

COMMONWEALTH OF KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES

IN RE: OPTOMETRIC CARE TECHNICAL ADVISORY COMMITTEE  
MEETING

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January 17, 2019  
1:00 P.M.  
CHR Building  
DMS Commissioner's Conference Room  
275 East Main Street  
Frankfort, Kentucky

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**APPEARANCES**

Matthew Burchett  
CHAIR

James Sawyer  
Steve Compton  
Gary Upchurch  
TAC MEMBER PRESENT

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**CAPITAL CITY COURT REPORTING**

TERRI H. PELOSI, COURT REPORTER  
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FRANKFORT, KENTUCKY 40601  
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APPEARANCES  
(Continued)

Carol Steckel  
Stephanie Bates  
Sharley Hughes  
MEDICAID SERVICES

Jean O'Brien  
ANTHEM

Thomas Brown  
HUMANA-CARESOURCE

Jennifer Largen  
AETNA BETTER HEALTH

Stuart Owen  
WELLCARE

Amy Sinthavong  
PASSPORT

Nicole Allen  
Dan Levy  
Lee Ann Ellis  
AVESIS

Ronnie Smith  
Cyndal Frame  
EYEQUEST

Howard H. Levin  
David Dunbar  
SUPERIOR EYE

Sarah Unger  
KENTUCKY OPTOMETRIC  
ASSOCIATION

## AGENDA

Call to Order/Introductions

Approval of November TAC Minutes

### Avesis:

- \* Aetna Adult Glasses Update - Korrekt Optical issue with dispensing glasses. Resolution?
- \* Korrekt Optical issue when faxing in adult glass orders - Discussion
- \* Medically necessary tint discussion
- \* Medicaid as secondazry payor denials - followup discussion
- \* Post review claims are taking four to five months to be paid - Discussion

### CareSource:

- \* Followup from November TAC - What happens to past denied claims that were not reviewed by a KY licensed optometrist?
- \* Recoupment on claims from two years ago saying patient was not eligible. DMS - What can offices do to appeal these type situations?

### Eyequest:

### Superior:

- \* TAC would like to discuss the 92015 refractory policy

### General MCO Discussion:

- \* Followup on foster children issues on pre/post authorizations from last TAC. Can the approval process be the same with all MCOs? Need more discussion

### DMS:

- \* Any update on adding a macular degeneration supplement to formularies?
- \* CPT replaced code 96111 with code 96112 and 96113. Request it be added to the vision fee schedule.
- \* Appeals process discussion
- \* Copay questions and discussion (on nonpayment of \$3 copay):
  - Copayment on patients with Medicaid as the second payor?
  - Copays on CLIA waived lab tests? What is the policy?

AGENDA  
(Continued)

- Copays on eyewear? Children glasses?  
Adult glasses (age 18 or 21?)
- How does a patient meet the cost sharing  
limit for a quarter?

1115 HEALTH Waiver Update:

Update from DMS on Waiver and My Rewards Program

- TAC would request webinar trainings  
before the go-live date to prepare  
offices of any new changes/review of  
the My Rewards Program

2019 TAC Dates:

April 11, 2019

August 5, 2019

November 7, 2019

1 DR. BURCHETT: I will call the  
2 meeting to order. And as always, let's make some  
3 introductions because we have some new people to join  
4 us now.

5 (INTRODUCTIONS)

6 DR. BURCHETT: Welcome,  
7 Commissioner.

8 COMMISSIONER STECKEL: Thank  
9 you.

10 DR. BURCHETT: That's a first.

11 COMMISSIONER STECKEL: That  
12 surprises me because I've heard that from several  
13 TACs. So, you all may regret it but I intend to be  
14 part of these TACs and more a part of the MAC.

15 DR. BURCHETT: Appreciate it.  
16 Moving forward, TAC members, we have the minutes from  
17 the last meeting in November and I'd ask that you  
18 look at those and see if we think there's any edits  
19 or what; and if not, we will take a motion to approve  
20 them.

21 DR. SAWYER: So moved.

22 DR. UPCHURCH: Second.

23 DR. BURCHETT: All in favor.

24 The minutes are approved from the last meeting.

25 As always, we typically just go

1 down the list of the MCOs and address the issues  
2 we've been working on.

3 If nobody has any objections to  
4 that, we will go ahead and start and we'll turn it  
5 over to Avesis and go from there.

6 DR. LEVY: Sure. The first  
7 issue was the Aetna adult glasses update which is a  
8 great value benefit for the adult population.

9 There were some issues  
10 connecting with Korreect and some of our providers.  
11 There were about 100 orders that were held. We kept  
12 a spreadsheet for that; and I was there yesterday at  
13 Korreect for about two and a half hours and they had  
14 like ten left to complete as of yesterday. So, just  
15 a little bit of a hiccup. We apologize for that but  
16 it is moving forward and no challenges.

17 Questions?

18 DR. COMPTON: Well, there may  
19 be more than that. We've held them in the office.

20 DR. LEVY: Absolutely. There  
21 will be a broader communication going out but we just  
22 wanted to make sure that that was taken care of.

23 I guess I can go with the next  
24 one, Nicole, if you're okay, Korreect, the faxing.  
25 We're at about an 85% electronic rate with submission

1 of claims coming in and material claims coming in.  
2 And, so, we are really cracking down on trying to get  
3 the remainder of those folks to electronically submit  
4 through our portal.

5 There are some stragglers out  
6 there, so, there's been some challenges with them  
7 interfacing with their portal because it's new to  
8 them and being able to get on and be able to process  
9 an order electronically through us to Korreect.

10 We're working with those  
11 specific offices. It's really how the office is  
12 interfacing with us getting them up to speed. We  
13 should have resolution on that in the next week or  
14 so. Lee Ann, am I pretty good on that?

15 MS. ELLIS: Yes, sir.

16 DR. LEVY: Okay. Thanks.

17 MS. ALLEN: Any questions with  
18 the ordering process for Korreect?

19 DR. COMPTON: By and large,  
20 Korreect does a nice job. We have very few issues.

21 DR. LEVY: They really do.  
22 They're great folks. They've expanded their lab.  
23 They're close to 30,000 square feet. They're in the  
24 state. They do a lot of veterans' work. They do a  
25 lot of Medicaid work. I think they're about 90%

1 digital right now. They really have put a lot of  
2 effort and monies into that lab. They're really  
3 doing a nice job. We come in once a month and we do  
4 a spot check. I pull some trays and start going and  
5 making sure everything is made as written. So, we're  
6 pleased with them.

7 So, medically necessary tints.  
8 As a clinician, I'm all for this. And if I'm not  
9 mistaken, is it 76254 is the HCPC?

10 MS. ALLEN: That sounds right.

11 DR. LEVY: It's not on the fee  
12 schedule. Is there any way we can get that code on  
13 the fee schedule because if it's on the fee schedule,  
14 we can pay it. If it's not on the State fee  
15 schedule, we cannot pay it.

16 COMMISSIONER STECKEL: Mr.  
17 Chairman, may I ask a question?

18 DR. BURCHETT: Interrupt  
19 anytime.

20 COMMISSIONER STECKEL: Why  
21 wouldn't tints be medically necessary? Stephanie  
22 Bates has joined us also.

23 DR. LEVY: They should be and  
24 they can be.

25 COMMISSIONER STECKEL: Why?

1 DR. LEVY: Oh, why would they  
2 be?

3 COMMISSIONER STECKEL: Why?  
4 Yes.

5 DR. LEVY: Let me give you an  
6 example. A severe example would be albinism, right,  
7 someone that's very, very, very sensitive to that and  
8 the tint can certainly help alleviate some of those  
9 signs and symptoms or the symptoms of that high  
10 glare.

11 MS. ALLEN: I'm sorry. If I  
12 may. If they're a child, it would be covered under  
13 EPSDT.

14 COMMISSIONER STECKEL: If it's  
15 medically necessary.

16 MS. ALLEN: If it's medically  
17 necessary.

18 COMMISSIONER STECKEL: So, I'll  
19 give you the albinism.

20 MS. BATES: So, that's where I  
21 was going with it. So, adults, the glasses in adults  
22 is out, right? And, so, they don't have to be on the  
23 fee schedule for something to be determined medically  
24 necessary under EPSDT. So, it won't be put on the  
25 fee schedule; but if someone who needs it out of some

1 sort of medical necessity like what you just  
2 described, they would have to submit a PA to the MCO  
3 with that request for that and the MCO uses whatever  
4 criteria to determine whether or not it's medically  
5 necessary and can pay for it regardless of whether  
6 it's on the fee schedule.

7 DR. LEVY: Okay.

8 MS. BATES: That goes for all  
9 services.

10 DR. LEVY: And, again, it was  
11 never a concern for medical necessity. We were just  
12 trying to be able to show that and be able to have  
13 the lab do it and we run our lives through HCPC codes  
14 and CPT codes.

15 MS. BATES: Well, that HCPC  
16 code is in your coding books that you have. So,  
17 we're not going to put it on a fee schedule because,  
18 then, that opens it up for everybody to see and, so,  
19 we don't do that. We don't put EPSDT Special  
20 Services on the fee schedule.

21 So, that would go for anything  
22 in your field of work, that if there is a HCPC code,  
23 somebody actually needs something, there's some  
24 special situation and it's a code and it's billable,  
25 as long as you PA it and the MCO through the UM

1 process determines that it's medically necessary,  
2 then, the MCO can pay for that under EPSDT.

3 DR. LEVY: We're 100% with you  
4 there. So, we'll just figure out a way to get that  
5 claim over with the applicable code. We've got it.

6 DR. COMPTON: Just to be clear,  
7 we send the PA to the subcontractor or to the MCO?

8 MS. BATES: Whatever the  
9 process is, depending on your MCO.

10 DR. COMPTON: And if they deny  
11 it, what's the next step?

12 MS. BATES: You have appeal  
13 rights just like any other denied service.

14 DR. COMPTON: For \$6----

15 DR. LEVY: And I've got to tell  
16 you, it's not going to be denied. It was more of an  
17 administration/operation on how to get that put  
18 through to our lab and what-have-you.

19 COMMISSIONER STECKEL: So, by  
20 saying it's not going to be denied, you're telling me  
21 that for every child that you're going to put a PA  
22 through, it is medically necessary?

23 DR. LEVY: It's going to be  
24 clinically approved. It's going to be clinically  
25 peer-reviewed - all our PA's are - with either

1 someone in the state or someone on my team. We know  
2 the things that require tint for medical necessity.

3 COMMISSIONER STECKEL: Okay.

4 DR. LEVY: Let me take that  
5 back. It's not open; but if Dr. Compton writes  
6 something down and I know exactly what he's talking,  
7 if he's going to go through the effort of putting in  
8 the prior auth and puts the diagnosis in, it will be  
9 reviewed by a clinical peer.

10 DR. COMPTON: I don't want to  
11 put it on here because it's the same issue we had a  
12 year ago. We reach out to our Customer Service rep.  
13 She tells us it's a non-covered service and sends us  
14 an ABN. We knew it was non-covered.

15 AUDIENCE: She said they can  
16 pay for it. It would be an add-on and that they  
17 could pay for it.

18 DR. COMPTON: Yes, that the  
19 patient could and that's not right.

20 AUDIENCE: And that was after I  
21 sent them the PA.

22 MS. ALLEN: And when you're  
23 sending the PA, are you indicating, are you checking  
24 off the EPSDT box if it's a child?

25 AUDIENCE: No, I did not do

1 that.

2 MS. ALLEN: There's a box in  
3 the top left-hand corner that identifies that it is  
4 an EPSDT service, and we do recommend just as an  
5 added coverage in the Remarks' section which is in  
6 the middle of the claim form or the prior auth form  
7 that you add in there also that this is an EPSDT  
8 medically necessary service and, then, that way it  
9 will get to Dr. Levy's team.

10 MS. BATES: And, Nicole, you  
11 know that not everybody knows what EPSDT means. So,  
12 I'm hoping that on that form that Avesis has that it  
13 explains what that means.

14 MS. ALLEN: It's not the Avesis  
15 form. It's the standard form.

16 MS. BATES: However, but it's  
17 up to the MCOs' teams to make sure that the providers  
18 that they're contracted with understand EPSDT and  
19 understand that a child can get what they need.  
20 There should never be a time when an ABN is given to  
21 someone and that a bill goes when Medicaid can cover  
22 it under EPSDT, outside of tint, just anything.

23 COMMISSIONER STECKEL: So, does  
24 everyone know what EPSDT is in this room?

25 DR. LEVIN: At Superior, we

1 have a form that the doc fills out, a non-standard  
2 form - I need transitions, albinism, a person gets  
3 hit in the eye, your pupil is very large in one eye,  
4 they needed tinting, then, we review it and, then, we  
5 send it back to the doctor for authorization. It's a  
6 similar type of situation.

7 COMMISSIONER STECKEL: And  
8 please don't misunderstand my statements. I want  
9 children to receive the medically necessary services  
10 that they have a right to, but I also don't want this  
11 to become a standard coverage issue for every person  
12 in Kentucky.

13 DR. LEVY: We appreciate that.  
14 Did that cover it?

15 DR. BURCHETT: I think so.

16 DR. LEVY: Okay. Nicole, do  
17 you want to do the next one?

18 MS. ALLEN: Sure. So, Medicaid  
19 as a secondary payor denial, there were some followup  
20 for discussion. We did receive one example of a  
21 claim that there were questions about Medicaid paying  
22 as a secondary payor.

23 So, if you don't mind if I open  
24 it up for discussion, if you can present what the  
25 issue was and, then, that will help guide the answer.

1 DR. COMPTON: I'm trying to  
2 make this a systemic problem.

3 COMMISSIONER STECKEL: So,  
4 you've heard my speeches.

5 DR. COMPTON: Well, I read the  
6 letter and I thought, oh, my goodness, what's going  
7 to happen.

8 MS. ALLEN: And if she says no,  
9 we can talk about it later.

10 DR. COMPTON: Subject to open  
11 records' stuff and all that.

12 So, here's my example but I'm  
13 sure it's happened to others. A Medicare patient  
14 with Medicaid secondary, a diabetic. We bill a 92014  
15 to Medicare who covers that as a medical diagnosis,  
16 pay their 80%. It doesn't always apply because if  
17 Medicare has paid more than the Medicaid allowable,  
18 that's a wash.

19 MS. ALLEN: Exactly.

20 DR. COMPTON: But if they  
21 haven't met their deductible or for various reasons,  
22 sometimes the rest of that balance goes to Medicaid,  
23 in this case, Avesis, and Avesis denies the code  
24 because you guys use those 92000 codes for strictly  
25 refractive diagnosis.

1 DR. LEVY: That's routine eye  
2 care.

3 DR. COMPTON: But you're the  
4 only ones that do it.

5 DR. LEVY: Right because we're  
6 the only ones administering multiple benefits.

7 DR. COMPTON: So, that gets  
8 denied. So, we either have to go back and put a  
9 different diagnosis in----

10 MS. BATES: What? Hold on.

11 DR. COMPTON: Not we. The  
12 generic we, the system.

13 MS. BATES: Dr. Levy, you  
14 explain it.

15 DR. LEVY: Yes, I will explain  
16 it.

17 MS. BATES: Not that you're not  
18 doing a wonderful job. I just want to understand  
19 from your perspective.

20 DR. LEVY: So, in our  
21 perspective, we are administering routine eye care  
22 benefits which is a routine eye exam and a pair of  
23 glasses and we're also doing all the medical/surgical  
24 - optometry, ophthalmology, right? So, we carve out  
25 all eye care services, the 3 or 4% from our MCO

1 partners and we administer the benefits.

2 The challenge is that we're  
3 utilizing one set of CPT codes to administer two  
4 benefits that we need to be able to exhaust and keep  
5 track of.

6 So, what we have done not only  
7 in this state and other states to get through this to  
8 work through our claims administration system and to  
9 work with our MCO partners is that we have used the  
10 four 9200 codes for routine eye and we have and use  
11 where most people are the high or the 99 E&M codes,  
12 so, the high 99 codes for medical/surgical services.

13 This way, we can differentiate  
14 and attach the E&M's to all the medical diagnoses and  
15 keep those four other codes for routine eye services  
16 - myopia, astigmatism, presbyopia, hyperopia, things  
17 like that.

18 Now, I have been in front of  
19 this room a few times and would love to offer out an  
20 alternative and a great fix that we have in other  
21 states that works flawlessly. It would be to  
22 incorporate the two "S" codes, S0620 and S0621 which  
23 would be a definition of a routine eye exam.

24 If we could have those two  
25 codes here, we would be able to exhaust the routine

1 eye exam and the routine eye benefit and, then, we  
2 could open up all the applicable CPT codes for eye  
3 medical.

4 And what Dr. Compton is saying  
5 is that on the Medicare side, if it's not us  
6 administering Medicare, they're using the appropriate  
7 codes but we're using those codes for something else  
8 and it denies out.

9 MS. BATES: So, what does  
10 Superior do?

11 MS. SINTHAVONG: So, Passport  
12 Health Plan is the one that pays medical codes and  
13 Superior pays the routine codes. We are actually  
14 talking about doing exactly what Avesis is doing to  
15 where Superior would manage all surgery and routine  
16 codes.

17 So, I don't know if you guys  
18 have other states that do that and if there's  
19 specific codes that the "S" codes would work for you.

20 DR. LEVIN: We don't use "S"  
21 codes. As Amy said, it's broken up. They do the  
22 medical, the ophthalmology and, then, we do the  
23 otometry.

24 DR. LEVY: If I could, we do  
25 this in other states with these two "S" codes. It is

1 flawless. It is awesome. And I know there is a  
2 concern because the "S" codes tend to have a lower  
3 reimbursement or because it's a different service  
4 from an ophthalmology comprehensive service. That's  
5 just discussions. It's really more of an  
6 administration/operations simplicity that would  
7 really fix a lot of these coordination of benefits  
8 when there's dual lease.

9 DR. BURCHETT: Our Board of  
10 Examiners have not approved those as codes we're  
11 allowed to use.

12 MS. BATES; And we're not  
13 going to add "S codes.

14 DR. LEVIN: How often has this  
15 happened because you just said Medicare usually pays  
16 more than the secondary one anyway.

17 DR. COMPTON: It's not often.  
18 And we'll also get--here's another example. I see  
19 the Medicaid patient who is diabetic because  
20 everywhere else, we bill the 92000 codes.

21 DR. LEVIN: Right.

22 DR. COMPTON: Out of habit,  
23 well, then, we just end up putting presbyopia instead  
24 of, you know. You're not going to exhaust their  
25 routine benefit but really they're there because it's

1 their annual dilated fundus exam. We've butted heads  
2 on this before.

3 DR. LEVY: And I don't mean to  
4 butt heads. It's an administration thing. So, in  
5 other states, we have been asked to use the lower  
6 92000 codes, 92002, 92012 to exhaust the routine  
7 vision benefit. That has worked very well.

8 So, I can bring certain things  
9 to the table here that would possibly be a solution  
10 if we could have open dialogue and come to an  
11 agreement, but the routine eye exam benefit and the  
12 material benefit is not going away.

13 MS. BATES: And I don't think -  
14 and, Commissioner, totally stop me if I'm off base -  
15 but I think this is an example of something that  
16 needs to be settled outside of a TAC meeting because  
17 at the end of the day, the State Plan services that  
18 Kentucky says an MCO who ultimately isn't you because  
19 you're the subcontractor.

20 So, the MCO that we contract  
21 with has to pay for these services, and there are  
22 certain rules with regard to Medicare like duals and  
23 all that.

24 So, at the end of the day,  
25 regardless of how Avesis or Superior or anybody is

1 set up, you have to pay for and make those services  
2 available where medically necessary, where it's  
3 whatever. So, he shouldn't have to come to a TAC  
4 meeting to bring this up. Like, it should be settled  
5 by now outside of a TAC meeting.

6 Now, if there is a bigger  
7 coordination of benefits or something that you see  
8 that could be solved here, that's one thing. So,  
9 your hands are tied.

10 DR. COMPTON: We kind of got  
11 off of----

12 MS. BATES: Right. Your hands  
13 are tied because you're getting these denials and you  
14 feel like your hands are tied because Avesis has a  
15 certain way of doing things but we've still got to  
16 get them paid.

17 And I'm happy to help outside  
18 of a TAC meeting, but I don't know, Commissioner.

19 COMMISSIONER STECKEL: You took  
20 the words right out of my mouth and the MCOs need to  
21 be involved in this. I guess because it goes to  
22 Avesis, do you have contracts with all five MCOs?

23 MS. ALLEN: Two.

24 DR. LEVY: WellCare and Aetna.

25 MS. BATES: So, WellCare is

1 right here.

2 COMMISSIONER STECKEL: Right  
3 and Aetna is here.

4 MS. LARGEN: And I'm right  
5 here.

6 COMMISSIONER STECKEL: So, who  
7 is your vision contract with?

8 MR. SMITH: My client. So, to  
9 his point, right now, Avesis is the only one that  
10 does process the claims for medical and for routine.  
11 We split ours out where Anthem does medical, we do  
12 routine. Superior is doing that, too, with theirs.

13 So, I think if there ever is a  
14 time where we do take on the medical and they take on  
15 the medical, this will become a larger issue.

16 DR. LEVY: I appreciate you  
17 saying that because that's what we're here to----

18 COMMISSIONER STECKEL: Are you  
19 anticipating doing that? I guess it would be your  
20 decision.

21 MS. O'BRIEN: We haven't worked  
22 out a contract on that.

23 COMMISSIONER STECKEL: But you  
24 all, Passport is anticipating doing it, correct?

25 MS. SINTHAVONG: We have, yes,

1 absolutely.

2 DR. BURCHETT: I've got a  
3 question. If you all split it out, then, how come we  
4 have to bill vision and medical to the same person?

5 MS. SINTHAVONG: Well, it's  
6 mainly the provider type. So, if you're going to  
7 have a surgery, that should come to Passport, not to  
8 Superior.

9 DR. BURCHETT: That's not what  
10 we've heard before.

11 COMMISSIONER STECKEL: This is  
12 way beyond the TAC meeting.

13 MS. BATES: Right, and this is  
14 the overarching issue.

15 DR. LEVIN: We cover medical  
16 for up to a scope of license of optometrists and,  
17 then, Passport covers any med/surg for ophthalmology.

18 MS. BATES: So, this is the  
19 overarching issue here and what would probably be  
20 most appropriate for this meeting if you all wanted  
21 to bring it is that providers should only be billing  
22 to the MCO. The MCO figures it out rather than  
23 subcon here, MCO here and you've got to figure out  
24 where to send your claim. So, that's what it sounds  
25 like.

1                   That's the overarching issue  
2 rather than the down-in-the-weeds issue that I see  
3 from this. And, so, I think we need to move on but  
4 that I believe is the overarching issue.

5                   MS. O'BRIEN: I think it  
6 becomes those misdirected claims like what we've  
7 talked about before.

8                   MS. BATES: Yes, but, really,  
9 Provider A no matter what type it is should send it  
10 to Anthem and Anthem should send it out.

11                   MS. O'BRIEN: And what we do is  
12 work internally.

13                   MS. ALLEN: May I ask? Is this  
14 the appropriate setting to talk about Kentucky's  
15 position on the "S" codes?

16                   COMMISSIONER STECKEL: Okay.  
17 Do you mind, Mr. Chairman, if I just talk about----

18                   DR. COMPTON: We're going to  
19 need some training on it but we're trying.

20                   COMMISSIONER STECKEL: The new  
21 day for TACs and MAC? Do you mind?

22                   DR. BURCHETT: No. Go ahead,  
23 please.

24                   COMMISSIONER STECKEL: And it's  
25 actually evolved. My thoughts on this have evolved

1 after I've met with most of the TACs. I think I have  
2 one or two left.

3 MS. HUGHES: You have about  
4 five or six left.

5 COMMISSIONER STECKEL: Okay.  
6 As TAC members, you should have gotten a letter  
7 outlining the changes that we're making as TAC and  
8 MAC members, but basically we want to use the TACs as  
9 policy discussion points.

10 The mission and the function  
11 and the statutory direction of the MAC and the TAC is  
12 to advise the Medicaid Program.

13 So, it is not to do one-off  
14 claims issues, and some TACs are more guilty than  
15 others, but here's where my thought process has  
16 evolved some.

17 There is a function for the  
18 providers, the MCOs, and, in this case, the  
19 subcontractors to be in the same room. Medicaid  
20 doesn't need to be in that room.

21 So, where we can facilitate  
22 that discussion by providing a room, providing  
23 everybody being here, we are willing to do that, but  
24 the TAC discussion - and I'm sorry, Mr. Chairman -  
25 but the whole way down to DMS, unless there was a

1 specific policy discussion should be a meeting  
2 between the providers, the MCO and the vision  
3 contractors.

4 And we're doing some other  
5 changes. We're meeting in this building. Some TACs  
6 met outside of this building and that's the reason  
7 why Medicaid Directors and Deputy Commissioners  
8 weren't at the meetings. It's hard for us to get out  
9 of this building for lunch, much less for anything  
10 else - not that you all aren't more important than  
11 lunch.

12 So, we really want to turn it  
13 to what can we talk about that would help the  
14 profession, help our beneficiaries and what are the  
15 overarching policy discussions, not individual  
16 claims, but I understand, Dr. Compton, about the idea  
17 that--to me, what the discussion evolved into is not  
18 your specific claims but what if the other MCOs split  
19 this out, then, it becomes a bigger issue than just  
20 one issue.

21 It's hard to describe what  
22 we're trying to do but it's policy issues, how can  
23 you advise the Medicaid agency. It's not an  
24 opportunity for, again, individual claims issues or  
25 even the issues with Korrekt Optical. The medically

1 necessary tint is on the line because, come to find  
2 out, you're following the medical necessity criteria.  
3 So, really, that could have been a meeting between  
4 you all, the providers and the MCOs.

5 So, I'm struggling with how to  
6 explain it but it's like obscenity in the Supreme  
7 Court - you'll know it when you see it - but really I  
8 do want to move to what is it in the optometry world  
9 that we, Medicaid, can do with you all to better  
10 provide services to our Medicaid beneficiaries, make  
11 it easier for you to participate, make it better for  
12 our members. So, that's what we're going to.

13 DR. COMPTON: I do have a  
14 comment or question. I think if we all get in the  
15 same room, we can figure something out, but is that  
16 subject to open meetings? Are we going to run afoul  
17 of the open meetings' statute?

18 COMMISSIONER STECKEL: Well, as  
19 long as there's not a Medicaid person in the room,  
20 it's not a Medicaid meeting. We just have  
21 facilitated a space for you all to meet. I'm not a  
22 lawyer, though.

23 DR. COMPTON: Well, other  
24 things I'm on with open meetings, you can't have  
25 three commissioners talk on the side.

1 MS. BATES: No. At that point,  
2 it's required of the MCOs to meet with their  
3 providers and work these things out. It doesn't have  
4 anything to do with being----

5 MS. HUGHES: The open meetings  
6 I think is statutorily required committees and so  
7 forth is where you get into that.

8 COMMISSIONER STECKEL: So, what  
9 I would suggest is if you all find a value with all  
10 these folks here, we do the Medicaid part first.  
11 Medicaid leaves the room and, then, it becomes a  
12 voluntary meeting.

13 DR. COMPTON: Lock the doors,  
14 right?

15 COMMISSIONER STECKEL: Then we  
16 leave the room and it's a voluntary meeting with no  
17 State personnel in the room. Our court reporter  
18 would leave the room and, then, it's a discussion and  
19 an opportunity.

20 The Hospital Association does  
21 this. We're looking at now with the FQHC's doing it  
22 and I think that the MCOs will find that it's a good  
23 opportunity to have bigger discussions and solve  
24 problems.

25 You're right, Dr. Compton. I

1 think if you get all the people in the room, nine  
2 times out of ten, you're going to come up with a  
3 solution.

4 DR. COMPTON: We butt heads but  
5 we shake hands when we're done.

6 DR. LEVY: Absolutely, and I  
7 appreciate that. I agree. And just to use this as  
8 an example, this "S" codes or offering all services,  
9 this is a national challenge. I sit on the Board of  
10 NAVCP and this is for all sixteen vision plans. We  
11 all interface nationally in the country with  
12 Medicare, Medicaid, direct to state.

13 So, it's something that we are  
14 bringing up on the national level. I don't want you  
15 to think it's just here in Kentucky.

16 DR. COMPTON: We can talk  
17 outside. They do. They work together. So, I was  
18 always just a little--we don't want to cross any  
19 boundaries.

20 COMMISSIONER STECKEL: No, we  
21 don't either. We don't either; but, in essence, the  
22 Chairman would adjourn the TAC meeting and once the  
23 TAC meeting is adjourned and we are excused.

24 Even if I stay or Stephanie  
25 stays, as long as we adjourn the TAC meeting, the

1 court reporter leaves the room, then it's just as if  
2 your association had asked for a meeting with all of  
3 these players and we made an arrangement for it to  
4 happen.

5 DR. LEVY: And we would love to  
6 have that meeting. We have some good ideas, too, and  
7 I think we can come to resolution and it probably  
8 will work for our partners, competitors.

9 DR. COMPTON: That is kind of  
10 the overarching thing. If we can get one system----

11 MS. BATES: One process.

12 DR. COMPTON: One process.

13 There you go. Good word.

14 DR. LEVY: That's great. Thank  
15 you.

16 COMMISSIONER STECKEL: Sure.

17 Sure.

18 DR. BURCHETT: Well, with that  
19 being said, would you all like to skip to the DMS  
20 portion and do that?

21 COMMISSIONER STECKEL: Well,  
22 and we're trying to be sensitive to this is your  
23 agenda and you didn't know all of these changes until  
24 we sent the letter and I'm here to talk about it.

25 So, we will defer to you. If

1 you want to go to us and then flip it, we can do  
2 that.

3 DR. BURCHETT: Let me say, too.  
4 When we first re-started our TAC, we had several  
5 issues because it was right when Medicaid switched  
6 over to go with the MCOs and we had several issues  
7 that were happening and we came to Medicaid at that  
8 time and said we're having issues. They said, well,  
9 take them up in your TAC and that's what we were told  
10 to do.

11 So, since the MCOs have  
12 started, that's what we have been trying to do is to  
13 take those issues up. I understand what you're  
14 saying, but, historically, when we re-started our  
15 TAC, that was what we were directed to do at that  
16 point.

17 COMMISSIONER STECKEL: And I'm  
18 sorry. I know that providers feel whip-shot when  
19 there's a new Medicaid Commissioner because it's like  
20 all of us have our own ideas.

21 One of the other things Sharley  
22 is working on, we've been having like two or three  
23 TAC meetings a week over the last two or three weeks.

24 So, once she gets a minute,  
25 she's going to come up with a list of this is who you

1 call if you have a problem about "x" because the  
2 other thing is TACs don't meet that frequently.

3 So, you will sit on an issue  
4 for the quarter or for the bi-monthly waiting for a  
5 TAC meeting where we could have solved it earlier.

6 So, once you get that list, if  
7 you will take advantage of that, that will be  
8 helpful.

9 The other thing, too, is when  
10 you do take advantage of the list Sharley is getting  
11 of the routine places that we say call here if you've  
12 got this kind of a problem, we look at it not just to  
13 solve your problem but is your problem indicative of  
14 a systemic problem. And, so, we do look at it that  
15 way in every call we get on a one-off claim.

16 And, then, sometimes we may  
17 bring it back to the TAC and say, look, we've got  
18 this issue. Here's what we think. What do you all  
19 think and, again, that becomes a policy discussion.

20 DR. LEVY: And if I could, the  
21 Association has been absolutely great, the KOA. I  
22 work with Sarah all the time. My team works with  
23 Sarah. So, there's a lot of communication.

24 So, to your point, I don't  
25 think a lot of things wait until a TAC. I think we

1 communicate on a weekly basis in some cases. I have  
2 direct conversations with a lot of these doctors in  
3 the room. And I don't speak just for myself and my  
4 organization. I speak for most. I think the KOA has  
5 done a great job in keeping us all together and  
6 getting things done and completed.

7 COMMISSIONER STECKEL: Okay.  
8 So, would you like us to answer your questions or  
9 what would you like us to do?

10 DR. BURCHETT: Go ahead.

11 COMMISSIONER STECKEL: Okay.  
12 Stephanie.

13 MS. BATES: I have to leave at  
14 2:00, so, let's do my stuff.

15 DR. BURCHETT: There you go.  
16 Let's do that. Go right ahead.

17 MS. BATES: I'm going to cover  
18 under DMS and on down what I know and, then, I'll  
19 tell you what I don't know and we can talk about it  
20 because I'm not sure about the macular degeneration.  
21 So, let's come back to that.

22 The CPT replaced code, is this  
23 a new code for 2019?

24 DR. BURCHETT: Yes.

25 MS. BATES: So, they should

1 have those updated this month. I'll check to make  
2 sure that it's on there but they're updating all  
3 those replacement codes and stuff right now. I think  
4 it's with the finance folks right now but I'll give  
5 you a more specific update on that.

6 Appeals process discussion.  
7 What do we need there?

8 DR. BURCHETT: I think that was  
9 just a general----

10 MS. UNGER: I think it was just  
11 a general how does it work and, then, if there's  
12 any----

13 DR. BURCHETT: Is there any  
14 info you all have on how to initiate or what to do  
15 because if we're going to communicate with our  
16 members, if you have a problem, you need to appeal  
17 it, a lot of them aren't very savvy on how to get  
18 that process going.

19 MS. BATES: So, Avesis,  
20 Superior, EyeQuest, Humana need to send those to the  
21 TAC because that's a process that's in the member  
22 handbook that we know they don't read from cover to  
23 cover. So, I would just not send the whole handbook  
24 but just let them know the process.

25 MS. ALLEN: The process is

1 outlined in the office reference manual. It's also  
2 outlined for every denial letter that the member may  
3 receive. So, the detail is there; but if you would  
4 like us to share that with you, we can get it to you.

5 MS. UNGER: I think that's what  
6 we're looking for, like, what you just said - where  
7 it's at, where you can find it. And I know we've  
8 talked about this but most members do not understand  
9 it. They don't see it or they don't pass it on to  
10 their staff people.

11 COMMISSIONER STECKEL: Well,  
12 they're providing dental services, not looking  
13 through a book.

14 MS. BATES: So, I think if you  
15 call can do that, Nicole.

16 MS. ALLEN: Yes. Okay.

17 MS. BATES: And, then, if you  
18 all have any followup questions and see  
19 discrepancies or anything, but all of those materials  
20 have to come through us for approval. So, they  
21 should be perfect. And, so, there's that.

22 MS. UNGER: Like, on the  
23 Medicaid side, so, if an appeal is denied and they  
24 want to appeal on to Medicaid----

25 MS. BATES: That should also be

1 in that that they give you, that they have to tell  
2 you what the step is to come to the State.

3 COMMISSIONER STECKEL: And if  
4 you feel like you're not getting what you need, reach  
5 out to Stephanie and we'll reach out to our  
6 contractors, the MCOs.

7 MS. BATES: Your copay  
8 questions, I just sent over the final document that  
9 has all of the copay information. So, if you could  
10 send that back out to them, and it should answer the  
11 first three because it's down to the code level.

12 And I will send it to you all,  
13 too, so you have it and it's going to go to the MCOs,  
14 so, you can see what we're sending out but it's  
15 basically the logic that we use that you all should  
16 have but I just tried to make it a little bit more  
17 clear and take out some weird dates that we had in  
18 there for fee-for-service. So, that should answer.  
19 It's down to the code level. So, there's that.

20 And, then, the cost-sharing  
21 limit, so, basically, it is done per quarter. It's a  
22 systemic type of thing and it's calculated basically  
23 on the date the claim is processed. So, it doesn't  
24 necessarily go by date of service.

25 And like I said, it starts over

1 every quarter; but in the system - and there's  
2 specific guidance on how to look up that cost-sharing  
3 net indicator in KYHEALTH.Net, and I can send that  
4 out to you all. It has been sent out before. It was  
5 all on the provider forums.

6 And, then, also just so you all  
7 know, there's going to be--let's see. Let me go down  
8 to the 1115 because there's going to be some--I see  
9 webinar. There are going to be webinars coming out.

10 We have a medically frail  
11 webinar that's almost finished. I will ask Reina  
12 about My Rewards. I feel like there's already  
13 something out there but I will ask about that.

14 And as far as updates on the  
15 actual waiver, right now, we're still working toward  
16 4/1 go-live systematically.

17 COMMISSIONER STECKEL: And you  
18 all know that people are earning dollars for their My  
19 Rewards currently. So, they should start with a  
20 pretty healthy balance.

21 MS. BATES: We've been pretty  
22 generous.

23 MS. ALLEN: I have a question  
24 on the cost-sharing. You mentioned that that's  
25 assessed quarterly and it's based on the pay date of

1 the claim. Is there a time or is there like by the  
2 fifteenth day after the last day of the quarter that  
3 that's assessed? Is there a time frame for that so  
4 that we can expect when the system would be updated?

5 MS. BATES: I'm sure there is.  
6 I don't know it but I will ask.

7 MS. ALLEN: Okay. Thank you.

8 DR. LEVIN: So, will all  
9 children have a copay for their glasses?

10 MS. BATES: No. No children  
11 will have copays. All Medicaid copay rules apply  
12 including exemptions. So, children are exempt from  
13 copays.

14 COMMISSIONER STECKEL: And we  
15 just got the SPA approval for our last small little  
16 group of kids. So, no children will have to pay a  
17 copay.

18 DR. LEVIN: Including foster  
19 care.

20 COMMISSIONER STECKEL: Correct.

21 DR. LEVIN: And children is  
22 defined as eighteen and under?

23 MS. BATES: Twenty-one and  
24 under.

25 DR. LEVIN: Twenty-one and

1 under. Across the board.

2 MS. UNGER: Well, but, then, I  
3 had that come up, that there was a--I guess it was a  
4 female adult that was under twenty-one but I guess  
5 she was a parent or caretaker who had a copay because  
6 the only reason she is on Medicaid is because she is  
7 the parent. So, would that be correct or not?

8 COMMISSIONER STECKEL: Good  
9 question.

10 MS. UNGER: Because the answer  
11 was she has to pay the \$3 copay because the only  
12 reason she is on Medicaid is because she is a parent.

13 MS. BATES: So, do this for me.  
14 If you don't mind, look at the document that's sent  
15 out; and if the TAC has more specific questions like  
16 that one because I don't want to just fly off with an  
17 answer that I don't know is correct and, then, just  
18 send it over to me.

19 MS. UNGER: Okay.

20 MS. BATES: Because we want to  
21 know, too, right?

22 COMMISSIONER STECKEL: Yes.  
23 That's really an interesting question. You've  
24 stumped the speakers. And we have had cases where  
25 there is allegedly letters going out in some

1       pediatric worlds that says that a person has to pay a  
2       copay and they don't. So, if you have possession of  
3       a letter that we know like that, then, if we can get  
4       a copy of it, then, we know where it's coming from,  
5       but I don't think that's the case in your world, but  
6       we have had those examples. So, we're running those  
7       down, too, but the twenty-one-year-old, interesting,  
8       interesting.

9                       MS. BATES: It would be  
10       interesting to see that example just to see in the  
11       eligibility system what it looks like to us.

12                      I don't know about this macular  
13       degeneration.

14                      MS. UNGER: Well, I think to my  
15       understanding--well, you explain what it is but I  
16       think that it won't be added. C.J. called earlier  
17       this week and said she didn't think it would be.

18                      MS. BATES: Okay, so, the adult  
19       stuff.

20                      DR. BURCHETT: If that's the  
21       answer, then, that's fine.

22                      MS. UNGER: Well, she said that  
23       Medicaid could not add on the formulary but she maybe  
24       wants a meeting to talk to the MCOs about possibly  
25       doing it from their side.

1 DR. BURCHETT: Okay. That  
2 makes sense.

3 MS. UNGER: It would be up to  
4 them.

5 On the cost-sharing, would  
6 someone within like the first five days of the  
7 quarter have already met their cost-share?

8 MS. BATES: That's what I'm  
9 going to go back and ask about the date, like when  
10 all these triggers happen. It would just depend.

11 DR. BURCHETT: Like the first  
12 day we were in office after the New Year.

13 MS. BATES: Let me remind you  
14 if you all don't know this. There are a lot of  
15 people out there on Medicaid that have zero income.  
16 So, that could be it, I don't know, but I will ask  
17 about the time.

18 MS. UNGER: So, if they had the  
19 zero, that may be why, even though they're in the  
20 copay section.

21 MS. BATES: It says, yes, they  
22 do get a copay but, no, the--the copay and the cost-  
23 sharing is different. They are two separate bills.  
24 That's because at anytime, they could have income.  
25 So, that means they would pay that copay, and that's

1 the way it was explained to me.

2 DR. BURCHETT: That makes  
3 sense.

4 COMMISSIONER STECKEL: So, any  
5 other questions of Stephanie or me?

6 MS. UNGER: Do you all want to  
7 talk about the foster children?

8 DR. UPCHURCH: We have the  
9 Foothills kids. So, what happens is a lot of times,  
10 those kids are not eligible for exams. And it would  
11 be nice if we had a prior authorization standard to  
12 do for that because we go ahead and see those kids  
13 because we have to see them. They're under State  
14 care and they're required to have the exams.

15 Then we send in and we jump  
16 through all kinds of hoops with you all trying to get  
17 that straightened out and we still get them denied  
18 and it gets a little bit frustrating because they're  
19 in our office and we have to see them. They are in  
20 foster care.

21 MS. BATES: So, the policy is,  
22 Commissioner, so, a child could have had an exam  
23 earlier in the year that's their normal exam. And,  
24 then, if they go into care, the policy at DCBS is  
25 that they have to have A, B, C and D regardless, and

1 this is one of them.

2 And, so, they have to go ahead  
3 and do that for those foster kids. And, so, it's  
4 hitting back and denying because they had it in this  
5 other normal world.

6 And, so, the question becomes  
7 do we automatically or the MCO, whoever,  
8 automatically go ahead and pay for that. I don't  
9 know.

10 MS. ALLEN: It's covered under  
11 EPSDT again.

12 DR. UPCHURCH: Yes, but we can  
13 have that all over it everywhere and it still comes  
14 back denied. It's happening over and over again, the  
15 length of us dealing with us or trying to and it gets  
16 just really--it gets frustrating because these are  
17 things that we have to provide for these children.

18 I don't guess the MCOs know  
19 that they're in foster care. There's no way that  
20 they can identify that.

21 MS. BATES: So, in the defense  
22 of the MCO, it is possible that a child comes into  
23 care and that foster care indicator isn't on there  
24 immediately because DCBS--you know, it's an emergency  
25 situation a lot of times.

1                   So, the very first thing DCBS  
2 is worried about is the safety of the individual.  
3 And, so, the thing that's over here is sticking them  
4 in the system and making them foster in the system.  
5 And, so, there is a chance the MCO wouldn't have that  
6 right away and it really isn't anything other than  
7 DCBS not getting that in the system.

8                   However, I wouldn't think--how  
9 fast do you submit those claims, though?

10                  DR. UPCHURCH: The day we see  
11 them.

12                  MS. BATES: The day you see  
13 them.

14                  MS. ALLEN: It should be  
15 covered under EPSDT. So, I will follow up with  
16 Aletha and see what obstacles she's running into and  
17 together we will follow up with you.

18                  DR. UPCHURCH: Well, we were  
19 supposed to have met with her yesterday and for some  
20 reason she had to cancel.

21                  The reason and just to clarify  
22 that a little bit, James and I are in a situation  
23 where there are a large - I don't know what it's  
24 actually called - they have one facility for girls  
25 and they have sixty or seventy girls and we have one

1 facility for boys and there's sixty to seventy, maybe  
2 eighty boys.

3 And, so, they're constantly  
4 coming and going, and, so, he sees the girls and I  
5 see the boys. So, we have all of those kids coming  
6 in and out. I don't know how big a problem this is  
7 everywhere else, but for us, it is because they're  
8 constantly coming in and out. There's probably five  
9 or six a week moving out, five or six a week moving  
10 in. I saw eight of them this week.

11 COMMISSIONER STECKEL: Okay.  
12 See what happens when you have your meeting.

13 Now, one thing that may help  
14 with this is when we do our new RFP for the MCOs  
15 which should come out soon - I laugh because I get  
16 onto CMS all the time if they say soon, soon - it's  
17 like stop it - later in the spring - let's just try  
18 to be a little more specific - we're going to have  
19 one MCO take on the foster care kids.

20 So, I think it will help both  
21 the foster care kids and the people that are serving  
22 them.

23 MS. BATES: And we're heavily  
24 writing in things like this that would--you know,  
25 there's processes that go along with this, but the

1 Commissioner is right. I think this will probably  
2 almost be alleviated then.

3 DR. UPCHURCH: That would be  
4 good. We just don't have the manpower to keep doing  
5 all of them.

6 MS. BATES: So, I do urge the  
7 others in the room if you could look and see about  
8 these denials, that would be good.

9 COMMISSIONER STECKEL: And even  
10 if there is a way that you know they're foster kids  
11 to put a note on there so that the claim can pend  
12 until--and I know very little about claims  
13 processing, unfortunately.

14 MS. BATES: It's very automated  
15 which is part of the problem.

16 DR. UPCHURCH: If they've  
17 already had their benefit and they don't have a  
18 benefit, then, we have to do a prior authorization;  
19 but even with writing these initials, and I get them  
20 all mixed up all the time until I hear you all say  
21 them, but even writing that across the top of the  
22 form, the people who are processing them don't appear  
23 to see that and they still deny them because they  
24 have no----

25 MS. ALLEN: And just remember.

1 Never write on the top of the form.

2 DR. UPCHURCH: Well, that's  
3 what Aletha told us to do.

4 MS. ALLEN: No.

5 DR. UPCHURCH: And, then, you  
6 said about a checkbox. There is no checkbox 35, not  
7 on the one that we send in. I need that form.

8 MS. ALLEN: Okay.

9 COMMISSIONER STECKEL:  
10 Stephanie and I, unfortunately, are going to have to  
11 leave in about eight minutes. So, why don't the two  
12 of you, three get together and, then, whatever we  
13 need to--this is important, so, we need to resolve  
14 this so that these kids--you get paid for treating  
15 these kids. They've got enough problems in their  
16 life.

17 DR. UPCHURCH: We're going to  
18 see them either way, but, still, it would be nice to  
19 get paid, too, but we are going to see them.

20 COMMISSIONER STECKEL: Anything  
21 else for Stephanie or I?

22 DR. SAWYER: Could I just make  
23 one comment about the \$3 copay? For my practice,  
24 because it is heavily Medicaid, it's really becoming  
25 a \$3 reduction in my fee because so many of my

1 patients walk in and say I don't have it. And we  
2 say, well, can you bring it back? I don't have it.  
3 I mean, \$3 doesn't sound much to us, but for some of  
4 these folks, they probably don't have it. I watch  
5 them go to the grocery store and I watch them go to  
6 the satellite dish or whatever and I think they do  
7 have it, but they tell me they don't have it.

8 So, it's a \$3 reduction. I'm  
9 going to see them. I'm not going to turn them away  
10 but that's kind of what's happening as of the first  
11 of the year. At least I've seen that happen a lot  
12 already and it's happening to all of us. We're  
13 essentially taking a \$3 cut is what's happening.

14 DR. COMPTON: I was going to  
15 ask when the RFP's go out but now I know. It's soon.

16 COMMISSIONER STECKEL: It's a  
17 bureaucratic term of art. We really are hoping by  
18 the end of spring - April, May'ish.

19 MS. BATES: I'm in RFP heaven  
20 right now.

21 DR. COMPTON: Will the TACs or  
22 the MAC have any input on who is selected?

23 MS. BATES: No.

24 COMMISSIONER STECKEL: I don't  
25 even have any input on who is selected.

1 MS. BATES: But if it helps, of  
2 all of what I know from my years of TAC and MAC  
3 knowledge have helped shape this RFP.

4 DR. COMPTON: Okay. That's  
5 good to know.

6 MS. HUGHES: And as an FYI  
7 alert, we do have the Model Procurement Act that  
8 determines how we award and so forth, too.

9 COMMISSIONER STECKEL: We will  
10 get challenged. There will be a protest. So, in  
11 order to try to successfully win this protest, we're  
12 going to adhere to the law, not the letter of the  
13 law, the statute and the regs and all of that; but as  
14 Stephanie pointed out, the work of the TACs and the  
15 MAC certainly informs that work.

16 MS. BATES: And by saying that,  
17 I mean the development of the RFP, not the decision  
18 on who gets it but it's putting things in here to try  
19 to alleviate some of these issues.

20 COMMISSIONER STECKEL: I think  
21 you will see the contract is a stronger contract.  
22 We're trying to move from widget counting to outcomes  
23 measurements, so, meaning someone gets their Alc,  
24 okay, big deal. Did you lower their blood pressure  
25 or their diabetes or blood sugar? Did they not have

1 an amputation? Did their eyes get better? We were  
2 talking about macular degeneration and diabetes  
3 impact. That's what we want to measure and reward,  
4 not, okay, so, you gave someone an Alc test.

5 I think you will see some  
6 additional compliance components. So, we're going to  
7 put in real teeth, too. If you don't do what we tell  
8 you to do - I'm looking for all the MCOs - instead of  
9 it being just a slap on the hand, it's going to be a  
10 very real penalty.

11 I know that they would all tell  
12 you that they're very real nowadays but no, and how  
13 to make it easier for our providers to participate,  
14 for our beneficiaries to get the benefits of the  
15 program.

16 I think you will see some very  
17 different tone and provisions in this RFP, many of  
18 which have been informed by the work that you all  
19 have done and the MAC has done.

20 DR. COMPTON: It would be  
21 wonderful if there were some sort of repository where  
22 we could see what their hemoglobin and Alc is. I'd  
23 say two-thirds of my patients have no clue and that's  
24 huge for the eye care.

25 MS. BATES: That's Kentucky

1 Health Information Exchange, the KHI. So, that's all  
2 developing behind the scenes, and, so, big stuff  
3 that's coming that will allow providers serving their  
4 patients to see----

5 DR. COMPTON: Medicare is  
6 trying to do that, too, but all those different  
7 systems don't talk to each other very well.

8 COMMISSIONER STECKEL: I agree.  
9 I agree. And, so, the KHI will help with that once  
10 it's rolled out.

11 MS. ALLEN: I just wanted to  
12 add a correction. Dr. Upchurch, I apologize. I was  
13 thinking of the ADA dental claim form for Box 32, but  
14 for the form that you are using for vision, it's Box  
15 19. Box 19 is where you would identify any notes,  
16 that claim information for the claim.

17 And I know I've said that at a  
18 couple of meetings, so, I want to really apologize  
19 that I was referencing the wrong form, but I have it  
20 up and it is Box 19. You're also correct. That  
21 EPSDT box is not on the form that you're using for  
22 vision. That is only on dental.

23 So, you would have to indicate  
24 EPSDT in Box 19. And please don't write at the top  
25 of the claim form. Our system, as Stephanie

1 mentioned earlier, there's so much to it that's  
2 automated. Our claims are imaged in; and if it's at  
3 the top, we don't read it. We'll read what's in Box  
4 19 but we won't read it at the top.

5 DR. LEVY: Why don't we put a  
6 communication out on our portal about this and put  
7 exactly the form and where it's supposed to go and  
8 send that out.

9 COMMISSIONER STECKEL: So, Mr.  
10 Chairman, unfortunately, Stephanie and I need to go  
11 in a few minutes. Would you like to adjourn the  
12 meeting, continue the meeting as a TAC meeting or  
13 what is your pleasure?

14 DR. BURCHETT: What is my  
15 pleasure? If it would please the rest of the TAC  
16 members, I would just say let's let them go and we  
17 can talk about the rest of these.

18 DR. COMPTON: We'll adjourn.

19 DR. BURCHETT: We'll adjourn.

20 MR. SAWYER: Move to adjourn.

21 DR. COMPTON: Second.

22 DR. BURCHETT: All in favor.

23 Meeting adjourned.

24 MEETING ADJOURNED

25