CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
PHYSICIAN SERVICES
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
May 19, 2023
Commencing at 10:00 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

William Thornbury, Jr., MD, Chair

Ashima Gupta, MD

Don Neal, MD

Eric Lydon, MD

Tuyen Tran, MD

CHAIRMAN THORNBURY: Okay. Good morning, everyone. I'm Dr. William Thornbury. This is the Kentucky Medicaid Physicians Technical Advisory Committee. Today is May 19th, 2023. We're meeting under the auspices of Title XIX.

Let the record show that we have a quorum with Drs. Neal, Tran, Gupta, and Thornbury. I don't see Dr. Lydon. I may be missing him. And if he is, I apologize.

Our first item of work would be to approve the minutes from the previous meeting. Is there a motion?

DR. NEAL: So moved. Dr. Neal.

CHAIRMAN THORNBURY: Yes. A second, please?

DR. GUPTA: Second. Dr. Gupta.

CHAIRMAN THORNBURY: All in favor of approval?

(Aye.)

CHAIRMAN THORNBURY: Approval of minutes without exception. Very good.

I want to take chairman's prerogative. We don't have Dr. Gupta very long, and I want her involved in this discussion. I'm going

to move us down to Item No. 6. We're going to add under general discussion an item that came up this week talking about code 66030 and the J code, J3751 (sic).

Cody, do you want to set this up for Dr. Gupta?

MR. HUNT: Well, I would defer to Dr. Gupta on this one. I believe she probably has much more expertise on the issue than I do. So I'll -- Dr. Gupta, I'll defer to you on this one.

CHAIRMAN THORNBURY: Ashima?

DR. GUPTA: Okay. Sure. I think that Commissioner Lee -- is she on the call? Maybe not. But I think she is already aware of this issue with at least one optometrist who has performed implantation of Durysta, which is an implant medication that lowers the intraocular pressure for glaucoma.

And it was actually in the -- I guess the bylaws or whatever it's called. That procedure is not an approved procedure to be performed by optometrists. It's only to be done by ophthalmologists.

So I think there's already been

discussion with Commissioner Lee and the KMA as well as the Kentucky Academy of Eye Physicians and Surgeons about removing the CPT code for that procedure, which is 66030 as well as the J code for the actual implant, which is J7351.

We're just asking basically to be updated on how close we are to removing those two codes from the optometry fee schedule, so we are not subjecting Kentuckians to illegal surgical procedures.

And the code that should be okay for optometrists to do is an emergency paracentesis, which is CPT code 66 -- sorry, 65800. So I just wanted to ask about an update. Maybe we can keep that on the agenda for the future.

MS. BICKERS: Justin Dearinger has his hand raised.

CHAIRMAN THORNBURY: Yes, please.

MR. DEARINGER: Yes. Good morning. My name is Justin Dearinger. I'm the director for the division of healthcare policy.

I apologize. I'm not on camera today.

My electrical panel decided that it didn't want to -- it no longer wanted to work for me anymore. So I woke up this morning to the smell of it frying itself, and I have some electricians working on it right now.

But I wanted to discuss this code really quick. We are aware of the issue. We have gotten a legal opinion from our office of legal services. And right now, we are in discussions with the Board of Optometry who has that service listed as one of the services available for optometrists to perform on their list of approved codes.

So right now, we're in discussions with them. And as soon as those discussions conclude, we'll have an update on what we're doing with that CPT code.

CHAIRMAN THORNBURY: Fantastic, Justin. We'll keep this on the agenda so that when we come across this again -- usually, we don't take a -- if I'm not mistaken, we're -- what are we in, May? Usually, we don't do a July meeting. We kind of skip that. That's usually time that we're in Frankfort meeting individually and then we

usually come back in the fall, but it'll give us some time to look at that. Would that be okay, Dr. Gupta?

DR. GUPTA: That would be great. Yes. Thank you so much. I really appreciate you letting me talking about this.

CHAIRMAN THORNBURY: Thank you. We'll move down to -- yes, sir. Was that you, Dr. Neal?

DR. NEAL: No.

CHAIRMAN THORNBURY: Okay. I'd like to move down to seven while we have Dr. Gupta so that if we have any recommendations to the TAC -- to the MAC -- let's -- let's come down and take the last one firstly about our discussion of developing a tool toward Medicaid primary care.

Cody, do you want to start us out on this?

MR. HUNT: Sure. So the two recommendations here on the agenda today work in tandem with one another and come as a result of several conversations that have been had here both at the PTAC as well as

with conversations that have taken place with the cabinet and DMS leadership.

The second recommendation here is to recommend to DMS to develop a tool to measure the Medicaid primary care spend or the amount of the budget that is spent within Medicaid that goes towards primary care services.

And the way it works in tandem with the recommendation above is that what we've found as we've looked to see which codes on the fee schedule that we could target for an enhancement as they relate to primary care, it's been rather difficult to determine which codes on the fee schedule would be most appropriate and be most helpful with some sort of enhancement. Because there's a lot of crossover between provider types that bill for the different codes on the fee schedule.

And so we think that it would be most appropriate initially for DMS to develop a tool to measure which codes would be most utilized in the primary care space and by which provider types so that we might have a better view of addressing which ones would be most appropriate to make an enhancement to.

CHAIRMAN THORNBURY: Thank you, Cody. Let me set -- I'll tell you how I look at it in my mind. The reason that we're interested in this particularly is the work -- based on the work of Barbara Starfield 30, 35, 40 years ago. When Dr. Starfield did her work, basically, the conclusions of that body of work was that health systems, no matter how small or how large they measured, that had more primary care -- what I would call quality primary care -- and at that time, the primary care being measured was physician primary care.

It wasn't -- I want to make sure that the panel understands it wasn't, like, nurse practitioners or physician assistants. This was primary care conducted by physicians, comprehensive primary care.

Systems that had that had better outcomes and lower costs every single time. That has never -- that conclusion has never been disproven.

And so until we have data that says that we need another or different or have a better system -- and we're waiting on that data, but

we've not seen anything since that time. We're looking to try to salvage the primary care system we have in Kentucky.

The reason that we're interested in doing that is the primary care system in Kentucky is actually what's providing, not the cough and cold that many people think in the urgent clinic. What we're really doing is driving the chronic disease care, the overwhelming majority of chronic disease care.

And that's got to be conducted here and for us in a commonwealth that doesn't have really the best outcomes. All of our numbers start with a 40 or a 50, you know, that we have a lot of chronic disease burden. Again, the way I look at it is for every one person actually working, we probably have one person on Medicaid in Kentucky. Well, we have to have a system that's sustainable, and this is the best system that we have.

What we're looking to do is, I guess -- I don't want to steal a page from you all's playbook at the DMS. But as an administrator, there's an old saying that if

you can't measure it, you can't really manage it.

And so one of the things that we're concerned about was, at one time, when we built our computer systems, primary care had their own codes, and other systems like consultants had other codes. And it was a simple matter to say, well, these codes related to primary care.

Unfortunately, now that -- a few years ago, those codes have all merged together. So to give you an analogy, suppose we all wanted to go out and buy running gear, and we were going to exercise for the summer. And I was buying Adidas, and you were buying Under Armour. And somebody is over here buying Walmart, and somebody's got, you know, another competitor.

Well, now we're all wearing the same shoes. We're wearing the same socks. We're wearing the same clothes. And if there are five people out there, maybe you can tell who is the high-end athlete and who is not.

But when you have a million people or 1.4 million people, it becomes very

difficult. And when we're trying to look at different specialties, we're not really sure how we can actually say, well, how are we going to support primary care. How can we direct resources toward that? If we're going to work in this medical care model developed by Starfield, how is this going to actually happen?

And, again, just to dovetail the second part of this so we can handle two at once, you know, it's been a year or two that the commissioner and other colleagues from Medicaid have said, well, give us a code or two or three that you can -- that we can help you guys with.

And the reason that we've brought up the 214 is because that does the heavy lifting for us because that's the code where we manage -- when people come in, they don't come in with one problem usually in my clinic. They come in with really between three and six problems in any given visit, and we're trying to kind of adjudicate those. And that's the code that really does the heavy lifting.

Now, there's more than one way to look at that. Even among the committee, we're not sure that this is the right thing to do. It can be very difficult.

But I would like to open up our discussion as a committee on, you know, can we move forward a recommendation for Medicaid to say, well -- or get some feedback on how do they see that they're going to measure primary care -- you know, if we're going to do anything about this, how are we going to delineate primary care from other services?

And what would be the things that we could give them, if anything, to say, well, this is something you could do to help primary care at least today until we can work out some issue?

Dr. Neal, I really would like your expertise because Florida has done really strong work and had very good outcomes with this. And I'm really not sure how they're measuring primary care at all. Could you take the floor, please?

DR. NEAL: Well, I think that Florida just chose all people who could prove

that they were specialized in either family practice, I think OB/GYN was probably included, and pediatrics.

And so they have actually, over the last seven years, paid Medicare rates to those that could prove those specialties. And they actually have just signed a new contract to take that forward another three or four years.

That alone has not been the thing that has kept primary care going in Florida. Of course, they only have -- about 18 percent of the citizens of Florida are on Medicaid; whereas, we're up in the 30 percent. And so it's a different thing.

I might add that in pediatrics, you're treating more -- I'm sorry. In family practice, Dr. Thornbury, you all are treating more of the chronic disease and that sort of thing. Whereas, in pediatrics, which is more than 50 percent of the Medicaid recipients in Kentucky, we're treating wellness, which is different. And that's what we specialize in, well care, immunizations, et cetera, which has become more difficult since COVID and

that sort of thing.

So I really feel 214 does not heavily lift us as much as it does you, I think. What we have gone to more has been the split visit or the modifier 25, which makes a split visit with a combination of a well code with a sick visit, which has worked fairly well.

But the problem we came in there was the limitation on the numbers of 914s. And so many of the old pediatricians have not used 914s because we were never paid for it. And so it's been a practice to go with undercoding, which was not a good idea, too. But I don't have the problem with that.

But I do have the problem with the coding system. I don't understand why we can't delineate who is seeing the Medicaid patients, and that's part of what you're alluding to, is that the nurse practitioners -- it looks like to me, that should be a nursing code and not a physician code. And I've never understood why that's not different, in other words, from our well visits as well as our 99 codes. So --

CHAIRMAN THORNBURY: It's probably

an IT -- I would think it would be an IT thing, but I don't want to speak on behalf of DMS. How do you guys see it? We would open the floor up to you all. If you have any ideas here, we would really entertain that. Does anybody feel comfortable kind of bringing this up on your side?

DR. THERIOT: Hello. This is Dr. Theriot. Oh, I don't know where I am.

CHAIRMAN THORNBURY: Hey, Judy.

DR. THERIOT: Hi. How are you, guys?

CHAIRMAN THORNBURY: Good. Thanks for joining us.

DR. THERIOT: I think -- I think it might be an issue of just pulling things on taxonomy and then we can get at primary care from that. I don't know. People like Angie maybe, you can tell me if I'm thinking the wrong way, or Justin. But instead of pulling by codes, pulling by the physicians by their taxonomy might be able to try and figure out what is going to primary care and what is not.

MR. DEARINGER: Yeah. Doctor, this

is Justin Dearinger. I'm not sure -- I would assume -- and this is assuming because I haven't asked -- you know, I haven't spoken on this specific topic with someone from IT. But I would think that there is a way to pull from provider type. I mean, I believe that to be true.

So I think we could do that. But I will check and find out and make sure and see if we can pull that specifically for primary care providers and maybe, like, their top ten or twenty billed codes.

I know we do that all the time for other provider types, so I don't know why it would be an issue here.

CHAIRMAN THORNBURY: Well, we would welcome that. I can tell you that I'll, again, support what Dr. Neal said. I think you're looking at the left arm and the right arm.

When you have pediatrics -- there are only a few specialties that do a lot of preventive medicine, and you're probably talking peds, OB/GYN, family medicine, and the general internists that are practicing in

primary care. Those people are doing the well-care part of the health system.

Regretfully, again -- I would say Dr. Theriot can chime in on this. In Kentucky, we have a very, very substantial burden of chronic disease care, and that's probably the other hand, which is when this doesn't work on the front end -- of course, the lead time can be really sometimes several decades on the well-care portion.

But when we end up with the sick-care part of it, that's really going to fall back on -- again, I think you want to -- the case that the Physician TAC would make is, instead of trying to come in and saying, I'm going to see you for the diabetes and then I'm going to go to the next person and I have kind of a schematic of what I'm going to follow, most of the people in our field are trying to say, well, can we deal with four or five -- three, four, five things at a time as a cohort or things that can be addressed in one visit instead of trying to schedule three different visits because we're trying to do three different bill ings because that's how we

earn our income. It's just easier for these people to get in one time, just take care of these things together if we can.

And I would say, Justin, that, you know, we can look at the top ten codes, but my goodness gracious, at least in the field that I work in, I don't know how they would -- I don't know how No. 1 and No. 2 wouldn't be 99214, 99213.

I mean, there might be other -- I'm sure there's lots of codes beyond that. But I think that that's what -- at least in our view. I know that, Dr. Neal, we said we had worked with our MCO partners to correct the 25 -- or the 214, 99214 so that they can understand the work that we're doing and our physicians can be compensated for the work that they're doing.

I don't know where we're at on a 25 modifier. That's a relatively common thing because, again, people in their office, it's just better to take care of the problem today as opposed to just put off the problem for a bigger problem tomorrow. So sometimes we -- rather commonly, actually, I would say we use

a 25 modifier to describe the work that we're doing.

Anybody else want to be part --

MS. BICKERS: Dr. Cantor has her hand up.

CHAIRMAN THORNBURY: Yes, ma'am.

DR. CANTOR: Good morning. I'm Dr. Cantor with UnitedHealthcare. There are provider types that delineate the difference between a family practitioner versus an OB/GYN or a primary care or even a nurse practitioner. So that taxonomy is what Dr. Theriot was referring to, and I would concur.

So you can -- we can parse it out. And I know if we're parsing it out, then the aggregated data, DMS could do that as well. And many of our state reports include distinctions based upon provider type for the care that's been given.

So then just as recognition, that procedure code, the E&M code, is one element to be able to parse the data. The other is the primary diagnosis and then all the subsequent diagnoses.

And there is lots of lines for all of the diagnoses to be input, and it would be your back office that would do that if those diagnoses have been checked in your assessment. And I would encourage that to happen because we're looking at every one of those diagnoses lines depending upon the need for what we're using. Sometimes we go all the way down to the very bottom of the claim. However many lines that will be, we look at all the diagnoses.

So that's where the distinction lies, is yes, you put in a modifier. But to substantiate it with this person had 20 diagnoses that I was trying to manage, and that's why I needed that much time. That's -- I hope that helps.

CHAIRMAN THORNBURY: Dr. Cantor, thank you for chiming in, and that does help us a lot. I don't recall that we've ever been told before that it was possible to parse that data, to parse that data out.

DR. CANTOR: We look at all the diagnosis lines. Absolutely.

CHAIRMAN THORNBURY: In my

practice, I thought we -- I thought we were limited to five diagnoses at a time. So we're not -- maybe that's just my back office.

DR. THERIOT: The old forms did, I think, limited it to four actually, the old claim forms. And now we go up to 12 or 15, I believe.

I'm just going to put a plug in for Z codes because Z codes are the ones -- like social isolation, domestic abuse, parental divorce. Those are the codes -- like, if -- granted, you're not going to get paid if that's the only code you put on a claim.

But those are codes, if you put it at, you know, No. 10, 11, and 12 on the claim, that better describes what was happening in that visit and might explain why it's a level four or five instead of a three.

And when people use those Z codes, it really helps -- as far as when you can only look at the claims, it really gives a better description of the work that was done on that visit.

CHAIRMAN THORNBURY: Thank you very

much.

DR. NEAL: Dr. Thornbury, could I jump in just a minute to --

CHAIRMAN THORNBURY: Of course.

DR. NEAL: -- bang the drum and clang the cymbal that you and I have been doing for some time?

We're bleeding primary care physicians from this state. At the same time, we are increasing the number of Medicaid recipients to one-third of the people here, many with chronic diseases.

Our concern has been that we're bleeding that because we're not producing the primary care physicians, and we're not reimbursing them in this state what we need to be doing. Only part of it is money, and I understand that.

