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

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Via Videoconference
May 17, 2024
Commencing at 10 a.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Charles Thornbury, MD, TAC Chair

Eric Lydon, MD

Ashima Gupta

Tuyen T. Tran, MD (Not present).

Don Neal, MD

OTHER SPEAKERS:

Chirag Patel

Cody Hunt

Commissioner Lee

Stuart Owen

MS. BICKERS: Good afternoon, everybody. This is Erin with the Department of Medicaid. It's not quite ten o'clock and we're still clearing out the waiting room, so we'll give it just a few minutes before we get started.

MR. PATEL: Hey, good morning, this is Chirag. How are you guys?

MR. NEAL: Good morning.

MS. BICKERS: Good morning.

MR. PATEL: I just wanted to ask before we got started, what are the appropriate rules of Zoom for this meeting? Do we raise our hand and then we get called on, or is that we have a more casual atmosphere, and we can interrupt when there's a point of assertion or point of difference? I just want to be respectful of the team.

MR. THORNBURY: Dr. Patel, can you hear me, this is Dr. Thornbury?

MR. PATEL: Yes.

MR. THORNBURY: Yeah, well, remember that this is a meeting of the P TAC, so as a guest, what you would do is I try to keep it

informal, but I think what I would probably do in your role is when we're entertaining a discussion I would try to work with the committee and have a dance there, so that as the committee begins to -- walks through its work and we're contributing together because we want to open the dialog up. Does that make sense, Dr. Patel?

MR. PATEL: Yep. Yep, I'll raise my hand appropriately when you --

MR. THORNBURY: You can do that.

MR. PATEL: -- open it up for discussion.

MR. THORNBURY: You can just chime in, it's okay. I think if we have a small enough group here, and I think we do. I try to follow the first rule of Roberts' which is only use as many rules as you have to. So just jump in if you can, okay?

MR. PATEL: Yes, sir, and I'll be as respectful as I can. Thank you so much.

MR. THORNBURY: No, I'm glad you asked. Thank you very much, good grammar rule.

MS. BICKERS: Good morning, it is

10:01 and the waiting room is cleared. I show three of five TAC members on, so you would have a quorum.

MR. THORNBURY: Are you ready to go?

MS. BICKERS: I'm ready when you're ready.

MR. THORNBURY: All right. Good morning, everybody, this is Dr. William Thornbury on behalf of the Kentucky P TAC committee. We meet under auspices of Title XIX. Let me, before we begin, I understand this morning that we had a pediatric death up in Louisville, and let me just comment and say that, you know, when a member of the Commonwealth loses their life, we all lose our life a little bit. And I hate to begin things that way, but it kind of helps us understand part of the reason that we're working together is to improve the overall health, and part of that is safety and preventive medicine.

We have three members today: Dr. Gupta, Dr. Neal, and myself. That will meet the quorum and we'll let the record show that quorum has been established.

We have a copy of the minutes from the last meeting, is there a movement to approve those or amend them?

MR. NEAL: So moved. Dr. Neal.

MR. THORNBURY: Good. We don't need a second for that. Is there any dissension, Dr. Gupta?

(No audible response).

MR. THORNBURY: No, very good. Then without objection those will be approved. Do we have any old business up that I'm unaware of? Any pending business -- Cody, do we have any pending business? Dr. Neal?

MR. NEAL: No, I'm not aware.

MR. THORNBURY: I don't have anything on my agenda. Cody, could you help us recall from last time?

MR. HUNT: Yeah, no old business.

MR. THORNBURY: Yeah, I don't have any. For the new business, I think the weight we want to shoulder today is the discussion on the Milliman study, and we're looking at enhancing primary care codes. And I think the overarching theme is, I think, for the last three or four years,

that we've been rather exuberant on this committee about suggesting that the best way for the Commonwealth to move forward and become sustainable with their health care over time would be through a more robust and sustainable primary care system. Of course, I think, we have a bias being physicians in our training, but I think that currently all the data in the models show that team-based care lived by physicians has been the most economical. If there's data that suggests otherwise -- consistent data, I'm not aware of that.

And so with that, we move forward to try to suggest how can we support that? In particular, in more specific ways, how do we support the primary care in these rural areas and who is actually practicing in these rural areas?

What we've kind of distilled this down to is if we have these small primary care clinics -- now, I'm not talking about the rural health clinics or the FMHCs. Those are kind of a different animal. They're really paid at three times the fee

that we get. It's apples and elephants, but what I would suggest is we looked at how can we make these sustainable, and under that umbrella we're looking specifically at what would it take for the Commonwealth to invest to keep these practices open? These practices pay state taxes, they employ local workers, and they know -- and being one of those, you know, I'll instill my bias here, but you know the community intimately, and I think that will be part of the secret sauce. How do we get these physicians that would want to come back, how do we mentor them to come back in the Commonwealth and sustain our rural communities?

With that being said, I want people to understand why we're looking at this because we think this is the best way forward and the best value for the money. For every dollar we spend, we think we're going to get multiples of that dollar out.

Cody, can you walk us into this? You're intimately familiar with it, and then that would allow everybody to jump in. And again, I spoke to Dr. Patel earlier for

those that have joined a little late. We want to encourage our MCO colleagues to join in this and help us be part of this solution. Cody?

MR. HUNT: Sure, so the -- kind of the basis for the report or what it was modeled after was the North Carolina -- I believe, the North Carolina efforts where, as a state, they decided to take all of the -- what the ACA kind of defines as the primary care codes and they moved all of those up to the Medicare rate for their Medicaid program. And so that's kind of generally the basis for what the report as was requested by the P TAC was modeled after.

And so we've got the report back here, and, I guess, if there's anyone from DMS who wants to, you know, chime in on some of this and maybe help explain it a little bit better. I guess, really kind of the most important or foremost question from the data in the report is what would the total cost, I guess, reflected on the state be, and you know, does the federal match come

in -- how would the federal match come into play with this? And I guess, really what would be -- what is the takeaway from DMS regarding the report? Is there a surprise about what it shows, or I guess, what would be -- what was the expectation from DMS with regard to what the outcome shown in the report is?

MS. LEE: Can you hear me? I'm having a -- can you hear me? I'm having a hard time trying to log on and to get into the meeting. Can you hear me now?

MR. THORNBURY: We hear you and see you, Commissioner Lee; thank you for coming.

MS. LEE: Hi. You're very welcome. And I apologize, I have not, because of other priorities, have not done an in-depth review of the Milliman case study for enhancing primary care codes. I don't know if any of my finance team is on the call if they have had a chance to look at that report, and if they want to weigh in.

But the one thing that I can say, as you all know, that Medicaid -- our Medicaid budget is a two-year cycle. The general

assembly just last month ended their session and did not allow any money for increases except for a provision in the budget bill that states that there is a 25 million -- there's $25 million that can be allocated to providers in 2026, but we have to have some sort of a rate study in order to do that. I'm not sure if the Milliman rate study encompasses everything. If it just looks at primary care, it's not looking at the entire Medicaid program, such as behavioral health, dental, those sorts of things.

So based on that study, I'm not sure if it's -- you know, we're still digging into all the legislation to see if it's Medicaid or if it's the legislators that need to conduct that study. So I don't think that right now, you know, there's money in the budget to give increases.

What I've been telling other providers and one thing that the secretary continually says is we will pay providers whatever we -- we don't care what we pay providers as long as we can get that state match. The federal match is pretty much

guaranteed, but the state match is what we need to come up with. And as you know, we have had some success with our hospital reimbursement improvement program, but the hospitals put up that state share to bring in those additional federal dollars, and they do this through a provider tax. Of course, not every single provider in the state participates in Medicaid, therefore, there is probably not an appetite to have a broad-based tax for all providers in order to increase reimbursement rates through the provider -- through the physician or primary care providers.

So that's one thing I can say, but if you all have dug into the Milliman cost study report, you have questions, I'd be more than happy to try to answer them. Or if anything jumped out at you that you find as interesting that we maybe need to look into a little bit more deeper would be beneficial.

MR. THORNBURY: Thank you, Commissioner Lee. Well, Cody, since you were kind of leading this off, I would tell

you how I -- there's -- you know, you have buckets in your mind of how you parse things out and this is the way I would kind of parse it out. And you can correct me if I'm wrong because certainly, I'm quite ignorant about a lot of the particulars on this. But with the majority of the physicians in Kentucky, they're retained by some type of health system.

When we had a national -- as our national health cares reform, I would say we're probably at 70 percent, maybe a little better than that in Kentucky that are not independent, but these are working for large groups or they're retained by an FQHC or something like that. And so those people are not paid, for example, the same way that, say, the primary care clinician in rural Kentucky is paid, so they're paid at the commercial plus rate.

