DEPARTMENT FOR MEDICAID SERVICES
THERAPY
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
May 3, 2022
Commencing at 8:33 a.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Beth Ennis, Chair

Linda Derossett (not present)

Kresta Wilson

Dale Lynn

Emily Sacca

Renea Sagaser

DR. ENNIS: All right. I'm going to give folks another minute or two.

(Discussion off the record.)

DR. ENNIS: So Renea should be on shortly, so I'll hold off on the minutes until we see if Renea or Dale or Linda are able to join us, but if we can start going through some of the old business.

Did we find out if the 92606 could be added to the schedule for speech?

MS. GUICE: Did I see Kelly Kitchen on this call?

MS. KITCHEN: Yeah. Sorry about that. I believe we're still looking into that. I have done some research and sent to Eddie, I believe. So as soon as we get some more information, we'll definitely get back to you.

DR. ENNIS: That's fine. And please let us know if there's anything that we can send information-wise.

MS. KITCHEN: Yes. Thank you.

DR. ENNIS: Okay. I wanted to --

MS. GUICE: Thank you.

DR. ENNIS: I'm sorry.

MS. GUICE: I'm done. I was just saying thanks to Kelly.

DR. ENNIS: Okay. Thanks, Lee. It's the one -- I love not having to drive to Frankfort. But I step on people on these meetings all the time, so I apologize.

Following up on the WellCare speech eval and treat on the same day. I know I got an email saying that that is their policy. Is there any potential to change that policy to align it with OT and PT?

MR. MINGUS: This is Jay with WellCare. I sent that over to our UM supervisor for further review. I've not heard back anything yet.

DR. ENNIS: Okay. So we will leave those two things on for our next meeting. And just as a follow-up to our question about prior auth being required, UnitedHealthcare does require prior auth for those first 20 visits. So we can add that to the yes prior auth column from the last meeting.

Okay. So some new business. I'm sorry. Was there a question? Hi, Renea. We have a quorum. Yay.

So I'm going to bounce back up and ask my TAC members if there are any changes to the March minutes that were sent out probably a week and a half after that meeting.

MS. BICKERS: And if you can turn your camera on when you vote, I'd appreciate it.

DR. ENNIS: Our cameras are all on, so Kresta, Renea, Emily, and myself.

MS. BICKERS: Thank you, Beth.

DR. ENNIS: Yep. Absolutely. Any changes to the March minutes?

(No response.)

DR. ENNIS: Okay. Then we will approve those and have those posted.

All right. Back down to new business. I'm actually going to add several things to No. 1 because UHC sent some policies over with some updates. And going through what's a combined old policy/new policy, there's several challenges that we're seeing.

The first one is the one listed here. The peer to peer that United is requiring is with the referring doc rather than the therapist. So when the therapist is

requesting additional visits, they're going to a person who really doesn't know anything about why.

And so we'd like to get either some more information as to why that policy is that way or potentially request that they change it to a peer to peer with the therapist.

DR. CANTOR: Good morning. This is Dr. Cantor with UnitedHealthcare. I apologize --

DR. ENNIS: Good morning, Dr. Cantor.

DR. CANTOR: Morning. I apologize. I'm on my phone, so it might look a little wonky.

DR. ENNIS: It's all good.

DR. CANTOR: Okay. The -- in my many years of doing utilization management, not just with UnitedHealthcare but with other competitors -- other health plans, sorry, the peer-to-peer call has -- in my experience, has always been with medical doctor -- M.D. to M.D.

And that's for -- so as an obstetrician, I would be talking to a neurosurgeon or vice

versa. And the expectation is the physician, the referring physician, understands well enough of what is being requested that the medical director from the health plan is able to have a greater understanding of the request at hand.

And I'm happy to take this back to our leadership and talk to them about it further, but I'm a little bit surprised. Having worked at other health plans, that it's always been -- even for therapies, it's always been a doctor to a doctor.