But one of our problems has been trying to determine who is seeing Medicaid patients, and that's what this discussion, quite a bit, is about. And we've been trying to get DMS to tell us who is seeing them. And now you're telling me that maybe the MCOs could delineate some of that information.

The federally-qualified health clinics, which are huge in Kentucky -- at last count, we had over 20, maybe 30. And they tell me that even though they are getting cost plus reimbursement, that they really cannot afford to hire physicians. And they can't find physicians to go on their staff. They may have a medical director, but that many of their patients, majority actually, are being seen by mid-level practitioners.

And that's one figure we've been trying to come up with, and I think you would echo that, Dr. Thornbury, that we're desperate to have that information.

That's fine. Go ahead.

CHAIRMAN THORNBURY: Well, yes. I guess the question really at this point is: What is the next step for us?

DR. NEAL: Right.

CHAIRMAN THORNBURY: It's very -- it's endearing to hear Dr. Cantor at least kind of say, well, they have a way of looking at that. I still believe that based on all the data that I've seen, even the data as of last year out of Hattiesburg and that ER

data, that says that these physician-led teams are still the most efficient, that's been my experience.

I mean, I have a bias because I'm a physician, but I'm married to a nurse practitioner. I train them. I train physician assistants. I work with all these different people in multiple settings, and I just think that that's the best system.

I think, again, we not only have an interest in this committee to offer the viewpoint of the physician, but we're here to look out on behalf of the commonwealth and the patients. We're trying to define sustainability.

And I think that's our biggest concern and has been for a couple of years, is that in Kentucky, we have three medical schools that are training physicians, and we're training them for other places. They leave. They're not staying.

And that becomes more and more and more dangerous, not only for us but for our MCO partners because this becomes more expensive to manage. The opportunity for profit for

them is not going to be as good and then they can't drive their mission. It's not good for anyone, in my opinion.

I still believe that the right thing to do here, for our committee, is to move forward and ask the MAC to see if Medicaid can move forward with defining a tool for us -- yes, Dr. Tran. I'm sorry. Go ahead, Dr. Tran.

DR. TRAN: I want to chime in and comment on this. I have a clinic that practices addiction medicine, primarily. And one of the issues that we have noted for the last 10 or 12 years is that many of our Medicaid patients do not have their primary care needs taken care of.

And this is certainly a discussion that we all are aware of. It takes these people a lot of time to find a primary care doctor who -- and address their primary care needs.

And in the beginning, we started to address some of these primary care needs, but we certainly are not capable of managing all of the preventive issues that a good primary care doctor could provide.

But we wanted to at least be a bridge until that person can get to a good primary care doctor, like managing their hypertension, their diabetes, et cetera, just so that they don't worsen. If nothing else, we can bridge them until they can see a primary care doctor which often takes three months or longer.

And these things take time. And we have much comorbid psychiatric problems, but we also have a lot of comorbid routine problems, like hypertension, diabetes, et cetera. And we started out managing some of these things or bridging them but, you know, we can only spend so much time because the reimbursement becomes an issue.

And I think that if you go across the board, many of these addiction types will choose one or the other. One, they will choose to stay focused on the addiction part. Or two, they will take care of the patient in total, and that is their addiction as well as their primary care and psychiatric needs. But, again, this has all taken time.

And, you know, I completely feel

Dr. Thornbury's pain in regards to many of our Medicaid patients are not getting sufficient care, and many of these things that we can do to help primary care are not being done because of time and reimbursement. Thank you.

CHAIRMAN THORNBURY: Thanks, Dr. Tran. Well, it would be one thing if -- it would be one thing if it just -- if they didn't care and it just went away. The problem went away. But unfortunately, that happens to, say, 85 -- 80, 85 percent of acute issues. They just become self-limiting.

The problem is that's not where we're spending and investing our money in Kentucky. The great majority -- I'd say over -- well over, in Kentucky, 75 percent, it's got to be -- that's what it is nationally. It's got to be a lot more here. But over 75 percent of the health dollar is being spent with chronic disease burden. And when you ignore things, well, they -- it doesn't go away. It just becomes more expensive for us down the road.

So if we're going to be responsible clinicians, if we're going to be responsible stewards of this money and our obligation, I think we need a way to support that. That's been the underlying philosophy of why we're interested in this particularly.

I'm open to a suggestion. I was going to divide the question and, say, well, should we move a recommendation to the MAC on asking DMS to provide a primary care spending tool so that they can administrate and manage -- we can start having discussions about how to handle this. I'm open for another suggestion on that.

But we've had this -- we've been going through this really for a couple -- two or three years now, and I've not seen anything -- I don't know any other way to move forward here. I don't know how to get any action if we feel this is an important issue.

Dr. Neal, I would let you make the final decision. You are our emeritus chair. You're more experienced than anybody in several states on this. What do you feel is

the right thing to do, sir?

DR. PATEL: Well, I had an opinion -- this is Dr. Patel -- before we have a recommendation.

CHAIRMAN THORNBURY: Go ahead, Dr. Patel.

DR. PATEL: Yeah. I'm the chief medical officer for WellCare. We have a very large medical -- Medicaid population. I'm an internist, pulmonary critical care, and sleep physician by trade, have worked in rural settings in North Carolina and in Georgia. So -- and I am very familiar with the Kentucky landscape, so wanted a level set with my background.

Before I am comfortable with going with this recommendation, I'd love to hear the group's thoughts on the reluctance from the primary care physicians around two things: Evolving the use of their data in their EHR and data integration; okay? I think sharing data is really important, so we know the outcomes of the work you're doing. I think you guys do fantastic work. We want you to get the credit.

But I think just augmenting fee for service is one side of the token; right? The other side is value-based care. There's been significant resistance from the community of primary care physicians around value-based care. Maybe that's pressure from the hospital systems pushing down too much work to you guys. I'm not quite sure which comes first or which comes latter.

But if we were to increase fees for primary care, I do think there has to be a very transparent, salient discussion about the adoption of value-based care in Kentucky.

CHAIRMAN THORNBURY: Well, I mean, my knee jerk on this would be, first of all, I don't think you're talking to the right audience. I mean, I think the problem you're talking about is a national audience.

I mean, Kentucky is one of 50 states, but value-based care is an issue throughout the country and has been for two decades. I think that the hope of value-based care has been good.

I think the problem has been you're talking about a capitalistic system, and in

value-based care, there's probably a practice over here that has one person in a room trying to figure it out. And you've got, like, three floors full of people that are smarter than they are, and you've already figured it all out.

And I'm talking from a Lean basis. I was trained by Toyota. I mean, I'm all about value-based care. But I don't know how -- I don't know how the Physician Technical Advisory Committee can serve your interests.

I hear your frustration, and I can appreciate the viewpoint of the MCOs, that they would want data. But, again, this is the PTAC committee for Kentucky, not a national-based system.

You know these are national-based issues, and these are -- I just don't know how that we would have the capability to solve the problems, Dr. Patel.

Dr. -- would anybody like to chime in on that?

DR. MOYER: Dr. Thornbury?

CHAIRMAN THORNBURY: Yes, ma'am.

DR. MOYER: Hey, it's Sarah Moyer.

I'm the same as Dr. Patel and Dr. Divya. I'm the CMO for Humana's Medicaid. And I know it wasn't a discussion item, and so I've got a little bit prepared.

I think if you -- I mean, I would love the chance to kind of explain more how the MCOs can help you, because I think there's a lot that we can partner on to solve this.

I'm a family physician by training, practiced full scope, and then ran the health department for the last eight years. And so I want the same things you guys do, and I came to managed care because I think it is a great tool to help you accomplish what you want to.

And so -- I mean, I've got a presentation. I'm sure the other MCOs would love to kind of share more of what we are doing with primary care, and maybe we could partner together to solve the issue that you're looking for.

CHAIRMAN THORNBURY: Cody, let me take the direction of their conversation a little bit differently. This is, I think, what Dr. Neal first brought out. You know,

using this type of modality to communicate kind of puts a few extra barriers -- this is a complicated topic, a very complicated topic.

I wonder if we could find a way, Cody, to put us together in the same room for an extended period of time where we can try to serve everybody's interests. Because I have a belief -- I don't believe this -- like, if I'm cutting one part of the pie, that somebody else is going to take a cut in their pie. I just don't believe that.

I just feel like that our interests are all aligned the same, that if we can provide the right care in primary care, that the MCOs can be even more successful and the commonwealth would be successful and so would the patients.