With FQHCs, again, they're paid triple what we're paid, so we're not even in the same league. When we get paid -- when we put the cost to it, we feel like we lose money with every single patient. We can't

even -- with the overhead that we have, we can't even make that work.

Now, do we still take those patients? Yes, we do. As service to the Commonwealth, we still see those patients. And what we're trying to do is we're trying to just become sustainable. And I guess what we're trying to get -- what I'm trying to get my mind around is well, I mean, I guess if I'm an administrator sitting at the top of the shelf saying, "Well, you know what, we just don't have money unless the Commonwealth gives us money." Well, I can respect that, but on the other hand, you know, I mean, you know, all the children aren't getting fed here it looks to me like, you know? I have a couple of them getting pretty fat actually, and I have a couple over here that are starving, and we gotta find a way in the budget to try to make these practices sustainable.

What I see is -- well, I'll give you an example. Well, this year there was a discussion about putting in another medical school. Well, I've been on these workforce

committees for almost 30 years and let me tell you what, you don't get more doctors by putting in more medical schools. You train more doctors to go to other states because they don't practice where they went to med school. They practice where they train, 85 percent of them are practicing within 80 miles of where they trained, and that's in the residency.

And so how do you do that? Well, how do you get more residency spots here? Well, you have to have places for these doctors to work. Even now it's very difficult to find these doctors a place to train even in med school. And what I'm trying -- the point I'm trying to make here is how do we get -- we're going to have trouble in rural Kentucky. How do you get doctors to come back to rural Kentucky and actually help build these primary care institutions? For every doctor we have in rural Kentucky, it drives about $2 million in that local economic system.

And so what I'm trying to do is how do you keep these small practices afloat

when you're talking about -- I mean, that's what we want to try to get -- our Medicaid budget must be $13 million, and I bet you we're talking about 40 or 50 or $60 million of that, it is a pittance. It's probably -- I think I did a number on it one time, it's gotta be less than -- it's less than .04 percent, and that's just to keep these guys so they don't lose money.

Dr. Neal, Cody, Ashima, can you jump in here, or can you please correct me if my thinking is wrong on this?

MS. LEE: Dr. Neal, you're on mute.

MR. THORNBURY: You were on mute, Donald.

MR. NEAL: All right, can you hear me now?

MS. LEE: Yes, we can hear you now.

MR. NEAL: Yes, okay. First, let me say to Lisa, is it not possible for that increase for Medicaid to Medicare rates from primary care to come from the MCO's budget within the budget as it is if they have interest in wellness in Kentucky? Because I can tell you, at the present time, for a

practice, a private practice of primary care in Kentucky to be sustainable, it can't see much more than about 30 percent Medicaid at present rates. And I can tell you that in Owensboro, which is not a rural area, maybe we're urban, just our pediatric patients are running probably 60 percent Medicaid at least. And I don't know about the adult population, I assume that it's probably 30 or 40 percent. But it's unsustainable at those rates of reimbursement for them to maintain, and the support has got to come from somewhere.

Now, the not-for-profit hospitals got an increase to commercial rates as Dr. Thornbury said, first inpatient, and now with outpatient. But I am assured by my local hospital, which is not-for-profit, that none of that is getting passed along to the primary care physicians, and I'm quite concerned about that.

So I'll stop there, but it's just unsustainable what we've got, and less and less medical graduates are going into pediatrics, and I think, probably in family

practice also. And we've got to stop that if we're going to make Kentucky a -- shall I say a more well state. We're about 41st, we came from 43rd in the last couple years, but we've got a long way to go if we're going to practice wellness.

So I'll stop there and see if Ashima has anything to say.

MS. GUPTA: So I practiced in Louisville and I'm not a primary care physician, but I mostly see children, pediatric ophthalmology, and most of my patient base is Medicaid. And the area where our entire practice serves is, you know, lower economic area, Louisville, and our entire practice sees a lot of Medicaid patients. So we are having the same issue with staying afloat as a private practice and not giving into private equity.

I also see so many patients now from other parts of the state and they all have Medicaid, so their access to subspecialty services is significantly limited. And for example, I had a patient from Owensboro who I operated on about a month ago, a

three-year-old, and normally everything's fine after surgery. But that patient had to be seen a week after surgery, which was unusual and had no money to drive to Louisville. I had to literally electronically send her cash to get her to buy gas and feed her kids because she missed a week of work to stay home with her kids.

I mean, this is not sustainable. And if I had to do that for every child that's driving several hours for surgery, I won't operate on those kids because it's too risky. So it's a problem mostly with primary care. I know in rural parts of the state, but even for subspecialty care, it's very difficult. You can't get people to go into pediatric ophthalmology.

MR. THORNBURY: Well, I just want to dovetail. I don't -- again, I don't want to be the person that comes and whines all the time because I don't believe that solves anything. I think part of what we have to do is we have to let the Commissioner and DHS understand what the problem is so that they -- if we can't present the problem in a

codified way, they can't do anything about it.

I can tell you what happened here, Dr. Neal, let me just kind of touch very briefly about the sustainability, and this is what we've been kind of worried about the last few years. Here in Glasgow, we've had five physicians leave. I have about maybe 40,000 people in the county, I've got 5 or 6,000 people that do not have a doctor in Barren County. In my private office, they have between 20 and 25 a day come in to be new patients. We have a family practice residency that has four seats here, they matched one, and the one guy that came didn't even want to do family practice. They just want to come here, finish up a year or so, and then they want to go do stuff like sleep medicine or sports medicine. They do not want to come back to Kentucky to practice primary care.

And we've asked those guys, "why?" And they say, "Well, you treat your doctors terribly". That's just what they tell us, that's kind of the summary when we've

interviewed the last four or five years, they said, "Well, you know what? You don't pay us well, you don't treat us well, you know, why would we want to come here?" And it really is like a family. It's like, you know, the children that you take care of, well, when they go to college they come back at Thanksgiving or Christmas, they bring their friends back. Well, you know, now these people are going to -- they're going to, like Florida, they're going to North Carolina, they're going to Texas. We can see kind of where they're going and we're trying to help you guys turn this around.

I think part of access to care, which we again, we've improved from 43rd to 41st. Part of that was our telemedicine initiative back in 2018 where now, we can try to minimize the travel time, try to minimize the expense burden of getting people seen by specialists and even primary care. We employ that as much as we can to try to keep people at their appointment dates.

But, Cody, help us walk through -- help the Commissioner kind of walk through

where we see this, and what -- I know that you're intimately aware of what's going on with the Milliman study. Can you please chime in, please?

MR. HUNT: Yeah, I think, just kind of as you all iterated kind of how we see it is how we have the physicians that are employed by the hospitals are kind of in a different category. RHCs and FQHCs are kind of in a different category in terms of the Medicaid reimbursement. And so what we have is kind of a select number of private practices that exist across the state that are just in a category all their own with -- in terms of the Medicaid reimbursement. And what we hear from them in terms of what they'll -- you know, kind of the biggest issue that they deal with regarding maintaining practice in areas that they serve, is dealing with the Medicaid reimbursement rate.

And so really, what the aim with the Milliman report is to try to get a better understanding of what a targeted approach to address that issue and attempt to make their

practices more whole and more sustainable so as not to interrupt patient care, and to be able to better serve the Medicaid population is to figure out what that cost would be and what the feasibility of addressing that would be.

And I think, generally, to go back, I guess to the question I raised before regarding the federal match for -- I guess, for a Medicaid reimbursement enhancement what would be the federal match percent -- or what percentage would the federal government cover?

MS. LEE: So the federal government, you know, we are a -- it is a partnership -- Medicaid is a partnership, and there are set fees that we -- that determines our match rate. So for example, anything administrative, salaries, that sort of thing that we do in the department, is a 50 percent match from the federal government. Services provided for our traditional Medicaid individuals, those that are aged, blind, disabled, pregnant women, children, is a 70 percent match. Services

provided to our KCHIP children, which are those children who are in households with income, you know, from 100 -- anywhere from 138 up to 200 percent, is an 80 percent match rate. And services provided to the Medicaid expansion population, which includes adults, is a 90 percent. So that's -- and then we get some enhanced funding for IT systems. So those are the set rates for us to receive enhanced reimbursements.

So there's really not a provision unless CMS would come out with something new that says you would get an enhanced rate for X, Y, Z. So for example, during the public health emergency, they gave us an extra 6.2 percent enhanced match rate because they knew that based on their directive that we could not disenroll anyone from the program during the public health emergency. That we would be -- it would definitely put a strain on our state dollars.

And again -- so there is no limit. There's not, like, a block grant or a cap on the federal dollars that we bring in. However, there is a cap on our state

dollars, and it's outlined in the budget every two years. So those are the dollars really that we really need to focus on is we want to give raises where can we get that additional state match because the federal government is either going to give us 70, 80, or 90 percent.

So where can we get those -- those additional state dollars? And that's, you know, lobbying the legislator is one. Provider tax, such as the hospitals pay right now is another. And then, for the FQHC services, for example, they -- the federal government still only pays 70 percent of those services, or 80 if it's a CHIP member, or 90 percent if it is a -- one of the expansion populations.

But the FQHCs are established in federal regulations, and they were established, you know, many years ago to serve as a safety net provider for some of the Medicaid -- or not just Medicaid, they have to serve everyone, and there are various criteria around those FQHCs. They have to provide a broader range of services.

Their reimbursement rate is established through federal legislation, so we have to abide by that. We do hold them, you know, accountable. FQHCs and RHCs, as you know, they have to either be in a medically underserved area or they have to serve a medically underserved population, so there's criteria and licensure that they have to go through in order to get that FQHC designation to get that enhanced rate or that perspective payment system rate we call it.

And the other thing that I wanted to address, Dr. Neal, you asked about the MCO budget. And the way the MCO capitation payment works, we pay the MCOs a per member per month rate for every member that is enrolled in that particular MCO. So with that money they have to provide every array of services: That's hospital, physicians, dental, so -- and we hold them to a 90 percent medical loss ratio. I think we may have even increased that to 95 percent.

So 90 -- at least 90 percent of the funding that those MCOs get have to be spent

on direct medical services. If they don't spend that money, it will come back to the department, but in the past few years and particularly since Covid, those MCOs have spent that 90 percent -- at least that 90 percent on services for members. And here lately, you know, we continue to look at their capitation payment to make sure that it's actuarially sound. Because that's a CMS rule that when the MCOs receive those payments they have to be actuarially sound meaning we can't underfund them they have to have enough payments -- enough capitation payments to provide services to the Medicaid population they serve. So that was one thing I wanted to address too.

And the other, Dr. Gupta, on your -- the, you know -- thank you for everything, you know, and thank all of you all for everything you do. But, Dr. Gupta, I mean, that story you just told showed how you went above and beyond for one of your patients. And the Department for Medicaid Services does cover nonemergency medical transportation, and outside of that

brokerage system, if a child, for example, has to have surgery, Medicaid can help get that mother transportation. We can also help pay for hotel rooms in case they need to stay all night, and maybe that's something that we need to provide some education on.

And I think, just in general, I would say that, you know, the Medicaid program in Kentucky covers 1.5 million individuals. We are a poor state. We are making some strides in increasing our overall health status, but we do have a long way to go. And I know -- I hear you, I hear your concerns, and the FQHCs do have a different payment structure. The hospitals are paying a tax, and, Dr. Neal, I'm a little bit concerned that -- to hear that the money in the HRIP program is not necessarily getting passed along to primary care docs.

And so the hospitals, in order to receive that, those supplemental payments that they receive through the Hospital Reimbursement Improvement Program have to meet certain quality measures. So we do

have a quality initiative within the cabinet. And also, the managed care organizations, we have been withholding 5 percent of their capitation payment to ensure that they meet certain quality measures. And if you all haven't heard about that, it would probably be a good presentation at your next TAC meeting to show what we are doing as far as holding individuals accountable for quality services that are being delivered to our Medicaid members.

I'll stop there and see if there's questions.

MR. THORNBURY: Thank you, Commissioner Lee. I'd like to bring in Dr. Patel who had his hand raised earlier. Our point of our MCO partners to kind of get his insight or answer his questions. Dr. Patel?

MR. PATEL: Hey, thank you so much, Speaker. So I wholeheartedly agree, right? I -- so let me give you my background that way I'm not just an MCO representee, I'm a practicing pulmonary critical care

physician. I have worked in rural Georgia, rural North Carolina, rural Texas, and then, urban Atlanta. So have had the ability and purview to see a variety of different populations, and I have made the rounds in almost every region in Kentucky myself to speak to providers directly. And so I wholeheartedly agree with all the assertions that have been made, right?

Should there be a different or a more augmented fee schedule for the primary care providers? Yes, absolutely, I think that's an appropriate discussion to have. What I would say about the maldistribution and the lack of primary care providers coming to the state of Kentucky, while it is a problem in Kentucky, that is a nationwide problem, right? You have areas of Georgia, North Carolina, West Virginia in particular, Indiana, South Carolina, Mississippi, Louisiana, and rural Texas which are having a very similar issue, right? Even though some of those states have many, many residency seats, right? Texas, North Carolina, and Georgia in particular, and we

see most of those graduates in primary care staying in urban, semi-urban, and you know, community-based areas as opposed to critical access in rural areas. And what a number of states have done, like Tennessee, is opened a door for other types of providers, right? And I'm not sure that that's the right answer in Kentucky. Like, international medical graduates are easy, some of the (indiscernible) to practice medicine.

But what I do know is the newer generation of residency graduates, and I work with a number of them from the Morehouse School of Medicine as well, is that they want to feel supported like the previous speaker spoke. And it's not just monetarily. It's with the ability to practice the most evidence-based guideline practice, right? They want to be in a place that's not doing polypharmacy. They want to be in a place where there's subspecialty support, like the pediatric ophthalmologist spoke about. They want to have the ability to comanage members, and quite frankly, you know, let's be honest, if they have a

patient who has a urinary tract infection and they send them to the hospital to get treated, patient dies by chance because of a heart attack, and the death certificate and the bill says sepsis, you know, that's going to be a huge dissatisfier for a new graduate.

And you know, so the implication of clinical legislation does play an impact on attracting the best talent to the hardest to reach areas, right? And so we've gotta think about this in a multidimensional way. Obviously, we should pay these clinicians more. Should we put better infrastructure and ethnic community kynects with subsidized federal dollars? Absolutely, but if you're not able to grant those newer graduates the appropriate infrastructure and support to practice medicine -- which is what we actually do, right? I know there's a lot of administrative burden and there's a lot of hassle nowadays, but it is still practicing medicine, right, especially for a newer grad. The attraction for coming to these rural areas is going to be slimmer and

slimmer, so that's the first thing, right?

I think the second thing that's important to acknowledge about the quality metrics and stuff like that, you know, the MCOs are quite a bit on the hook too, right? We've talked about the MLR. The quality withhold program has a significant withhold, right? It's 2, 3 percent. It's several, several tens of millions of dollars, and you know, that money has been gamified to pay-for-performance programs for the providers, Medicaid providers, primary care in particular. Over the last three years that I've been here, the amount of money that's being left on the table by primary care providers in particular would close the delta indifference for the infrastructure that may be lacking in some of these rural practices.

I mean, I know you guys do a fantastic job, but there is significant vexing hesitancy on the provider cohort and the patient cohort. There's significant hesitancy for preventative screenings, and so if you bring a new clinician into the

market, they're going to be looking for their peers to also be practicing the most evidence-based literature. And so I think there's multiple interventions that are abound for you to answer this question and get a long term solution. And one solution of just increasing rates is a great short-term solution, but it's not a long-term sustainable solution to have a equitable distribution of a provider network through rural Kentucky.

MR. THORNBURY: Thank you, Dr. Patel.

MR. PATEL: And I'm speaking from experience, right, in another state.

MR. THORNBURY: Thank you, Dr. Patel. There's a lot to chew on here. I made a couple of notes, I'll do my best with the different hats that I wear. The first one is, I think with many states that are rural, we already understand the model of what brings physicians back, and that model really is firstly, they need to be -- the most successful models have people from that area. So if you're able to retain say rural Kentucky students that go to school, that's

part of it because they have a base and a network to retain them. But part of that is they have to have rural mentorship. We found that particularly in primary care, if they don't have a mentor to go back to, they will get lost in the stream. They'll say, "Well, you know, I'm just gonna stay in Louisville." So we kind of know that model.

Now, the problem as we elucidated here is when we don't support these rural primary care practices, there's no mentorship, and that's what I'm seeing now. I have to mentor people from both UK, U of L, and U Pike, and they can't get enough mentors. Every month I'm getting a phone call, you know, can you take a student because we don't have enough people, these practices are closing.

Again, in the last two years, in Glasgow, we've lost five of these people. I'd say we lost another ten in the last five years before that that have moved or passed away. For the -- from wearing my KBML hat on, just to be perfectly transparent, I served as the president of the medical

licensure board for the last four or five years, I can tell you that we already have a statute in place where we can bring in these other physicians. But I would just caution you, it's not quite as easy, I think, as it's being presented. A lot of these people have -- may not have adequate training that -- now, while many do, many of them don't, and the licensure board does have a system for conducting a thorough review of that.

And we do let these people in, and we do have exceptions, and so I don't want the group here to think that that's not happening. That's a different part of the legislature and executive branch working together, but KBML does a very good job getting safe physicians in Kentucky, and we do look at other people. And we do that every board meeting, I'm there with a full board meeting four times a year, and I'm there every month with a panel meeting. So I assure you that that is being conducted.

I would say that, again, I'm just a very simple-minded person, I think. I try to think things in very simplistic terms,

but it just seems to me if I'm getting this correctly, that the FQHC money, which is coming from you guys, I mean, eventually, it's -- you're paying about three times what you're paying us, and it just seems to me like, you just want those guys to go over there where you're paying them less. I mean, you don't need any extra money, you just don't. If they go to the FQHC, you're gonna pay a lot more money as opposed to these rural practices. Why don't you just pay them half? I just don't get it.

I mean, you know, I mean, if -- and again, maybe I just don't get that. I would say to answer the part of, you know, the increase, trying to get people -- holding primary care --

(Inadvertent interruption).

MR. THORNBURY: Give me just a second.

(Interruption continues).

MR. THORNBURY: Got my daughter here listening.

(Interruption continues).

MR. THORNBURY: Children, God, love

them.

But I think, again, I'm trying not to lose my train of thought here, but you know, when you add more clicks -- I understand that you want quality. But you see what's happening is you have an overall system out of reach. Oh, it's just another click, it's just another phone call. I can't tell you the amount of people who we have in our office just doing the extra click, that extra phone call, the extra prior authorization that's not covered. I mean, it's, right now, I think the AMA represents it as two days a week of physician time, and then nobody pays for that.

So you people forget about that, like, it's being required for us to do. I'm in an ACO, and it is a -- even for a private practice, it is a great, great burden, and until you come down and work with us and do that job -- now, again, this isn't like one of my specialty colleagues that may have one or two little CHIPs that they have to come -- I've got probably 30 that I've got to correct, and I've got to do it on a daily

basis.

I just think that you need to understand you need to hear this from our point of view that, again, I'll just conduct -- I'll try to make the point that Dr. Neal made, and Dr. Gupta made: It is not sustainable. And so you're having more and more people -- what we're seeing is and what we're telling you in a more forceful way -- we try to tell you gently -- the people that you want to be here are leaving. They are not coming back in. I know in your mind you think that they're coming back in, but they're not. Again, when we matched one person that doesn't even want to be here in Glasgow, and I've got a med school at Bowling Green 30 miles away.

That's what we're seeing, and I've called around to some of my other colleagues, they're seeing the same thing. Yes, we're putting people in those spots eventually, but they don't want to stay. They had never intention to stay. You're just putting people there, they have other ideas in mind, and how do you get people

from Kentucky to want to come back there? You have to have these primary care practices to bring them in and mentor them, and slowly, one or two a year, they get less and less and less. And now, the only way I see to sustain it is economically.

Now, I think when we have to tell you that, I mean, if you expect us to solve that problem, that's not going to happen. There are not enough primary care rural doctors that can march to Frankfort and put on white coats and tell them, "You need to pay us more." That's not going to happen. And if you can't solve the problem, then eventually the problem will become overwhelming. You will kind of wonder, "Well, how did we get in this spot?" You might not be now, but it might be three years, five years, seven years from now, but it's going to be a position where you cannot get out of what you've gotten yourself into because these clinicians take a decade to grow, and it takes three or four years just to get them established so that they don't leave the community.

That's again, I mean, I've done this workforce thing for almost 30 years. I can tell you what it takes because we're trying to get people to come back in, it's very, very hard. The new doctors that come in do not work like the old doctors. They come in for three years then they move somewhere else. They come in to do their contract then they go somewhere else and try to get a better contract. It may be a rural area, but most likely, it won't be a rural area, that's what I can tell you.

Cody, can you help me out here?

MR. HUNT: Just to kind of shift us back to the report, I guess, a little bit, Commissioner Lee, were you all surprised by the total paid utilization amount? Is that -- you all keep track of that regularly, or was it higher or lower than you may have expected?

MS. LEE: Hey, Cody, I'll have to go back and take another look at that report. I haven't had it in front of me in a little bit, so I'll need to go back and take a look at it, and we can -- and I'll be able to

discuss in more detail at the next meeting, but I haven't. And again, would look to see if my -- if anybody on my team has had a -- took a deep dive into that report to see what they -- to get their thoughts and viewpoints.

MS. THERIOT: I have not had an opportunity to look at it really closely, but I will.

MR. HUNT: Okay, thank you.

MS. GUPTA: Cody?

MR. HUNT: Yes?

MS. GUPTA: Cody, this is Dr. Gupta, just as your review, can you just tell us -- just remind us why we wanted this review to begin with? It was based on what North Carolina has done; is that correct?

MR. HUNT: Yes, so what North Carolina did, I believe it's a couple years ago now, were in an effort to maintain but also strengthen their primary care workforce serving in their underserved areas, they made the decision to move the ACA kind of highlighted primary care codes to be at 100 percent of the Medicare rate to help

sustain their primary care workforce. And so with the report, the request was to come up with kind of a figure for what it would cost Kentucky to model that effort.

And so the report kind of highlights all of those ACA recognized primary care codes, and takes the paid amount and the total utilization amount, and then computes it for if it would be at 100 percent of Medicare rate. So for example, for a 99213, the Medicaid paid amount is $43.20. And then for Medicare, it's $83.93. And so it took --

MS. LEE: I'm sorry, I was just going to ask, do you have that report that you could have it in front of you or on your screen that if we give you sharing capability that you can share it so others could look at it?

MR. HUNT: Sure. Yeah, I could do that.

MS. LEE: Yeah, that may help us walk through it a little bit better and look at some of the -- some of the actual data points.

MS. BICKERS: You're a cohost, Cody.

MS. LEE: Thank you, Erin.

MR. HUNT: Okay. I think this is it. Let's see -- okay, can you all see that?

MS. LEE: If I squint. Is there any way you can increase it just a little bit?

MR. HUNT: Okay, let me move around the zoom screen here.

MS. LEE: There you go. Now it's getting bigger. There, okay.

MR. HUNT: Change this -- okay, so yeah -- yeah, so it took, you know, these ACA recognized primary care codes, and then we've got the Medicaid paid amount, and then the Medicare paid amount, and then so the percentage change for that. And then, I guess, this number here would represent 248 million which would be -- which is the total cost that we're at now for the utilization rate of those codes.

And then I believe this would be -- let me see --

MS. LEE: Yeah, this would be the annual impact, so you could see --

MR. HUNT: Mm-hmm.

MS. LEE: -- so we have our fee-for-service population, which, as you know, those individuals who are in long-term care home and community-based waivers. So the annual fiscal impact you can see there would be 233.2 million, and I am assuming that that is total funds. So just take about 70 percent of that would be federal. I can do some quick math, so about 70 percent of that would be federal funds, so if the total is 233.2 million, that would be 163 million in federal funds.

So let's get some -- and so that would be 70 million in state general funds that would be needed to facilitate that increase. And in the budget, the latest budget with 25 million, it wouldn't even touch -- it wouldn't even touch, you know, 100 percent of Medicare if we were allowing to use the entire 25 million for the physicians. So -- and that tells you exactly what we would need in the next budget cycle which would be about $70 million to increase it overall.

And then you see on the managed-care

side only would be 224 million if we increase to 100 percent of Medicare. And again, that's total funds, so that's what we would be looking at.

And I don't know, Cody, was there something in there too -- in the report -- I'm just trying to recall the report. Seems like there was something on if we just increased it -- those are the codes. If we just increased those -- I think that first page was -- yeah. That very first page was if we only increased a few codes, like North Carolina raised just some of their -- or maybe the second page. Yeah, right there. Those are just some of the codes.

So those evaluation of management codes, if those were increased to 100 percent of Medicare, it would be 136.9 million total funds, which would be about 95 -- or 96 million in federal funds. So you'd need about $40 million just to increase those few codes right there, those evaluation of management codes to Medicare rates.

MR. THORNBURY: Cody, if I could

dovetail in on what the Commissioner's saying, does this represent all primary care physicians? I mean, for example, when we're looking at this number, is this the FQHCs, and the rural health clinics, and the hospital doctors? I'm focusing in on the rural practices, the ones that are struggling, the ones that are actually getting this money.

MS. LEE: Yeah, the FQHCs and RHCs were excluded.

MR. THORNBURY: Okay, how about the doctors that work for the health systems? Because that's most of the doctors really. It's not those, most of them work for the health systems, you know? You know what I'm saying, Cody?

MS. LEE: Yeah, I would assume based on the data if they were enrolled as a provider type 6465, and it was limited only to primary care specialties. So I would assume that if they work for a health care system, if they are a part of a hospital or somewhere else, that they would be included, this wouldn't be just, I guess, independent

practitioners is what you're trying to get at, I assume.

MR. THORNBURY: I guess what I'm thinking of if you actually take the amount of money which was whatever we said it was. Did we say it was 50 million or 40 million? And you multiply that by 30 percent, that would be the real number. The real number is how many of these practices that aren't getting this because a lot of them are already getting paid appropriately. The 70 percent of them are because they work for health systems. The 30 percent of them that really aren't, that's the real money, that's the delta there that we're looking at. What number is that?

MS. LEE: So I don't know, how would we identify those in the system, I wonder, if they're just individual practitioners, if they're independent practitioners in their own business? I'm not -- I'd have to go back to my data team and see -- to see what -- how we could kind of maybe tease those out. Because I think that's what you're asking, correct? Is if you take out --

MR. THORNBURY: Yeah.

MS. LEE: -- all providers who work for a health system, like, if they work for Baptist, is that what you're saying? For example, I know we had --

MR. THORNBURY: Yes, ma'am.

MS. LEE: -- we had -- in Frankfurt, we had a practitioner had a practice, and they were bought out by Baptist, so now, all those providers, independent practitioners are part of Baptist, so we took those out.

I can go back and see if somebody on the team -- Erin, if you'll just take a note to see how we can remove any practitioner who's part of a larger health care system and rerun this report. And since the report has already been generated, it should not take a lengthy time to get the data back. I know you all waited, I think, quite a bit of time on this report. So it wouldn't take too long to run that.

And then while we're doing that, we can also see if we can generate a report -- as we've been sitting here having these conversations, maybe generate a report from,

I guess, I would say 2019 until now, on the number of independent practitioners, those particularly primary care providers that have been enrolled in the Department by county by year if you think that would be good information for you all to review.

MR. NEAL: Well, we would --

MR. THORNBURY: More information -- I think -- I was trained by Toyota. I think more information is always better than less information. What I'm trying to get my mind around is, you know, what's likely to be the real cost that we're looking at here, you know? Is the real cost to support those practices that are actually getting the $40 instead of the $80 -- it's not all of them, it's just a sub fraction. And again, the only way that I can spitball it is to say, "Well, just in Kentucky, 70 percent are employed by health systems so that leaves about 30 percent."

Now, the 30 percent, a fraction of those probably will be supported by the FQHCs and RHCs. Well, they will be excluded too, and I'm trying to figure out what's the

delta there that eventually when you come down to the number what's the real number that it would take to support even -- not all the codes, but just say, 99213, 99214, which is the majority of the work. If you just talked about, say, maybe you're talking about 22, or 24, 26 percent of your practices that you just picked those two codes, what's the delta? Is it 20 to 25, is it 35? That would be -- I'd want to know what that number is so I could get my mind around it.

And maybe the way to get that, Commissioner, you're right, is to try to figure out and parse out how do we figure out who's actually getting that reimbursement, and that would take a real analytics lift. That would really be a hard to come by.

MS. GUPTA: Cody?

MR. HUNT: Yes, Dr. Gupta.

MS. GUPTA: I'm just curious if you know how North Carolina did it? Is it just for a certain number of codes? Is it like Dr. Thornbury's discussing, was it -- is it

just for the, you know, independent private practice rural health care primary care doctors? Because, I mean, how have they made it work? If it's already been done, seems like, let's just copy what they did.

MS. LEE: I mean, I -- I don't know, Cody, if you want to answer that I could kind of try --

MR. HUNT: I was going to say, I don't know the specifics of the details on how they got into that. I don't know the -- I also don't know the diversity of their payment models either, but, you know, to Dr. Thornbury's point, for the set up that we have now, the hospitals would probably, you know, they would take a -- you know, technically, under the model like this, it wouldn't affect them because they're already getting paid. Their reimbursement rate for these codes is already higher than what the change would be, so they wouldn't be an effected category.

So yeah, it is a good question of how or what is the real number with that in mind.

MS. LEE: I am familiar with North Carolina's Medicaid director. We sit in on several calls together, at least one a month. I could get a little bit more information from him, but basically, I mean, from what I understand, you know, it was just included in the budget to give that raise.

And then, again -- and I do want to make a correction. When we were talking about quality a few minutes ago I said 5 percent withhold from the MCO contracts, it's actually 2 percent. So I just wanted to correct that.

The FQHCs, again, that's a federal rule, so that's a little bit out of our hands. But if you just look at those top two codes there, Dr. Thornbury, the 99213 and 99214, it looks like those are -- that's the biggest bulk, like you said, of the codes of the services. So it looks to be about 69 percent -- $69 million. Again, 70 percent of that is about 48 million, so about 21 million in state funds would need to be --

MR. THORNBURY: Well, if I -- if my -- back to the math calculations are correct, you're talking about a tenth of 1 percent of your budget. It would be 0.0016 percent of the Medicaid budget if the budget -- I'm guesstimating 13 billion.

I mean, my thought would be to say, if you're going to -- either you believe this scenario or you don't. The scenario we're painting is to sustain people to come back in primary care, to do this, you have to support these. Now, you either believe it or you don't. If you don't believe it, well, you don't believe it. If you believe it like we do, and we think the data probably supports that, then I think you'd have to try to say, "Well, how can we find 20, 30, $40 million, you know, a tenth of 1 percent of your budget?" And I think you may have to go back to the MCO partners.

I don't see how the Commonwealth -- I don't see how you're going to get enough people to go to -- enough rural doctors to go to Kentucky to say, you know, "Representative of somebody, I want you to

put in 25 more million dollars." I mean, everybody wants something every time, I've done that dog and pony show enough. But I would hope that the MCO partners might say, "You know what, by golly, this guy might be right. If we could support these practices, they could take more patients. Well, we're going to pay them half what we're paying the FQHCs and the RHCs, and these people are going to go somewhere, they're not just going to sit at home." And it might just be the money itself, it would pay for itself.

But I don't want to speak on their behalf. I mean, I'm not here to do that. They're our partners, they have to speak on their own behalf, but it just seems to me that's where the savings lie. I mean, it's not an expense. You all see it as an expense, but I see it as a savings. I'd much rather pay this guy full Medicare rate as to pay this guy over here, three times the Medicare rate.

And eventually, you could -- I just think that's the way to do it. I think it would be an investment. I think you would

have to invest in that, but I think if the practices were healthy, they could retain more people and they could see more people. I know that's the way for us, there's just so many people we could hire, we can't hire anymore. Because the truth of it is, even though we can see 20 more patients a day, we can't afford to see 20 more patients a day. But it's kind of an ironic position to be in. That's just my practice, that's anecdotal, but that's the best insight I can give you, Commissioner.

Does anybody else kind of -- I mean, I feel like we're monopolizing the conversation and that's not the intent. The intent is to help try to solve our problem together. Does any of the other -- Dr. Lydon, Ashima, do I have any of my MCO partners? Judy, do you have any thoughts on this, or can you give us some -- can you advance the ball a little bit?

MS. THERIOT: I mean, you make good points, but I don't see a way to get even the new practitioners into the rural areas because they just don't want to go. They

just don't want to go there, and I don't think it's because of finances honestly. I think they don't want to raise a family in a rural area, you know, they like the city, they like, you know, the things you have in the city, they think the schools are better. And so even if they go to a rural area at first, they're going to leave that area once they have a family.

MR. THORNBURY: Well, let me help you out there, I think what the workforce study says is they don't go back when they don't have mentors. For example, if you're expected to live in Louisville and do the Louisville things, well, then you're going to live in Louisville. But I don't live in a rural area, and what I would say is I live in a place that's close enough. Like, I'm close enough to Bowling Green that if I want the fine arts, if I want a more exotic dinner, if I want to fly through the airport, it's an hour and 15 minutes away. I'm close enough, but when we have mentors here where younger doctors can come back and work with them and become ingrained in the

community, well, there are great benefits.

You know, my school systems are superb here, you know? I mean, outside the door I don't -- I'm not -- there are people marching the street, like they're on TV. These are attributes of rural America that a lot of people choose, and you may not believe it, but a lot of doctors choose that. We just can't show them that because we can't get them here. The people that were doing that work, like Dr. Neal and I have said, they are retiring and leaving and they're not coming back because there's not enough sustainability.

Now, they don't come back for money, you're right, they don't. But it has to be sustainable, and right now, I think -- I would hope that we can all agree when you're getting $40 for a level three, I think, in my practice you can see that just -- you can't even make the business end work. Our overhead is 70 percent. And we can't change that, I'm not at liberty to change that. And I think we're just trying to say, "Can we just keep it sustainable so we can get

the doctors to come back?" I need the mentors here to bring those people in. If I could get them to work with a partner, come join me, you could be part of this too, and they're here for three or four years, then they see the life that they have, and a lot of these people would like it.

We do have kids that come back, we do, it's just uncommon. Dr. Neal?

MS. THERIOT: I --

MS. GUPTA: Can I chime in, this is Dr. Gupta?

MR. THORNBURY: Yes, Dr. Gupta.

MS. GUPTA: I think that, you know, if we could increase the reimbursement for independent rural health care primary care doctors to what appears to be almost double, the Medicare rate is double basically Medicaid, at least for those two codes, and incentivize young physicians other ways, as well, to practice in rural Kentucky. Like maybe, partial loan forgiveness or, you know, something like that, and foreign medical graduates that meet certain criteria. Then you're increasing small

businesses in rural Kentucky, which is what we're losing, you know, with primary -- with private practice, and that would significantly better the lives of physicians.

As you say, many physicians don't want to be in a big city, they would like to stay in a -- you know, in rural Kentucky and give back, but they need some incentive at least to get there and experience why it is good to be there. That's just my two cents.

MS. THERIOT: Well, I agree, and I certainly agree with the mentor aspect that you mentioned because for the nonphysicians on the call, if you have -- when you're done with your training, you are not prepared to practice on your own. You need somebody, not only to help you and mentor you with the doctoring stuff, but also with the business side of things.

So it's -- I'm looking at Dr. Neal because he's a pediatrician, but you definitely -- I mean, you need somebody to teach you really how to be a doctor.

MR. NEAL: This is Dr. Neal; can I

say a couple of things? Can you hear me?

MS. LEE: We can hear you, Dr. Neal.

MR. NEAL: Oh, okay. Sixty years ago, pediatricians started the idea of the medical home, and the family practitioners came along after that. We are rapidly losing this concept of the medical home, and that's going to cost a fabulous amount of money because it looks like we're drifting toward episodic care, and that's what's happening with all the urgent cares, and for that matter, a lot of the mid-level practices.

It's not just North Carolina. Florida, seven years ago, gave primary care docs Medicare rates. It hasn't changed their problem of people going to the rural areas either, but it's really helped. Because even in Owensboro, which is a rather progressive growing city, we have health care deficit areas just like -- and they're not areas of the city. It's 50 or 60 percent of our children are on Medicaid, and it's just unsustainable, as I said before.

Somehow, if we're going to move Kentucky into becoming healthier, which will eventually save money -- in the short term, it may cost money, but we've got to get communities involved. We've got to get everybody involved in this discussion. Kentucky started this with KenPAC, Lisa, you remember that. And your remark to me was about the reason we didn't continue KenPAC -- which, KenPAC, some of you all may not remember, was the first per member per month for physicians that would see Medicaid patients. And it, at first, involved a provider tax, which is just a nonstarter. We don't even want to talk about that, that's not going to work.

But, Lisa, again, I bring up the -- -- you said it didn't accomplish what we wanted to accomplish. What we wanted to accomplish was having every patient that was on Medicaid have a medical home, and not enough of us worked hard enough at that time to make sure that that happened, and I think that's probably why it failed. But even though that was just $4 per member per

month, that kept a lot of primary care doctors' offices afloat during the time that we had that. And unbeknownst to some, the MCOs, in spite of the fact that Kentucky didn't make that part of their contract, did continue to pay that to try to sustain some of the practices that were obviously providing quality care to Medicaid patients.

And that's what we've got to do because the patients haven't changed. They still want to be cared for by the most highly educated -- and I'm not going to use the word provider -- professional that they can find. And they want them to care for them, but they also want to be cared about, and I think that's one of the things we see changing. And both young and old in my town cannot find a physician, and the legislature has got to take that up, and a beginning is to change from Medicaid to Medicare rates at the very least. And you say, "Well, here's what it's going to cost." Well, did anybody push the legislature this year? Did anybody inform them of our primary care disaster that is happening before our eyes?

I was told by high up officials in the Primary Care Association, and I'm trying to be generic about that so I don't indict anybody in particular, we don't hire doctors, we're only hiring nurse practitioners because that's getting the job done and we don't have to have primary care oversight. And again, what Dr. Thornbury -- point he made is that they're getting now $195 for the same visit that we're basically getting for a sick patient at $43, and that's just ridiculous. I realize they have to do all of these other things but think about the things that the medical home supplies for the pediatrician. And that's one of the problems with this value-based care is they don't concede that providing the medical home alone is worth something.

So I can talk about that for hours, but I'm going to stop because it's really, sometimes I feel like we're standing on top of the mountain screaming and all we're hearing is an echo, and it's time to quit talking about it and make something happen, folks. That's all I've got to say, thank

you.

MR. THORNBURY: Dr. Neal, I think we are all empathetic. I mean, I think the P TAC is empathetic, it's just, it's almost our job has changed, you know? It used to be that we would present things to the TAC and to the MAC that we thought were of physician interest, and we -- somehow, four or five years ago, we just moved away from that. We're not trying to lobby for doctors, I mean, we're trying to lobby for the health of the Commonwealth, and if there's a better system -- you know, Robert Wood Johnson, the Commonwealth fund, and remember we brought that speaker in here? If there's a better system for the United States -- I'm not saying go back and I would do the system the same way, I wouldn't, but this is what I'm left with, and I don't know a better way to do it except through primary care.

Now, I think it's a fool's errand if you think that -- and I'm married to a nurse practitioner -- if you think that other less trained clinicians are going to be able to

solve this problem. I'll tell you what my clinic is: It is a chronic disease clinic. People come in there with 8, 9, and 10 things at a time, and it's like they're going to Walmart with $10, they're going to get as much as they can get. And we try to do as much as we can at any given appointment. It's not the cough and cold, it's really not.

I just don't know what the MCOs think is going on here, but again, these are chronic disease clinics and we're just trying to patch this up so that these people do not deteriorate. Because who's costing more money than anybody in the health system? Well, that would be people like diabetics. You know how many in Kentucky here -- we're in the middle of the cardiovascular capital of the United States and we have all those issues and somebody's trying to keep the wheels on the cart here and I just don't see any other way to sell it to you.

And I think -- again, I think what we are asking is can you -- you know, can you

help us explain this to your -- to the people in the different branches of government and have a real sit down with your MCO partners? I can't understand for the life of me -- I mean, I just don't understand the economics behind: How can I pay somebody three times something, and over here pay once? It just seems to me the MCOs would be on the ball here and say, "Well, we've gotta get this other thing going, we're going to save a bunch of money." I mean, I just don't understand that, but again, I don't speak on their behalf, but I do know that what you're losing here, and I'm seeing it before my eyes. You're losing the mentorship, we're losing people here, like, I just this year we've lost two doctors. I lost another girl the other day that had a bad outcome after a pregnancy, she'll never work again. I'm now having doctors that I trained that are becoming disabled or leaving, and I just -- there's nobody to bring these people back, and we have a very, very complex thing here. This is not Vermont, this is not Colorado, you

know, or Utah where we have a lot of healthy people. We have a lot of very sick people, and it takes -- you're talking about a lot of variables here, and a lot of variables for every visit.

This is not -- listen, I'm not getting two people a week in for some type of allergy problem. But, you know, I get people every day, and at the end of the day, you feel intellectually exhausted because there's so many problems that we're dealing with. And the only thing we can do is try and explain it to you: I don't see how you're going to go up any higher than 41st if you don't have any some type of reasonable primary care. I don't know how that primary care is going to be sustainable unless DHS and the MCOs can come to some type of solution of to do it because we can't solve that problem for you. We are not going to go to Frankfurt and say, "We, dammit, demand more money." It's not going to happen.

So since it's not happening, what's happened in the last ten years, are we in a

better spot or worse spot in primary care than we were ten years ago? Well, I'll let you be the judge of that, but I can look around and out of my doorstep and I can see issues. And I hope that you'll hear our plea because I think that's part of what we're saying here, and it's part of -- I think part of the agenda. If you look on the agenda, what else is on the agenda?

Well, there's nothing to talk about, I mean, that's why we didn't have our last meeting, there's nothing to talk about. We have -- the little, teeny problems, well, they have a way to get solved, but we don't have those things. I'm sure, a long time ago, when this committee was established, there was a lot to do every month, and don't have a lot to do. When we sit in on this, we sit in on can you make Kentucky's health care sustainable? And we're in this same boat.

It reminds me of when I tell people about the heart and the lungs, and they say, "Well, which one is it, the heart or the lungs?" I say, "Look, they're in the same

boat: What happens to one is going to happen to the other." What's going to happen to us is going to happen to the Commissioner and DHS. What happens to them is going to happen to the MCOs. It is going to be all of us, and we're all in the same boat, and the problem is we don't have the oars. We just don't have -- we can only tell you what's going on, and the boat is sinking.

I feel like -- I feel like -- Dr. Neal, I feel like I'm, you know, I feel that I'm becoming -- I'm getting in a position where I don't want to be preachy, that's not the point. The point really is that we're trying to tell you that we see this really substantial problem, I would summarize this by saying I don't think it takes a lot of money. I mean again, I'm coming up with a tenth of 1 percent of your budget. That's what I'm coming up with. Maybe it's double that, maybe it's two tenths of 1 percent. But I don't think it takes a lot of money to sustain these practices, and I think the value is substantial.

But you know what, I'll leave it there. That's what we believe. You may not believe that for a number of reasons. You may be smarter than we are. You have a room full of smart people, but we're trying to help you all help the Commonwealth.

Cody, Dr. Gupta, Dr. Lydon, Dr. Neal, do you have any thoughts here? I mean, I don't see there's reason to have any more talk about it, you know? I mean, we don't have any recommendations, I have nothing to put before the MAC. I'm telling you directly.

MS. GUPTA: Commissioner Lee, this is Dr. Gupta, I had a question for you. Are you still on the call?

MS. LEE: Yes, I am, go ahead.

MS. GUPTA: Okay, so I know the budget has already been made for this next two years. But I know, you know, there might not be an immediate short-term solution to this, but just thinking long-term, which Cody told me several months ago that this is a long road. That would it be worth starting to speak with our

legislators about this problem and trying to get in the -- when the next budget -- I guess in two years -- is on the table to try to get whatever amount is needed to be in that next budget?

MS. LEE: Absolutely, Dr. Gupta, and, you know, I hear you, Dr. Thornbury, I hear you, Dr. Neal, I hear everything that's being said. We are all in this together. The health care landscape continues to change.

I hear what you're saying about the FQHCs, that's a federal mandate, there's nothing we can do about that. But I think what we can do is get armed with information. Again, how many physicians, primary care physicians? What are the trends over the past few years? How can you get that information? Get information about what other states, such as North Carolina or whatever state we want to look at -- we typically look at surrounding states. What are the rates there? And the only way that we're going to make a difference is go armed with that information and have somebody see

the concerns that you all are raising here.

We hear it, we see it, what can we do about it? How do we make progress? How do we shore up the primary care provider system and whose story do we need to tell besides the physicians? You know, is the member's -- Dr. Gupta, is it the member that you had to pay money for her food and her gas? Is it those members that we need to tell their stories, and how do we gather that information in a very concise format to present, and who does need to present that information to the legislators?

I mean, the department can do so much. I know that, you know, there's several lobbying firms that go before the legislatures, and unfortunately, Medicaid is a huge program, and physicians are competing with every other provider-type. You're competing with dentists for example, you're competing with the behavioral health, you're competing with the hospitals. And where those dollars get invested is decided in their budget bill.

So I definitely agree, Dr. Gupta,

that, yeah, there needs to be some long term -- I don't know what we can do in the short term, but I think long-term, going armed with that information and showing exactly what you're seeing out in the field is going to be very helpful.

MS. GUPTA: I'm just going to throw this out there because I know we talked about this a few years ago, but if we could just get that soda tax like Arkansas did, which could just support rural primary care.

MS. LEE: And you know, the Dental Association talks about that a lot too. There are certain dentists, and I don't know if The Kentucky Medical Association wants to partner with the Kentucky Dental Association, get people together and get information -- get that information on how it's being done. And you know, partnering and going together because if you're fighting against each other -- if the dentists, for example, want money and the primary care or the physicians want money, that collaboration, you know, it's going to be, you know, united we stand, you know,

divided we fall. And if there's all these -- you know, the legislators are hearing from five and six and seven different entities about we need more money. It's kind of overwhelming, and if you get together and they hear from -- here's a solution, here's a soda tax, here's a solution, or any other type of solution that may be out there, you know? It's going to be, you know, maybe a little bit more successful.

I know that we have a long road ahead of us. The Medicaid program is 57, soon to be 58, it has been around a long time. It has gone through many, many changes. The population that we serve continues to grow. The services that we deliver continues to grow. There's always a new request to either cover another provider type, cover a new service, so how do you -- you know, how do you know how to spend those funds? And when you're covering a new provider type, there's -- you know, I've been in Medicaid 20 years and -- or 24, and the bulk of the policies that are put before us, the new

policies, they were eventually going to save money. And I don't know that we do enough analysis to see when we implement a new program, a new provider type, a new service, if we do enough analysis to see if it actually saves money in the long run, and that's something else we need to do. Because if we're not seeing the results that we want, we need to go back and reevaluate what it is we need to do in order to, No. 1, our first and foremost goal is to improve the lives of those we serve. And two is, you know, how do we take care of our providers and make them sustainable? What can we do to assist with the limited resources that we have?

MR. THORNBURY: Well, Commissioner --

MS. GUPTA: Dr. Thornbury, I was thinking that, you know, I know it's a long road, but to start the process, like, with our KMA meeting in August talking about some resolutions to present.

MR. THORNBURY: Well, that's certainly a thought. I think -- again, I think you're looking at three years out, if

we have a budget in two years and another year to make that happen. Now again, I'm putting on a KMA hat. I don't serve on that board anymore, and I feel a little reluctant talking about the political solution because I don't -- being on the board of medicine, I really try to put myself at arm's length of any of that discussion. I try to -- I served in a different capacity there, so I don't want to be directly involved in political solutions. I don't think that's a good place for me to be, and I feel uncomfortable doing that.

I think that that's one solution, but I do think the way I would tie it in, is what the Commissioner Lee said, this is difficult, but I think what we're trying to do as a committee is serving the Commonwealth by saying, "Well, we feel that this is your best value. We think that this is the Starfield Model. We think that's what all the data says." And while I do respect, I'd like to look around, and by other states, I'm really more interested in looking around with people that are

successful. If I hang on with a bunch of losers and they're all around me, well, I want to see somebody that's winning, and I want to see, well, how did you guys do it? How did Florida do it, you know? What are the -- like, Tennessee. I know a lot of people are moving to Tennessee, they're not moving to Kentucky. Well, what's going on over there? I kind of want to know how people that are winning are doing it, and if I can borrow or steal whatever they're doing, I'd like to know.

But I think, again, today, this is -- I appreciate the commissioner being here. I understand the duties that she has to shoulder and the constraints that she has. I'm not oblivious to that, and that's not invisible to me. Thank you, Doctor -- I mean to Commissioner Lee.

I would say, unless there's more open business, I don't really think that, you know, kind of being more exuberant about this is going to be any solution. I think we've told the MCO partners what we think, you know? They're businesspeople, let them

put a pencil to paper and see if it makes sense to them, and maybe they'll invest in it. Again, I think it's a trifling of their budget, but I think it would be the -- I think it's even now -- it used to be generic drugs were the best value in health care. I think with the way health care expenses have gone up in pharmacy, I think you're back to primary care is your best health care. And given the complexity, I think in some states the nurse practitioners would be fine, but what I'm seeing in Kentucky is what we said all along: They're not going to rural areas, we know that. You know, they're not -- what I see them do now is Botox. Around here the nurse practitioners don't work at clinics, they do Botox and diet clinics, that's what they do around here.

But I think that they are smart people, the MCOs are, and they will eventually figure it out or they'll leave. They'll say, "You know, we can't make any money here, we're going somewhere else." But that's just -- that's business, that's economic. I think for DHS, we've told their

leadership what we feel is going on, we've tried to make the best evidence, we've brought in people from around the country to look at that. And I think we have a report here that says, "Listen, we're talking about a few tens of millions of dollars. We're not talking about a billion or two or three billion dollars to change your life in Kentucky."

I think we made our point, and I would say thank you for everybody for being here. I'd like to move us on, there's no recommendations. Do we have any other topics that need to be addressed? Cody, do you have anything on your agenda?

MR. HUNT: I guess, just as a follow-up to kind of close off that bit, Erin, or Commissioner Lee, I think as we talked about a little bit earlier, we could get the condensed version of the report that just has 99213, 99214, and a narrowed approach to the physicians that would be impacted. So like we talked about, the independent practice physicians and not -- and then, make sure to exclude, including

the employed physicians as they wouldn't be impacted.

MS. LEE: Okay, we'll see if we can get that done.

MR. HUNT: Thank you.

MS. BICKERS: Cody, was that 99213 and 99214?

MR. HUNT: Yes.

MS. BICKERS: Thank you.

MR. THORNBURY: Thanks, Erin. With no recommendations, our next meeting is scheduled for July 19th this year. As long as you have me as your chair, I'll meet as long as we have something on our agenda to talk about. If we don't have anything to do on the agenda, then we won't hold a meeting, but I'm going to hold that spot open, and then again, we'll move forward together.

Is there any other business before the committee today?

MR. PATEL: Yes, I'd like to --

MS. GUPTA: Dr. Thornbury?

MR. PATEL: -- add some items for next time's agenda so we can ensure that we have a meeting.

MR. THORNBURY: What was the -- what was that, please?

MR. PATEL: I'd like to add some items to next time's meeting agenda to ensure that we have the meeting. I'd like to talk about --

MR. THORNBURY: Well, I'm your chair, if you'll put something before me that's worth meeting about, we'll talk about it.

MR. PATEL: Okay, I'd like to propose us talking about the impact of the sepsis two bill in clinical practice, and I'd like to talk about GLP use in the state of Kentucky and its impact or non-impact on diabetes measures, outcomes, and its relation to cost.

MS. LEE: And who is speaking, please? I'm sorry, I just see iPhone. Who is this?

MR. PATEL: Patel.

MS. LEE: Dr. Patel, are you a part of the TAC? Are you a member of the --

MR. THORNBURY: He's a MCO partner, Commissioner Lee.

MS. LEE: Okay.

MR. THORNBURY: Well, Dr. Patel, let me take the second one firstly. Do you have enough data -- do you have maybe four or five, six years of data with the GLP-1 use? If you're going to deal with obesity, you have to look four, five, six years down the road. I don't think you can look a year or two into that. Do you have enough data to where you think you can -- we can solve a problem here together?

MR. PATEL: I think I have enough compelling data to show practice patterns, lack of outcomes, I can bring rural data from Kentucky and the rest of the globe. There isn't six years of prospective data anywhere yet, right? So I do think it's still a worthwhile discussion given the cost implications to the Medicaid plan.

I know we spent a lot of time today talking about, you know, if dollars were available for other people, like primary care physicians in rural areas, do I think as a good steward of clinical care and a good partner, I think it's a worthwhile discussion to be had.

MR. THORNBURY: We might could. Dr. Patel, have you thought about taking that up with the Commonwealth's P and T Committee? I used to chair that committee, that might be the best venue for that.

MR. PATEL: We have these discussions around GLPs everywhere since providers and physicians are the dispensing arm of these medications, and considering that clinical literacy is, you know, a very important thing to make sure everybody's getting the best evidence-based care. That's also a health equity issue, right? I still think that is an appropriate discussion to have, but I will defer that decision to the esteemed Speaker.

MR. THORNBURY: Well, what I'm just trying to figure out if we're going to take -- again, we're here to -- if -- I'm trying to just walk this through in my mind, if the GLP-1s are great, are not great, and we have a recommendation to -- what, the MAC? And the MAC's going to do what? The MAC's going to tell the MCOs -- it just seems like this needs to be more of a P and

T Committee issue than it is -- like, there's a big problem with the medical practice. The medical practice of medicine in Kentucky: Here's a problem with it, we want to fix it. Or we have a problem between doctors and MCOs, and this is a problem that we want to fix. I don't say that that's -- I'm just try to figure out what we can do if we come to a conclusion together? The MAC wouldn't say -- we would not tell the MAC, "You need to quit using GLP-1s." Our committee wouldn't tell them that. The P and T might tell them that, but we wouldn't do that. What do the other members of the committee --

MR. PATEL: My ask of the --

MR. THORNBURY: -- think about it? Dr. Neal --

MR. PATEL: -- my ask of the committee would be to have a consensus around the agreement of what is considered the appropriate evidence-based body of literature that we can all refer to for GLP use.

MR. OWEN: And this is Stuart Owen

with WellCare. I think the issue is the prescribing. He's talking about the prescribing is coming from the doctors.

MR. THORNBURY: Okay.

MR. OWEN: And therefore --

MR. THORNBURY: And so --

MR. OWEN: That was -- yeah.

MR. THORNBURY: So our committee's going to do what? We're going to tell doctors not to prescribe it? What's our committee going to do?

MR. OWEN: Well, just --

MR. PATEL: Our committee is going to agree upon the appropriate evidence-based guidelines, and then whatever those guidelines are, doesn't matter good/bad, appropriate/inappropriate. Whatever is decided as an evidence-based body, we would educate and inform our provider network as to the most appropriate guidelines to the usage of the medication and treatment modality.

MR. THORNBURY: Yeah, I mean, I see what you're saying. This is just not the right venue for that. We're not here to

parse scientific evidence on a drug product or a class of drugs. That's the Commonwealth's P and T Committee. That's just what they do, I chaired that committee. I just think you need to be talking to them. I mean, I can review that.

MR. PATEL: Okay, I'm sorry.

MR. THORNBURY: I don't mind opening the discussion, Dr. Patel, but I mean, I don't see our committee making a recommendation to the MAC about a single drug class. I guess, it's why -- I'm not sure -- Dr. Gupta, Dr. Neal, Dr. Lydon, do you see -- I'd be happy to acquiesce to that, it's just not the work that we generally do.

MR. OWEN: I just want to -- sorry, Stuart. So what we've actually seen is a lot of members getting prescribed GLP-1s without a diabetes diagnosis, and so that's kind of the key concern here.

MR. THORNBURY: Well, I agree. Well, I mean, but that's not what we do. I mean, they shouldn't be prescribing it. If they don't have a diagnosis, they shouldn't be

prescribed that unless they have an indication and it's on your formulary.

MS. LEE: I --

MR. OWEN: Right, and it's more of an awareness because we are seeing that being prescribed by the docs without the -- and you know, I guess, maybe just, you know, awareness for this TAC to --

MR. THORNBURY: So you want us to tell the MAC for the MAC to make doctors aware of it?

MR. OWEN: Oh, I think Dr. Patel --

MS. LEE: Hi, this is --

MR. OWEN: -- was just asking for it to be an agenda item, not a recommendation.

MS. LEE: Yeah.

MR. OWEN: Not a recommendation, just an agenda item.

MS. LEE: So hi, this is Lisa, this is the Commissioner for the Department for Medicaid Services, and, Dr. Thornbury, I agree. Those issues -- Stuart, Dr. Patel, those issues have been put forth to the cabinet by the MCOs. So, you know, Dr. Thornbury is the Chair of the TAC, and

he is the one that -- he and his TAC members set the agenda, so thank you for your input.

MR. THORNBURY: Yeah, and I respect that. I see it's a frustration to you. I'm just trying to do the work of what we do: We make recommendations to the MAC, and we're trying to inform -- we deal with very large-scale issues, not that GLP-1 agonists aren't a lot of money. It's just that we're dealing with the foundational issues of health services.

MR. PATEL: Respectfully, I'll withdraw the agenda item. I did not know that that was not the purview of this TAC. I'll withdraw the agenda item.

MR. THORNBURY: No, and I appreciate your intellectual integrity there, thank you. And I am interested in that. I think we say no a lot to a lot of people, and I practice on that.

Did you have another agenda item, Dr. Patel, that you were interested in?

MR. PATEL: No, I would withdraw my sepsis agenda item, as well, now that I know the appropriate purview of this TAC.

MR. THORNBURY: Okay. And again, I would urge Dr. Patel and all of our MCO colleagues to contact me directly, or offline, or Cody. And Cody does a lot of the work that supports our committee, and if we can get things on the agenda that, again, that are going to move the ball forward for the governance of health care and health systems, that's what we're trying to do is help the MAC make those decisions. Or something that is very physician centric.

Anybody have anything else: Dr. Neal, Dr. Gupta, Dr. Lydon? Anybody else?

MS. GUPTA: Dr. Thornbury?

MR. THORNBURY: Yes?

MS. GUPTA: I just wanted to let you know that I will not be available July 19th.

MR. THORNBURY: Very good, thank you, Dr. Gupta. Anybody else?

MR. NEAL: Nope. Lisa, thank you for coming. As always, we appreciate it.

MR. THORNBURY: Thank you from us and for all of our members, Commissioner Lee. I know you have a really pressed agenda, and I know that you hear it at every meeting that

you're in but thank you very much for coming. We greatly value -- and I personally value your experience.

MR. NEAL: Yes.

MR. THORNBURY: You really -- you're an excellent administrator, and I certainly don't want that to be lost in our discussion today. Thank you.

MS. LEE: Thank you, all, for everything you're doing for the Medicaid patients. I truly, truly mean it when I say the Medicaid program was created for Medicaid members, but we can't take care of our members if we don't take care of our providers. I appreciate your partnership. I know we have a very difficult task ahead of us in improving the lives of those we serve.

I know that there's a lot of things we need to do to get where we want to go, and it does seem like all the time we're climbing an uphill battle and that we are shouting at the top of the mountain and only hearing an echo, but we are making strides. We are making some positive progress, and

hopefully, you know, just keeping our eye on that prize is going to help us as we move forward.

And I look forward to our next conversation, and as always, reach out to me if you have any issues that I could be of service with the Medicaid program. And particularly, Dr. Gupta, anytime you have an individual that may need a little bit of assistance with a nonemergency transportation, or even a hotel room to stay all night when their child is having surgery. So thank you, all, for everything you do.

MS. GUPTA: Thank you, appreciate it.

MR. THORNBURY: Thanks, Commissioner Lee, thank you, everybody. I call this meeting adjourned.

(Meeting adjourned at 11:34 a.m.)

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CERTIFICATE

I, Tiffany Felts, CVR, Certified Verbatim 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 12th day of June, 2024

Tiffany Felts, CVR