DR. ENNIS: And I will suggest -- I appreciate that, Dr. Cantor, but I will suggest that that has changed over the last five or six years. And many plans are doing therapist-to-therapist peer review for therapist requests.

DR. CANTOR: Okay.

DR. ENNIS: And in some cases, they're even doing like peer. So if it's a pediatric therapy request, it's with a pediatric therapist.

DR. CANTOR: So that's currently within the other MCOs, they are doing that?

They're doing therapist to therapist here in Kentucky?

DR. ENNIS: There are some. There are also commercial providers that are doing that.

DR. CANTOR: Okay.

DR. ENNIS: So we would request that that be the case, especially because outside of the Medicaid/Medicare world, we have direct access. We don't have to have it referred to us from a physician. So it's usually our plan of care that we are justifying and providing evidence for additional visits on.

And for us to have to relay that to the M.D. to then relay that to another MD, it becomes this giant game of telephone --

DR. CANTOR: Oh, sure. I get --

DR. ENNIS: -- where things get lost in the shuffle. So it would be more efficient, and we believe more appropriate, for those peers to peers to happen with therapists.

DR. CANTOR: So just to be clear, so DMS is asking us to do this, or is this

the TAC that's asking us to do this?

DR. ENNIS: This is a TAC request. I can't speak for DMS.

DR. CANTOR: Okay. All right. I will take the request up further and work with that. Thank you.

DR. ENNIS: And, Dr. Cantor, I'm also going to just let you know that I think this is going to come down from national as well because this isn't just a Kentucky policy with United.

And so our national folks from our organizations are also trying to address this at the top levels of UnitedHealthcare, so this may not be the only time you hear about it from the therapy groups.

MS. MARSHALL: And can I add something? This is Pam Marshall, Dr. Cantor. Another thing, I think, that impacts the Kentucky members is the, you know -- I think our pediatricians have high volumes of children that they're serving, and that factors into this.

It's very -- we hear from pediatricians that, you know, it's very taxing on their

time when they're managing primary care and much higher-level things to try to stop and have a peer to peer on a therapy when it's -- you know, it shouldn't be that difficult for access to care.

DR. CANTOR: I hear you. I truly do understand the limitations that come and then when you get out of your expertise and the time management. I certainly do.

I appreciate that. I will take this away, and I'll be working on it and hopefully have something by the next TAC, if that timeline works for you all.

DR. ENNIS: I appreciate any feedback that we can get. Thank you so much. And just to tag on before we get to the next bullet point, because there's several things in the UHC policy that we'd love some clarification on.

One is when you look at the list of allowables -- so what defines habilitative services -- it looks like they just cut and paste from the rehabilitative. And I will say for me personally reading that, seeing that habilitative services have to have a

disabling condition is a little distressing to me.

And I don't know if that's just meaning something that's causing a delay or something that would be classified as a disability. Because not all of our kids that need -- have services have a specific what you would consider disabling condition. Does that make sense?

DR. CANTOR: Honestly, no. That's starting to sound really out of my wheelhouse.

DR. ENNIS: That's okay.

DR. CANTOR: So I'm not -- I was going to ask for some more clarification on the codes, the actual codes that are being questioned or concerning in your mind. If there's some way to -- maybe via email, if you can help with that, that -- that would help.

DR. ENNIS: Absolutely. Absolutely I can do that. And then the other pieces that are in there that we'd just like some clarification on relate to that referring physician relationship. We understand that

they want the plan of care signed by the M.D. and that they want the progress note signed by the M.D.

Is there a time frame in policy within which that has to happen?

DR. CANTOR: I thought we were giving 30 days.

DR. ENNIS: Is that what my therapists are hearing?

MS. MARSHALL: I -- this is Pam Marshall again. We have tried to look that up in writing. It's nowhere that we can find in writing, so clarification on that would be helpful. Because, again, the pediatrician offices are swamped and, to be frank, they're pretty annoyed that they have to do that.

DR. CANTOR: Well, I thought we did this last summer, and my -- so that's why my memory is a little foggy but --

DR. ENNIS: I think what we were talking about last summer was date of service billing and documentation.

