PHYSICIAN SERVICES TECHNICAL ADVISORY COMMITTEE
OCTOBER 18, 2024 MEETING

TRANSCRIPT OF ZOOM MEETING

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The foregoing zoom meeting was held, pursuant to notice, on Friday, October 18, 2024, beginning at the hour of 10:00 a.m., Chairman William Thornbury, M.D., presiding.

PHYSICIAN TECHNICAL ADVISORY COMMITTEE MEMBERS PRESENT:

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

DR. THORNBURY: Good morning, everyone. I am Dr. William Thornbury. This is an October meeting of the Kentucky Physician Technical Advisory Committee. We meet under the auspices of Title XIX. We do have a quorum here with our members.

I would entertain a motion to approve the minutes from the last meeting as our first order of business.

DR. NEAL: So moved.

DR. LYDON: Second.

DR. THORNBURY: Very good. If there is no objection, we will accept that and move forward to old business.

On Item 4, it looks like, let's see, we are reviewing the updated Milliman cost study for enhancing primary care codes. Cody, could you

share your screen with that, please?

So as we kind of get things engineered here, I would say we firstly want to thank DMS and their leadership for authorizing the study. The physician's TAC has been working on this Medicaid physician's fee schedule for the past couple of years. And I think we now believe we probably have a targeted approach with a projected dollar amount to the proposed enhancements.

This critical information provides a picture for the true weight of resources to achieve the tax code mobilizing sustainable primary care within our --

We will wait on you, Cody.

MR. HUNT: Can you see it?

DR. THORNBURY: Can you guys see that? I have it over here. Okay. Very good.

By way of background for those that don't have prior knowledge of this agency, the PTAC has requested that DMS has completed by their partnership with Milliman 2 targeted studies for physician fee schedules. The first most robust study forecasts a projection to move all, and I repeat, all of the ACA designated primary care codes to 100 percent of Medicare physician fee

schedule. That estimate totaled about $248.2 million. Of course we have to keep in mind there is a 70/30 split between the federal and state governments. This would place DMS's burden at about $74 and a half million per annum.

The second study forecasted -- projected mobilizing only the 99213 and 4 codes to 100 percent of Medicare rate for primary care providers. Now that would include all providers; physicians, nurse practitioners, physicians' assistants. That is, we are talking about primary care not employed by a hospital RHC or FQHC. And we discussed the payment differentials that those groups are under. That is substantially different than the groups we are talking about here.

That estimate was the more modest $130.8 million with the 70/30 split. My take on it was it was about $38 million.

Cody, you will have to remind me. But I think when I did the calculous on this, it came out to like kind of a rounding error, like it was about .2 percent of the budget that we are talking about here. And I could be a little wrong on that.

But I think we felt like it was a rather

modest investment to help sustain the primary care workforce because a lot of these private practices across the Commonwealth are actually in these very small rural or underserved communities, both not only rural but sometimes even inside the urban areas.

Cody, do you want to chime in on this a little bit?

MR. HUNT: Yeah. Just say that's part of the effort here in taking the much more limited approach in looking at the 2 specific codes and looking at the population of physicians that are most affected by a lower, you know, physician -- Medicaid physician fee schedule. So that being our independent practice, often rural, but also urban primary care physicians as well as our other primary care providers, APRNs, and PAs.

Hence that was in large part the thought behind just getting a projection for these 2 codes. It's how can we have or what can be the biggest impact in the most targeted way. And that was how this was arrived at.

DR. THORNBURY: It looked to me like that, at least in the former study, part of the information or the data that we kind of sifted through

demonstrated a disparity for these practices in that 99213 was exactly 50 percent of the Medicare rate where 214 is functionally 50 percent. It is 56 percent. And just to be candid, I am just unaware of any medical practice that is sustainable with that business model.

And I think it is common knowledge, at least in our field, that since 2001 the reimbursement for physicians is down 29 percent over the last 23 years. There is no COLA or cost of living adjustment. And I think that these studies kind of add a little bit of meat to the skeleton that we discussed over the last couple of years.

I would open this up to the members of the TAC for their opinions before we kind of bring in our DMS or MCO colleagues.

Dr. Neal, do you have a thought here?

DR. NEAL: There was some discussion early on as how this would affect everybody. Because, what, 60 percent or so or more of our primary care physicians are now employed. And the not-for-profit hospitals are getting Medicare rates now for all out-patient procedures -- I mean out-patient visits as I understand it.

And there was a question of would this be

passed along to the physicians. And a couple of hospitals that I have talked to said, well, they would look into that. But, no, that wasn't certainly being directly passed on. So that kind of comes up as a question in my mind.

DR. THORNBURY: Uh, huh. Dr. Gupta? Dr. Lydon?

DR. GUPTA: Do we want to bring up what happened at the KMA meeting at all regarding this?

DR. THORNBURY: I was unaware of it. I was at the meeting but I don't recall this. If it was brought up, I don't have any recollection. I had my mind on some other business at KMA.

Yes, go ahead.

DR. GUPTA: We did submit a resolution regarding this. And the consensus, they did end up passing it. But they wanted all of the codes. Is that right, Cody?

MR. HUNT: Yeah. There was a resolution passed at the KMA annual meeting that directed the KMA to advocate for enhancement to all of the physician fee schedule as it relates to the Medicaid program. And I guess that kind of gets us to where we are now insofar as affecting the change to the physician fee schedule in this way

is that it will have to be a legislative approach. Given that we are not in a budget year this year, it is likely something that could be up for discussion and be addressed in the next budget session in 2026.

DR. THORNBURY: Well, if I was going to try to look at this as objectively as I can, let me take the other side of it and see if I can reason my way through it.

Why is -- I mean, again, why is, even if I am just moving even over the major codes which is 213 and 214, why is .2 percent of my budget, why is that important? It just seems like, you know, I mean everybody has heard a lot about no one that I have ever met is ever paid what they think they are worth. Okay. So why is this important?

But I would say that there is a praedial optimum here of a point in the scale when you kind of eventually just the last straw kind of breaks the back of the camel. And so the practices that we are talking about here, the ones that are not employed by the hospital, the ones that are not under like paying doubles, we will call it RHC is probably getting double, FQHC is probably getting triple.

Well, you know, if you don't count those practices, why is this tiny group of people important? Because I would say that these are the people that actually are in these rural areas and keep the Commonwealth kind of going. Because really you are not -- to me you are not talking about the sick care system like the cough and cold. You are really to me talking about the chronic disease system.

And these are the people that have kind of -- well, they don't work for money. They work because they have a belief in their life or a belief in the system that they are trying to make a difference. And these are the people that take care of that kind of at risk population. You kind of lose these people. And all of a sudden, this tiny group of people that kind of help things stay under control, could -- all of a sudden they end up in the ER. And then the ER is just trying to get them out because either you -- at the ER you go home, you go upstairs, or you go to a tertiary care center but you don't stay.

So they don't really care about the chronic disease care. They are saying get out of my ER now.

If you don't follow up the chronic disease care, well, it may not get you now. But in 2 or 3 years all of a sudden, well, now you are on dialysis. Or you just kick these people over to RNCs or FQHCs. And now the Commonwealth is on the hoop for a lot more money.

So it seems like a pretty -- to me it seems like a pretty modest investment. But they make, you know, they may not see it that way. I guess the MCOs may not see it that way. But I think the legislative fix would be to try to say can we reason to assist with a tiny, tiny amount of investment to get the -- the very most you are talking 75 million of -- what is the budget here? 18 billion? Is that the budget for these guys?

I mean it is -- Cody, do you know? Do you know the number? I just don't know off the top of my head. It is a pretty big number.

DR. THERIOT: Yeah. It is about 18.

DR. THORNBURY: Yeah, okay. About 18 billion. So, you know, I think -- say, well, what we want to try to do is find the most modest investment to give us the biggest outcome. And this is -- I think we are aligned with Starfield's model of primary care being the best outcome. I

used to say generic drugs, but I am not going to say that any more. But I would say primary care which can offer -- you know, you are asking us to do 2 or 3 things. And I think this is a pretty modest investment of getting it -- even if you are talking about these tiny codes, you are talking about half that much. You are talking about .2 percent of the budget. And I think the outcome to make these practices at least sustainable, you know, even half of Medicare rate is, you know, that's a --

I don't know. I would open it up to our colleagues from the department or our MCO colleagues. I just would like to see it their way or maybe they can help me understand this a little better. And I just -- I just have an immature way of looking at it.

Is there any thoughts on this? Go ahead, please.

DR. PATEL: I have my hand raised.

DR. THORNBURY: Yeah, I am sorry. I just can't see it. Go ahead, please.

DR. PATEL: No problem. This is a Chirag Patel, CMO at WellCare.

DR. THORNBURY: Hi, Dr. Patel. Welcome.

DR. PATEL: Thank you.

So I, like you, 100 percent agree. Primary care, primary care medical home, that's the backbone of delivering good chronic condition management in the universe, not just in Kentucky. But I also am a pragmatist. You know, we would be supportive of increasing the value proposition of the code. But, you know, we would like to look at the problem in totality. Like, you know, the BH providers and the BH utilization and cost is driving some of this other behavior where it is rob Peter to pay Paul.

Now, if we could bring that under, you know, the 50 or 75 percentile, maybe there would be more resources and attention to the real problem in delivering chronic care condition management.

DR. THORNBURY: Thanks, Dr. Patel. Does anybody else have a -- would anybody else like to chime in here, please?

DR. LYDON: So, you know, this is Dr. Lydon. I am a psychiatrist not in the primary care. But I think what we are talking about is very important even for myself and my office.

It is a struggle to make ends meet. It is a struggle sometimes to, you know, when I am looking

at the checkbook on the day before payroll to see if I have got enough money in there to meet payroll, and you look at kind of reimbursements and where we are at and even working with other organizations. And I am also very involved in working with Communicare in central Kentucky and we see a lot of patients. It is just, you know, I know budgets are tighter.

But the other thing is when you are looking at trying to provide services, it is harder and harder to stay in practice. It is harder and harder to keep office doors open as the reimbursement narrows. And I think it starts somewhere. And I think starting with, you know, the primary care starting at the bottom of the pyramid to try to solidify it is a good place to start and a good place to look. And I think we are headed in the right direction with this discussion.

DR. THORNBURY: Thanks, Dr. Lydon. Anybody else have a thought on it?

DR. GUPTA: I guess the question is, is DMS able to allocate that .2 percent now without legislative action?

MR. DEARINGER: This is Justin Dearinger,

director for the division of health care policy. How are you all?

DR. THORNBURY: Hey, Justin. Thanks for coming.

MR. DEARINGER: Absolutely.

So the answer is, no, not currently. So the budget process, like you said, it is not a budget year. That budget has been set for the next 2 years. That would have to be an increase that was done through the legislature so that we could have those additional funds.

As you all know, there is a -- I believe there was a $25 million increase next year which was in 2025. But that money was appropriated through the legislature to be determined by LRC as to which -- how that was utilized. So Legislative Research Commission will let us know where that goes and who that goes to, that 25 million.

But as of right now, that answer would be unfortunately not. And we realize that not only physicians, but we have a lot of provider types that, you know, with rise of an increase in costs that would need some increases at some point.

DR. THERIOT: Hi. This is Dr. Theriot.

I think it is a little bit more complicated

because we would have to do a rate study as well and we would also have to do an SPA and do different things. So it is, unfortunately, not something you just click and turn on.

DR. THORNBURY: And I think that's -- Dr. Theriot, I think is consistent with the sentiment we have had in the last couple of years. I think we all respect the administrative way that DMS is set up.

Cody, you can remind me about this. But I think we have already forwarded our recommendations on this like a year or 2 ago to the MAC. Am I not mistaken on that? I am pretty sure I am right.

MR. HUNT: Yeah, you are correct. The MAC has talked -- has discussed this previously. And just from KMA outside perspective, this is something that we are working on with the legislature as well trying to address.

So we certainly understand the budget constraints within DMS to move funding around on this issue.

DR. THORNBURY: Dr. Gupta, was it 1 year ago or 2 years we sent that your all's way?

DR. GUPTA: I feel like it was last November.

DR. THORNBURY: Okay. Well, I think at this point, I think this is more informational and it tries to move us I think -- I think the way I would try to see the TAC looking at this is I don't want to see this as the whiny children that always want more. I would rather see this as a way to move our policies forward to give us more of what we need in Kentucky.

It is certainly self-serving because you are talking about the physicians TAC. But even if it weren't the physicians TAC, I think this is the way I would want to try to proceed trying to invest the smallest amount of money for the biggest outcome.

But -- and I think we all understood that this was going to be a legislative solution. I am glad it ended up being such a modest amount. And I think we just have to ask our legislators how they feel about this.

But, you know, I have a philosophy that people get the government that they deserve. You know, whatever you vote in, you know, you have to live with that. And I can tell you in the last 3 months, I know 2 practices that have gone out of business, 2 private practices that had -- one guy,

he called it retirement. But it was he went out of business.

And the other 2 guys left to go to a different state. They said they just couldn't do it. Now I am not saying -- I do not want to infer that this is related to Medicaid. But I would just say that, you know, that that is part of this process. And if we are trying to recruit physicians or other practices for primary care in Kentucky, I think this is one of the things that we will have to communicate to the legislature.

And I don't want to beat this one over the head. I think we have already discussed this kind of ad nauseam. But, again, I think this adds some meat to the bones of what we are talking about.

Is there any other thoughts on this before we kind of move us forward into new business?

DR. NEAL: Dr. Thornbury?

DR. THORNBURY: Yes, sir.

DR. NEAL: Don Neal. Just very quickly.

The unthinkable that this budgetary change would not come from DMS, that this would come out of the budget of the MCOs. We in primary care are becoming not for profit and that's kind of what you are talking about.

They seem to be for profit. Is it possible that some of those increases could come from the MCO's monies that they already have and that it all not have to come from Kentucky's budget? I am sure that is the unthinkable. But it seems to me as we transition from treating sickness to treating wellness and we are trying to improve the situation of the health of the citizens of Kentucky, in particularly those on Medicaid, that in the long run it would save them money to have those of us in primary care who I feel are delivering very good primary care but we are not going to be there.

It is simply we are not filling our residency programs. And I will be very brief about this. But I just think that we may need to think out of the box on how this happens and ask for help from them which will help them in the long run.

Is that nonsensical?

MR. OWEN: This is Stuart Owen with WellCare. Could I chime in a little bit?

DR. THORNBURY: Please. Thank you, sir.

MR. OWEN: Yeah. And so I am just going to be very candid.

It is a great point that Dr. Patel brought up

and I don't know if you all are aware. But since the COVID pandemic, the Department for Medicaid Services has prohibited any kind of prior authorization or authorization after any threshold for behavioral health. And also no limits. And also in late 2022 increased the rate for psycho education on the behavioral health fee schedule by about 350 percent.

And unfortunately that environment has been greatly exploited by particularly addiction providers. And so I know that's kind of the perception, MCOs are making money. We are not making money. We are not making money. And the behavioral health spin has been completely out of control because it's been exploited by some unscrupulous providers certainly.

And we have been lobbying. And we have been lobbying for the psycho education rate to be dropped back to what it was. And you could use those -- that funds to pay like primary care for example. And so that's been a huge --

I will tell you, MCOs are not making money. And a huge cost driver has been the out of control, particularly addiction behavioral health spin. And the argument is access. And we have

argued access to what. Because it is particularly providers that have a business model of providing a high volume of very low value/non-clinical care because it's low wage high profit margin services. And it is all about profit margin. And they hang onto members and hang onto members and hang onto members. And it is not resulting in clinical outcomes and helping actual Medicaid members.

So there is a great, great -- I am talking about a huge amount of money being spent on that. And that's like a very serious cost driver, a huge driver for the MCOs. But we are not making money.

DR. THORNBURY: I appreciate your insight, Stuart. Thank you very much.

MR. OWEN: Certainly.

DR. THORNBURY: For a lot of us that don't follow things like Buprenorphine, that wasn't clear to us.

MR. OWEN: Well, the Buprenorphine is fine. It is actually the -- it is peer support. In a particular -- they have an army of peer support. So if you are a Medicaid, Kentucky Medicaid member with addiction, unlike with medical, if you had a medical condition, you are getting a great deal of peer support which is essentially AA and emotional

support.

Because we have providers, they hire an army of them. It is cheap. It is GED, you have to have a GED in the disorder. And so that's what they are rendering a super high volume of. And also, psycho education is another service, like I say, where they increased the rate by about 350 percent. And we immediately saw a provider shift from clinical care, like intensive out-patient/patient program or psychotherapy, to psych education and peer support. That's what you get if you have addiction.

And, again, it is a huge cost to our services. It is not the clinical stuff. It is either the very low value, like I say, you know a ton of psycho education, you know, which is basically explaining your care. That makes sense on the front end when you are starting treatment or checking in every now and then. But not like 14, 16, 20, 30 hours a week and then the same thing for peer support.

So, anyway, that's the problem. It is substandard care actually. And we would not accept it with medical. But we are with -- if you've got addiction unfortunately.

DR. LYDON: I would like to -- I can reiterate that. I work down in Hardin County. This is Dr. Lydon. Sorry. And I see on the in-patient side here at Baptist Health Hardin, we get a lot of folks from a lot of those unscrupulous kind of halfway houses, sober-living houses. And that is a problem just like the gentleman before me was stating. I just want to make sure that when he clarified at the end that it was substance abuse treatment.

Initially it was behavioral health. Behavioral health is not the problem. I think a lot of the substance abuse treatment centers are where it is not a medical model, physician-driven treatment or organization. The nonphysician substance abuse treatment programs are a problem. I see a lot of the folks that are enrolled in those in the hospital on the hospital side.

So it is not -- be careful of lumping it into behavioral health. And, you know, want to -- the net should be cast just on that substance use, nonmedical/nonphysician driven entities and treatment programs.

MR. OWEN: Yeah. I agree. It is the addiction providers. You are right.

MODERATOR: Dr. Thornbury, there are a couple of people with their hands raised. Dr. Teichman I believe was first. And I hope I didn't butcher your name, sir. I am sorry.

DR. THORNBURY: Yeah. Yes.

DR. TEICHMAN: Close enough. Jeb Teichman. I am the chief medical officer for Passport by Molina. I want to agree with all -- with everything that's been said by my colleagues at WellCare and Anthem. I also want to point out as to the profits for the MCOs.

I don't know if you are familiar with what or you followed this street yesterday, Elevance Healthcare reported their earnings missed their target and their stock is down 12 percent. And that's solely because of -- well it was blamed on the Medicaid book of business. All MCO -- it sunk all MCO stocks.

So, yeah, we have finite resources. We have to be good stewards of their resources. And as a primary care physician myself, I totally support this effort. But it is a matter of taking money from Peter to pay Paul. We have a finite resource. We have to figure out how to use that.

We have the dentists with a problem as well.

And I agree. It is all about access. And I surely don't want to see practices closing. But it all -- to Dr. Theriot's point, it is not a matter of just flipping a switch. Even though we support this, it will affect the rates. A rate study has to be done. And then the legislature has to agree to up the rates.

DR. THORNBURY: Thanks, Dr. Teichman. Do we have another person with their hand up?

MODERATOR: Yes. Dr. Cantor.

DR. CANTOR: Hi. Good morning. Thank you.

I couldn't agree more with my colleagues as well. I would like to add that, and confirm in terms of where the profitability margin has weakened, UHC is in a similar vein. But what I would like to say is that it is important to not dilute the distinction between paraprofessionals and professionals from a rate perspective. If we are going to dilute the professional rates, it will make Kentucky a harder state to get more professionals to stay -- to come and stay.

It is not the first time that our DMS colleagues have heard me say that. I think it is worth repeating and keeping that in mind as the rates are being evaluated for 2025 and in the

future.

So I feel like that that is a pretty clear statement. So if there are any questions, I would be happy to articulate further.

DR. THORNBURY: Thank you, Dr. Cantor.

Let me -- let me see if I can move this forward. I think what my take on this is is we all have a shared vision here of the frustration that our Commonwealth -- and, again, I am looking at it through the lens of the physician TAC, but I try take a more broad-minded approach. But I think we all have a shared vision of the stress.

And I would suggest that, ironically, on appearance that both the MCOs, likely DMS, and the physicians here are all suffering the same consequence when we only have a finite amount of resources. And right now it appears to me, and I think the evidence likely suggests, that we are putting resources to a place where you can double or triple the resources but you are not going to get any better outcome.

The problem is when those resources go into one direction, the things that could provide value for the Commonwealth are being -- well, they are not being paid attention to. And when that

happens, we are going to get a poor future.

I know here in Glasgow we have a residency and we matched 2 of the 4. And when I went to query, it wasn't just we are not doing a good job or we are a bad residency. It was, well, no. The people don't want to come here because they don't see a future in Kentucky. I said what do you mean. He goes, well, they try to go where they feel like they are going to likely practice. And he goes, no one wants to practice in Kentucky so they can't get kids to come here.

And I know Dr. Neal has kind of alluded to this. But I think we're seeing the canary in the coal mine having difficulties. So I think when we move -- all move to the legislature, I think it is not inappropriate to suggest that all of us look at this the same way. And I think our message, our share message to the legislature, should probably be gentle ladies and gentlemen, can you please look at the value of the resources that you are moving forward in these paraprofessionals that aren't providing what we feel like is true value. And try to provide the resources in an area where we think we can get long-term value and better care.

I think -- you know -- I don't think we need to move any more resolutions forward. I just think that we can all come to an agreement. And that's probably what the minutes ought to suggest, Kelly, is that we all share an agreement on the likely move forward and the move forward is legislative.

So, again, I think when we all speak, it would be appropriate to suggest that all of us do see this the same way. Is there any dissention about this philosophy? I want to get that on the record if there is a dissention where someone doesn't see it that way.

DR. THERIOT: I would just add that when you go to the legislature, make sure they have an appropriation to go with the change. Because oftentimes they will make a decision like this one but then not do any appropriations to pay for it.

And when that happens, we have to, you know, stop providing other services.

But I would like to actually talk about some ways that you can now increase your rates. And that would be by entering into a value-based program with one of the MCOs since you are, you know, the primary care, the main primary care provider in your areas. And, you know, if you

want to, you know, take on I don't know congestive heart failure or something like that and you can, you know, you are doing a great job of doing that, the MCOs can have a personal program that they create with you to, as you are doing a good job and meeting metrics, they will give you more money on top of just the claims.

So I don't know if any of the MCOs want to talk about that.

DR. THORNBURY: Would anybody want to chime in from our MCO colleagues about that investment?

CHUCK: Hey. This is Chuck.

I think conceptually that sounds fantastic. Let me talk about what's happened nationally and then I will talk about what is happening in Kentucky.

Nationally what we are seeing, particularly in the government sponsored insurance space that less and less providers want to engage in value-based care because there is a lot of effort, administrative and clinical, to reach those dollars.

And then in Kentucky, we have, I think, over 80 percent of our providers in some type of BBC arrangement, upside only, that means pay for

performance. That means you close a gap, you get paid. Does that translate necessarily to chronic condition management? It doesn't. You see transaction activity. Nevertheless, what we found, especially in our more critical access rural regions, that providers are not set up to do these activities, from a clinical standpoint, from an EHR standpoint or admin standpoint.

And we often see providers leave 20, 30, 40, 50, 60 percent of their allowable earned dollar left on the table. And we look at totality. It is several million dollars by Medicaid book of business. And that includes pediatrics, right?

Like, respectfully, we have a 2 percent withhold program with the state, right, which is several tens of millions of dollars per MCO. And we actually cascade those exact same metrics word for word down to the provider. And the providers aren't able to do those things for us even though we give them the list, we put resources in their practice, we will make calls for them, and we are still not able to do it because it is an inefficient model.

And so while BBC was touted as the panacea, it is not. And I don't know necessarily that is a

lever that we can pull for any meaningful change full stop.

DR. THORNBURY: I certainly understand that and appreciate how difficult that is. I think part of the -- part of the challenge there is on the one side, you know, when I look at the MCOs, you know, they are in a world of data. They are in an administrative world. That's how they view the world.

The practices, of course, are trying to -- they are just trying to take care of what comes through the office through the day. And, particularly -- and we are talking about these rural practices, these people that don't have special contracts -- well, they are the people -- exactly the people that probably can't provide that kind of data. And the sentiment I read here, I think, is what you alluded to is 2 percent of the budget. But to fix the problem, it takes 22 percent. It takes a tenth of that to likely improve the problem. And that's the sad irony here. And it is a challenge.

I think you can meet the 4 pillars of congestive heart failure care and nobody may know about it except the fact that your patients are

doing better and using less resources.

But you are right. If you can't prove that, and I don't see that -- candidly I don't see that these practices will ever be able to do that. They just don't have the resources to do it. They can't hire the people. And, no offense. But when you are getting half of Medicare rates, of course they can't afford the people to do it.

So I think, again, moving to the legislature, we would have to ask them to have the wisdom to understand this. But I think they will have to have that wisdom. I don't see that the practices can do it themselves. At least from my view. I could be wrong.

Dr. Neal, do you see it differently, sir?

DR. NEAL: No, I do not. I agree with you.

DR. THORNBURY: But it is certainly nice to have an inside. And actually -- it is not to actually all be looking in the same direction together for one time. Sometimes I come to these meetings. It frustrating that we are all trying to do the same doggone thing. And there is an appearance that it seems like we are on opposite sides of the table and I am not really convinced at all that we are on the opposite sides of the

table.

I just don't think we are communicating in the best way.

But I think today we do share a common vision. Is that fair enough to say? Well, since we moving to the legislature on this, I think we all have enough ammunition to speak with insight into the others.

I will just take us forward here to item 5 on new business. The first portion was reviewing 907 KAR 3:005. That's the daily limitation of E & M services. This was kind of a new issue that came to our attention over the last 6 months or so. We have been alerted to some concerns by a number of primary care pediatric practices regarding item 7's language and its administration.

Presently in section 4 -- no, section 7, there is language. And I am going to try to quote this, correct me if I am wrong. Coverage for an E & M service shall be limited to 1 per physician per recipient per date of service. And so I think practices attempting to remain respectful and in compliance of CMS's 2021 CCI corrected coding issue and the revised CBT coding guidelines have found challenges to providing the standard of care

services, what I would consider standard of care, for primary care and preventative medicine with appropriate reimbursement.

Cody, you have done some work on this. Can I kind of pitch the ball over here to you to kind of step in for just a second before we move forward on this?

MR. HUNT: Sure.

So this is an issue that we have heard a lot about over the course of the last 6 months particularly from our primary care physicians as well as our pediatricians. And it is creating a lot of confusion and difficulty amongst practices both in terms of billing and providing care.

And particularly when it comes to billing for a visit where, say, an annual wellness exam and preventative medical care provided in the same visit, in other words the patient submits for their annual well visit but also receives treatment for an untreated chronic condition. And so the physician then addresses, you know, both of those issues. And they meet both the time and the medical decision-making standards.

But then when they go to submit for reimbursement, they are only able to be reimbursed

for essentially one of those services due to the prohibitive language in the regulation.

And so it has just caused a little bit of confusion and difficulty amongst practices. And also, at least the latest the national CPT guidelines that we have looked at, they don't prohibit this billing practice and I believe Medicare, it doesn't mandate that payers cover both. But they allow for both to be billed but with a modifier of 25 attached or so long as the time threshold and medical decision-making is components of those codes and those visits.

So, yeah, that, in essence, is what we have been hearing about and what we are seeing.

DR. THORNBURY: Well, I guess what is the committee's; Dr. Gupta, Dr. Neal, Dr. Lydon, how do you all look at this and have you all had any challenges here?

DR. NEAL: I can tell you after 60 years of practicing pediatrics --

DR. GUPTA: In a specialty practice?

DR. THORNBURY: Let me put Dr. Neal who started. And then, Dr. Gupta, I will come back to you. Thank you.

Donald?

DR. NEAL: Okay. I will be just as brief as I can.

With every well child exam, there may be something else; a diaper rash, you may find an ear infection, or they may have called for a sick visit and needed a well visit so they get that added. This gets complicated. But it is just a futile effort of the primary care physician trying to eke out enough pay for the patient that he sees to keep him in business.

And I review charts all day every day. And so what I am seeing in the EMR is there are 2 visits. And, interestingly enough, that creates 2 charts if they want to be paid for 2 different visits. And interestingly enough, in one chart it may show the ear is normal. And in the other record that is created, it shows ear is abnormal which is a kind of anomaly that is created from that.

But the bottom line is this. The only reason this really exists is that we are just trying to eke out enough to stay in business, not to make a profit to get rich. And I just, as an older physician, I just -- this whole thing of this extra visit at the same time bothers me.

The surgeons had a different reason for it because they do a surgical procedure and do something else on the same day. But that's different for the primary care doctor. We are adding these as what we call split visits. But it is just a way to -- everybody is trying to game the system. And I don't know any other simple way to put it.

DR. THORNBURY: Dr. Gupta?

DR. GUPTA: Well, I don't really have anything to add from specialty care.

DR. THORNBURY: Yeah. I would like to think of my clinic as more as a chronic disease clinic. I think part of this frustration is we have many of our MCO medical officers and doctorial course. This is kind of a more part of the revolution of it. It is spinning back around again.

But primary care is a really unusual part of our health system. And it is unusual because when we came up with CPT coding and reimbursement, well there is one way, for example, our specialty and sub-specialty colleagues are paid because they come in, they look at a problem, and then they go forward.

Primary care does it different. It's paid --

they attempt to pay it the same way. But they don't perform the same function. And so that's why it struggles. On the one hand, you want them to provide sick care; cough and cold and UTI and, you know, this, that and the other thing. Then on the other hand, you are asking them, well, we want you to prevent stuff down the road because we don't want a sick care system. We want a well care system. And that takes time to work with people to try to explain to them why they need their colonoscopies, why they need to be in front of the ophthalmologist for their eye care, why we need to get these immunizations.

And the third part of it is, and particularly with these adults in Kentucky, we have these kind of very sick group of people that use a lot of resources. And, you know, they are the diabetes, the hypertension, dyslipidemia, the heart failure. And we are trying keep that in check. And yet, in the same visit, you are almost trying to do what I see is in my office and my patients are like -- maybe it is just because of the people that I get -- but they come in with their diabetes, hypertension, dyslipidemia, and, you know, they have a little -- they sprain their ankle, I don't

know, they have a little something else going on.

Then on top of that, you are trying to say, listen, you missed your colonoscopy. We talked about this the last couple of times. You didn't keep your appointment. I want you to get this immunization. You are trying to do that in all one way.

Now that is part -- that is in and of itself a problem. But the challenge here is, well, how do these practices -- again, these are the practices that are struggling at the 50 percent of Medicare rate -- how do you do all of that. Because just the staff it costs to generate all of the care that they need is a money loser. But how do you do all of that at the same time and then be sustainable?

And you say, well, these are the rules that you have given us. You have given us this 25 modifier. You have given us that, that, this, that and the other thing. And, Cody, again, correct me if I am wrong. I know there was some information came out yesterday. But I think the thought today was you are going to try to provide the care visit that they came for. And for some of the MCOs, you can provide a 25 modifier and try

to say, well, this is what we are doing. We are telling you what we are doing. We are trying to be honorable partners. Again, this is a CCI initiative. We are trying to, at least in our practice, we try to be as honorable as we can.

Am I seeing this the right way, Cody? Or am I looking at it the wrong way?

MR. HUNT: No. You are right. And there has been a varied approach to this by the MCOs. They have kind of -- the ones we are aware of and heard about. Those situations, it's been a little bit different. I know Anthem did a policy change this year to make it 150 percent allowable of the bill code when there are 2 E & Ms in one visit. So we appreciate, you know, certainly appreciate that effort. We think that's a step forward in the right direction.

I don't know if any of the MCOs would be willing to share how they handle this currently. It might be helpful for you all.

DR. THORNBURY: I would welcome their insight. You guys can chime in. Again, I am sorry. The way my daughter has my screen set up, I can't see people raise their hand. And I am not smart enough to figure out how to move it around.

Can you all just kind of chime in for me?

MR. OWEN: I am just going to say this is Stuart with WellCare and I honestly don't know.

DR. THORNBURY: Well, it looks like, Stuart, that kind of what the administrative way around this is you bring them in for one thing. You say, well, you know what, we are not reimbursed for this other thing. We will bring you in for another time to talk about. We'll do your preventative medicine. But we are going to bring you in another time to talk about the diabetes.

And then what eventually would honestly happen was they wouldn't come back. Or they couldn't afford to get a ride down. Some of our people pay like 90 bucks to come to the doctor. That's all we have to -- we pay a lab. We pay a lab. We don't make money. We pay a lab to come in so the people have a place to go to the doctor and have a lab at the same time because they can't be transported.

So what would happen is, is they would come in once. But you could ask them to come back in again. Well, you put them on the schedule. They might think they could come. And I would say 70 percent or 80 percent wouldn't come. And the

problem there is, of course, now there is a hole in your schedule. And the practice becomes less fiscally stable because they are inefficient.

And then you say, well, we are going to try to capture under 2 charges and 2 different dates, you promote a system that is inefficient. Because you are not trying to -- you are not trying to exploit the MCO. You are just saying, well, this is the care we provided. We just can't provide it. We just can't do it all at once or provide it in one setting.

It just seems like that nobody really kind of gets what they want with that. It seems like the more you try to avoid it, the more problems it causes for the patient and the professional. And eventually down the road it causes trouble for the MCO when their diabetes kind of goes haywire.

That's the way I see it, Stuart.

MR. OWEN: I see the point.

DR. THORNBURY: Yes, sir.

MR. OWEN: But I think the truth is probably someplace in between, right? Like I alluded to the several millions of dollars, hundreds of thousands of dollars that the PCPs are leaving on the table. If you brought that kid in, did that

combo 10, you would get an extra 60 bucks.

Or you did the A1C and did the micro-optimum, you get another 80 bucks. You wouldn't have to bring that second time in. And so, you know, there are ways -- you know, business is a game, right? And so there are other ways I feel like that the providers could reduce the actual clinical burden and reach a higher revenue stream. But that requires the front office staff and the fiscal leadership of that practice to be savvy to what's written in those contracts.

And we often find that there is a huge gap in understanding what is actually written in those contracts. And what the physicians do is just churn and burn through patients and think that's the only way to get that end margin.

And I think that's a huge gap.

DR. THORNBURY: Well, I think you are probably -- I think it is extraordinarily good insight. It kind of reminds me of the analogy of like you have a child and you can have the candy if you can jump up to the shelf and get it. And, of course, it is on a shelf they can't jump up and get. And I think that is one of the challenges.

I wonder how our MCOs, our MCO partners,

could work with these practices to help educate them and say, listen, you are doing this. Can we help you understand the administrative part of this because we want better care for these patients?

And can you -- that would be my thinking. And I wonder how much we are missing in our practice because we just don't understand, you know. We are not contract experts. We are medical experts.

DR. PATEL: Here is something I ask all you guys on the call to do just a litmus test.

I would say these value-based contracts probably change between 5 and 15 percent every 2 years. Metrics change. Denominators change. Nuances change. Right? And so the way to get to the money changes is ask your person who is your contract person, hey, has our contract with such and such or any of the Medicaid MCOs for quantity changed in the last couple of years. And if they say, yeah, ask them what changes. See if you were notified.

If they say no, that means they are probably not well-informed with the language in the contracts or the amendments. And then that will

give you a litmus of where you are in terms of really earning the top dollar available in those said contracts.

DR. THORNBURY: Thank you.

MR. ELLIS: I'll chime in. This is Herb with Humana.

I will say that we do abide by the modified 25 so we follow CMS's guidelines. We also follow the standard NCCI PtoP guidelines as well, you know, the procedure to procedures as well.

If there is an interest and if Stuart is okay, I can take this back to the all MCO meetings that I hold on Fridays. Normally it is not today. But every other -- it is -- normally it is on Fridays. And we can bring this back up to the rest of the MCOs and see if there is an appetite to see if we can maybe possibly streamline the ability to utilize that modified 25 across all the MCOs. I mean I guess it doesn't hurt to ask.

DR. THORNBURY: I would like to just step aside from my presiding officer position and just say, as just a member of the TAC. In my work with Humana, they have been exceptionally good about this. Humana does provide a comp -- in my mind and I might be wrong here -- but they provide an

comprehensive preventative examination for our people. We see that they get in to do that. We actually make an effort to get in to do that. At the same time, we do work with their chronic diseases. And we set aside special time for that. It is not just this and that. But we do that. And it has worked out very well for those patients and they have been extremely pleased with that program.

So I would say a tip of the hat to you guys. At least in my private practice, we have seen a very good result and it seems to be working for us to the best of my knowledge. And I would thank you for the consideration.

MR. ELLIS: Sure.

You know, and if anything -- and I am not just saying this for Humana, I know it is true for all the MCOs -- but, you know, we absolutely are hyper-focused on preventative measures, right? We want our members to be preventative of whatever the issues are going on in their life. It is so much smarter to prevent something happening than to them go back and treat something that's now occurring because we didn't prevent it in the first place.

So -- you know, and Humana, if you look at everything -- and again I am not trying to single out just Humana -- but everything that we try to focus on is that preventative thing. And that's true for the member, right? They would rather get their flu shot as a preventative measure hopefully than having to suffer the consequences of getting treated for the symptoms. And so that's why, you know, we put that out there. That modified 25 to distinguish that this is a separate, you know, visit like a separate item that's being addressed with the member that should be documented in the medical records.

And then also in addition to the school sports physicals that we offer as well separate from the E & M visit.

DR. THORNBURY: Yes, sir.

Does anybody else have -- anybody else have anything, anybody else would like to add something here?

DR. GUPTA: This is Ashima Gupta.

I have a question about the value-based contracts. Do those only pertain to primary care or also to specialty practices?

DR. TEICHMAN: I guess I could chime in on

this. This is Jeb Teichman.

Our BPC contracts are primary care driven. The quality measures are primary care things like immunizations, well child visits, well adult visits, A1C, colonoscopies, mammograms. There are different goals for different -- for pediatrics and adult. But I -- the BPC programs we are talking about are primary care. There may be other programs for the specialists. But I haven't seen that yet.

DR. GUPTA: Okay. Just curious. Wanted to make sure we are not missing out on anything.

DR. BRUNER: This is Dr. Bruner, Anthem. It is primary care and also we have some for in the obstetrical world as well.

DR. GUPTA: Thank you.

MODERATOR: Angie Parker with Medicaid has her hand raised.

DR. THORNBURY: Yes, Angie.

MS. PARKER: Good morning.

I am Angie Parker. I am director of quality and population health with the department for medical services. And, Dr. Thornbury, I believe you worked with us a few years ago when we developed the quality strategy.

DR. THORNBURY: Yes, ma'am.

MS. PARKER: Yes. And so we do have that.

And I don't know if I have presented at this TAC regarding the value-based purchasing program that we have with the MCOs. And if we have not, I would be more than happy to share that with you all at a future meeting.

But we have do have 6 measures that they talked about earlier that the MCOs, and we keep 2 percent of their capitation rate back for them to make sure that they are targeting these specific measures. 3 of them are immunization, well child visits, and a diabetes control as well as social determinants of health.

And then they can also be eligible for a bonus pool. And I don't -- I can -- if they meet 4 of the 6 I believe, but I could be wrong. I have done this plenty of times. I should know all of this. Anyway, I would be happy to present that information to this TAC if you think it would be useful.

But I do know that some -- they are primarily primary care driven I would say. But there is some, because we are focusing primarily on chronic condition of diabetes and child care for those

measures.

DR. THORNBURY: Well, Angie, I do remember working with you. Yes, ma'am. And let me say up front that I want to appreciate all of the work you and your team did. That was a lot of work.

And, yes, ma'am, Cody, I would like to put this on for the next agenda. We can kind of tie this into the work that our Humana colleague is leading with their group to see, again, our goal here isn't to eke out more money for any group. What we want to do is we want to put the resources that we all have in the best position to help the most people.

And I think that, again, based on Starfield's medical home model, that in our health system we ask primary care to predominantly do these preventative services, not solely but the great majority of that is in primary care's hands. So that's why we are going to look in that direction.

But can we put this on the agenda, maybe kind of tie this together so that we can kind of see if we can begin to move the ball forward? I know we all want to try to accomplish the same goal here. And maybe we can find a way to thread that needle so that we can get some better insights on how

people are working.

Cody, can you see that we do that next time please?

MR. HUNT: Yeah. I will pen those 2.

DR. THORNBURY: Yeah. We'll put that up on the agenda firstly. Thank you, Angie, very much for chiming in there.

MS. PARKER: Quality is -- I can talk about quality all day long. So, I mean, if it comes down to net, you know that was brought up earlier, network adequacy and making sure that people are showing up for their appointments. So there is a lot of little different areas that are hard to target. But I would be more than happy to provide some additional information on that.

DR. THORNBURY: Does anybody else have their hand raised? Or does somebody else want to talk about this subject?

MR. ELLIS: I was just going to second what Angie had said, you know. It is definitely more tied to the primary. But there also are value-based stuff tied to the BH side. So she will have the more comprehensive information on all of that.

Again, this is Herb from Humana. And I will

take back that 25 modifier discussion back with the rest of the MCOs discuss on our Friday calls.

DR. THORNBURY: Herb, let us know how -- if you would like be -- again, if you would like to present -- again, that's a little bit of a challenge. That's a private group. And you all have your meeting. If you think it is appropriate, we would welcome you to be part of the agenda. If you don't think it's appropriate for any number of reasons, we would not -- certainly would not want to press that issue with you guys.

But, again, if we can move together, I would rather do this together to kind of solve this problem as opposed to be pulling against each other. But I would welcome that to try to find the best way to provide, again, preventative care for the long run. I think that is just the wisest dollar investment we have.

MR. ELLIS: Yeah. I mean you can put me down at least for a follow-up on the next TAC on this. But, you know, again, every MCO has their own opportunities to make their own decisions. And Humana can't force United or WellCare to do one thing. But we can at least talk about it.

DR. THORNBURY: If there is -- again, if there is a shared opinion that you all would like to present together, that would be great. If it is not, we will accept that for what it is.

Cody, can you make sure that you iron out the rough edges with Herb before we get there so that we have kind of -- the meeting runs the best way there? Would that be okay, sir?

MR. HUNT: Yeah. Sure. Absolutely.

DR. THORNBURY: Okay. Well, let's move this forward a little bit. And our other new item agenda with is some -- I have it on my agenda as recoupment. And generally speaking recoupment has become kind of a more substantial topic for us as well. I wanted to open it up to conversation.

I know, Dr. Gupta, in particular you wanted to address this matter.

Ashima, what's your thoughts here?

DR. GUPTA: So this is just mainly from personal experience this past year from -- mainly from one particular MCO that I have been receiving several letters requesting recoupment for patients who were eligible at the time of service. And when I, you know, spoke with my rep, I was told that -- that this was the decision. I guess

Kentucky Medicaid had made that change. And so, you know, I guess those patients went to Kentucky Medicaid for a brief period of time. And this is basically for me personally. It's newborns that I have seen in the NICU.

And so, you know, there is nothing that I can do about it. They just take the money back. And some these are from almost 2 years ago. And it is just so time consuming and so difficult for me to have to deal with that.

And I guess my main question is, I mean it is mainly from one MCO. And I am just wondering, like, is it just a ticking time bomb from the other MCOs? Or why is it just like one MCO having this issue with, you know? And Kentucky Medicaid is telling them that after a couple of months now that that baby is no longer part of that MCO for that period of time.

DR. THORNBURY: Ashima, let me understand this. I heard this come up a few times and maybe I am misunderstanding it. And, Cody, please help me if I -- to have my mind around this.

But is this one of those circumstances where the physician or the health group, the group that is providing care says, well, we checked. This

beneficiary is covered. And you get a confirmation. You provide the care.

And then somewhere down the road, one month, three months, six months, a year, they say, well, it turns out that we are going to deny coverage. And even though we told you they were covered, we want our money back. Is that right or am I misunderstanding that?

DR. GUPTA: Are you asking me?

DR. THORNBURY: Yeah, Ashima.

DR. GUPTA: Yeah. That's what it seems like. I mean, that's what -- because now when I go back to check eligibility during that time, yeah, now that MCO is not showing up as active. Another part of, you know, active with Kentucky Medicaid during those certain visits, like maybe the first visit was covered. And then, like, you know, I see these babies like every 2 weeks while they are in the NICU. And then they are no longer covered.

Now when I go back to check those visits, now it is a Kentucky Medicaid. And it is really just with this -- mainly with one particular MCO. So, I mean --

DR. THORNBURY: Okay. Cody, can you help us provide a little sunlight here?

MR. HUNT: You will see Justin has got his hand raised. He maybe can probably speak to it better than I can.

DR. THORNBURY: Hey, Justin. I cannot see anybody's hand raised. My wife and my daughter is killing me. Help me out here, brother.

MR. DEARINGER: No. You are fine.

So that's correct. We have -- the eligibility system is not perfect. And the eligibility is not my division. But any time that -- and unfortunately this happens when you have Medicaid eligibility system. Any time that you see an individual that is eligible for Medicaid on the day that you see them, you are going to get paid. Who that payment comes from may change.

And so, you know, again the reasoning I don't know exactly why the system determines why that eligibility changes for individuals. But unfortunately it does. We have worked on that issue. We have got, I think, a little better as far as time frame goes. You know, hopefully you don't see those long 6 month drawbacks. And hopefully it is more 2 to 3 month now. And I think we are still working on that process.

But some of the things that we have done to kind of mitigate those issues is that whatever the Medicaid coverage that it switches to, we have tried to stress to our MCO partners, and we do, of course, there at Kentucky Medicaid, too, we make sure that we look at everything for timely filing, any timely filing issues that come along with that when you refile that claim so that we can override that.

We always make sure we work with the provider on whatever those cases may be to make sure that they receive payment.

So, unfortunately, that is the case with Medicaid and some of the eligibility issues that an individual may show up just, for instance, say they show up, they have WellCare since Stuart spoke earlier. And then later WellCare recoups the money for that individual member. And so then when they go back on and look, it shows now that they have traditional fee for service Medicaid. So that they would have to rebill that fee for service Medicaid.

Our future system, what we are trying to do, is any time that recoupment takes place to be able to cause kind of a chain reaction where it

automatically reprocesses through whatever new system. That's going to be difficult to do but we are working on it. But, in the meantime, what we can do is offer any support and technical assistance that if you have that happen, to reach out to make sure that you all are paid. And, you know, you are never going to get recouped for that instance and then not get paid. Right. It is not like we are saying they are not eligible now, we are taking the money back. It has just got to come through a different source.

DR. THORNBURY: Ashima, does this help you at all? Or do you have a contact or a way to work with DMS to -- I am not talking about you per se. I know you as the example. But you represent a group of people that we want to address. And is that group, is there a way to work with DMS to understand that you can rebill that in a different way?

DR. GUPTA: Yeah. I mean -- so this is for a small private practice that I manage myself for just in-patient consults. So I do my own billing. And by doing this, I have learned a lot about insurances and things like that. So, like, for me, for example, now I have to put in so many more

hours to refile those claims. And, you know, if I was hiring someone to do that, it is just such a waste of money, you know, for me to have to pay someone. Now I need personally to get additional training which I have to pay for to learn how to do all of that.

So it is just so time consuming. And I wish there was just a better way that, you know, I take the time to check eligibility. And I just feel like that is just -- like this is a -- these are major companies. These mistakes should not be happening. And, you know, can that MCO just get their recoupment from Kentucky Medicaid instead of coming back to me? But I know that's not going to happen. But it is just -- it just needs to be more streamlined. You know, for me a small practice, we are not talking about like millions of dollars. But for other practices, you know, it is just so time consuming.

I am just venting. But, you know, I know that kind of --

MR. DEARINGER: No, I appreciate that, Dr. Gupta. But that is something, a concern that we have had. And we actually have multiple facets that we are looking at. The best way to do that,

whether it would be to have some kind of system where the MCOs reimburse, you know. And it becomes a little bit more of a problem when it is MCO to MCO rather than MCO to fee for service or fee for service to MCO. But we are working on that. We are attacking that in multiple heads. So we are looking at it through the system's perspective. And we are also looking at it through maybe agreement's perspective.

But I do appreciate the fact that you brought that up. We realize that. And it is an inefficiency in our system. And we are actively working to try to make that better and fix that.

DR. THORNBURY: Justin, I would say we appreciate that. That would be something you all could do that we could never accomplish. So I would say to those guys who are a part of your team, I would say thank you a lot.

Let's turn around here. There is a subset of this recoupment in behavioral health. Cody, could you help us, you and Dr. Lydon, help us with this, understand this query?

MR. HUNT: Yeah. It is not something that you have to spend a great deal of time on. Just wanted to mention regarding behavioral health.

The consumer advocacy TAC chair, Dr. Schuster, had asked the physicians TAC to poll physicians on Medicaid audits happening in behavior health. And so we went through KMA and reached out to a number of psychiatrists.

The feedback was varied. Some were aware of audits that had been happening. Some had experienced audits with their practice. Others hadn't. But for the ones that had, they said there had been an uptick in audits. They cited that there had been an increase in the number of records requested. And the records requested had been more extensive, sometimes going back to up to a year.

And one group in particular said they were having issues specifically with labs. The audits were looking for documentation of medical necessity and seeking to ensure that each lab has some effect on medical decision-making. And that's by and large the extent to which psychiatrists told me that they were experiencing an uptick in audits. And, again, that's in response to the conversation that the MAC had at their previous meeting where Dr. Schuster asked various members to poll some of their groups.

DR. THORNBURY: Well, firstly, thank Dr. Schuster for pitching this our way, send him our compliments. And please let him know that we brought this forward to address.

Eric, can you give us some insight into this, please?

DR. LYDON: No. Well, I checked with my office staff. We don't have any -- we may have had some audits but nothing that we have noticed. Some the people I work with, I haven't -- I didn't -- haven't had a chance to check with. So I don't have any new insight to it.

I know we do get pushback from time to time on labs and, you know, labs being ordered and labs calling us and going, hey, there is no medical necessity for this. And I have got somebody with bipolar disorder that I have on Lithium. And they question why I am getting a BMP and a Lithium level. Say, well you got to check levels make sure I am not killing their kidneys. It is routine standard practice of care and they are saying the labs are being -- no medical necessity. And it is like, then who do you fight? Do I go back to the person at LabCorp or Quest? I mean it is just labs, justifying labs can be difficult.

That's where I run into some problems.

DR. THORNBURY: Well, on the face of it, not knowing any more than I know, there is a couple of ways my mind wants to break this argument down.

First, I think we alluded to it early in our conversation together where you have what I would call the healthcare profession, particularly your physicians, your psychiatrists, with their training, their experience, they have one way to look at the world.

Then you have these people that are kind of physician extenders that are -- they look at the world sometimes a little differently and their experience is not as robust. I can see that being an issue.

Another one that concerns me is I don't know how many of our colleagues know about, here in the last few months there has been a move forward to move some of these Alzheimer's type dementia labs. I have an idea that these are very expensive. And my concern is, you know, are they being used adequately. For example, you can -- if you pay for these labs to see, well, does somebody have Alzheimer's based on some report, is it really necessary to get, you know, do we need that or can

we make the diagnosis? Is it going to --

I only order labs when it is going to change what I am doing or if it is part of the monitoring system that we can generally agree on. It's something we need to monitor like a Lithium and some renal function studies.

So when I break it down, that's the kind of thing that I am looking at. Darryl, do you have some thoughts here?

MODERATOR: Dr. Thornbury, someone has their hand raised.

DR. THORNBURY: Yeah. I noticed Dr. VanCleave. Sorry about that.

DR. PATEL: Yeah. You know, in the spirit of, you know, we all want the same thing in transparency and trying to get to the right place. Yeah. I would say that BH audits are probably up. I am not saying that we are doing it. But I do know that they are up. And why are they up? Because as Stuart has alluded to in multiple TAC meetings over the last several, feels like years but it is probably months, that there is a cottage industry of advanced practitioners and non-clinical folks just driving up utilization.

And so for us to make sure that, you know,

the people who we are stewards for are getting the right care at the right cost, we are doing audits. We meaning the collective we of MCOs across the country and the universe.

DR. THORNBURY: Yeah. I understand that.

Cody, do you have any thoughts on this or do you have any more information for us?

MR. HUNT: No, that was all I had on that.

DR. THORNBURY: Yeah. Well, I certainly see their perspective and I think this is one of those things that -- well, you know, it is not -- I can't live in the world that I wish I could live in. I live in the world that I live in. So I think when we saw some of these physician extenders becoming independent I think if you work in an ER, if you work like in a hospital-based system where you see people come in for admission. If you work I am sure for the MCOs and you see quality of care, there are just discrepancies there. And I don't want to push that button too hard.

So I certainly see their point of view on it. I don't think that auditing people as, you know, for negative reinforcement is the right thing to do. I think, you know, we are trying to get to a

shared position where we are trying to promote appropriate testing and monitoring for appropriate conditions as a way to remove those 3 percent of people that aren't doing the things that they should be doing or to help educate people that need better education. I understand that. It is hard to push back on that and I don't think I would want to.

Does anybody have anything else on the subject?

MR. HUNT: I would just add from our KMA perspective, I don't know that we have had any direct outreach, at least as regarding issues in this space is more or so. Because I polled those groups that I heard about.

But certainly would need to listen. If we do get any more feedback, we can circle back on in.

DR. THORNBURY: Okay. We have a little time. I try to get us out a little early. I can't always be successful with that. But in respect of everybody's time, we have a little time for open discussion.

Is there a concern that should be brought forward today or something that we can look into and add to our agenda the next time we meet? I

would open the floor for all of our MCO partners, for DMS, or any of my colleagues here.

Okay. Well, I don't think we have any recommendations today. We have -- Cody or Kelly, do you know about when the next meeting would be kind of penciled in for the end of the year?

MODERATOR: I don't believe there is another meeting scheduled for the end of the year. We are currently working on scheduling all 17 TAC meetings and the MAC meeting for the year 2025. We hope to have those out by the end of the month. We do appreciate your patience. As you can imagine, that does take some time to get worked out with our zoom account. But we are working on that and we will get that out as soon as we can.

DR. THORNBURY: Well, Kelly, I don't envy you the headache that you have. Again, with our to partners and our colleagues, I try to only bring meetings together when we have something to work on together. We don't have meetings just to have meetings.

I would be extremely complimentary of all of the members here today. I thought this is best meeting we have had. I think it is the best meeting we have had in a couple of years. And,

again, it's a better tone to work together. And that's -- it is -- I have a 2 year old child that can knock down blocks. It is very hard to build the energy to sustain a project or an initiative to work together to solve problems which is what I think what we all want to do here. And that's the intention of the committee so long as I am on the committee and the presiding officer.

Thank you everybody for being here today. Dr. Theriot, it is great to talk to you as always. If there is no other business, I would adjourn the meeting.

Thank you everybody and we will see you next year.

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 PHYSICIAN SERVICES TECHNICAL ADVISORY COMMITTEE, 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 15th day of November, 2024.

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

My Commission Expires: 7/15/2027