I would like to find a way to get us together so that we can try to get Dr. Patel, Dr. Cantor -- that we can get all these physicians and partners -- Judy, I would want her there. I'd want -- is that possible, Cody? What's -- how would you solve this problem for us?

MR. HUNT: Yeah. I'd be happy to try to set up a meeting for you all offline sometime during the interim period in between the next meeting date. And they said we were appointed to have a July meeting. So if you all wanted to have a further conversation kind of outside the bounds of this set meeting time, I'm happy to try and set that up for any of our MCO partners or DMS partners who would like to participate.

CHAIRMAN THORNBURY: Dr. Neal, how would you feel about that? Dr. Tran?

DR. NEAL: This is Dr. Neal. We're already working on that. One of the entities, the Foundation For a Healthy Kentucky, is already looking, as one of their priorities, to look at this problem. And they have the Howard Bost forum that takes place in the fall.

Now, whether we could do anything before that or not. But that's been my suggestion all along, that we do something that would get all of us together to discuss because it affects us all in one way or the other, as you say. And we don't want to take a piece

of the pie, but we've got to figure this out for Kentucky.

Other -- every state is trying to figure out this same kind of problem. They're all having it. They're dealing with it in different ways. And ours is almost unique because we have -- we probably have a bigger percentage of Medicaid recipients than any state, do we not, percentage-wise? Can anybody answer that?

DR. THERIOT: New Mexico has -- 84 percent of their population is Medicaid.

DR. NEAL: Okay. They just beat us easily. All right. Well --

DR. THERIOT: But there's not too many others that beat us.

DR. NEAL: Well --

MS. BICKERS: Justin Dearinger has his hand raised.

CHAIRMAN THORNBURY: Yes, Justin.

DR. NEAL: Right. Okay. Erin -- can we ask her -- what's going on inside Medicaid that you might share with us or inside DMS as far as this problem? Is it being discussed? I know we met with the

secretary during the session, and we met with Lisa at the same time. Can you share anything that they might be talking about?

CHAIRMAN THORNBURY: Justin, do you want to chime in on that and then perhaps Dr. Patel?

MR. DEARINGER: Yes. Absolutely. So we are aware of all of these issues. As you can probably tell, many of our other provider types have similar issues in their own ways as well.

One of the first things, getting back to the original topic that you had asked about, again, some of the reports, I can't say exactly. But we do reports for provider types all the time.

If you will email me, or email Erin and she can send it to me, exactly what you would like in a report from us, we will submit that and get that report ran for you. If there's some issue with -- that we can't get exactly what you want, we'll let you know that.

But I don't think anything that you've asked for would seem like that we wouldn't be able to -- be able to get for you to have

that data and that information that you need.

Secondly, we're looking at all of our provider types currently, looking at the fee schedules, the rates, the codes, availability. We have multiple studies going on currently on each of those topics to try to enhance payments.

Unfortunately, because it's every provider type that are having kind of the similar situation right now, it's difficult for us to increase payments wholesale or fee increases wholesale.

But, you know, there's a myriad of issues and problems. There's availability of clinicians. There's no-show issues. So we're trying to take all of those issues and trying to come up with a plan of action to eliminate as many of those problems for providers as we can, increase the amount of providers that take Medicaid, increase the sustainability of providers that accept Medicaid patients, so that the availability and quality of care for our Medicaid recipients increases.

Part of that will be -- like you said,

when we ask for specific codes to research, that becomes very important. Because we can't -- the budget won't allow us to do, as you can imagine, wholesale increases of rates or fees. We don't have that kind of budget, especially when every provider type, you know, is asking for the same thing.

But what we do -- can do and what we do do on a regular basis is take specific codes that you may feel are hard to do because of the reimbursement rate, codes that you feel like you lose money on when you bill those codes or perform that procedure, codes that you're not making any money on at all. That way, so you don't -- aren't incentivized to perform those services for Medicaid recipients.

Those -- sending in a few codes to us, we take those all the time from different provider types. We research those codes. We look at the Medicare rates. We look at other states' rates, we look at private insurance pay, and then we look at what we're paying. And we increase codes in that manner all the time.

So I encourage you all to send me or send Erin exactly what you would like for us in a report. And then after you view that, maybe send us a few codes that you would like to have us research and look at to see if we can do an increase. That would be something immediate we could do.

And then long-term, again, we have a lot of long-term studies currently going on with a lot of different issues that tie in all the different problems that we're seeing throughout our provider types. And a lot of those things are coming -- are culminating and will hopefully be -- we'll have a lot more data toward the end of the year on a lot of those different projects.

CHAIRMAN THORNBURY: I have Dr. Patel firstly and then Dr. Tran behind him. Dr. Patel?

DR. PATEL: I actually took my hand down. I have no additional comments. Thank you so much.

CHAIRMAN THORNBURY: Okay. Any time, Dr. Patel.

Yes, Dr. Tran?

DR. TRAN: Yes. Two comments. No. 1, I would really appreciate the opportunity to participate in that in-person type of discussion with the group. I think it's a wonderful idea.

The second comment I would make is, instead of making the enhancement to the 99214, is there a possibility to create a special HICS code or some special code specifically reserved for primary care physicians who are going to pull these very complex primary care-related issues?

And I just want to make somewhat of a trite statement here because I think we all recognize and know this. The No. 1 burden for the state of Kentucky has always been chronic medical issues. That's where most of our mortality and morbidity comes from. And that's because we don't incentivize our physicians to manage it.

And similarly, the second big problem that we're having in Kentucky, compared to other states, is the problems related to opioid use disorder and the lack of managing it.

And, you know, with OUD -- and I don't want to just harp on OUD all the time. But it's the No. 1 issue that we have in the state. And sadly, we lead the rest of the nation in this problem.

We've got to start incentivizing people to start managing these chronic issues. And more importantly, as I stated, we see a lot of primary care issues in our clinics, and we just choose not to co-manage it.

It would be nice if we can start helping out our primary care colleagues with providing some of that primary care and then hand them off to the primary care to do the more complex preventive issues.

Again, we're all -- if we can incentivize people to pitch in and provide some of this very complex care, I think we may end up with a better overall statistic. Thank you.

CHAIRMAN THORNBURY: Thank you, Dr. Tran. Well, let's do this. Let's look at this this way. I think that rather than -- what I don't want to do is I don't want to push to the back things that have not

been well thought-out, well-considered, and adjudicated all the way.

I'd feel a little more comfortable setting these items aside. Let us get a face-to-face together, see if we can come to some type of overall philosophy and plan together as a group; that is, DMS, our MCO partners, and the TAC.

And, again, I'm open to any new information. I'm open to any new philosophy that will help us solve these great problems in Kentucky.

Right now, the philosophy that I'm working with, until proven otherwise, would be Barbara Starfield's model and then trying to use that model to induce savings over time. That was the whole reason that we put through in 2018 the telemedicine. It wasn't to rack up the bill. It was to keep people from missing their appointments, trying to get people in earlier.

And I'm still -- we're still hopeful -- we've still not had definitive data on that decision, but I think that's one of the decisions that we've had to make in Kentucky.

We have to take some risks.

Our downside is so substantial that if -- we really can't wait for four or five -- I mean, for 10 or 15 or 20 other states to figure it out. We're one of the top, I would say, five states with this type of burden. We're going to have to figure it out up front.

But I would say -- I would like our colleagues, Dr. Moyer, Dr. Patel, Dr. Cantor, all of our MCO colleagues -- I've heard more from you today than I've heard in two years. And I'm very open to having these conversations and candid conversations so that we can solve this problem. All of us want to solve the problem.

I can understand -- and I'll dovetail on what Justin said. There's just not enough blanket to pull the blanket over everybody. Everybody is going to want more all the time. I understand that. I understand an eight-year-old philosophy.

But we can't drive a health system that way. We have to drive a health system with what's going to actually work in not only the

shorter term but in the longer term. And I'm open to having a discussion on how we can try to solve this together.

Cody, I'm going to leave it to you as our admin to try to work with these parties and their leadership to see if we can find time -- we usually do not take a July meeting.

But I'll tell you, I would be willing to make time in my life and schedule because I think it is important enough not to put off for four or five months, to say, if we can get together, perhaps in a central place, like either a Louisville or Frankfort, if we can get our -- wherever these people are, I'd be willing to make our time and try to get our team there to have candid and hopefully fruitful discussions if that's what the MAC -- the PTAC would like to do.

Dr. Neal, Dr. Tran, Dr. Gupta, what would you say about that?

DR. TRAN: I would concur.

DR. NEAL: Go ahead.

CHAIRMAN THORNBURY: Dr. Tran?

DR. TRAN: I would concur with your

comments.

CHAIRMAN THORNBURY: Thank you. Dr. Gupta, was that agreeable to you, ma'am?

DR. GUPTA: Yes. Definitely.

CHAIRMAN THORNBURY: Cody, can you. Work with our colleagues at DMS and our MCO partners to see what we can -- if we can find a time to get together maybe in July. I'm just guessing July. It's kind of a quiet time, and usually our schedules sometimes aren't as burdened with all the meetings that we have in life.

MR. HUNT: Yeah.

CHAIRMAN THORNBURY: And then kind of -- can you work on that and get back with us? Would you mind doing that, sir?

MR. HUNT: Yeah. Be happy to.

CHAIRMAN THORNBURY: All right. Well --

MS. BICKERS: Dr. Thornbury, this is Erin. Oh, I'm sorry.

CHAIRMAN THORNBURY: Yes, ma'am. Yeah.

MS. BICKERS: I was just going to say, you guys do have a meeting scheduled for

July 21st that is already on everyone's books. So I don't know if you wanted to keep that or maybe just try to reorganize that day -- or not reorganize. Excuse me, reschedule.

CHAIRMAN THORNBURY: My guess is, Cody, that -- I mean, Erin, that probably Cody will start with that day.

MS. BICKERS: Okay.

CHAIRMAN THORNBURY: It's kind of in there in philosophy. We just never take it. But this year might be the exception to the rule. And I just want to make sure that if we have that day, that, again, these senior leaders, these medical directors really would be an important part of that. I would not want to have a meeting without them.

MS. BICKERS: Absolutely.

CHAIRMAN THORNBURY: And I want to be courteous to their schedule. I mean, we had that -- I would assume, Cody, that -- I would assume that this is something we should do offline, to find out that if everybody can actually be there and then kind of come back

to that.

But the plan would be to keep that scheduled meeting and try to work around that and try to find a place that we can all agree would be the place that we would want to try to meet. Would that be okay? Cody?

MR. HUNT: Yeah. That sounds good to me.

CHAIRMAN THORNBURY: All right. That is -- that's probably what we'll work around and then we'll go from there; okay?

MS. BICKERS: That sounds good to me.

CHAIRMAN THORNBURY: Thank you very much. I'm going to move us back up to try to --

DR. TRAN: Dr. Thornbury?

CHAIRMAN THORNBURY: Yes, sir.

DR. TRAN: Dr. Patel had his hand up.

CHAIRMAN THORNBURY: Yes, Dr. Patel. I didn't see you. I'm sorry.

DR. PATEL: Yeah. No worries. Just one last comment. Would love to meet in July. We'll definitely be there in some

capacity. The only thing I ask is -- you had referenced a model. And what we'd like to do is -- as you said, in Kentucky, we don't want to wait for the other states to figure this out for us. However, every other state has some level of success in some different initiatives. We'd like to bring some of those examples, some of those models.

Because you know this better than anybody. Flattery is the best form -- mimicry is the best form of flattery; right? And so there is no shame in copying something.

And so if somebody has already done the due diligence and the hard work, we'd love to look at some of those models. So we don't have to recreate the wheel here, and we don't need the lead time.

So if you're open to that, I think Sarah has some ideas. I have some ideas. Dr. Cantor has some ideas. We'd love to bring those evidence-based models that have shown ROI, and we can have an honest, open dialogue on what may or may not work.

CHAIRMAN THORNBURY: Well,

Dr. Patel, I think we would all welcome that. No matter what your point of view is, I hope that our -- our entire goal is to help Kentucky be successful.

And I think, again, we would welcome your models, particularly those that you feel have good evidence-based. I think we are scientists here, and we want to move in an evidence-based direction.

So yes, sir, I welcome all of your recommendations. And everything is on the table. Everything for us is on the table.

Well, let's --

DR. PATEL: Thank you.

CHAIRMAN THORNBURY: Let's move back up here. We have some new business. Cody, let's run through this, so we can be respectful of everybody's time. I'm going to bring us to Item 5, SJR 54, this year's new law. Can you set us up for that?

MR. HUNT: Sure. So this will be probably a brief one, having that the general assembly just wrapped things up a little less than two months ago.

Senate joint resolution 54 was a

resolution that was passed this year, and it directs DMS to study the efforts in other states to account for social risk and health-related social needs and Medicaid payment models and then to review federal regulations related to Medicaid reimbursement and the ability for states to design reimbursement models that effectively address social risk and health-related social needs.

And DMS has been charged with determining the appropriateness of the Area Deprivation Index as a valid measure of social risk and health-related social needs and then to further develop a proposal to modify Kentucky's current Medicaid reimbursement model based on the Area Deprivation Index score of the location where a healthcare provider practices.

And as has been discussed previously, Medicaid reimbursement, of course, is of great interest to the PTAC, and so any effort that could result in an adjustment being made there, particularly an adjustment that would impact the primary care physician workforce, is something that'll be of interest to this

group.

And so just wanted to get a brief update if DMS has anything to share about any work that they've undertaken to begin addressing this. I think it's a fairly short timeline from when this has to be reported to the general assembly. I believe it's November of this year.

And so if there's any update to share, I would be happy to hear that. And also any updates moving forward, I think the PTAC would be happy to hear those as well.

CHAIRMAN THORNBURY: That's a pretty tight timeline. Justin, did anybody -- I'm sure you guys are already working on this, you and your team. Do you have kind of an idea that -- of where you guys are going to go with this?

MR. DEARINGER: Well, this is Justin Dearinger. We are currently working on this project. We've got multiple staff working on different areas and topics. I think there's a therapy rate aspect. So we're working on all of those things.

We will try to have something done and

put together by sometime in June to be able to send through our management here in the Cabinet For Health and Family Services and then over to the governor's office. And then hopefully by that point, we'll be able to share that with stakeholders.

But the final report that'll be approved through the governor's office to send over in November, I'm not sure exactly when -- but I would say we'll be able to share some of that information in July.

CHAIRMAN THORNBURY: Yeah. I was thinking this dovetails with what Dr. Patel brought up about these different ways to look at the problem. And I would just say privately to you, I really am empathetic to your staff. That's a pretty tough timeline, but I admire what you guys are doing.

Cody, give us 907 3:015. Let's talk about that.

MR. HUNT: Sure. So 907 KAR 3:015 is an administrative regulation that don't -- doesn't appear to be active. It exists, I guess, in the registry, but it's no longer active and isn't utilized. It appears to

have been inactive, I guess, since around 2015.

But this admin reg would have allowed a primary care physician who had 60 percent of their annual Medicaid billing that was for codes 99201 through 99499 or 60 percent -- it encompassed the vaccine codes that are also established in 907 KAR 1:680. Then that physician would have been eligible for a supplemental payment.

And this is a policy, of course, that I think is still undertook in other states around the country and is something that I think seems like it was popular, at least in some areas.

And so, I guess, I was just curious and wanted to get some perspective on what -- why did the policy go away? Did the federal rules change? Was it a successful program, or was it not?

So if there's someone from DMS who could speak to the history of this policy, I think the PTAC would like to hear that.

CHAIRMAN THORNBURY: Justin, is this you guys again? I don't know the

history on this. Dr. Neal might, but I don't.

MR. DEARINGER: Well, and I -- this predates my existence in Medicaid as well. But from what I understand, this was a policy to try to incentivize providers.

We had a very limited budget increase for vaccine-related incentives and incentives for primary care. It was a very limited amount of money that came through. State funds, I believe.

And so we were able to do this program as long as we had the funding. And then when the funding ran out, they did a short look, I think, at what outcomes that they would benefit or outcomes from that special reimbursement rate. There weren't any measurable items, I don't believe.

I tried to find that study. I was unable to find it. We have it somewhere there in our archives buried. But I'm going to try to find that for you all.

But that's why it was never reinstated. That money never came back, and we never got that money again. And so it was -- again, it

was a limited amount of money that we got that I think was specifically earmarked for vaccines, and the commissioner at the time used it in that way.