DR. CANTOR: No. It was the first eval could be done without a referring M.D. and then that would give the -- there would

be no barriers, no hiccups to get the patient to the therapist. That eval could be done. Then the plan of care would be given to the referring M.D. for the referring M.D. to be able to sign off on, and I thought that was 30 days. I thought that's what we did last summer, but I --

DR. ENNIS: Well, and then in the new policy that they just sent out, it says that the M.D. or PA must have an office visit prior to the referral, prior to the patient being seen.

DR. CANTOR: Really?

DR. ENNIS: I'll forward you the policy that was forwarded to me --

DR. CANTOR: Okay. Thank you.

DR. ENNIS: -- just so that you know what we were looking at to help with our questions and concerns. I think a final one in there that I'll just throw out, just because we're, you know, throwing it all at the wall right now, is that there's a requirement for a start and stop time for each CPT code which is phenomenally burdensome.

DR. CANTOR: Really?

DR. ENNIS: Yes. It's listed in the policy.

DR. CANTOR: Okay. Yeah. That is -- there's some new information there for me.

DR. ENNIS: So, Dr. Cantor, if you wouldn't mind, could you put your email in the chat box? And that way, I can forward the policy to you that I received.

DR. CANTOR: Yes. Happy to.

DR. ENNIS: That would be wonderful. Thank you.

DR. THERIOT: I know this is burdensome for the therapists, but it's also burdensome for the pediatricians.

DR. ENNIS: Absolutely.

DR. THERIOT: And pediatricians sometimes -- this is going to sound horrible -- refuse to sign off on the plan of cares because they say I'm not a therapist. How do I know? I don't know what these things mean.

And so you either have people just signing everything because you're supposed to

and it goes off. Or they, you know, are curmudgeons, and they don't want to sign anything. And then the kid doesn't get care. So I don't know -- I don't know -- I don't know so...

DR. ENNIS: Thank you, Dr. Theriot. I appreciate that that's coming from you. Because when it comes from us, it sounds like griping, but it's the reality.

DR. THERIOT: And we got a lot -- we have a lot of kids in our clinic that go to therapies, and so it's a lot of things to sign. And maybe the curmudgeons are just tired at the end of the day. I don't know. But the people that aren't curmudgeons end up getting the things for the curmudgeons to sign so...

DR. CANTOR: Dr. Theriot, do you -- what would be your best-case scenario for -- I don't mean to put you on the spot for it, but just as we're talking, do you think that not having any oversight by the pediatrician is -- without those signatures, that's really what that means. Do you think that that's the best-case scenario?

DR. THERIOT: I do. Because the pediatricians aren't trained to -- I mean, they hopefully will pick up a delay, but they're not trained in, you know, speech pathology or physical therapy or anything. So they just want -- they know the kid is delayed, and they want him to get services. And they want to make sure they're getting services, but signing off a plan of care, they don't --

DR. CANTOR: Yeah.

DR. ENNIS: And I will say, Dr. Cantor, just to jump in, it doesn't mean that they wouldn't get follow-up reports. I know with every child I see, any progress note, reassessment goes to the referring pediatrician as long as the family has signed off on that.

So it's not like they wouldn't get updates on what's going on, you know, for their purposes and to integrate into their records. But it's -- it's a huge burden for everybody to have to do this constant back and forth.

DR. CANTOR: Sure. Sure. I get

that, so taking that away as well. Thank you.

MS. SACCA: Beth, this is Emily. We also need to just remind everyone this is also happening in the adult population as well. And so from a standpoint of even our orthopedic surgeons who will come and say: Why am I signing off on a plan of care? I sent them to you because you guys are the experts in mobility and function.

So we want to make sure that we are progressing them according to what you are -- you know, they are very in line with what we do from an orthopedic perspective, but they know the value of our services. So it's happening kind of in -- in all realms.

DR. ENNIS: It is a lifespan issue. Absolutely. Thank you, Emily.

Okay. So the other item that is under new business is kind of a question for the Cabinet. You know, we get NCCI edits almost constantly. I don't know what the rhyme or reason is for when they make these edit changes. They say quarterly. It seems like it's more than quarterly to me.

And practices are doing the best they can with all of their billers to keep up with those edits, but they don't always get loaded into the MCO systems or into the Medicaid system quickly enough to accept those changes when they're billed. And then providers are having to re-bill because they're getting claims denied.

Is there any timeline for this? Is there any changes need to be put into the system within this amount of time kind of situation so that practices can know, okay, maybe I don't even try to bill these edits until we know they're in the system? I mean, I don't know the best way to handle this.

MS. MARSHALL: Beth, it's Pam Marshall. I just wanted to add something to you to give perspective, is all of the EMR systems that therapists use, most of them have automatic updates according to CMS.

So, like, for example, when the NCCI edits come out April 1st, they're automatically applying those edits to the claims. So then we -- our claims are going out correctly according to CMS. However, we

get them all back unpaid because, like Beth said, they're not updating their systems.

And then our fear is we go back and -- you know, they're telling us we can't process it like that. It has to have a 59 on it or whatever. If we go back and make that correction, it's technically out of compliance, and we won't know when they're editing, when they're updating their system to apply the new edits.

So then we're going to have another round of unprocessed claims that have to be corrected. So there has to be some kind of clear understanding so we understand when are they required to make that update.

DR. ENNIS: Any thoughts from the Cabinet? I know it's a loaded question to throw at you at 8:30 in the morning but...

MS. GUICE: This is Lee Guice. I'm not entirely sure -- I'm not entirely sure what the requirements are for loading NCII edits -- NCCI. Sorry. There's the loaded part. I'm not entirely sure what the requirements are for loading.

I know that we get the updates, and

they're loaded for us quarterly. I don't know if anybody is having any problems with their fee-for-service NCCI edits. But we'll have to do a little bit of research to find out about requirements; okay?

DR. ENNIS: I appreciate that.

MS. GUICE: And I would ask the other MCOs to perhaps be ready to talk about -- find out and talk about when -- what their process is for loading these edits. And so maybe if we just -- everybody knows what the process is, then we can figure out some way to abide correctly by it.

DR. ENNIS: Sounds great. Thank you.

Okay. I'm going to throw it out there now for any other concerns from my TAC members.

MS. SACCA: Beth, it's Emily. I had -- I feel like I'm picking on UHC today, but I promise I'm not. We actually had a member reach out saying that they had an interface issue with a prior auth, and they went to do an old-school fax for authorization and was told, due to their reps

predominantly working from home now, they are no longer accepting faxes for authorization.

So the question became: When interfaces are down, how do they handle those? And the response was wait for a rep that could take up to 48 hours so -- to call. So if they do a prior authorization on a Thursday, it may not be back from a business perspective till Monday and then you're trying to determine whether or not you need to delay care for the patient.

So just trying to get an idea of that time frame or interface issues and faxes being a -- you know, a possibility, even electronic fax support versus old-school system -- centralized system faxing. But that was something that was brought up to me here this past week.

DR. ENNIS: And I know that that is a national issue as well. I will say for UnitedHealthcare's benefit, it's not just a UnitedHealthcare issue. A lot of the payers are eliminating that paper fax piece, but I would like to see a backup of some kind.

Dr. Cantor, I saw you un-muted.

DR. CANTOR: Yes. Yes. It would be helpful if I could get some details around that because that really helps me push the thinking on that, to know the scenario, what happened.

MS. SACCA: I'm happy to give a -- they've got a call reference number and everything else, so I'll send that your direction.

DR. CANTOR: Fabulous. Thank you.

MS. SACCA: No problem.

DR. ENNIS: Other issues from the TAC?

MS. MARSHALL: Beth, it's Pam Marshall again. I just -- I have one to bring up to see how we're going to approach this. Is there anybody from Anthem or Blue Cross Blue Shield on?

DR. ENNIS: I've lost track of my list.

MS. OWENS: Hi. This is Holly with Anthem.

DR. ENNIS: Great, Holly. Welcome.

MS. MARSHALL: Hi, Holly.

MS. OWENS: Hello.

MS. MARSHALL: Hi. I just want to bring up something that's been recently happening. And so far, we're seeing it on the commercial side, not Medicaid yet, but I don't -- I don't know if that's coming. I don't know what the plan is.

But the -- what we're seeing is a random application of all the F series ICD-10 codes. So anything -- you know, F80, F80.2, you know, whatever we use in the F series which tends to be all developmental. That's anything a speech language pathologist would be treating such as receptive language, phonological disorder, anything in a developmental -- when there's an undiagnosed young child, that would fall likely in an F series code.

And it appears that one of your lawyers has found a loophole with CMS, and the F series are classified as mental health codes. And they're then saying, well, we have to apply the claims to mental health benefits even though an SLP or an OT or a PT is not a mental health provider. And then you're applying the entire claim to the deductible

according to the mental health benefit.

So I think it would be wise for the therapy TAC to discuss -- and we have brought it up the chain to our national organization to address it there. Because it does feel like an unfair application of benefits.

DR. ENNIS: And I don't think we've seen it on the Medicaid side, Pam.

MS. GUICE: And I don't think that you will because we don't have deductibles on the Medicaid side of things.

DR. ENNIS: I think the bigger concern, Lee, would be: Would it come out of the mental health visit benefit versus the therapy visit benefit if that was applied? And my understanding is that this all started with a lot of the parity laws that happened related to mental health, which is a great thing. I'm all for it. But it's added some confusion.

So I think, Pam, it's on the radar. We'll keep an eye if we see it in the Medicaid side. We can push from here. But I think it is on the radar nationally. Because I've heard it on our national payer meetings.

So I know at least PT and OT are addressing it from that perspective. Renea, I haven't heard from ASHA.

MS. SAGASER: I actually haven't heard either, so I'll check in with them this week.

DR. ENNIS: Okay. But I think, you know, when you look at the coding manual, it's mental, behavioral, and neurodevelopmental, is the heading for those F01 to F99 codes. So I think, you know, the neurodevelopmental piece is separate from the mental piece, so I think there's wiggle room there to have them figure it out.

MS. OWENS: Yeah. And, again, this is Holly with Anthem. And I'm not aware of that happening at all for the Medicaid side. You can certainly -- I'm going to send an email to our regulatory team to look into it, too. But I also work with the utilization management team, and I am not aware of that happening for Medicaid.

DR. ENNIS: Perfect. And we also appreciate that you're not making us use AIM, extremely appreciative. I will send flowers.

Any other concerns from TAC members, Kresta? Renea?

(No response.)

DR. ENNIS: Okay. Anything else from community members?

(No response.)

DR. ENNIS: And fair is fair. Anything from MCOs?

DR. JAMES: Yes. This is Dr. Tom James with Passport.

DR. ENNIS: Hi, Dr. James. How are you?

DR. JAMES: Okay. After last month's meeting, I sent in a sample of a form for being able to have a consistent process for reporting patients' progress and what the goals are. I don't know whether anybody else has received that or what -- where the status is. But having something where you're not having to send in 80, 90 pages of therapy notes and can have a way that crystallizes what the goals of treatment are with how to --

DR. ENNIS: That would be wonderful. I have not received it. Do you

know where it was sent?

DR. JAMES: It was sent -- let me see. Last month, there was one individual who asked for it and then it was also sent to Angie Parker. But if there's somebody else that we need to get it sent to, then -- that's why I asked the question because I know that sometimes pieces of paper do get lost.

DR. ENNIS: Absolutely. I am going to put my email in the chat.

MS. BICKERS: If you want to email it to me, I can send it out to the group as a whole if you'd like.

DR. ENNIS: That would be great.

DR. JAMES: Okay.

MS. BICKERS: And I will drop my email in the chat box as well.

MS. SAGASER: So to clarify a question, because a lot of us do a lot of Passport. Is this a new form that we're going to have to do on top of our progress notes, re-evals, daily notes? Like, are you asking us to type up --

DR. JAMES: No. I'm asking -- it's

more a case of being able to reduce some of the paperwork --

MS. SAGASER: Okay.

DR. JAMES: -- that comes through by having a simple form that can say, look, we're making progress here. This is a child. This is an adult who has specific needs. Here's our goals. Here's how we're progressing towards those.

None of us want to pay for futile care, and there's times when maintenance care is absolutely appropriate. But there's limited resources that you all have, and there's a lot of people in Kentucky who need your support. So trying to have a form that will help all of us make things simpler is what the goal is.

MS. SAGASER: This is --

MR. JAMES: We've had it on our Web page for a year, but nobody finds things on Web pages.

MS. PARKER: This is Angie with DMS. Just to clarify, the document that Passport wants to use would have to be submitted via a certain way to DMS for review

and approval. So I don't know whether or not that's happened.

DR. JAMES: It happened last year, Angie.

MS. PARKER: It's been reviewed and approved by DMS?

DR. JAMES: Yes. I shall verify it, but that's what I was told by Ann.

MS. PARKER: Okay. So the MCOs should be able to -- if it's been approved, the MCOs should be able to distribute that to your providers. But you can certainly send it to Erin as well, and she can get it out to the TAC. But we have to make sure that there has been DMS approval on the form.

DR. JAMES: Yep. And I shall double-check on that because -- rather than just relying on what I was told.

MS. PARKER: Okay. Thanks.

DR. JAMES: I've learned from you.

MS. SAGASER: Yeah. So just to clarify -- because a lot of use EMRs. Is this something that we'll be able -- like, will we have to build this form in our EMRs to send out, or is this something where we're

getting it out of our EMRs and typing out and then sending back? Just because I haven't seen --

DR. JAMES: Think in terms of a very simple summary.

DR. ENNIS: So would this, Dr. James, be in the portal for the request for additional visits?

DR. JAMES: Yeah.

DR. ENNIS: Okay. We are happy to take a look at it, and we appreciate that. Thank you.

DR. JAMES: And you may make suggestions that we then may take back through getting DMS approval but something that we can make collectively --

DR. ENNIS: Absolutely.

DR. JAMES: -- a simple way to report and a simple way to get -- a more timely way to get responses back.

DR. ENNIS: We appreciate that.

MS. MARSHALL: Hey, Beth. It's Pam Marshall. I just want to comment. Like Renea said, you know, most of us have EMR systems. And to make it less of an

administrative burden, we definitely need things that pull directly from documentation.

So, like, you know, a therapist, just like a doctor, doesn't have time to repeat information on a different form neither do our therapy staff have that kind of time to do that; that if, whatever form it is, that an administrator has to pull that information from their documentation.

Like, we find it easier just to send the documentation than to have to fill out or create another document because it's outside of the normal flow of documentation. So that's just my recommendation.

DR. ENNIS: Absolutely. And we'll take a look at it, Pam. I think one of the things that we've run into is that when we are sending our documentation in, we know where everything is. Very few other people do. And so that tends to slow down the system, require these peer to peers, all of those kinds of things.

So if we can find a way to make something, you know, within that same portal that you have to go into to put that

information in that gives them the high points, then I think it will be less work for everybody in the long term, and that's why we'll take a look at it and see.

DR. JAMES: That's the goal. Thank you.

DR. ENNIS: Absolutely. Thank you, Dr. James. Anything else from MCOs?

(No response.)

DR. ENNIS: Okay. I will be attending the MAC meeting at the end of the month. I'm sorry. Was there someone?

MS. BICKERS: Beth, I have an item really quick if you don't mind.

DR. ENNIS: Please. Go ahead. Yes.

MS. BICKERS: Your next meeting is July 12th.

DR. ENNIS: Yes.

MS. BICKERS: So we have gotten our equipment. I've learned how to use it. So I didn't know if you guys wanted to vote today on returning in person, but we will also still be offering the Zoom link. I know some people travel and don't want to do that.

So the one thing I have discovered about the equipment is the way that it focuses. We're going to have most people at one end of the table. So your TAC is a little bit smaller with six members, so it would be a little bit easier versus some of the ones that have 12 members.

So we may have to -- you know, if we find that we have too many people to cram on camera, we may have to do some resituating and have some people log on virtually. But we wanted to go ahead and start offering the option to come back in person as the TACs prefer.

DR. ENNIS: And, Erin, I'll give you some history. I think -- oh, gosh. When did we start this TAC? 2014? 2013? And we have -- because I'm a tech geek and a little obnoxious, we have always had a virtual option as a component of our meetings. It was just, because of the regulations, I would drive to Frankfort to be present, and everybody else would remote in because we're all over the state. And DMS is all over the place, and the MCOs are all over the place.

And so honestly, when the pandemic forced this, I personally was thrilled because I didn't have to drive to Frankfort.

I am going to throw out there that July will be my last meeting, and so APTA Kentucky will be working to send another name in. I am pursuing other opportunities. I'll go that way for now.

But I will -- I will be stepping down both from the chair role and from the TAC after the July meeting. So we'll -- we'll have to get a new chair voted in at that point, but I'll throw it out now.

What do you guys think as far as in person versus staying virtual?

Thank you, Dr. Theriot. I appreciate the sad face.

MS. WILSON: I vote virtual.

MS. SAGASER: I can do either. I'm pretty close to Frankfort.

MS. SACCA: I can do either.

MS. SAGASER: I like the option of staying virtual if I'm traveling, though, or in another area, so it is nice to have that option.

DR. ENNIS: I think as long as the regs will allow us, I think we would love to stay virtual. I know Linda is in Pikeville, and Dale is in Owensboro, and the rest of us are scattered around the middle of the state. And I don't know who my replacement will be and where they will be from.

MS. BICKERS: As far as I know, remaining virtual is still an option.

DR. ENNIS: Okay.

MS. BICKERS: So until I hear otherwise, we can continue with virtual meetings and then if, at some point --

DR. ENNIS: It's not that we don't want to see you, Erin.

MS. BICKERS: -- everybody has to come back -- no one wants to sit with me in a room. I see.

DR. ENNIS: No. There are things I miss about driving to Frankfort, but 64 in the morning is not one of them.

MS. BICKERS: I could only imagine. So virtual is fine with me. I will make note if that's okay with you guys, and we will just keep on rolling that way until we're

told we can't do that anymore.

DR. ENNIS: Sounds good. Am I correct that we have no items to push over to --

MR. LYNN: Hey, Beth. I'm on now.

DR. ENNIS: Oh, hey, Dale.

MR. LYNN: I apologize.

DR. ENNIS: Welcome to the end of the meeting.

MR. LYNN: I actually overslept.

DR. ENNIS: It's okay. I heard you were partying at a conference recently.

MR. LYNN: Yes.

DR. ENNIS: So we basically just decided we're going to try and stay virtual as long as we can.

MR. LYNN: Okay.

DR. ENNIS: Are you in agreement with that?

MR. LYNN: Either way is fine with me.

DR. ENNIS: Okay. And am I correct in assuming we don't have anything to push -- I'll report to the MAC about our meeting, but I don't think we have any items to push to

the MAC right now.

MR. LYNN: Nothing that I know of.

DR. ENNIS: Okay. Then we will rejourn (phonetic) here back -- that's the wrong word, but I haven't finished my coffee. We'll meet up here again on the 12th of July and go from there. We appreciate everyone's time this morning. Thank you so much. Thank you, Erin.

MS. BICKERS: Take care, everybody. Have a great day.

MS. GUICE: Have a good day, everyone.

(Meeting adjourned at 9:10 a.m.)

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C E R T I F I C A T E

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

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

Dated this 5th day of May, 2022.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR