PHYSICIAN SERVICES TECHNICAL ADVISORY COMMITTEE
MAY 16, 2025 MEETING

TRANSCRIPT OF ZOOM MEETING

MAY 16, 2025

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The foregoing zoom meeting was held, pursuant to notice, on Friday, May 16, 2025, beginning at the hour of 10:00 a.m., Chairman William Thornbury, M.D., presiding.

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PHYSICIAN TECHNICAL ADVISORY COMMITTEE MEMBERS PRESENT:

William Thornbury, M.D., Chairman
Ashima Gupta, M.D.
Don Neel, M.D.
Eric Lydon, M.D.

CHAIRMAN THORNBURY: Good morning, everybody. I am Dr. William Thornbury. It is 9:02 Central, 10:02 Eastern time. This is the Kentucky Physicians Technical Advisory Committee. We meet under the auspices of Title XIX. I want to address our quorum. Dr. Gupta, our MAC representative, Dr. Neel, our chair emeritus, Dr. Tran, Dr. Lydon and myself are all here today and that will meet our quorum.

Our first effort is to review and approve the minutes from our previous meeting. Do any of the members have any comments, additions, deletions or suggestions or do I entertain a motion approve those?

DR. LYDON: So moved.

CHAIRMAN THORNBURY: There is our motion. All in favor.

GROUP: Aye.

CHAIRMAN THORNBURY: Yes. Very good. With this we do not require a second on that.

Our old business, the first item I have up here is 907 KAR 3:005. Cody, before I get into that, I just want to let our members know that we do have a 90 minute meeting today as I am sure all of the executives here can appreciate. The spring and the fall, everybody wants to have their meetings. And they all want to be on the same day at the same time.

So we have 90 minutes and want to be cautious about addressing our comments in our work today.

Cody, can you set this up for us and let's get going?

MR. HUNT: Sure.

So at the last Physicians TAC -- I know it's been a little bit of time since then. It was towards the end of last year -- but at the last meeting, there was some discussion regarding this regulation. And it's specifically in reference to the language in section 4, subsection 7, 907 KAR 3:005, which states, coverage for an evaluation and management service shall be limited to one per physician per recipient per date of service. And

it had previously been shared when you all had discussed this prior that this specific language had created a lot of confusion and difficulty amongst practices, both in terms of billing and providing care over the course of the last year. And even just recently as of February of this year, there have been some issues.

There has been at least one MCO that has pointed to this regulation or this section of the regulation as the basis for recouping claims where there was a sick and well visit billed for the same patient on the same date. And there have been multiple practices that, at least that KMA, that reached out to us and shared that they have had a significant amount of claims impacted by this.

And so it has really created a lot of strain on these practices in terms of cash flow, writing the appropriate care when the patient is in the office at the appropriate time, as well as billing confusion.

Because as far as we are aware, you have the other MCOs that are largely allowing for the 2 codes to be billed with the modifier 25. And then at least one that does not.

So the inconsistency has caused much of the issue here. But it is also a section of the regulation that has gone unchanged for quite some time.

So since the last Physicians TAC meeting, there have been some discussion amongst all of the MCOs regarding their policies. And the feedback that was shared from that was that the majority of the MCOs had policies that went beyond what the regulation allowed for. And those policies are in line with the national CPT guidelines which advised that situations where multiple E and Ms are necessary, both codes are billed using the modifier 25 to establish the distinction.

We also have had some conversations since the last TAC meeting with DMS about this issue and are aware where that was left is DMS was going to discuss the policy with the MCOs' CMOs as well as pull some additional data and take a look at what other state's policies were on this issue.

And so that's the brief recap of the issue and currently where it stands, Dr. Thornbury.

CHAIRMAN THORNBURY: Thank you, Cody.

I would like to address the why behind this before I open the discussion. I think, as I see

it, I think all of the honorable physicians and all of the honorable health systems want to be compliant with Medicare's current coding initiative. And, with that, we are trying to fully document what it is that occurs in the actual encounter. With, for example, many specialties; you come into nephrology, you have stationary chronic kidney disease, they want to talk about that. And then we are to go on to the next patient.

The primary care, the role of primary care and the charge of primary care is a little different. Part of what we do is we prov,ide in the health system, we are the people that actually provide the preventative medicine. So in the long run for the MCOs and for our Commonwealth, we are trying to prevent -- we are trying to mitigate substantial expenditures in the long term by providing the wellness integrative care. So that is one charge.

Another issue is we provide chronic disease care. We provide the overwhelming majority of chronic disease care. That's another charge.

The third thing is we provide acute care and that keeps people out of the emergency rooms and

the urgent clinics. It is really not appropriate, in my opinion, for our value I think there is better value in the lower cost to try to address these in a better venue. So when you are asking a particular service to conduct 3 roles, then I can just think of -- it happens on really an hourly basis and, you know, we'll have somebody in. We are providing -- we have them in the office. A lot of these people cannot get, particularly in these underserved areas, it is very difficult to get them actually into the office. And, you know, after for every 10 patients we schedule, maybe 3 or 4 of them won't show up.

And, you know, if they ever leave, it is going to be hard to get them back. And so a lot of times, we will take a bird in the hand as opposed to, you know, one in the bush because we have them there. That's our philosophy. We're here to try to treat these patients in the most cost effective manner the needs of that patient so that it doesn't get into a more of a substantial problem.

And I think what we are trying to suggest is the 25 modifier helps us in the current structure of CPT to explain what it is that we are doing.

Now, these clinics and health services are taking liability. They are taking time to document and they are providing the service and that a lot of times is not seen in the actual schedule. It doesn't show up on the schedule because, you know, they will come in with one thing and you get the, by the way thing. And you are like, well, do I address that now or do I address that later. And some of these things, you know, are better addressed up front before they become significant problems.

And to me that is the why behind this.

Let me kind of open the floor up to our membership. And then I certainly would like to bring our MCO partners in on this as well. Who has some thoughts on this?

DR. TRAN: Dr. Thornbury, I would like to segue into what Dr. Thornbury has just commented. And I similarly agree. I want also to want to point out that I am also looking at it from the patient-centric perspective.

For many of our patients, we all know that travel, transportation is one of the most significant barriers to healthcare. And to ask these patients to make frequent trips is quite a

burden.

And so from that vantage point, if you have got them here in your office and they have another problem and you can handle this problem but maybe another provider can handle this problem, go ahead and have that person taken care of right there and then. So, for example, in our practice, we manage mostly addiction. The patient comes with addiction. And, by the way, I have been having this cough and it's making me short of breath. And you know what. I -- we have a semi-urgent care type clinic over here. Dr. So and So is on duty for that. Why don't we have you see Dr. So and So over there and take care of this instead of having the patient make another trip to an urgent care or the emergency room for that visit.

So from my vantage point, I think that we have to look at the perspective of the patient's access to care.

Many of my colleagues complain they have a patient scheduled to do a procedure on the right elbow. And, by the way, can you look at this thing on my left leg. Well, that's a separate problem. And, you know, no, you have to come back another day because I can only see you for this

problem today. I am doing this procedure on this problem today and you have to come back another day to have the second one taken care of.

I think that's a significant burden and hinderance to the patient's care.

DR. NEEL: Dr. Neel. I would like to speak to it briefly, Chuck, if I can.

You know, as a pediatrician, preventive care is our major goal. And it is becoming more on more difficult to get the patients in for preventive care which is primarily immunizations, growth, et cetera, and social determinates obviously.

But what we are seeing is is that many of our visits are initiated by an acute illness in the child. And rather than go to urgent care or the emergency room, they call our office and want to come in. We find that they are behind on a preventive visit. So, obviously, we really need to do both things. So it takes enough time now to do the well visit. But then to address the illness which for most children is not the chronic illness as much as it is the acute illness, whether it is an ear infection, whether it's croup, whether it's flu, whatever, and we have to

address that issue. Which often leads to laboratory. It also leads to prescriptive medicines also.

And so those 2 issues have to be addressed, both well and sick. And I am reviewing the charts of our pediatric patients, the group that I work for from Florida to California to Arizona to Connecticut. And I can tell you that that is being done at many, many visits by our pediatricians. And it is being paid by most of the MCOs because most everybody is out there.

So I can tell you that it is so important for us in pediatrics to have those services. Because if we just get to charge for the well visit or just for the sick visit, it just simply does not take care of our costs. So I will stop there.

CHAIRMAN THORNBURY: I would like to, if it is okay, I want to get everybody's perspective on this. And, in particular, I am most interested in Dr. Theriot's work.

Judy has been out front on this topic. Dr. Theriot, can you hear us? I know you are on the call. I would like to bring you in here. I really would value your wisdom on this.

DR. THERIOT: I -- I mean I agree being a

pediatrician as well. A lot of times you have to do 2 visits at the same time. And we have been working on amending the regulation for that. And I believe Jonathan Scott is on this call. And we have amended the regulation. I don't know where it is in its journey. But it will be -- it will be fixed.

CHAIRMAN THORNBURY: Well, I certainly -- one of the things that I wanted to point out is we have to look at this from everybody's point of view. And the point of view I don't want to miss is our MCO partners. You know, they have a budget. They come in in a very generalized way to try to provide a certain amount of care and try to provide that effectively and efficiently. And I think this whole thing doesn't really work. I see it from the basis where I understand the provider, obviously I see it from the health system's point of view, the scheduling and missing things.

But really from their point of view is if it doesn't save money in the long run for us, which is what this whole thing is designed to do, it really is not functional. You know, it is just one way to move beans from one pot into another.

And that's not the intent here.

The intent here is to try to run a more efficient system so that, in the long run, you look at 1 year, 3 years, 7 years down the road that making these implementations, it will save us money and it will save real money if we can see. And I would encourage and invite any of our chief medical officers or any of their representatives to chime in on this. I will be very interested to see how they see it.

MS. MOYER: Hey, Dr. Thornbury. It is Sarah Moyer from Humana. We agree with you. I mean transportation is an issue in Kentucky. Anything we can do to get our members into the office and treated while they are there. And it also helps on the continuum. So the value-based care, too. Right? Like we don't care how many office visits they have as long as they are getting treated.

It does sound like maybe it's just the one MCO issue. And so it sounds like it is getting fixed, too. So I don't know which one that is. But we will just address maybe some one on one conversations.

MR. ELLIS: This is Herb with Humana for claims operations. And, you know, I want to add that the regulations are out there now, you know,

about the same services on the same day that is not covered per the regs. They don't address modifier 25 being an option to use to get around that. Now CMS does. And that's put out by CMS. And I think almost all of the MCOs -- I am not sure which one it was -- but I am pretty sure that almost all of the MCOs are utilizing that modifier 25 to show it is a separate, distinct treatment on the same day as another one. And I know we do.

CHAIRMAN THORNBURY: Well, we appreciate that. Thank you for your thoughts.

DR. NEEL: Don Neel. Can I just interject one thing? And Sarah and I have debated this point for several years I think.

But we are transitioning from treating sickness to treating wellness. And treating sickness saves money in the short-term. But treating wellness is a much longer treatment. And so to save money with wellness takes a long time. This is discussed and I think we have talked about this a lot. But I just want to make that brief point.

MR. ELLIS: And I don't think anybody would disagree, right, that preventative care in the long run is the most cost effective way for our

members.

DR. NEEL: Good.

MS. KITCHEN: This is Kelly Kitchen. I am the branch manager with physical health. And Justin is unable to be with us today. But I do want to let you know that we are addressing your concerns and we are submitting a request to have the regulation updated to legislation.

We don't have a time frame as to when that will be complete. But we are in the process of sending an updated regulation for approval through legislation.

CHAIRMAN THORNBURY: Thank you, Kelly.

MS. KITCHEN: You are welcome.

CHAIRMAN THORNBURY: Dr. Teichman, do you have any thoughts on this at all or is this -- are we just kind of repeating ourselves with Dr. Cantor.

DR. TEICHMAN: Good morning. This is Jeb Teichman.

CHAIRMAN THORNBURY: Hey, Jeb.

DR. TEICHMAN: How are you all this morning?

As a pediatrician, I also support of taking care of all problems when you are face-to-face with the patient. I am not sure if we are the one

MCO that you are referring to. I know this has been an issue with some of the practices I have talked to. And I know that we have taken steps to honor modifier 25 the first of this year.

CHAIRMAN THORNBURY: Well, let me say for everyone here, that the -- I think -- what I don't want this to, you know, like we are trying to shame one MCO into reconsidering their work. The point of it is is I think is we are trying to suggest is, well, how pervasive is this and what's the current opinion. That's not what this is about.

I think we all have the same goals. And here we are just trying to be as reasonable as we can to try to get all viewpoints on the table. I am not here to disagree with anybody. But if we can't understand that there is a problem that we can't see or a problem that we don't understand, then we can't address that. And that's not the point of our shared work together.

DR. PATEL: Hey. This is Chirag Patel. Can you guys hear me?

CHAIRMAN THORNBURY: Yes, Dr. Patel.

DR. PATEL: I very much agree with my CMO peers as well. I think you should get all the

care you can in one instance. However, I would be remiss if I don't give you the converse and the alternative, right?

100 percent of all pediatric visits don't have to have a sick visit attached. Right? And so if we were to see a given provider overnight start to have 75, 85 percent of their visits under certain circumstances, it would draw attention to that personal practice pattern. And so I just want to make sure while we give everybody the benefit of the doubt doing everything in the moral interest and the clinical interest of the member, that is not always the case.

CHAIRMAN THORNBURY: I think everyone here understands that.

DR. TEICHMAN: Just Jeb Teichman, again.

One of the things that I have seen with the use of modifier 25 is the use of modifier of a well visit with high level E and M, like a level 4 E and M. There is a lot of overlap between the correct coding of a well visit and a 99214. And it is hard to rise to the level of a 99214 or 99215 with a checkup.

I have seen some practices exclusively coding modifier 25 with the well visit and a 99214. And

you will have to agree that when you are spaced with a child, for example, who is there for his 6 month old checkup that has an otitis, that does not rise to the level of a 99214.

DR. NEEL: This is Dr. Neel. I would agree with Tran. I review charts daily. And I can tell you that we have to look at the coding which can be difficult. Sometimes it gets tied to RVUs and that bothers me. Because I get the feeling that we are attaching that because of what it gives us in remuneration. And that's troubling. So I agree with you.

CHAIRMAN THORNBURY: I would say that I would have to agree with that, too. That's -- although my part -- I don't practice pediatrics as part of my practice. I think we can all agree on -- again I think using correct coding initiatives, to be honorable about coding and be honorable to the patient is all we are talking about here. I don't think we are talking about other -- and I don't support things that are inappropriate or, you know, that's not the work we are trying to accomplish here.

Dr. Cantor?

DR. CANTOR: Hey. Good morning.

Dr. Thornbury, this is Dr. Cantor. I am in the car so I apologize for the background noise. I agree with everyone's comments from all sides of this perspective. The only thing that I would add is if there are specific examples that could be given to us or to the MCO that isn't -- has this going on, that is super helpful in being able to understand how it is being picked up from our claims system perspective. Maybe it is something, you know, I don't know if it is us. I don't think it is us. But I don't know if it is us. But I would welcome examples. Because maybe it is some switch. I can't explain everything in claims. But things like that happen so I welcome examples. Thank you.

CHAIRMAN THORNBURY: I would turn my eyes to Cody. Cody, do you think KMA can help us, and again with Dr. Neel's experience, particularly with his audit review, maybe if we could work with Dr. Cantor and our other MCO partners to try to provide some concrete examples of what this might look like, what would be appropriate, what would be not appropriate.

Can we work on that?

MR. HUNT: Yeah, sure. Like I said, it is

just one MCO that had the specific issue tied to the regulatory language. And we have had conversations with varying levels of staff in that MCO regarding that issue. I think the first time it happened, it did get ultimately resolved. But then there was an instance earlier this year, and I don't know ultimately how that practice found resolution with the claims that were affected this year. But certainly can follow back up with the MCO.

CHAIRMAN THORNBURY: Well, I hope that -- and it appears to me that we are generally of like mind and we want, again, what is the most cost effective in the long run for the health system. We are trying to respect the values of the patients. We understand that health systems are trying to do things efficiently. And I understand, again, intimately well being a provider what it's like to be in front of that family.

But I think here we generally are looking at this in the same shared vision. So if we could work toward that as our next step, would it be appropriate to move this from this part of old business into our recommendations at the end of

the meeting if the members want to do that?

DR. NEEL: Yes, I think that's fine. Dr. Neel.

CHAIRMAN THORNBURY: We can bring it up at the end and kind of move that into your basket, Dr. Gupta.

Cody, if I can, are there now other new ideas on this topic? I don't want to exhaust it. But I think if it is not, I probably will move us into new business.

If we have Angie on today, I am kind of looking in her direction. Cody, if Angie is here, could you set this up for us, please?

MS. PARKER: This is Angie Parker with the Division of Quality and Population Health. And I am on the road so I am on my phone but I do have some staff, Troy Sutherland and LeeAna Trainer, who will be presenting regarding the VBP and quality initiatives that we are doing.

CHAIRMAN THORNBURY: Let's do this. Angie, before you jump in there, Cody, would you set this up for the members that may not have been present or be unfamiliar with that work before Angie and her team pick this up, please?

MR. HUNT: Sure.

So last year and I think maybe the year prior, I believe 2023 to 2025, is the implementation time frame that Angie and her staff will be referencing.

But the Physicians TAC had had some discussions previously on the quality measures and the value-based efforts that were being established by DMS to improve the quality outcomes. And so there was some curiosity on kind of where that stood and just to get an update on that work here today.

MS. PARKER: Okay. And Troy Sutherland has a little PowerPoint that he is going to present and give you an update on that. I will say, and this is part of the presentation, that the value-based purchasing program with the MCOs officially started January 1, 2024, and it is based on HEDIS measures. Therefore, we are still getting the final results of the 2024 measurement year. So we don't have that yet.

But I am going to turn this over to Troy in just a second. But I do want to address the previous topic that was talked about.

So if there are continued issues with this MCO, please bring those to the DMS. And there is

a provider inquiry email box that you can send, if you continue to have those types of issues, we would certainly like to look into that ourselves.

So with that said, I am going to turn it over to Troy. Thank you.

CHAIRMAN THORNBURY: Hey, Troy. Can you hear us?

MR. SUTHERLAND: Sorry about that. I am trying to get my screen share. Can you guys hear me okay?

CHAIRMAN THORNBURY: Good luck with this, buddy.

MR. SUTHERLAND: Can you see that presentation?

DR. NEEL: I am not seeing it.

MR. SUTHERLAND: How about now?

DR. NEEL: I see it. Dr. Neel.

MR. SUTHERLAND: Can you see it? Good. Good. All right. Success number one.

Thank you all and good morning to everybody. As Angie mentioned, my name is Troy Sutherland. I am the quality branch manager in the Division of Quality and Population Health. I just want to give you a -- go through this brief PowerPoint to give you guys an update on where the VBP program

stands and what we are working on currently with quality initiatives and some of the reporting, I guess, timelines for this year for the VBP.

Okay. So the value-based payment program, VBP, model aligns incentives for enrollees, providers, MCOs in the Commonwealth to achieve Medicaid program goals and access outcomes, quality of care and savings in the lineup with the 2023 to 2025 Medicaid managed care quality strategy.

The managed care organizations will be incentivized through the VBP program and the payment strategies are tied to achievement of the outcomes. The program started on January 1, 2024. And we will see the 2024 quality management results reported to us this fall. And we will likely see that reporting the first or second week of October. That's normally when we get that reporting in.

So the MCO VBP program design, there is a 2 percent withhold from the total contract value. There is 6 core quality performance measures plus a bonus pool for eligible MCOs. The MCOs must achieve a 3 percent or 4 percent point improvement to honor the withhold dependent on current

performance. They must earn the withhold on 4 core measures and maintain performance on all core measures to be eligible for the bonus pool.

The scoring basically entails this is a pass/fail. There is no partial credit with this. There is no withhold earned for missing the 3 percent or 4 minimum improvement. And, as I mentioned a minute ago, those HEDIS measures, we will get that report from our external quality review organization very likely the first or second week of October. And we can evaluate the MCO's performance at that time looking at the measurement year for '24.

The -- let's see. So the -- just to go through the VBP core measures, the 6 core measures we are looking at, the HbD good control is HbA1c less than 8. That's the percentage of members 18 to 75 years of age with diabetes Types I and II whose Hemoglobin A1c was measured to be in good control during the measurement year.

Postpartum Care, that's the PPC measure, the percentage of deliveries that had a postpartum visit on or between 7 to 84 days after delivery. The chide and adolescent well-care visit, 3 to 21 years of age, the sum of stratifications total,

that's the WCV measure, that's the percentage of members 3 to 21 years of age who had one or more well-child visits with a PCP or an OB/GYN practitioner during the measurement year.

There is a childhood immunization status that is the CIS Combo 10 measure. That is the percentage of children 2 years of age who had a combination of 10 vaccines by their second birthday. Immunizations for adolescents, that's the IMA Combo 2 measure, the percentage of adolescents 13 years of age who have one dose of a Meningococcal vaccine, one dose of Tetanus, Diphtheria toxoids, yeah toxoids, and a cellular or Pertussis, Tdap, and 3 doses of the Human papillomavirus, the HPV vaccine, by their 13th birthday -- sorry -- by their 13th birthday. I will note that the HPV there is -- it is report-only for the first year. We recognize some of the difficulties in getting children or getting children in a place to take all of those vaccines. So we decided to report-only on that specific piece.

Social needs screening and intervention, the SNS-E measure, the percentage of the members who were screened using pre-specified instruments, at

least once during the instrument period, for unmet food, housing, and transportation needs and received a corresponding intervention if they screen positive. And, again, for this one, this is report-only for the first year. I think that that was a newish measure when we had decided on that. So -- and we decided just to make it report-only for the first year.

Let's see. The bonus pool measures. There is 4 of these; metabolic monitoring for children and adolescents on anti-psychotics, the APM measure. It is a percentage of children and adolescents 1 to 17 years of age with ongoing anti-psychotic medication use who had a metabolic testing during the year. The follow-up after emergency department visit for alcohol and other dependents is the follow-up within 7 days of an ED visit total. That is the FUA 7 day. That's the percentage of emergency department visits for members 13 years of age and older with the principal diagnosis of the alcohol or drug abuse or dependents who had a follow-up visit within 7 days of the ED visit.

We have the weight assessment and counseling for nutrition and physical activity for children

and adolescents, counseling for nutrition total. The WCC measure, that's the percentage of children and adolescents 3 to 17 years of age, who had an out-patient visit with a primary care practitioner or OB/GYN during the measurement year and had evidence of a body mass index percentile documentation, counseling for nutrition, and counseling for physical activity.

And, lastly, breast cancer screens, the BCS measures, the percentage of women 50 to 74 years of age who had at least one mammogram to screen for breast cancer in the past 2 years.

And just to move on to the -- just to give you an idea of some of the current DMS quality initiatives and the activities that we are working on currently. We have a tobacco cessation performance improvement plan with all the MCOs that launched on January 1 of this year. I will note that those performance improvement plans generally go into a 3 year plan in looking at performance improvement. We submitted our 2025 annual technical report to CMS this past April. They do require an escrow generated report with several different -- many different focuses the CMS requires. That's due by April 30 of every

year. We have gotten that submitted.

A couple of focus study developments that we have been working hard on, we are looking at continuous glucose monitoring. And one looking at community health worker focuses that we will launch later on this year probably, I would say, July/August I believe is when we will get those kicked off. We are just about finished up with the development of those. Excited to get those started.

We have been working on a breast cancer screening PIP that is going to launch July 1. There is a little bit different time frame for this when, like I said, normally these PIPs go for 3 years. This one will actually be a 4 year PIP. There is a couple of new performance measures that will get started sort of during the -- once the PIP gets going. And so we have added an extra year to include those. Again, we are excited to get that one started. And then -- and really try to improve some breast cancer screening efforts in the state.

There is 2 focus studies that were begun last year that are currently in review; one of those has been reviewed by us and is in the hands of the

MCOs right now for review and comment. And we will -- the other one, we will be getting from our external quality review organization very soon. And that's disparities in postpartum visits 48 hour ED revisits, maternal morbidity and death during the 12 month postpartum period among Kentucky Medicaid managed care enrollees with a live or non-live birth delivery. And lastly on that one, the disparities in emergency department visits among all Kentucky Medicaid managed care adults and follow-up care for adults with multiple high risk chronic conditions.

And then moving on to give you an illustration of some of the quality reports that can be found at the below web address. We do have some work to do in getting some of those updated and getting the most recent reports out there. But it gives you an idea of some of the reports, if you are so inclined to go out there and look through some these reports, some of the access and availability surveys, and those are out there that looks at using Secret Shopper Surveys with different provider types to sort of gauge and access members' ability to make timely appointments.

We have comprehensive evaluation summaries. And I don't know specifically on that one. Again, if you are so inclined to go through and look through those reports out there, there is 2 really good ones that I would recommend to start with, one of those being the Comprehensive Evaluation Summaries. The 2025 report is getting ready to be finished and we will get that posted out there. And also the annual technical report that is already out there for 2025. They are large reports but they are very comprehensive. But I think they explain quite a bit about the efforts from a quality perspective that we are engaged in, you know, really month to month and year to year. And they are just really good reports out there for giving good explanations to Medicaid and really highlighting those pieces.

That's all that I have. Any questions from anybody on the TAC today, I welcome those.

DR. NEEL: Yes. I have a couple of question. Dr. Neel.

Can you go back to your first graph there that had to do with the value based for -- no. Go to the next one. Yeah, right there. Okay.

First I might say very quickly, we're about

30 years late getting this done. Okay. We started with something called KenPAC for about 14 years. That was 30-some odd years ago. And we were trying to just help access to care if nothing else. And we were trying to get what we didn't call value based things. We were just trying to get measures, HEDIS measures, put in to assure that children both have access to care and that physicians would be able to make enough income to see Medicaid patients.

And it was ultimately decided that we didn't increase access to care or save money so that KenPAC was done away with.

But I don't understand why on child and adolescent care why are we not seeing -- it was the reverse before. We wanted to see 5 visits up to 15 months of age, well-visits, because we thought those were the most important because those are the ones that led to the next item which was childhood immunization status because we could get them in, we could get theme vaccinated. And I don't understand why, because those later visits, 3 to 21, although important are not nearly as important as the first visits.

So I would like your comment on that. And I

can tell you right now, pediatricians are just begging parents to get immunizations at this point. So I can't tell you how -- almost needs to be a bullet there, time spent debating with parents about immunizations.

So I will stop there because I could go on forever and ask you to comment on that.

MR. SUTHERLAND: You know, I think a lot of it is that if you notice with a lot of these measures, I think we have really tried to focus on some of the things I think that uniquely, maybe not uniquely, affect Kentucky. But just some problems or some issues that have been there for Kentucky for a long time like the diabetes piece, the focus on women and children. And it was really determined that we were going to look at a total of 10 measures. And we would felt like that the measures that we had chosen for this I think had the most opportunity for improvement and bringing to bare all of the expertise and the efforts of all, at the time, 6 MCOs. Now 5 obviously. But I think that that is sort of the thinking that went into choosing these measures.

You know, we could have had 20 measures probably. But for -- I think for ease of

measurement and for keeping it, I don't want to say as simple as possible, previous efforts with VBP I think were really complicated. Calculating things -- this is sort of before my time -- but some of the information that was shared to me about previous efforts with VBP is that it was just cumbersome and it was hard to calculate. It wasn't entirely successful.

So I think going into this design, I think that's what we were trying to look at; women and children and diabetes and having, you know, measures that we could get report on and would certainly make the biggest impact for our members.

Did that answer your question?

DR. NEEL: Yes.

Well, still the question of why didn't get picked of 3 to 21 versus the other. I still would debate. And I wanted the other pediatricians to comment on it, I would appreciate it.

MS. PARKER: Well, just before you get to that, this is Angie again. Regarding -- this is a HEDIS machine that is determined by the National Committee of Quality Assurance. The conditions for that is through the years and they make changes as they see necessary. So that is the

reason why that particular measure is defined the way it is. If that answers your question why that measure is defined the way it is.

DR. NEEL: Okay.

CHAIRMAN THORNBURY: Thank you, Angie.

DR. GUPTA: I have a question, Mr. Sutherland. This is Ashima Gupta.

These are all measures that the MCOs are ideally supposed to achieve, correct?

MR. SUTHERLAND: Yes.

DR. GUPTA: So is there a pathway in place for them to achieve this? Or is it just all they just come up with their own plan, each MCO?

MR. SUTHERLAND: I think that it is really I think how they want to approach it. I think that, you know, we don't dictate to each of the MCOs in how to do it. I think it is -- they all have plans in place already, you know, before really that the creation of the VBP on how to address, you know, whether it is vaccinations or whether it is well-child visits or whether it's, you know, postpartum care.

And I think that by really us focusing on this, I think it allows the MCOs to strengthen their already in place, you know, processes to

ensure that they hit those percentages and potentially get that withhold back. But I think we allow the MCOs to really chart that path.

DR. GUPTA: One question about the immunizations.

That's already been a tough situation, you know, all of these years. But now with, you know, with the misinformation from the federal government, you know, is there something that DMS along with the MCOs could provide to try to, you know, along with the -- I mean I know the American Association of Pediatrics is already trying to put things in place. But just like get more education about the truth about immunizations. Because I feel like that is something that is already becoming so difficult.

MS. PARKER: Yes. And that's one of the -- excuse me for interrupting. But, yes. And we understand that. And that's one of the reasons why we have the immunization measure that we are looking at. I mean this was -- we know that there was issues with children getting their vacations during COVID. And then -- so we needed to ramp that back up. And we meant to -- anything communication-wise that our providers can include

in their visits. We know the challenge that all you receive that people just say no.

The MCOs are doing education with the members and the providers as well. We are looking with public health on HPV. I can't think of the word right now. But getting the information out on HPV and the importance of that immunization or vaccination. So there is a lot of work going towards that. And I think it takes all of us to get the right information out when the wrong information is coming out from our federal government.

DR. NEEL: Dr. Neel, again. A quick comment.

This is basically for the MCOs. Then the MCOs have to then work with their clinicians or their primary care providers if you would. I hate that word. But, anyway. I don't want to see this get into a punitive situation. Because we are all in a war right now trying to make this happen. And we are all in this together. And it is to the advantage of the MCOs and we, the clinicians, to make these things happen. And it is really difficult.

So I hope we are not going to get into a war between the MCOs and the clinicians. I hope you

understand that. And how do the MCOs feel about that? Because you are putting this onto the MCOs. But then they have to -- that really only happens if it -- if it happens to the primary care physicians. Do you understand what I am saying?

MS. PARKER: Yes, sir.

MR. SUTHERLAND: Go ahead, Angie.

MS. PARKER: And I think it is for the betterment of your patient, right? So, yes, I understand that they have -- the MCOs can do value based contracts and I think they do a lot of that with primary care because we are all working together to make sure our children are getting preventive services, that our diabetics are getting the care that they need, that our maternal health patients, enrollees, are getting the pre and postnatal care.

So this is where and why we are doing what we are doing. And it takes all of us. And I appreciate, Dr. Neel, what your concerns are. But we are hoping that with all of us working on this, that we will get our children vaccinated, that we will get our diabetics under control.

So it takes time. Just like Troy was talking about with the performance improvement plans. You

know, it is 3 years when looking at those. So it takes a while and you have to start somewhere. And this is where we started to -- decided to start with this value-based purchasing program. The MCOs were already doing quality initiatives in a lot of these areas. It is just that because there is a lot of the numbers that we all know are not where they need to be in the state of Kentucky or elsewhere probably. But we are targeting our children, our mothers, and chronic conditions. And where we can, because we can't boil the ocean as much as we would like to.

But this is where we are starting.

DR. PATEL: So I agree with Angie. We can't boil the ocean. And the MCOs, we don't always agree on everything but we do agree on this. Like this is a great place to start. Now, are there some things within the matrix and the administration of the program that we can improve on year over year? Yeah. It is a journey, right?

And so know this, that the MCOs are working together through the KPCA quality committee and the CMO committee. We have a lot of dialogue about this. We interface with Dr. Theriot quite a bit about this, having back and forward dialogues.

It has been instructive and informative. We do a ton of direct to member work improving health literacy. We are in the schools. We are in the community. We are in the congregations. Those are things that you guys probably don't necessarily feel or see from us. But there has been an immense amount of effort from the MCOs to push this forward and not push all of the work back onto the provider. Right?

We also know that you are facing immense pressures and volume in our practices and often are understaffed or the construct of your practice is not conducive to managing all of this. And so we have tried to take some of that off your plate as well.

So, agreed. We are in this together. This is important work, probably the most important work we talking about today. And we are all in it with you guys as well even though we don't always agree on everything.

DR. GUPTA: I have one more question, Mr. Sutherland.

So if the MCOs do not achieve these measures, are they financially penalized?

MR. SUTHERLAND: Yeah. I mean if they don't,

yeah, the withhold stays with DMS. So I think that you could consider that a penalty.

DR. GUPTA: If they are penalized, will the physicians or providers be penalized downstream as well?

MR. SUTHERLAND: You know, it is a hard for me to comment on that. I would like to think not or I don't know how that would come about. But that's just really, in my thinking on that, that that wouldn't happen.

MS. PARKER: It is dependent on what your contract is with the MCO. If you have a value-based purchasing program with the MCO, I think that would determine that. Now if you don't have a VBP, no. I mean, it should not come down on the providers.

DR. GUPTA: But I think in the end, you know, it depends on the providers to get this done. And if they are not able to get it done, then, you know, someone is going to have -- in the end, the providers always end up taking the hit. But even so, these are -- can be very difficult measures although I totally agree with all of these measures and this will be one. But a financial burden is just -- I don't know -- I feel like in

the end is not going to help anyone and it is very difficult to achieve.

It would be great to have a bonus. But penalties are -- they just make things much worse.

MS. PARKER: Well, that is not the goal. We want the MCOs to achieve. We want to give them back their money. This is the ultimate goal for that. So -- because everybody wins. And I can talk about quality all day. You can tell once I get a little bit passionate about it because I am, you know, I know everybody is trying to do the right thing. And sometimes other outside sources get in the way of that.

But I can -- I appreciate your comment. And if that does come to fruition, I would think that we could address that at the time.

CHAIRMAN THORNBURY: Angie, Troy, we greatly appreciate the effort, that DMS is behind this, and taking a little time from your all's schedule today to kind of work on that. I can't help but foreshadow that, you know, with the continuous glucose monitoring, when selected with correct people, how much of a dramatic change I have seen in people that were completely used to be you could not control, no matter what you did, you

really couldn't get buy-in with them. They just -- for a number of reasons that really weren't the provider's fault, they just had no influence. But kind of getting the patient seems to be, at least into my abstract sense, is trying to get them involved with that has really made a difference when we select the patients correctly.

Do I think it is necessary or even recommended for everybody? Absolutely not. You know, not the current cost structure. But with the right people, it has really made a difference. I am very interested to see how that data comes out over time.

MS. PARKER: Well, let me just tell you, Dr. Thornbury. We have been working with the Center for Health Care Strategies for the last year and a half -- and I don't know if Lisa Harris, she is my branch manager for population now -- where we are doing all kinds of work regarding CGM. So I am so glad you brought that up. And if you would like for us to talk about that at the next TAC, we would be more than happy to.

CHAIRMAN THORNBURY: Well, there is a couple of things I would like. I definitely -- well, I have an intellectual curiosity. I did general

surgery and I was boarded in family medicine. And really I do -- I am kind of a functional internist and I really run a chronic disease clinic.

So I am very, very, very interested and I like the current data, you know, the current line choosing, you know the meta-data for the internists say over 80 you are going to have problems, below 80 you will not have problems.

So to answer your question specifically, yes, I welcome that if it is not too much work on your guys' end. I would like a brief presentation. And another thing, you know, Cody, I see kind of Jonathan is kind of meandering in the background here. In 4 or 6 weeks, can you just kind of put a little note to yourself to kind of follow up with Mr. Scott to see how he is doing and see where we are headed on this on the 907? I just don't want to lose track of it.

But, Angie, I appreciate it. And, Troy, thank you very much. I know you guys are kind of getting called out today. But I think everybody on this call is -- I think everybody here really has quality at heart. And, again, my goal is to try to make sure that every partner in this trip together, we are taking benefits. Because unless

we all win and everybody gets a piece of this pie, it is not going to be sustainable.

So I think we all are really -- hey, Jonathan. I saw you kind of hanging out in the background.

MS. PARKER: Well, I can come and talk about quality any time you all want to. Troy and I are more than happy to.

CHAIRMAN THORNBURY: Cody, could you negotiate that with Angie next time? And we want, if it's okay, Jonathan, I am going to have kin of come and knock on your door a little bit. Okay.

MR. SCOTT: Sure. And I was going to say, I have a presentation about the advisory committee changes we are making. But I know you all have some additional items on your agenda. Did want to mention that we have a presentation that we can go over with that for you all as well.

CHAIRMAN THORNBURY: We can do that next time. Is that okay, Cody? We are a little tight on time this time. Now, of course, Jonathan, in the background, we have been kind of keeping close to that. I will just foreshadow, again, we have Dr. Gupta that is kind of rolling off on the MAC. And, Ashima, I cannot thank -- I want to thank you

publicly for all of your hard work and your leadership on that.

But we are trying to get people in place for that. But, yes, sir, we would like that if that's okay.

MR. SCOTT: And we're are accepting applications for the next 2 weeks. So by May 29, the new Medicaid Advisory Committee and the Beneficiary Advisory Council will be, you know, we are accepting applications right now. Hope to have them in place. That's really all we need to say. But, I guess --

CHAIRMAN THORNBURY: Glad to work with you on it. But thank you for the gentle nudge.

Cody, we have a -- I want to move kind of into Item 6 which is our open discussion. I know Dr. Tran had brought some concerns regarding information that we have on reimbursement for vaccinations and the physicians' fee schedule.

Dr. Tran, if you are still with us, do you want to set that up for us?

DR. TRAN: Yes. Thank you very much, Dr. Thornbury, and thank you members for allowing me to bring this subject up.

It has been brought to my attention that

there have been some issues regarding retroactive disenrollment of patients who were previously verified as eligible and actively enrolled at the time of service. So the scenario is such.

Providers who are taking care of their patients, verify eligibility in the KYMMIS system portal to confirm that the patient is, indeed, active with insurance coverage. Provider then provides the services and is subsequently paid for services. Then the provider will receive a letter from Medicaid stating that the patient has been retroactively disenrolled due to patient being ineligible at the time of service. And this leads recoupment of reimbursement.

And my concern with this issue is this places tremendous amount of concern and financial problems for the provider. And this creates a lot of uncertainty in regards to patient access. If I, as a provider, am always worrying about whether or not my services will be, quote, recouped by Medicaid later, it makes it difficult to provide said services.

So I can see all sorts of problems.

And we did investigate this. And the explanation we received was that sometimes the

Medicaid portal is not up to date. And it may state that the patient is eligible and active. But then it is not up to date and later shows something different.

I hope that we can have members of our MCOs here address that question and issue.

CHAIRMAN THORNBURY: Thank you, Dr. Tran. I want to make sure that we understand the problem.

Is there anybody else that can help us? I am not sure that I understand it. I mean it sounds like you are wanting the providers to be psychic or something. I mean you give them a spot to go check. The person that they checked on is eligible. And then kind of retrospectively say, well, by the way, that data is irrelevant and we are holding you accountable. I am not sure I -- it doesn't make any logical sense to me.

You know, am I sure that I understand this correctly or is there another way to look at this?

DR. NEEL: Dr. Thornbury, I can tell you I know of at least 2 pediatricians that essentially went out of business because of this very thing. This is not new. It happens. You can't be a psychic and know that those people are going to be retrospectively disenrolled. And so this makes

absolutely no sense. And the problem was is that you received these funds over a long period of time but the MCOs, or back then the insurance companies, wanted to be repaid say $100,000 in 2 weeks. So this is the kind of thing. So this isn't new. It has continued.

DR. GUPTA: Dr. Thornbury, actually this came up in one of our MAC meetings in the last few months. And what we were told is that, yeah, there is like this confusion sometimes or the portal is not up to date. And DMS, you know, did take some responsibility for it and that they were working and it. But it is kind of like a, you know, not a glitch but just they know about it but having difficulty fixing it.

And, I mean, this has happened to me so many times when I see babies in the NICU. I get paid and then asked for a recoupment up to 2 years later. And it is such a burden for the provider to try to recoup, or first, to refile that claim. And I wish that the MCOs could work with DMS together on the back end and just give each other whatever money is due to, you know, to the correct company rather than putting that burden back on the provider.

That is not our fault.

It is an error on the insurance company's part. And I wish that they would just figure it out with whoever the correct provider should have been or correct insurance should have been. So, I mean, I just wanted to bring that up. And then I would love to hear from the MCOs and DMS.

MS. BICKERS: Dr. Thornbury, Chelsea Agee has her hand raised. She is the branch manager for the MCO contract.

MS. AGEE: Hi, yes. Good morning. My name is Chelsea Agee. I am the branch manager of the contract monitoring branch in health plan oversight. So I just wanted to bring a little bit of clarity to this issue.

Now Jordan Griffin, she is our eligibility and enrollment branch manager. I do not believe she is on so I can't speak to some of the eligibility issues that were mentioned.

What I can say is that a lot of these are tied to SSI approvals. So I don't know if you are familiar with SSI. But when they are approved, that goes back to the date of their -- when they applied. So SSI can take quite a long time to approve members. And so when they do get

approved, they go back to that original SSI effective date. And so that does change and can change their enrollment retrospectively.

So what we have done for those particular cases, we actually have asked our MCOs as of April 1 of this year to not recoupe for any members whose eligibility has changed due to SSI issuance. Behind the scenes, DMS has a change order that we are working on for our system. That will eliminate this completely from happening. So, you know, once that system change goes through, you shouldn't see that for SSI issued enrollment, you shouldn't see those recoupments taking place.

If you are seeing any recoupments that have been initiated from the MCO April 1st to date, we would just ask, and I will put our in-box email in the chat, but we would just ask that you please send those over to us. You know, if we could have the actual copy of the letter that you receive that explains the recoupment, what shows the date that they initiated it, et cetera, and that will be really helpful. And then we will follow up with the MCOs on those cases to ensure that they are not recouping money. Any money 4/1 and beyond

should be returned to the provider until we can get this system fix in place.

CHAIRMAN THORNBURY: Chelsea, thank you very much.

If I may for just a moment. I am, because of the opportunities I have had in my life, I am in a position of being in a lot of very senior meetings around the Commonwealth, this is probability the best piece of leadership that I have seen in the last 2 years. And I will tell you why.

The point is to try to see who ends up with the stink bomb here. Because the stink bomb is all of it. All of this is our responsibility. But here, what I have seen -- what I see is is here is somebody taking responsibility until we can get the smooth edges all worked out for all of us because we have a system with humans. And in that system, it cannot be perfect. It is not going to be perfect.

But this piece of leadership really, I can see how the providers are trying to do the best they can. And because of this current system that we have because it is not a perfect system, they are being injured. And that injures our families. And then when the families are injured, the whole

Commonwealth suffers. But my great compliments, Chelsea, to you and more specifically to your leadership -- and I hope that you will pass that along -- I want you to know this is the best part of my day right now.

Cody, is there anything else that we had on our open agenda that we had kind of brought up here in the last week or so?

DR. TRAN: Dr. Thornbury, I have a few more items on the agenda if I could.

CHAIRMAN THORNBURY: I'll try to get them in. I do have a very hard deadline of 10:30 which means I have to run another meeting.

DR. TRAN: You mean 11:30, right?

CHAIRMAN THORNBURY: 11:30. 10:30 Central.

DR. TRAN: Okay.

CHAIRMAN THORNBURY: Yes, sir.

DR. TRAN: So, Chelsea, thank you for that.

And similarly we have had situations where the portal states that the patient is not actively enrolled and we provide the services. The patient pays for the services. And then later, we get letters from Medicaid that, oh, the patient was retroactively enrolled and you need to reimburse all of those payments back.

And, again, we happily do that.

However it also creates a lot of accounting issues and problems. So I would very much appreciate if you guys could take a look at that aspect as well. It would be really nice if we could do whatever the portal says is actually happening.

The second thing, if I may, is I have a second item. And that is, you know, with all of these issues related to the finance of many of our practices, the cost of labor, the cost of resources, the cost of office supplies, overhead, et cetera, we are getting quite a few letters from the MCOs stating that starting next month or starting this next fiscal quarter, we are going to essentially reduce reimbursements much below the Medicaid fee schedule listed across the board.

And while I understand that the MCOs have to do what they need to do. But it is terribly difficult and challenging for the physicians to have to burden this reduction. We are already having to look at the costs of labor as I stated, the cost of office supplies, overhead. And then to get decreased reimbursement just adds onto the tremendous burden.

And while I don't expect to have a ready answer for that, but I do wish that DMS could take a look at that so that we don't wipe out every practice that we have. Go ahead.

MS. AGEE: Sorry. I was just going to respond to that. Yeah. I will take back, for your first point, I will take back the enrollment question about not having, you know, not having any insurance and then it be being added later back to our eligibility enrollment team and see if we can follow up with some more information for you on that piece.

For the additional piece, you know, I will say contractually MCOs are afforded the ability to negotiate rates with their provider network. MCOs, you know, they have that autonomy. And so I definitely understand and hear the concern about provider operation and just, you know, making sure that providers feel whole at the end of the day. And so I am happy to take that back as well and see if we can have some meaningful conversations with our MCO partners around those reductions.

But just want you to know I don't have an answer today but I do hear you and we will look into that.

DR. TRAN: And one third item that I really would like to address. And that is, in our practice, we serve a very fragile population, the addiction space. And many of these people are on very complex medications that require drug monitoring, et cetera. And they frequently need laboratory studies to monitor the safety of the, you know, the liver transaminases, et cetera, et cetera. And to make it worse, they are extremely difficult to get phlebotomy only because their veins are scarred down. And so we have to hire specific phlebotomists who are a little more experienced to do patients with scarred veins.

So we have 2 problems. One is patients rarely will go to an outside center to get their blood drawn. And then, two, these guys are difficult sticks. And many of the MCOs are now telling us they are going to include the phlebotomy and all that into the office visit. And how are we going to pay for the phlebotomists who are specifically trained to do this -- to do this procedure if it is already included into our office visit which is, again, we are complaining about?

And so this just adds one more layer of

burden when we are just trying to attempt to provide the best care for that patient.

So, again, I don't expect an explanation. But just so that DMS is aware of the situation because I think it does place a lot of stress on our providers. I can only see the primary care docs who are trying to do the right thing to get their laboratory studies, get their metrics in. But the patient doesn't always comply with getting these laboratory studies done.

So bundling this into the office visit I don't think makes a lot of sense for us.

MS. AGEE: Okay. Yeah. This is actually the first that I have heard of this particular concern. So I have taken a few notes here and I can follow up with also our behavioral health team, our policy team, to kind of get some of their insight. You know, maybe additionally Dr. Theriot just so that, you know, we have a full understanding of what the MCOs' policies are and we can ensure that, you know, that -- because I would imagine that this is probably an exceptional type of scenario. So to include it on a per diem office visit for providers who may not even need that type of service seems a little odd to me.

But I am not a clinical person.

So -- but, yes. I have written this down. I will take this back and again follow-up with some of the other points here as well.

DR. TRAN: Yeah. I believe the MCO in question is WellCare.

MS. AGEE: Okay.

DR. TRAN: And I return the floor to Dr. Thornbury. Thank you for the opportunity.

CHAIRMAN THORNBURY: Before I -- I want to move into the recommendation item set on our agenda, but I don't want to go without making sure that I at least open the floor to see if there are any concerns or any agenda items that our MCO partners want to bring forward or want to nudge us on for next time. I certainly want to keep an open floor for that.

Does anybody have any concerns or anything that we can address here in the time we have remaining?

MR. HUNT: Dr. Thornbury, I think there was one other question that you wanted to address during the open discussion. It was about the 2025 physician fee schedule when it would be published.

CHAIRMAN THORNBURY: Oh, yeah. Yes. I got

lost in -- I thought that was one of Dr. Tran's three. Has that been published yet? Do we know where we are on that, Cody? Or does anybody from DMS, would they have kind of off the cuff information?

MS. BICKERS: Kelly Kitchen, would you be able to advise if it's been posted? I know they are in the process of posting some approved schedules. I just don't want speak on which ones because I am not positive.

MS. KITCHEN: Actually, yes. So sorry about that. The physician fee schedule has been approved. And we are currently working the system changes and updating, working on actually getting all of the updates made to the fee schedule. And as soon as that is done, we will get it posted. And I apologize. It has taken over --

CHAIRMAN THORNBURY: Cody, could you help us work with Kelly so that we can get that to those interested parties? Would that be okay, Cody?

MR. HUNT: Yeah, I can do that.

The reason the question got brought up, there was a couple of pediatric practices that had some questions about what the rates would be for certain vaccines. And I know that they had -- I

believe they had communicated to DMS, to the Governor's office, a number of different channels about those. So they were just curious kind of where that all stood.

CHAIRMAN THORNBURY: Okay. Chelsea, is that kind of one of the multiple eggs in your basket here this time? Cody, do you need to look to Kelly or Chelsea on that? I just want to make sure we are following up with the right people and the right things.

MR. HURT: Yeah. I can email Kelly.

CHAIRMAN THORNBURY: Okay. Okay.

So -- and then, again, some of these items we may need to just touch on briefly or, if necessary, a little more extended with our next meeting. Just make sure that I don't get that off my agenda, okay, that we fully extinguish the prior and all those. All right?

MS. AGEE: Dr. Thornbury, I do have one slide that I would like to share about a survey. The survey ends at the end of this month. So if that would be okay. It is just a really quick --

CHAIRMAN THORNBURY: Yeah.

MS. AGEE: Thank you, Erin, for making me co-host. All right. Are you all able to see that

screen?

CHAIRMAN THORNBURY: Yes.

MS. AGEE: Okay. Perfect. So just wanted to announce a survey that Kentucky Department of Medicaid Services is putting out for our stakeholders. This is in regards to the managed care and SKY programs. So this survey will be open through the end of the month. And you will be able to access it by this QR code or the link. I believe Erin will also be able to share this in her follow-up so you can click on the link.

But this is just for all of stakeholders, so members, providers, sister agencies, this is just a way for us to engage with the stakeholders, to look at our MCO performance, you know, just look at the program overall and make sure that, you know, we are all in alignment with our stakeholders about how we want to carry out our managed care programs.

So if you all wouldn't mind to share with your networks, the more participation the better. Because these results really help us drive how we structure our program. And that was it.

So thank you all so much.

CHAIRMAN THORNBURY: Thank you, Chelsea. I

will move us to 7.

We have one recommendation before the TAC today, that being the Physicians TAC recommends to the MAC that DMS submit 907 KAR 3:005 to remove the daily per patient limitation on billing for E and M services. Is there any further discussion or is there a motion on that?

DR. GUPTA: So moved.

DR. NEEL: Second. Dr. Neel.

CHAIRMAN THORNBURY: Okay. If there is no more discussion, those members of the physician TAC in favor of that?

GROUP: Aye.

CHAIRMAN THORNBURY: Any opposed to it? Without exception, we will move that forward into Ashima's care.

Our next meeting is July 18, same time, same channel, 10:00 a.m. eastern time. I want to thank our CMO partners and the chief medical officer, their support staff. I want to thank Chelsea and Kelly and all of the DMS colleagues that have supported us. And we have each of the members of the TAC here; Dr. Lydon, Ashima, Dr. Neel, Dr. Tran. And I don't think I am missing anybody. But thank you all. I know it is a lot of time out

of your schedule. But I appreciate you keeping us on time today.

And I am looking forward to our next meeting. We are adjourned.

Thank you guys.

CERTIFICATE

STATE OF KENTUCKY

COUNTY OF FRANKLIN

I, Georgene R. Scrivner, a notary public in and for the state and county aforesaid, do hereby certify that the above and foregoing is a true, correct and complete transcript of the zoom meeting of the KENTUCKY PHYSICIANS TAC, taken at the time and place and for the purposes set out in the caption hereof that said meeting was taken down by me in stenotype and afterwards transcribed by me; that the appearances were as set out in the caption hereof; and that no request was made that the transcript be submitted for reading and signature.

Given under my hand as notary public aforesaid, this the 18th day of June, 2025.

/s/Georgene R. Scrivner
Georgene R. Scrivner
Notary Public - ID KYNP73241
State of Kentucky at Large
CCR#20042109

My Commission Expires: 7/15/2027