CHAIRMAN THORNBURY: Well, the thinking that I would have was maybe this -- the reason and the resultant manner -- the way it was implemented may not come back; for example, it might not be something for vaccines. But it might be a program that if you were going to support your primary care, you could use this program or a program analogous to this to say, well, we're going to do this. If we're going to support primary care, this might be the arm to do it. It would be something to maybe keep in couch on our July conversation. Just a thought there.

Let's see. We have a spot for our MCO representatives who really -- again, I would just applaud the fact that you're here today and that we're getting so much information.

Do you guys have anything, Dr. Patel, Dr. Moyer, Dr. Cantor, that's on your agenda that you'd like to bring up today?

DR. CANTOR: Hi, there. This is Dr. Cantor again.

CHAIRMAN THORNBURY: Yes, ma'am.

DR. MOYER: Go ahead, Dr. Cantor.

DR. CANTOR: Okay. Thanks, Dr. Moyer.

Is there a way for me to share some slides, for me to share my deck and then I can send it out?

MS. BICKERS: Give me just a second, Dr. Cantor.

DR. CANTOR: Thanks. Thanks. Some slides around missed appointments and then some EPSDT initiatives.

But before -- while she's doing that, I would like to enhance and promote the well-child visits. So for any of the pediatricians in our group, we recognize with COVID how far behind our kiddos have gotten on their vaccinations. Specifically, it's the flu shot and HPV shots that seem to bring our rates down.

And from what I'm hearing from our team, that it's not so much the providers. It's the patients themselves who have reluctance

around the HPV vaccine. My background as an OB/GYN, I have a lot of comfort in that area. But let us know how we can help you with that.

DMS has put in place quality measures specifically around immunizations for children and adolescents. So you will be hearing a lot of that from us as the -- time moves on. And we'll put a lot of focus on the well-child visit along with those immunizations. So --

MS. BICKERS: You should be able to share now, Dr. Cantor.

DR. CANTOR: Okay. Thanks. And on Zoom, it's -- where is -- how do I share? Got it. I found it, I think. Is it window or entire screen? Entire screen. Here we go. Got it.

So just some information around the missed appointments. I know this group has been interested in that in the past. It'll also be shared in an upcoming TAC. But members receive mailings for the first three missed appointments and then they receive a phone call following the fourth missed

appointment.

What is really of most importance to you all should be that the -- we find 80 percent of the time, that there is no reason for their no show. And this is coming from the claim.

I get it, that it's yet another administrative burden to check the box to figure out why they didn't come and then put it on a claim. But the more depth of detail that comes -- just like Dr. Patel was saying, data drives our knowledge. Data drives our initiatives and then it helps us change outcomes.

We're doing our best to get ahold of the number, to get them to you, to not have that missed appointment. But without understanding why they're missing the appointment, it becomes harder for us to impact that. So that's something I wanted to share with you.

And then in terms of EPSDT and going back to the kiddos specifically in this age range, we do provide a gift card if they're getting vaccines and then they're receiving

texts and IVR phone calls. Spanish-speaking members get an opt-in for that. Those specific members' measures, all of these are HEDIS measures. And I'm happy to share more detail if that is of interest to you.

We are also doing some Pfizer outreach programs with postcards, and we do have a primary care professional incentive, a PCPI within KPCA and the -- our clinical quality consultants are happy to meet with you. I'm happy to meet with you.

If you hear from Sarah or Becky, please know that physician practices receive a 40-dollar incentive for closing out care gaps this year, per gap, get an extra $40 on that.

And I can -- I know that others want to speak, so I'm just going to share this one last slide on HPV mailers. Again, that's one of the vaccines that seems to bring the rates down.

So that's -- that's all I had to share. Thank you.

CHAIRMAN THORNBURY: Thank you, Dr. Cantor. Dr. Patel? Dr. Morgan -- Moyer? I'm sorry, Dr. Moyer. Do y'all have

anything?

DR. PATEL: I do not.

DR. CANTOR: Dr. Moyer, you are on mute. There you go. Now you are.

DR. MOYER: Thank you.

MS. BICKERS: And, Dr. Cantor, you'll have to stop sharing your screen so that she can share her screen.

DR. MOYER: It looks like I have the option of stopping it for her, so I'm going to go ahead and do that. So Sarah Moyer. I am a family physician and recently joined -- well, not recently, more or less. But I joined Humana, so this topic of primary care really speaks kind of true to my heart.

So I was trying to figure out how to do the big screen. There we go. You guys see the big screen? Am I in the right --

DR. CANTOR: Yes. Yes.

DR. MOYER: Okay.

DR. THERIOT: Perfect.

DR. MOYER: Can you see the, like, note section, or are you just seeing the Physician TAC?

DR. THERIOT: No. This is

physician, no notes.

DR. MOYER: Okay. All right. So couple of things we're doing with primary care. We really like to collaborate with you all. And so just encourage, if you haven't heard from us, please email me. I know our quality teams and our providers teams are always trying to reach out and connect with you.

Dr. Thornbury, I think you're part of AP -- I think it's APCM, one of the joint practice groups. So thank you for being part of that, and we have lots of quality meetings with them and give extra bonuses as we reach to our combined goals of improving the quality in primary care efforts.

So happy to have meet and greets. We offer lots of provider trainings. You can find those on our provider page on our Web page for physicians. I know it's been mentioned a lot of times that chronic disease is a big driver.

We're really seeing an increase in behavioral health, and so we have trainings specially designed for physicians in primary

care related to behavioral health. Just trying to help you improve those skill sets as that becomes a growing issue here in Kentucky.

Our teams are willing to collaborate on any members. I will go through how to reach us. And as Dr. Theriot mentioned, it's really important to put those Z codes because not only does it help with the billing and giving more money to your practices, it triggers my case managers to be able to reach out and help the members to close any gaps that they might have that are preventing them from getting to your office or even being able to be the healthiest they can be.

Then we have those joint operating committees, whether it's your practices directly or your systems. So, like, we meet with the Kentucky Primary Care Association, the individual practices for primary care. And then as needed and willing, willing to meet with your practice directly as well.

And then the value-based contracting, I know you've heard that. That's something we want to get more in. We agree with you. The

more primary care, the more physicians our members are seeing, the healthier they are. The less ER visits they have, the less hospital admissions. So just trying to make that -- incentivize that for our primary care practices. It's really important for us.

So value-added services, always want to make sure our physicians are aware of these because I don't think they're used enough. So those Z codes, you put them in. We help connect people to all these. Our case managers help connect them. I have their web -- their email address at the end if you want to refer them.

And I apologize. They are working on the building. So if you can't hear me, just raise your hands, and I will try to move. But won't go into depth. I will send this out.

But we -- we try to help with those social determinants of health that may be preventing your member from being -- your patients from being the healthiest they can be.

And then the same thing with the

incentives. I know Dr. Cantor mentioned it. We all have them. But the great thing about Humana is it's all claims-based.

So if you are billing for these things, we remember when they do it. Your member -- your patient automatically gets it. They just have to sign up for the app, which is on the next page, but just another way to just encourage your members to come in and get these things done.

Whether it's the chronic care screenings, with following up after a hospital admission, all those quality metrics, the HEDIS metrics that you're trying to reach, we have incentives for them.

And they just have to send them to the app and then it's claim-based. You bill it. The member gets it. The patient gets it.

So that was -- oh, I forgot to add the -- I will add the number and how to reach our case managers. But they are there to help you -- help you share -- help you make our members healthier, and my brain is not working with that drilling in the background.

We're willing to be partners, and so

we're excited that we're going to get together in July and talk more.

But please -- I didn't realize that the health insurers could be a partner when I was seeing patients, and so just really kind on a roll now trying to make sure that all of our practices and physicians know that we are here to help you.

And all of those things that are difficult to do on a day-to-day basis because you are so busy just seeing patients, please, just send them to us, and we can help with those extra pieces.

And I'm willing to answer any questions, and I'll open up that information as well to you, so you have it in your back pocket to use.

CHAIRMAN THORNBURY: Thank you, Dr. Moyer. That was excellent.

MR. OWEN: This is Stuart Owen from WellCare. I'm no doctor, and I'm no clinician, but I do have something to share.

CHAIRMAN THORNBURY: Hey, Stuart.

