  
15 shows them the proper food and then they can learn  
16 how to prepare that food, it is like -- but that's  
17 not payable.

18 DR. GUPTA: But even for pediatricians,  
19 because I have never seen a nutritionist at my  
20 pediatrician's office, but I feel like it would be  
21 so useful for a pediatrician to have a  
22 nutritionist. Because the pediatrician does not  
23 have time. But if they can flag a patient and  
24 send that patient to the nutritionist. I mean  
25 even if it is small things.

1           I see so much diabetic retinopathy. And  
2           these patients, you know, half the time they don't  
3           even know what the hemoglobin A1C is. And I just  
4           kind of tell them, like, you know, I am not an  
5           internal medicine doctor. I just try to tell them  
6           like 1 or 2 small changes that I think that can  
7           help them. But, you know, that is nowhere near  
8           where a nutritionist is.

9           MS. WHEELER: So I actually myself am a  
10          registered dietician. And never went into  
11          clinical practice for this reason. Because you  
12          are working against an environment that is averse  
13          to what you are trying to do in a one-on-one  
14          situation. So I went into public health.

15          So I agree with you. We need a greater  
16          presence. I recently relocated here from  
17          Pennsylvania and they had a grant that was funding  
18          a registered dietician in M.D. partnerships in  
19          pediatrician offices where we were going and  
20          talking about the importance of early intervention  
21          for overweight and obesity.

22          So that's an idea of something that  
23          potentially we could run with. I think that was  
24          like a 4 year grant they were bring -- and we had  
25          a presentation and we talked about the 5-4-3-2-1-0

1 and I don't even remember what they are. But 5 or  
2 more servings of fruits and vegetables, less  
3 screen time, zero sugar sweetened beverages, that  
4 kind of thing. So I could see that being a need  
5 here.

6 But I agree with reimbursement for medical  
7 nutrition therapy even though I was too frustrated  
8 to do it on my own. It is necessary. And I am  
9 plugged in with the dietetic association here  
10 locally and I know of several registered  
11 dieticians who have their own provider ID and are  
12 billing for Medicare services and would be  
13 interested in doing that on the Medicaid side.

14 But, you know, it is getting all of the  
15 powers aligned to make that happen.

16 DR. HOUGHLAND: So at the risk of kind of  
17 beating the same drum, I also think -- well, this  
18 is one of those areas where finding ways of  
19 creativity in a highly regulated environment all  
20 the way up to the Feds is somewhat challenging but  
21 it is kind of fun, too. And I think, you know, as  
22 we move away from thinking about, okay, this  
23 provider being reimbursed for this particular type  
24 of service, it is where alternative payment models  
25 really have a lot of opportunity and a lot of legs

1 to it. Because then you can stop thinking about  
2 it. We look at what is attributed population,  
3 what is total cost of care for that attributed  
4 population, how many diabetics are in that. Here  
5 provider, let's work together, figure out what the  
6 type of resources are going to be needed. You  
7 allocate it within your attributed panel.

8 If you have 10,000 diabetics across your  
9 50,000 attributed panel -- thinking in round  
10 numbers -- this is what we think the service they  
11 need, this is what we think the cost is, you  
12 figure out how to do it. If they need  
13 transportation, if they need a dietician, et  
14 cetera, and we stop telling people exactly what to  
15 do to -- kind of frameworks. But what we say is  
16 that we expect this kind of result. You figure  
17 out how to do it.

18 That's where we need to go. Now, the problem  
19 that we all know is that whenever the world isn't  
20 all -- everybody in the world isn't there at the  
21 same time. It is hard to retool and live in both  
22 sides. But I think these types of things in  
23 trying to get to where we want to be, it is going  
24 to force it more quickly. It's something that we  
25 are interested in doing. I know in our different

1 meetings, we talk about this a lot of ways. But  
2 it is like who is going to put their foot in more  
3 fully first and what is the tipping point to kind  
4 of push towards it.

5 But I fear that as long as we keep talking  
6 about this code getting paid this amount by this  
7 person, we are kind of getting stuck in the same  
8 place.

9 DR. HOUCHIN: Fee for service paradigm kind  
10 of thing.

11 DR. HOUGHLAND: You know, I don't know -- my  
12 organization can't be the only one to do this and  
13 we can't push it. But my true belief is is that  
14 my core profession can. And that's this group as  
15 others that can actually force that conversation  
16 and the consumer can force it more. But as one  
17 company, I can't do it. And I dare say that the 5  
18 of us sitting here, 6 sitting here, can't do it  
19 even collectively. There is powers that prevent  
20 that from happening. But the collective force of  
21 the physician community and consumer can.

22 MS. LADY: Under the Public Health  
23 Commission, as Dr. Tran was discussing, at KMA,  
24 they are going to narrow their focus because  
25 diabetes is so huge to preventing it. And so they

1 have talked about a lot of different things. And  
2 one of them to Dr. Houghland's point was instead  
3 of having individual services, you would have like  
4 a package where that as part of that if you have  
5 got a -- if a physician identified a patient as  
6 pre-diabetic based on fasting blood sugar or A1C,  
7 whatever those guidelines are, then they would  
8 move into prevention mode. And then part of that  
9 prevention mode would include a medical  
10 nutritional therapy piece. It would include  
11 probably some counseling maybe. I don't know what  
12 all -- or a really mean doctor like the one I have  
13 who says lay off the carbs. I mean, it -- so  
14 that's what we -- so our -- I think that's where  
15 our focus is going to move.

16 Last year we did focus on the flu. It was  
17 really successful. We worked with Medicaid and  
18 public health, the Foundation for Healthy  
19 Kentucky, and some other partners. And I think  
20 the MCOs can be really helpful in this, though,  
21 because I think, you know, we think there is a way  
22 to do a pre-diabetes prevention where it is the  
23 same for all of us and you don't have like this is  
24 our diabetes prevention program. This is ours.  
25 If you could have one that was consistent. And,

1 to your point, make sense, affordable, have  
2 everything be part of that from one -- maybe one  
3 cost. And then you guys have the data you can  
4 measure it.

5 One of the groups we are talking with in June  
6 is with the -- through the Kentucky Board of  
7 EMS -- is paramedics. Because they have -- the  
8 paramedics here, they have got para-medicine  
9 programs going on. And probably some of you are  
10 familiar with those. And they are identifying  
11 patients that -- and they have gotten a lot of  
12 grant money to do this.

13 But they not only identify the frequent  
14 fliers that call 9-1-1, they are narrowing their  
15 focus down to where they are getting out in the  
16 field and they are seeing patients that are on the  
17 cusp of maybe they -- something happened and then  
18 they are discovering they are pre-diabetic at that  
19 stage. So they are trying to figure out how to  
20 stop it there.

21 And so we are going to chat with them and  
22 see. Because at some point, they would need a  
23 physician to treat them. And so if we can have a  
24 referral pass.

25 So I think there is a lot. But that's a

1 valid point. But I do think you could do it in a  
2 cost affordable way. And we are looking at what  
3 other states are doing as well. But, yeah,  
4 sometimes I don't know. So I will keep you posted  
5 as KMA progresses with this. And I will be  
6 reaching out to some of you who have already  
7 expressed an interest, Anthem, Dr. Payne, who have  
8 talked to us about diabetes prevention.

9 So, anyway. You can talk about this all day.

10 DR. TRAN: We can. And, you know, I am the  
11 numbers type guy who sits and analyzes. We know  
12 the natural history of diabetes which starts out  
13 with pre-diabetes. We know what the natural  
14 history if left alone and what the incidents and  
15 prevalence will be. It will be very easy to  
16 narrow our focus to just that pre-diabetic  
17 population.

18 The first barrier is going to be providers.  
19 You need to identify these pre-diabetic patients  
20 for us. Most people don't do that. There are  
21 very strict definitions as to what pre-diabetes  
22 is. And many doctors do not add that diagnosis.

23 What interventions are we going to do? And  
24 it is very simple to just look at the population  
25 and what is the natural disease progression for

1 pre-diabetes to diabetes within a time frame? And  
2 then compare it to our intervention arm to see if  
3 we did achieve an absolute risk reduction. And we  
4 have a metric that we can measure quite easily.  
5 The intervention now can be broken down into  
6 should we start with limiting what assistance  
7 programs can purchase you. Should we start  
8 dictating to people what they can eat and what  
9 they can't eat? I think that is going to be a  
10 horrible discussion. And we won't get very far.  
11 And what else can we do instead of that.

12 And what we can do is impact what we can  
13 impact and that is, hey, you do have diabetes or  
14 pre-diabetes. I need you to start watching sugars  
15 more and we need to have campaigns and programs to  
16 specifically focus.

17 We will never be able to do what we can't  
18 impact and instead focus on what it is we can  
19 impact. And maybe a group of doctors do need a  
20 sit down, each practices and say, here is what I  
21 can promise. Here is what I can do. And here is  
22 what I need to do and work out these deals with  
23 our colleagues here and insurers.

24 DR. HOUCHIN: Just real quick. So UK -- I am  
25 sorry -- UK has an embedded R.D. at the pediatric

1 clinic. My wife's a pediatrician there at UK.  
2 And so they are kind of getting out in front of  
3 this.

4 And then the other thing is our, you know,  
5 cohorts in New England, non-MCO cohorts, DPC  
6 clinics, direct primary care. You know, they are  
7 doing a lot of health coaching and holding folks  
8 accountable. So here is what we recommend that  
9 you eat in terms of calories, et cetera. And  
10 then, you know, a non-registered dietician can  
11 call and ping them frequently about, you know,  
12 hey, are you sticking to your diet? What's your  
13 weight today? A lot of them are linking this  
14 stuff to smart apps. And a lot of those things  
15 are currently not things I think that an MCO can  
16 necessarily pay for. But they are very innovative  
17 and they work. We have got pretty good data.

18 DR. TRAN: In the VA, we have quite a few  
19 nutritionists, dieticians who do. And, you know,  
20 I know we kind of laugh but nutrition is important  
21 for every disease.

22 DR. HOUCHIN: Absolutely, yeah. I probably  
23 need one.

24 DR. TRAN: Not just diabetes. Everybody  
25 benefits from proper nutrition. I know we don't

1 have randomized controlled studies to demonstrate  
2 that good nutrition is better for your health, but  
3 I think most of us would agree. So, you know, how  
4 do we -- we should get away from this model of  
5 everything we do has to have a reimbursement. We  
6 should get to the model of what outcome is it that  
7 we want to achieve at the end of the day.

8 DR. NEEL: I can speak as a pediatrician, we  
9 have turned to the schools for years. Because as  
10 we talked about earlier, we are doing away with  
11 home ec and we are doing away with recess because  
12 those are not things that are tested for. And the  
13 teachers tell us, we are going to teach the test.  
14 So we are trying to get more health questions on  
15 the testing. And we were not able to do that over  
16 the last several years. But we have got to turn  
17 to the schools because we can't teach the parents  
18 it seems like so we have got to teach the children  
19 what is proper dieting. And that's difficult to  
20 do. But we are trying to do that because kids are  
21 starting kindergarten thinking that their perfect  
22 diet is chicken tenders and fries. And you see  
23 the double line going around Chick-fil-A every  
24 morning. There is a reason for that. The kids in  
25 the car are getting that.

1           So we have got to gradually work on that, I  
2 think. We pediatricians are finding less time to  
3 talk about those things in our visits than we are  
4 other things. We are learning more on the  
5 computer than we are in the child. And I can tell  
6 you that another thing we are dealing with,  
7 particularly in teen-agers now, is video games.  
8 And that's almost taking the place of diet. And  
9 it is a problem for us. I thought I would share  
10 that with you.

11           DR. GUPTA: I totally agree with you. I  
12 really feel like to get to the root of the problem  
13 long term, it has to start in the first 5 years.  
14 And when I see a mother come in with a baby -- you  
15 know, I am pediatric ophthalmologist. So if I see  
16 a baby less than 1 and I am pretty sure I am  
17 hoping that they haven't started screen time yet,  
18 I tell that parent, I'm like, the best thing you  
19 can do is never have this child use a tablet or a  
20 phone. Just don't. Because we see all of that.  
21 I see so many problems with kids under the age of  
22 10 because of screen time.

23           And if they don't start then -- I mean  
24 eventually they are going to use it -- but they  
25 are not going to be like glued to it. So to get

1           them at that very young age is so critical. And I  
2           wish we could do something more. Hopefully we  
3           can.

4           VICE CHAIRMAN MCINTYRE: Anyone else? Okay.

5           The next item is TAC recommendations. Do  
6           either of you have any? I don't have anything to  
7           send to the MAC.

8           DR. TRAN: I would be very much interested in  
9           hearing more updates regarding the portal, the  
10          provider enrollment portal. I think it is a much  
11          needed service. And my personal experience is we  
12          have had applications submitted. And it seems  
13          like it goes to this black hole and we don't  
14          really know what happens to it. We can't really  
15          follow it.

16          And we have 2 providers that we started the  
17          enrollment process back in December. It is now  
18          May. And we haven't heard anything more other  
19          than after doing some investigating one was held  
20          up because something was applied improperly to the  
21          CAQH portal. And that's why I was very  
22          interested.

23          If we can just ensure that the future portal  
24          has a built-in feedback so that, hey, you are  
25          missing this or, hey, you are missing that. And,

1           you know, we can pursue that. That's the only  
2           request I would ask of, you know, Medicaid because  
3           I think this will be a wonderful thing to start  
4           with. And I think that if this becomes  
5           successful, this is something we might encourage  
6           our providers. And at KMA, we are doing some of  
7           that already. And legislature people, I think you  
8           guys are aware, this compact, this relationship  
9           that we have with surrounding states, if you are  
10          licensed in the surrounding states we will accept  
11          your license.

12                 The only barrier or hurdle is each state has  
13          its CME requirements and whatnot. And we just  
14          have to adhere to those. But that's a much  
15          improved move compared to where we were say 5  
16          years ago. And yet if you happen to live on that  
17          border, you have to apply for 3 different states  
18          which is really unnecessary.

19                 So I think that we should applaud Medicaid  
20          for at least doing this. So I want to make that  
21          public.

22                 VICE CHAIRMAN MCINTYRE: Anything else? Wrap  
23          up, round table meeting and event reminders. I am  
24          going to turn --

25                 Does anyone have anything else before we

1 adjourn?

2 MS. LADY: Well, the telehealth summit is  
3 May 23 for those of you. It looks great and it  
4 was great last year.

5 DR. TRAN: May 23?

6 MS. LADY: It is in Bowling Green, May 23 at  
7 the WKU Knicely Auditorium which is pretty easy to  
8 get to. It is the same days as the MAC. I won't  
9 get to go to the MAC. I am excited about the  
10 tele-summit. They have got some good speakers  
11 lined up.

12 DR. TRAN: Stephanie, I am just curious only  
13 because -- and I know that the VA world is quite  
14 different than regular people world -- but how are  
15 these other providers who are proposing to do  
16 telehealth ensuring that we have HIPAA compliant  
17 --

18 MS. BATES: You asked that at the beginning  
19 and I said that I would get back with you.

20 DR. TRAN: Is anybody doing this yet? Is  
21 there anybody out there doing it?

22 MS. BATES: Doing what? Oh, yeah. It is a  
23 current service.

24 DR. TRAN: That's what I mean. I am just  
25 very curious.

1 MS. BATES: But like I said before, it is all  
2 covered. The telehealth board is in charge of  
3 that. And they are in charge of the transition.  
4 So I will get back with you on that for what it is  
5 going to look like 7/1 going forward.

6 DR. TRAN: Okay.

7 VICE CHAIRMAN MCINTYRE: Our next meeting is  
8 September 6, Friday, at 10:00 a.m.

9 And thank you all for coming.

10 MS. HUGHES: Dr. McIntyre, we do have a new  
11 chief of the staff for Medicaid. It is Genevieve  
12 Brown. She just started yesterday. So she just  
13 wanted to come down and meet you all.

14 VICE CHAIRMAN MCINTYRE: Thank you. Meeting  
15 adjourned.

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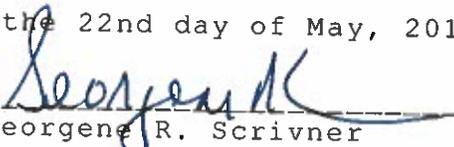
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CERTIFICATE

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 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 22nd day of May, 2019.

  
Georgene R. Scrivner  
Notary Public - ID 445375  
State of Kentucky at Large  
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My Commission Expires: 7/15/2019