MR. OWEN: If I'm still allowed.

CHAIRMAN THORNBURY: Of course.

MR. OWEN: And, first of all, by the way, Dr. Moyer, talking about the Z codes, again, that's very critical. It does help us, the MCOs, identify the social determinants of health needs of our members, so -- and I know you don't get paid for them but just to echo that. Thank you very much for bringing that up, Dr. Moyer.

So now let me share. We have -- oh.

MS. BICKERS: Hold on one second, Stuart, and I'll make you a cohost. My apologies.

MR. OWEN: No problem. We have an ER diversion initiative that I just want to touch on that's care managers. And I -- you know, I don't even have to share actually. Am I good now, Erin?

MS. BICKERS: I'm trying to find you in the --

MR. OWEN: Well, I tell you what, let me just go ahead.

MS. BICKERS: I'm sorry.

MR. OWEN: It's just one slide. No. It's no problem. It's just one slide.

MS. BICKERS: Oh, there you are.

MR. OWEN: What we do -- this is an ER diversion at our care management team, like I mentioned. So we look at the Kentucky Health -- we get data from the Kentucky Health Information Exchange, KHIE. I don't think all providers participate in that or not, but it's so critical.

We get as soon as it happens -- a member has an ER visit that was preventable. It's for a preventable condition. It wasn't truly an emergency, and that's captured in there. And, of course, we also have our own claims data and other internal sources that we look. So we basically scrub -- we're trying to identify who went to the ER and really didn't need to go to the ER.

And so we've got three care managers that we launched this 1/1/23, and they look at that. And so they will outreach those members, and so -- you know, using those tools.

And so No. 1, they look at: Do you have a primary care doc? And if not, okay. Let's get you a primary care doc. And then -- or if you do, have you been? Why not? And

then, you know, get an appointment with them.

They also emphasize medication adherence. But they will go -- our care manager will go with you, the member, to your PCP appointment. Or if you get referred to a specialist, they'll go with you to the specialist appointment as well.

And so the whole point, again, is diverting people from ER, getting them to their primary care doc. Again, we launched that 1/1/23, and it's going -- it's been well received so far. And that was it.

CHAIRMAN THORNBURY: Stuart, thank you very much. Does anybody else from our MCO partner side have anything?

MS. MOORE: Yes. Hello.

CHAIRMAN THORNBURY: Yes.

DR. BRUNNER: Go ahead.

MS. MOORE: Yes. Sorry. This is Tristan Moore from Aetna.

CHAIRMAN THORNBURY: Hi, Tristan.

MS. MOORE: I'm stepping in -- so our medical director couldn't be here today, so I'm going to present on behalf of her. So I'm also going to share some slides if you'll

just give me just a moment.

Okay. So I'm a registered nurse. I'm our director of pop health here for the Aetna plan. And similar to what you've heard from a lot of the other MCOs, we have a lot of great programs and things in place to help support primary care.

There's a lot of slides in this deck. We're certainly not going to go through all of them. There's about 22 slides. Some of that is just informational for you to see after the fact. I'm going to try to just touch on some of the high points here.

So Aetna understands access to high-quality primary health care is essential for addressing key priorities and obviously shows -- has been shown to improve health equity and health outcomes.

Our approach to primary care support includes a person-centered approach, prevention, early intervention, accessible programming, and integrative partnerships and then data and evidence-driven strategies.

We really strive to maintain or improve the physical and psychosocial well-being of

individuals and address any health disparities through primary healthcare support.

More specifically, and what you'll kind of see bulleted here on this slide, we provide administrative support through our provider relation liaisons. We have quality management solutions implemented through our quality of practice liaisons.

As you've heard mentioned before, our value-based contracting and shared savings agreements are in place to reward providers for providing quality care.

And then, of course, we encourage our members to seek and receive primary care services through many incentivized programs, which you've heard mentioned as value-added benefit programs, and we've got a whole suite of those centered around a lot of preventative health and primary care support.

We also support members in their health journey through care management and pop health programs that you'll see kind of in those appendix slides at the end of this deck in more detail.

And then offer ancillary services like telehealth to support care administration by providers and ongoing education to our members through health literacy and presentations.

So we recognize the need to align the right resources with the right individuals at the right time. So we have certain health conditions in populations that we identify as priority areas for the plan that we base on needs of the community, the state, our enrollees, and really the overall population of Kentucky.

So you can see some of our priority areas listed there. These do shift based on population health data, HEDIS performance, and specific plan and DMS priority -- strategic priorities.

Currently, some of the priority areas include child and adolescent wellness, immunizations, women's health, behavioral health, diabetes, health equity, member satisfaction, and access to care.

These next three slides highlight our quality practice liaisons. We've had

clinical liaisons since early 2022. We've been working to refine their processes and workflows over the last year. They've really been focused on building relationships with our provider partners through quality breakout sessions and providing quality support in tandem with our provider network team.

So this gives some additional detail on how we support providers through our -- we call them QPLs. They provide strategic consultations that's focused on connecting quality management initiatives with specific opportunities at the provider level.

So they work closely with providers to enhance HEDIS understanding, mitigate utilization trends. Their role is very vital in localizing and customizing and implementing quality solutions that fit the needs of the providers as well as improve member health outcomes.

And then some of this is a little redundant here on this slide, but it just further breaks down some of the specific functions of our QPL role related to the gaps

in care report review.

It could be assisting providers with member panel issues, sharing best practice approaches to improve member satisfaction, and then administering provider information, education about certain programs that we may offer to support members such as our value-added benefits and then offering HEDIS and CAHPS resources as well.

So that kind of wraps up my portion. Megan Johnson is on, and she's going to speak a little bit to our SKY program. So, Megan, I'll go on mute and get you over here.

MS. JOHNSON: Perfect. You can go ahead and go to the next slide. My name is Megan Johnson. I am a family nurse practitioner, and I am the director of quality for the SKY program.

For our SKY population, we do have a very specialized group of members. So in support of our providers, we offer several different opportunities for trauma-informed care trainings.

We've partnered with University of Kentucky, and we offer basic trauma-informed

care training by the UK Center on Trauma and Children for free. That's offered quarterly. It's a three-hour training. And social workers and psychology providers can receive CEUs for those.

We also have a trauma transformational learning collaborative with the UK Center on Trauma and Children, and this is kind of a step-up for those providers who've been offering services to our members and would like to learn even more about trauma-informed care.

This is a 20-hour training. It's a three-day training. We offer it twice a year for free for our providers, and they're able to earn 18 CEUs for social work and psychology.

Next slide, Tristan. For our -- there we go. For our SKY providers, we do offer monthly provider virtual office hours with our -- Michelle Marrs who is our provider liaison. She does these every third Thursday from 11:00 to 12:00 p.m. And she talks about topics that are specific to our SKY population, so medical consent, timelines for

services and assessment.

With our SKY population, we are required for them to have dental, vision, and physical services within 14 days of enrollment in the SKY program.

We do have specific medical information for court requests and judicial review of medical care. So she offers trainings and is able to discuss with providers on a one-on-one level those issues that are important to the SKY population.

Next slide, Tristan. And then we have a few specific programs within SKY that we work with our providers on. As I was mentioning before, we ensure that all of our members have completed their annual clinical, dental, and vision visits.

We offer 25-dollar gift cards for each of those that are completed within that 14-day time frame with an enrollment with us. We also offer care management to all of our members.

So it's a little bit different than the general line of business where members can opt in and out of care management. All of

our members are enrolled with a care manager. Just some are with different levels.

So we offer weekly care management where they have contacts with those members weekly. And then we also offer a lower level where those members are stable, and they just need their well visits. That would be every 90 days, we would be in contact with our members.

So we work with our primary care providers to make sure that all of our members are engaged with us in our care management program.

We also prioritize assessing for social determinants of health needs within our population, especially our transition age youth population. We know that once our members age out of the system, that they have lots of needs. So we start assessing for those at age 14 and making plans for when they do age out of the system.

And we also work with a lot of our providers to do medication reviews, specifically for those youth that are on psychotropic medications. We have a poly

pharmacy program where we work with a lot of providers that partner with us to make sure that our kiddos are not on any more medications than they need to be.

And that wraps up my portion. Do you guys have any questions for us?

CHAIRMAN THORNBURY: Thank you, Megan. Dr. Brunner, anything from your end, sir?

DR. BRUNNER: Yeah. I'd like to thank you. You know, getting back to the primary care issue in Kentucky, Anthem has funded over half a million dollars in scholarships to four different colleges to help the education of those going into the healthcare field, and the stipulation is that they practice three years in rural Kentucky.

Moving over to some of our quality-based measures. I think our goal and the goal of all the MCOs is preventative care, primary care, good dental care. And I think our healthy reward program reflects that.

I'm going to have Stu Cox in a second share the screen here, if you could make him able to share, Stuart Cox. He's our quality

director.

You know, our healthy reward program helps the members or incentivizes the members not only with primary care but with dental care, our pregnant moms with prenatal/postpartum care as well.

We are actually -- we just started a provider incentive for HPV vaccines because, as Dr. Moyer shared, we are having -- and Dr. Cantor shared, we're having -- that's where our deficiency is, is in the flu and the HPV vaccine. So our provider incentive is also tailored to that.

Stu, are you on? Are you able to share your screen with our healthy reward program? Can you --

MR. COX: I am on and available.

DR. BRUNNER: Thank you.

MR. COX: If I can have that capability, please.

MS. BICKERS: You should be a cohost.

MR. COX: All right. Thank you. Let me know when I'm sharing, please.

DR. BRUNNER: There you go, Stu.

MR. COX: All righty. Well, first off, our healthy rewards. We wanted to make sure that we're focusing clearly with members around prevention screening measures. We know that with all of the MCOs, we all have opportunities in those measure areas, getting the members in, both the adult and child members, to their providers so that that opens the gateway for the provider then to help provide education and to discuss the opportunities for vaccinations, cancer screening for children, the weight assessment, nutrition counseling, the physical activity.

So we've structured our document -- the provider document -- this is available out on our provider portal to download as a reference for physicians to use to help coach the members about the availability.

But one of the things we did, we paired on the flyer our -- not only our adult well visits but our adult -- our dental visits next to each of these.

And we actually do -- even though it's not a HEDIS measure, we do provide an adult

dental incentive to members, recognizing the importance and the correlation of the importance of good dental health in addition to getting in for wellness visits as well. There's a lot that goes hand in hand.

And in addition, we've talked with our behavioral health providers as well about -- and tried to leverage, where possible, if we get those members in, can we have them also discuss -- as members become a little more stable in their lifestyle, can they start to address well visits and getting in for screenings and preventive-related treatment around -- or screenings around the cancer domain in that as well.

You can see down the list here, we've got a pretty robust -- in addition to the cancer screenings, our vaccinations, our chronic conditions listed here. And in addition -- oops. I'm sorry about that. Let me get down on the second page. And some of our behavioral health measures.

One important one is that seven-day follow-up on that behavioral health. That, of course, is part of our managed care

quality strategy at the state. That's emerging as a replacement for the EDU-, OUD-related measure.

We know that the seven-day follow-up for alcohol and substance emergency department visits is a critical follow-up piece. So we want to help them make sure that we're doing incentivization, getting case management connected with those members.

So as you can see down here also, we've got some others, a suicide prevention quiz, smoking cessation. Again, smoking is not a HEDIS measure as well, but it is critical in the overall well care for our members and for cancer prevention as well. So we wanted to highlight that.

Again, down here, that post -- prenatal and postpartum visit is critical as well.

So in addition, as you go out to our provider portal, we also have the provider incentives that are in addition to our value-based program -- the provider programs that are there. We've got incentives for the HPV vaccination, for utilization of Cat II codes which leads to the closure of gaps.

There's an incentive for that. And then on smoking cessation counseling.

Any questions?

CHAIRMAN THORNBURY: Any questions for Dr. Brunner?

(No response.)

CHAIRMAN THORNBURY: Well, thank you very much.

MS. MURPHY: This is Becky Murphy with Passport health plan or Passport by Molina.

CHAIRMAN THORNBURY: Hi, Becky.

MS. MURPHY: I am representing today for Dr. James. He could not be here today. He's out of town at a meeting, so he gave me a couple of bullet points to share. I do not have any slides. Some of this may be kind of redundant from what the other MCOs have shared, but I will kind of give you a brief overview of what we do to assist our PCPs.

We'd like to engage and gain the perspective on a lot of our programs and a lot of the things that we do within the plan. And so we do have multiple different

committees that the physicians are part of. And, you know, if anyone is ever interested in being part of a committee, just let us know, and we can see what's available at that time. But we're always looking for physicians to provide their feedback.

We do our annual provider satisfaction survey to look at ways that we can better serve you all through, you know, helping with the members and your offices and what we can do to, you know, be a better liaison between us and the plan -- or between you and the plan.

We have provider relations representatives that are always available. If you need anything, all of that information and who your rep is is out on our website.

As far as collaboration on the quality goals, we do have a value-based incentive plan. Currently, the value-based plan we have is covering 2,000 of our members, about 60 percent of our population. And in 2023, the value-based providers were outperforming the nonvalue-based providers across all targeted quality areas for NCQA and HEDIS.

We have a quality improvement team that regularly engages with the targeted PCP groups that serve 265,000 Passport members. They work to include information on quality incentives and actionable member-specific reports to address the quality gaps for the providers.

We coordinate -- for our coordination of case management with the PCPs, we have a case management group that works with the members and with the PCPs, so we can kind of make sure that you all take -- kind of take some of the burden off you all and make sure the member is getting the care that they need.

We do have the healthy rewards program that provides member incentives for targeted activities such as seeing the doctor, managing chronic conditions, performing screening or other wellness behaviors, and that list is also out on our website.

There's several of those that the members, just if they get their routine wellness exams or -- you know, they get rewards for those. We like -- we have rewards also for Weight Watchers for members,

all kinds of different things that would help them out.

We also have programs to develop PCP -- to help the PCPs and the care they provide. We have a high-risk OB program that helps the -- you know, to help the member get through the OB care, so we have, you know, healthy babies.

And we have a fabulous group of community health workers. They do anything from helping members get to their appointments, helping them get the medication they need, following up with them to make sure that they're getting the screenings they need.

They're really good at closing the gap in between the member and the provider. Because, you know, a lot of our members, if they're hungry or if they're homeless, the last thing they're thinking about is going to their providers. So we want to make sure that we treat the member, the whole member, and make sure that they have all the care they need, that they do have -- the medical as well as physical needs are met.

I think that is about it. We do have -- for the behavioral health providers or for any of the providers, we have a free psych hub. It's a program on our website. And providers can sign in, and it's free.

They can get education on different behavioral health topics. I believe there's even some -- they can get CEUs through that. So that's also a free program. For EPSDT, we send out reminders and birthday cards to make sure that we get, you know, those kiddos in for their checkups.

So I think that -- I mean, we could probably go on forever for all the different stuff we do, but those are just some of the highlights.

CHAIRMAN THORNBURY: Well, thank you very much. Do we have anybody else from the MCO side that I don't see?

Well, all good things must come to an end, and I guess that would be today, too. I certainly want to thank -- again, let's start with just the MCO partners, Dr. Brunner, Dr. Moyer, Dr. Patel, Dr. Cantor. And, of course, I know we don't have Dr. James here,

but Becky, thank you for presenting on his behalf.

We always like to, again, acknowledge our leadership. That will be Justin and his team at DMS. And, of course, Judy, thank you for being here, as always.

Our membership, we did -- Dr. Lydon did join, our psychiatrist. I didn't mention him, but I saw that he joined. Of course, we had Dr. Tran, Dr. Gupta has kind of been on and off, and Dr. Neal. Thank you all for a very robust meeting.

We usually don't take a July meeting, but I think this year, it will hold value. And I think that we will probably see what we can do about trying to get everyone there for an in-person meeting so that we can try to take another step forward in this process of trying to solve these larger problems in Kentucky.

Lastly, but most importantly, I want to thank Cody for setting all this up. Cody Hunt is our administrator from our end. Cody, thank you very much for your hard work.

If there is not anything else -- does

anybody have anything before we close?

DR. NEAL: No. Good meeting.

CHAIRMAN THORNBURY: Very good. If not, then our next meeting is 21 July of this year. And I'll call this meeting adjourned. Thank you, everybody. Enjoy your weekend.

MR. OWEN: Thank you. You, too.

(Meeting concluded at 11:30 a.m.)

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C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 30th day of May, 2023.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR