

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

IN RE: OPTOMETRIC CARE TECHNICAL ADVISORY COMMITTEE
MEETING

August 15, 2019
1:00 P.M.
CHR Building
Medicaid Commissioner's Conference Room
Cabinet for Health & Family Services
275 East Main Street
Frankfort, Kentucky

APPEARANCES

Matthew Burchett
CHAIR

James Sawyer
Steve Compton
Gary Upchurch
TAC MEMBER PRESENT

CAPITAL CITY COURT REPORTING
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APPEARANCES
(Continued)

Judy Theriot
Sharley Hughes
David Gray
MEDICAID SERVICES

Jean O'Brien
ANTHEM

Amy Cummins
Paige Greenwell
HUMANA-CARESOURCE

Candace Guney
AETNA BETTER HEALTH

Stuart Owen
WELLCARE

Steve Hoagland
Micah Cain
Becky Murphy
PASSPORT

Nicole Allen
Daniel Levy
Mel Taylor
Dale Miracle
Shelly Grainger
Alethea Vaughn
AVESIS

Ronnie Smith
Cyndal Frame
EYEQUEST

Sarah Unger
KENTUCKY OPTOMETRIC
ASSOCIATION

Cindy Holman
COMPTON & COMPTON EYE CARE

AGENDA

Call to Order/Introductions

Approval of April TAC Minutes

Resignation of TAC Member Karoline Munson, O.D.

Updated Vision Fee Schedule on website

Foster care children discussion

New Business:

- * Aetna Better Health Incentive being offered to those members to obtain their annual diabetic dilated eye exam

- * MCO Vision Contractor Updates
 - Passport (September 1, 2019)
 - Humana-CareSource (January 1, 2019)
 - MAC recommendations at the July meeting - wellness exam to include routine vision exam
 - Availability of practitioners in seeing a patient in a certain time frame
 - WellCare/Aetna recoupment/DOS discussion

Future 2019 TAC Date:

- * November 7, 2019 @ 1:00 p.m.

1 DR. BURCHETT: I guess we will
2 go ahead and get started. Thank you all for joining
3 us today for the Optometric TAC meeting here.

4 Once again, I see faces I may
5 not think I've seen before. So, I'm just going to
6 have everybody go around the room and introduce
7 themselves.

8 (INTRODUCTIONS)

9 DR. BURCHETT: Thank you all.

10 MS. HUGHES: Dr. Burchett, if I
11 could, just a couple of things. The Commissioner was
12 called out just right before this, so, she is not
13 going to be able to come in, I don't think. If she
14 gets back from whatever it was, she might try to come
15 in later.

16 DR. BURCHETT: That's fine.

17 MS. HUGHES: And some time
18 during the agenda, I would like to be able to just
19 talk a little bit about this program, if you don't
20 care.

21 DR. BURCHETT: That would be
22 good.

23 MS. HUGHES: And before you get
24 down to talking about some of the MCO information,
25 because we are in a critical period, could we hold

1 those until the very last?

2 DR. BURCHETT: Yes.

3 MS. HUGHES: And, then, at that
4 point, David Gray and I will get up and leave. We
5 don't want anybody to think we're doing anything,
6 talking about anything that we shouldn't be. So, if
7 you don't mind to do that for us.

8 DR. BURCHETT: That's perfect.

9 MS. HUGHES: We don't want to
10 risk having somebody argue about it.

11 MR. BURCHETT: Which issues
12 would you prefer I move so that I know exactly which
13 ones we're looking at?

14 MS. HUGHES: Anything with the
15 MCOs, like the Aetna Better Health. Now, the vision
16 contractor, that's fine, but the WellCare and the
17 Aetna Better Health, if those could be later on in
18 the agenda, we would appreciate it.

19 DR. BURCHETT: That's fine.
20 Perfect. I just want to make sure we don't put you
21 all in a precarious situation.

22 MS. HUGHES: We appreciate
23 that.

24 DR. BURCHETT: The first thing
25 is we will look to approve the minutes of the last

1 meeting. Have we seen the minutes?

2 DR. COMPTON: I think we got
3 them. It's been a long time ago. We haven't met
4 since April. I move we approve.

5 DR. UPCHURCH: Second.

6 DR. BURCHETT: All in favor?
7 The minutes are approved.

8 The next order of business is
9 Dr. Munson, due to her work schedule, has not been
10 able to attend the last couple of TAC meetings.

11 So, she has requested to resign
12 from the TAC. So, we honored that request and we're
13 currently looking to find a fifth optometrist here in
14 Kentucky to replace her. So, we're on the lookout
15 for that right now.

16 MS. HUGHES: Just let me know
17 and I will get her on all the stuff.

18 DR. BURCHETT: Sounds good.

19 DR. LEVY: So, that
20 replacement, optometrist, do you guys, when you look
21 to do that, if you don't mind me asking, is that
22 someone that practices maybe in a different mode of
23 optometry instead of maybe an independent or somebody
24 like maybe a retailer or a commercial optometrist?

25 DR. BURCHETT: I think

1 historically we've just looked across the state for
2 one who may be interested to do it. And, two, we
3 kind of look at practice modalities. We kind of look
4 at regions in the state to try to get good
5 representation.

6 DR. LEVY: Thanks.

7 DR. BURCHETT: The next item on
8 the list is the updated fee schedule. I just want to
9 thank the Department for getting that taken care of
10 for us. I know it has been a process.

11 And in speaking of the process,
12 just so we're better prepared because we know that
13 you all have requested from us to let you know when
14 we know that codes are changing or being discontinued
15 or things like that, what kind of advanced time frame
16 would you all need to make sure changes are made in a
17 timely manner because I know some of these codes have
18 been changed but they've been changed for several
19 months before we got them on the fee schedule
20 changed?

21 MS. HUGHES: As soon as you all
22 get them, that would be great. I don't know if the
23 Association receives them or just you all get them.

24 DR. BURCHETT: But as soon as
25 we know that something is going to change.

1 MS. HUGHES: As soon as you
2 know, if you can let us know. Yes, that would be
3 awesome. You don't have to wait until the TAC
4 meeting.

5 MR. OWEN: One thing I will
6 say. Lee Guice was at a meeting where she indicated
7 there's a new process that's going to be every July 1
8 and January 1 an update and she said you have to
9 submit ninety days in advance of whichever date. You
10 want to make sure it gets onto that next update.

11 MR. GRAY: I was going to say,
12 ideally, because for us to run it through DXC, which
13 is our external resource that's involved in loading
14 those codes, if we can get those that hit January by
15 no later than - we can get them earlier - no later
16 than September 30th in terms of being able to get
17 those loaded by January 1, and, then, certainly,
18 whatever, April 1, I guess, to hit the July 1.

19 MS. HUGHES: And you can send
20 them to me. I can look up Lee's email address, but I
21 can send them on to her. You don't have to wait
22 until a TAC meeting to do that, though.

23 DR. BURCHETT: Sure. We just
24 wanted to make sure because I think I had heard a
25 long time ago that there was a new process in the

1 works but I couldn't remember if that had started.

2 MS. HUGHES: Thanks, Stuart.

3 MR. GRAY: We really want to
4 thank this TAC and the Optometric Association.
5 Through that, it really brought to light some things
6 that we as the Cabinet and the Department for
7 Medicaid Services needed to deal with beyond just the
8 optometric codes. It turned out to be a bigger issue
9 but that really was the impetus for us to do some
10 self-examination of our current process.

11 Also, I think we historically
12 have just adding new codes. We didn't take any old
13 ones out. So, we cleaned that up and that makes it
14 easier when we add new codes if we've got a cleaner
15 database going in versus having to churn through
16 because it truly dated back like decades, I think.

17 So, there's been a lot of good
18 that has come out of this discussion this year. So,
19 thank you for that.

20 DR. BURCHETT: Sure.

21 DR. LEVY: Is that loaded? Is
22 that up on the website currently?

23 MS. HUGHES: Yes.

24 DR. LEVY: It is? Thank you.

25 MS. ALLEN: If I could ask.

1 Are you doing the updates as the CPT is updated? So,
2 every year, they add and they delete codes. Are you
3 automatically doing that or are you looking to us to
4 provide you with the recommendations?

5 MR. GRAY: I think as much as
6 you can provide those to us. Don't just count on us
7 automatically getting them.

8 MS. ALLEN: All right.

9 MS. O'BRIEN: I think for the
10 medical it seems to happen automatically, but when it
11 comes to the----

12 MR. GRAY: Optometric and
13 therapy.

14 MS. O'BRIEN: Optometric and
15 therapy and dental seems to be the ones that we just
16 need to get those codes to them. That's what I'm
17 seeing. Medical seems to be updated all the time the
18 first of January. It's the other ones, or physician
19 fee schedule, I think that's what it's called, but
20 not the vision.

21 DR. BURCHETT: Thank you all
22 again for getting that updated.

23 Next on the agenda it looks
24 like is revisiting the foster care children
25 discussion. I'll let James speak to that a little

1 bit.

2 DR. SAWYER: Well, it's the
3 same thing as we've talked about every time, just
4 about every time at least anyway.

5 I deal with girls that are
6 incarcerated in a group home and they either are
7 showing that they have coverage, and, then, when we
8 bill for it, they don't have coverage, or they're
9 showing they don't have coverage and we either go
10 ahead and try to see them or whatever because we've
11 been told they're supposed to be covered either way.

12 And, then, I had one the other
13 day. Is it the one I sent you? I can't even
14 remember what I sent the other day to the office that
15 was--I think it was a recoupment, if I'm not
16 mistaken. I was recouped after a patient had been
17 seen, paid and, then, it was months later, it was
18 recouped.

19 So, all of the things that can
20 go wrong are going wrong.

21 MS. ALLEN: Can I help with
22 that one? So, for the incarcerated members, we did
23 receive direction that Medicaid dollars cannot be
24 used to reimburse for services that an incarcerated
25 member received.

1 MR. GRAY: Institutionalized.

2 MS. HUGHES: I think part of
3 the issue is that sometimes--I think, if I remember
4 correctly from previous meetings, once DCBS takes in
5 a foster child, they only have so many days to get
6 them seen by certain physicians.

7 So, a lot of times that is
8 happening prior to DCBS even getting the eligibility
9 status to us. I think we're always going to have
10 that time line, that there's that lapse because you
11 all have to see them in whatever amount of time.

12 So, they're probably not
13 showing up on kyhealth.net at the time you're seeing
14 them because we don't have the eligibility.

15 You may have to hold the claims
16 and check. And, then, once their eligibility shows
17 up on kyhealth.net, then file the claims. Otherwise,
18 we're not going to pay it if they're not showing in
19 our system.

20 I don't know for sure how long
21 it takes DCBS to process them when it does the
22 eligibility. I can certainly ask, but I think that
23 probably is where a lot of that issue is. What's the
24 time line that they have to be seen? Is it like
25 within a week or ten days?

1 DR. SAWYER: It's pretty close.
2 I really don't know for sure.

3 DR. BURCHETT: Two weeks at
4 most.

5 MS. HUGHES: So, it's not
6 giving us time to get them showing as eligible.

7 DR. SAWYER: Often these girls
8 have been somewhere else within the year or even as a
9 few months' time. And, then, their eligibility is
10 showing as if it's been used, which it has obviously,
11 but, then, we're still required to see them, too.

12 MS. HUGHES: I mean, we would
13 love to have suggestions from you guys if there's
14 something you all think we could be doing to help you
15 all other than holding the claims until you see that
16 they're showing----

17 DR. BURCHETT: I would think if
18 you could find out how long it takes them to process
19 it to change their status and, then, see how we can
20 work to change that requirement of the ten-day, two-
21 week, whatever to be past that time that the status
22 has changed might be beneficial.

23 MS. HUGHES: Okay.

24 MS. VAUGHN: And what about
25 even a group home foster home status for these kids?

1 That's, I think, one of the biggest deals. There's
2 no status for these kids in the system. When we view
3 the children in the system, it doesn't say that
4 they're group or foster or anything like that.

5 So, the providers don't know
6 when they see it. We don't know when we see that
7 status in the system that those kids require multiple
8 exams or multiple vision exams or multiple pairs,
9 five or six pairs of glasses, depending on how many
10 times they change foster homes, group homes, if
11 they're moving from place to place.

12 That would make it so much
13 easier for those claims to be processed.

14 MS. HUGHES: Doesn't our system
15 show that their eligibility is foster care?

16 MS. VAUGHN: But that is just
17 for the MCO.

18 MS. HUGHES: So, you're shaking
19 your head, so, it must show to you.

20 MS. ALLEN: It is showing but
21 it's not clear for the provider. So, the foster care
22 members are put into groups. Each of the MCOs have a
23 group that members are put into. There is a foster
24 care group. I'm sure you guys see it on your site,
25 too.

1 But at the provider level, what
2 they see in the portal, they don't see the groups
3 necessarily that the member is assigned to.

4 We can do some education. We
5 can help the providers look a little bit further so
6 that you can see that the member is assigned to the
7 group home.

8 But along the lines of what
9 Alethea is suggesting, if there were extended
10 benefits for foster care children, and I think the
11 2020 July RFP will take care of that when the foster
12 kids are carved out in the Sky Program.

13 So, I think that that will
14 probably take care of it, but to hold us over, if
15 there was a way to either----

16 MS. HUGHES: Now, are you a
17 provider?

18 MS. VAUGHN: No. I work in
19 Provider Relations. I work with the providers.

20 MS. ALLEN: She is with Avesis.

21 MS. HUGHES: So, it's not
22 showing in your system they're foster care?

23 MS. VAUGHN: What I'm saying
24 is, when we come in contact with the providers--so, I
25 work directly with the provider. When the provider

1 is reaching out to us, the biggest thing that is an
2 issue is when that member has already been seen.
3 These foster home or group home kids, they're being
4 seen multiple times. Sometimes, as I'm explaining,
5 the member is being seen multiple times throughout
6 the year. They're getting multiple pairs of glasses.

7 The provider has to take extra
8 steps and we have to take extra steps. What I'm
9 saying is, it would be much easier if the member
10 could just be seen and the provider didn't have to do
11 anything extra. We didn't have to do anything extra.
12 If there was some type of way for that member to just
13 be seen and the provider didn't have to go through
14 anything else.

15 There's different steps the
16 provider has to take, different steps we have to take
17 to ensure that we can provide that additional
18 benefit. If those members were in the system and
19 they could have however many exams, ten exams,
20 however many pairs of glasses and there not be any
21 additional steps being taken by us or the provider,
22 so, carve that out.

23 MS. HUGHES: But what he's
24 saying is these are new people being taken into the
25 foster care system.

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DR. SAWYER: Well, not necessarily.

MS. ALLEN: Not necessarily.

DR. SAWYER: Just like she's saying, they have come new to our county, new to whatever. They may have been in Louisville in the same system and they saw an optometrist there, got glasses there in March.

Then, they come to me and they left their glasses at the last placement. And, so, now they're here and they don't have their glasses and we start all over, and oftentimes they're not even showing in the system at all by that time because it's so quick.

MS. UNGER: How many children is this in a time period? Like, is there a stat? I mean, is this something that you could carve out even for the next year that DMS takes over these foster children and you bill through DMS or no?

DR. UPCHURCH: That would make it easy because whenever it was DMS, it was one exam per provider per year. That's what Medicaid says in its regs or it used to say at least and still does. And, so, it didn't matter if they saw Steve Compton over in Franklin and, then, they were switched to my

1 community six months later and needed another exam.
2 That was a different doctor, so, they went ahead and
3 paid me. It wasn't a problem.

4 But now with the MCOs, it's a
5 problem because they've used their benefits. We have
6 to go through this circle of events. Like Alethea
7 said, I see that they don't have coverage but I've
8 got to see them. They're in my office. I've got to
9 see them. They've been brought by the State Foster
10 Care there for me to see.

11 So, I have to fill out a prior
12 authorization. I have to put all the letters on
13 everything, the EPSDT's, whatever those letters are.
14 I have to put all that stuff on there and I have to
15 give them a copy of the exam.

16 I have to go through all these
17 different steps and, then, hope that when it gets to
18 Avesis or wherever, that the person that's looking at
19 it there understands the problem because it's not
20 Alethea that knows exactly what's going on. It's
21 another person that's looking at the claim, whether
22 or not they will deny it or they will approve it.

23 It's got to be approved
24 eventually but sometimes you're jumping through so
25 many hoops that it's cost me more than what it's

1 worth for the exam.

2 MS. HUGHES: For next year,
3 that should solve the problem because all the foster
4 children are going to be on one MCO.

5 DR. UPCHURCH: But do we have a
6 fix between now and then? That's what we're after
7 right now.

8 MS. HUGHES: I don't know that
9 there is a fix between now and then.

10 DR. UPCHURCH: Because James
11 has about seventy or eighty girls that are being
12 circulated constantly. I have about seventy or
13 eighty boys that are being circulated constantly.
14 They're coming and going on a daily basis and it's a
15 problem for us.

16 MS. HUGHES: I'll take it back
17 to them, but so far they've not--you know, this has
18 been an issue, I know, since January when I had taken
19 over the TAC and they've not come up with anything.

20 So, possibly as a result of
21 moving them all to one MCO is the plan to fix it.

22 DR. LEVY: To that point, we
23 were just having a little sidebar on this. We can go
24 back to our partners and see what we could do to make
25 an efficiency here.

1 I agree with you. For this
2 population, that's way too many hoops.

3 DR. UPCHURCH: And Alethea is
4 having to deal with--me and James are sending stuff
5 to her constantly and she's dealing with it.

6 DR. LEVY: She likes you,
7 though.

8 DR. UPCHURCH: She does and we
9 love her - don't get me wrong - but it's extra work
10 on us. It's extra work on her and she's overloaded
11 now. And I'm not taking up for her but I know she is
12 because she's having to work for somebody else right
13 now and she's not complaining about that, but it's
14 just extra work on everybody that really doesn't need
15 to happen.

16 MR. GRAY: I think in terms of
17 this next ten months, I agree. By the time we worked
18 out a solution, we would be at July 1 of next year.
19 We're ten months to go.

20 If there was something Avesis
21 and EyeQuest could do because it's very painful when
22 it happens. And if you've got bad geography,
23 depending upon where you're located at and where
24 these different facilities are located around the
25 state, they're not big numbers that we're dealing

1 with.

2 MS. HUGHES: Right. It's big
3 numbers for these guys but it's---

4 DR. UPCHURCH: It's not big
5 numbers because there's not that many facilities, but
6 it's happening with every optometrist in the state, I
7 guarantee you, just not on the same scale it is with
8 us.

9 DR. LEVY: It's an
10 administrative burden. So, we're going to put
11 together a few ideas, right, and we already have one
12 or two just that quick and we'll share that and maybe
13 we'll be able to come up with something in the next
14 ten months to make an efficiency here.

15 MR. SMITH: I was going to say,
16 too, I mean, it sounds like an ad hoc process. I
17 know we've worked with some of you providers. Our ad
18 hoc process, because we know long term the goal is
19 for them all to go to MCO, but ad hoc wise, we really
20 try to (a) we will have someone contact you guys and
21 explain exactly how to submit it. And we've really
22 been just doing it and I know it's tedious but it's
23 ad hoc and that's more so just faxing it over on the
24 cover sheet foster.

25 And our claims processing team,

1 so, to your point, everyone within that team is aware
2 -we have an internal work flow - foster kids in
3 Kentucky, you know, when you receive these, they need
4 to be processed because obviously they're moving to
5 another. You know, it's required.

6 So, that's something that,
7 again, it's probably not the best solution but it's
8 the one that we've come up with.

9 MS. O'BRIEN: I'm thinking
10 about five years when I met with you all at Passport
11 is that it's been a constant problem for years with
12 foster kids. And what we used to do at the home -
13 and I see Judy down there - is that they brought in a
14 paper and I kept that paper and I delayed the claims
15 going in because of trying to get things in the
16 system so that I could make sure that I was getting
17 payment.

18 But we always had the same
19 issue you are having is with going to a different
20 provider. I don't remember issues with every MCO but
21 I do remember issues and you do have to pull a lot of
22 documentation. I understand and it's been a
23 longstanding concern. I do think, though, going to
24 one MCO is going to really get us out of the problem.

25 DR. LEVY: To your point, is

1 there something we can do together, your group, our
2 group so we give them one process?

3 MS. O'BRIEN: Yes.

4 MS. FRAME: That's what I was
5 wondering, coming up with some sort of process----

6 DR. LEVY: Yes. Why don't we
7 work together so they have one process for foster
8 kids.

9 MS. O'BRIEN: At least until it
10 gets to next year.

11 MS. HUGHES: For the current
12 foster kids, even though they may be coming to you
13 from another county, if they're already enrolled in
14 foster care, when you all get--you have a select
15 eligibility group.

16 So, for the current foster care
17 children, you all should have that information to be
18 able to know that this is a foster care kid and not
19 have them to have to jump through hoops, correct?

20 MS. ALLEN: That's what we're
21 talking about is to do an automated process. We know
22 who the foster care kids are. They're assigned to a
23 particular group ID. So, it is expanding the
24 benefits for those foster care members that are
25 assigned to that group ID.

1 saw them. I'm just saying, you're probably very
2 efficient. Within the next two or three days, you
3 all are probably filing the claim----

4 DR. UPCHURCH: Same day.

5 MS. HUGHES: Right.

6 MS. UNGER: But with your
7 issue, the patient was already in the system with the
8 MCO. You filed everything and now they're coming
9 back and being recouped----

10 DR. SAWYER: Yeah. I've had
11 some recouped.

12 MS. UNGER: ----saying that the
13 child was never under the MCO in the first place.

14 DR. SAWYER: Correct.

15 MS. HUGHES: And with those
16 instances, you probably want to just give us the
17 information and let us check on it. We can't figure
18 out why without knowing what's going on with that
19 particular----

20 MS. UNGER: And that one was
21 sent to that MCO.

22 DR. SAWYER: That's why we call
23 Alethea.

24 MS. HUGHES: And if you're not
25 getting those resolved quickly, let me know. I'll be

1 more than happy to get our MCO Division on to
2 whichever MCO it is and say, come on, get this taken
3 care of or what-have-you, that you're not left out
4 there stranded for any amount of time.

5 DR. BURCHETT: And moving
6 forward with that, though, is there a process for--I
7 know they're moving them all to one MCO. That's
8 great, so, now they're all housed in one position but
9 does that change the process any?

10 MS. HUGHES: Now, that I don't
11 know. That would be Stephanie----

12 DR. BURCHETT: Because if you
13 just put them all in one group but the process hasn't
14 changed, we're going to still run into the same
15 issues.

16 MR. SMITH: What we're going to
17 have to talk about on our side is and work with the
18 MCOs is the benefit limitation because right now
19 they're still set up with the standard limitations
20 just like any other child.

21 So, basically, we would have to
22 work to see if we can - and we get that approval - if
23 we can unlimited basically at a certain point, within
24 twelve months. If we released that benefit
25 limitation to where there's no limitation, then,

1 those claims would go through without having to work
2 this. But, again, we have to work with the MCOs and
3 also get that approval by DMS as well because it's
4 written right now where every child has a certain
5 standard of limitations right now.

6 MR. GRAY: Which makes sense.
7 By creating that under one MCO, we have the ability
8 to structure that.

9 MS. VAUGHN: They shouldn't
10 have any benefit limitations. If it's a foster child
11 group home, they shouldn't have any limitations.

12 DR. UPCHURCH: Right, but are
13 you going to be able to get--on those new ones that
14 are being put in foster care, is there a way to speed
15 up the process of letting the MCO know that this
16 child is a foster child because that ends up causing
17 problems on the new ones?

18 MS. HUGHES: When they come in
19 with a new foster kid, do they not come in with any
20 information to let you know this is a new foster kid?

21 DR. BURCHETT: They've got
22 their folder, their binder, yes. That's it.

23 MS. HUGHES: So, you all know,
24 then, that they are foster kids. Do you know if they
25 are a new or an existing?

1 DR. BURCHETT: Most of the
2 people that I see, yes, because most of the families
3 that I know are foster families from where I
4 practice, and I see them all the time. So, when they
5 come in with their kids and there's a new one, I say,
6 oh, so, do we have somebody new today. And they will
7 say, yes, they came into my care two months ago or
8 last week or whenever. So, yes, usually I can tell.

9 DR. UPCHURCH: But do you know
10 if they were coming from a previous foster care?

11 DR. BURCHETT: If I dig deep
12 enough and ask, yes.

13 DR. SAWYER: I don't. Mine
14 come with one sheet of paper and that's it. Mine
15 come in a van. They come in a van full and they
16 bring one sheet of paper and I don't know where they
17 came from, what their status was, is, anything.

18 MS. HUGHES: Well, let me check
19 and see how long the process is of getting them from
20 DCBS, taking them into foster care and us getting
21 them set up in the Medicaid eligibility system.

22 And if they could work on
23 something because, honestly, if they're currently
24 enrolled and indicated as a foster care child, even
25 if they were in another county, I don't see that

1 there should be that much of an issue with the MCOs
2 and Avesis and so forth to be able to get those gone
3 and processed without you all having to jump through
4 hoops that way, but let me check and I'll get back
5 with you.

6 DR. LEVY: And I do like for
7 this population per provider. I agree. That makes
8 sense.

9 DR. SAWYER: That used to be
10 the ever population, the whole population of
11 Medicaid, one per provider per year.

12 DR. BURCHETT: And it still
13 says that on the fee schedule, so, I'm not sure why
14 it's not. I mean, that's the way it's set up.
15 That's probably the way it should fall out but that's
16 above my pay grade.

17 MS. HUGHES: Mine, too. So, I
18 will get back with you on how long it takes. And,
19 then, if you all can get back with me and let me know
20 what we can do and I can get that out to the TAC
21 members also.

22 DR. BURCHETT: So, is everybody
23 good with foster care?

24 Moving forward, we will skip
25 the next item on the agenda, I think, from what I

1 heard earlier and go to the MCO vision contractor
2 updates. Whoever wants to go first - Passport,
3 Humana.

4 DR. HOAGLAND: Thank you.
5 Steve Hoagland, Chief Medical Officer with Passport.
6 Glad to be here this afternoon. I won't take up a
7 lot of time.

8 Hopefully, it's not a surprise
9 at this point. We are making a transition in the
10 middle of that for our Vision Benefit Manager.
11 Avesis will be pulling that together for us. It
12 helps us kind of broaden our relationship and I think
13 bring a lot of different scale. Hopefully, we'll
14 also create some efficiencies for the practices
15 because of having operated with them, etcetera.

16 For me, every transition should
17 be easy. It's like every system should be easy. You
18 turn the computer on, it's supposed to work but I
19 realize that it doesn't always happen quite that way.

20 We want to be responsive to
21 that; and if you do identify anything that is not
22 operating exactly the way that you would expect it
23 to, please reach into any of us and we'll work as
24 quickly as we can to resolve any issues that may come
25 up. Again, knock on wood, we are working very

1 diligently to try to minimize any potential impacts.

2 DR. BURCHETT: Any questions?

3 Humana.

4 MS. CUMMINS: I was just going
5 to read this network notification that was sent out
6 July 18, 2019 because it kind of explains it very
7 well.

8 Humana and CareSource have
9 mutually decided to terminate their current alliance
10 partnership between the companies servicing the
11 Kentucky Medicaid market effective December 31, 2019.

12 Humana will become the existing
13 contract sole administrator effective January 1,
14 2020. Expect things to remain business as usual
15 through the remainder of 2019, continue submitting
16 claims for Humana-CareSource-covered patients, call
17 Provider Engagement Representatives to get questions
18 answered and access the Humana-CareSource provider
19 portal.

20 Humana will distribute
21 transition details and provider reference materials
22 in the fourth quarter of 2019 to educate and aid your
23 transition. There will be no disruptions of coverage
24 or negative impact for your Humana-CareSource-covered
25 patients.

1 Humana and CareSource are
2 mutually committed to maintain a high standard of
3 care and responsiveness throughout the transition
4 period. And if you have any questions, you can reach
5 out to your Provider Engagement Specialists.

6 MS. ALLEN: And, so, Dr.
7 Burchett, in addition to that, I think what you guys
8 are looking for is the announcement that Avesis will
9 become Humana's Vision Benefit Administrator
10 effective 1/1/2020.

11 DR. LEVY: And that's
12 comprehensive eye.

13 MS. ALLEN: Yes. That's
14 comprehensive eye. So, we will be doing the routine
15 eye and the eye medical, similar to how we are
16 administering the other plans, and the same is true
17 for Passport. We will be doing the full package.

18 DR. BURCHETT: So, my question
19 is, are the coverages going to be any different
20 between the different groups?

21 MS. LEVY: I think the benefits
22 are pretty much the same.

23 MS. ALLEN: Yes. The benefits
24 are pretty much the same with the difference of the
25 adult material benefit. The value-added benefit will

1 remain as they are for the MCOs unless an
2 announcement is released.

3 So, as of this point, so, 9/1,
4 Humana-CareSource vision benefits will remain the
5 same. The adult members are not receiving a material
6 benefit. And for 1/1/2020, as we understand now, the
7 benefits for both Humana and Passport will remain the
8 same; but if we know of anything, of course, we'll
9 let you know.

10 DR. BURCHETT: Thank you. Any
11 questions, gentlemen?

12 DR. UPCHURCH: Is there any
13 possibility of adding adult benefits? Do we know
14 that, Humana or Passport either one?

15 MS. ALLEN: I think it's
16 something that's always considered, but at this
17 point, a definitive answer on this isn't there.

18 DR. BURCHETT: Fair enough.
19 Moving forward, then, the next item Steve will lead
20 us on.

21 DR. COMPTON: This next one,
22 it's just a question I had sent to the KOA office,
23 but at the MAC meeting, I think it was the Primary
24 Care TAC - it could have been someone else - made a
25 recommendation that Medicaid recipients entering high

1 school get a complete physical.

2 My question was, would that
3 include or could that include a comprehensive eye
4 exam as well? I'm just kind of throwing that out
5 because they made the recommendation. That's not
6 carved in stone. My thought process was, if it is,
7 maybe eye care should be included if it all comes to
8 pass.

9 MS. HUGHES: Right.

10 DR. LEVY: Why high school?

11 DR. COMPTON: That was their
12 recommendation.

13 DR. LEVY: In other states,
14 I've seen it where it's right before a child starts
15 school or elementary school.

16 DR. COMPTON: We have that.

17 DR. HOAGLAND: If I could offer
18 a little bit, and Dr. Theriot knows this better than
19 I do. Looking at our data of how children and
20 adolescents engage in care, we do a pretty good job
21 up through beginning of junior high and, then, it
22 falls off dramatically.

23 Part of that has to do with
24 some of the requirements that exist around visits
25 that children have to have before entering into

1 school. It pretty much falls apart as it enters
2 adolescents. And a lot of the potential carrots or
3 sticks, depending on which side you look at things,
4 as far as getting parents and children and
5 adolescents to engage in care goes away.

6 Sports physicals are sometimes
7 a thing that people have looked to, but as you know,
8 it's pretty rudimentary what's offered there. It's
9 not necessarily the most preventative of services.

10 And, so, when we look at our
11 preventative schedules for adolescents, it's much
12 worse than it is for younger children.

13 DR. THERIOT: If it was
14 required, it would also help immunizations because
15 most of the kids will get the immunizations if they
16 come in but they just don't come in.

17 MS. HUGHES: And you all can
18 certainly make that as one of your recommendations
19 that you make to the MAC.

20 DR. COMPTON: I think we're
21 about to. I'm trying to wordsmith it to phrase it
22 right.

23 DR. LEVY: Any of the other
24 ancillaries, were they part of the conversation as
25 well?

1 DR. COMPTON: We weren't part
2 of the conversation either. I was just at the
3 meeting and my ears perked up. So, I would move, Mr.
4 Chairman, that we recommend to the MAC that if the
5 Primary Care TAC's recommendation is approved, that
6 it would also include a comprehensive eye exam for
7 those recipients by an optometrist or
8 ophthalmologist, not by the pediatrician or whoever
9 is doing the primary care.

10 DR. SAWYER: Second.

11 DR. COMPTON: And I'm open to
12 changing the phrasing of that.

13 DR. LEVY: I just have a
14 question, if you don't mind. So, they would get the
15 exam if they already haven't received an exam, right?
16 We wouldn't want to give them another exam if they
17 just had one.

18 DR. COMPTON: Get one in May
19 and another one in August, no, unless they're foster
20 care.

21 DR. LEVY: That makes sense.

22 DR. BURCHETT: I would envision
23 it much like it is now when they enter school and
24 fill out an entering school form, and if they've
25 already had their exam, we just have to fill that out

1 for them.

2 DR. COMPTON: Maybe it's if
3 they've had one in the last year. If it's been over
4 a year, they're eligible for another one anyway.

5 DR. UPCHURCH: You have a
6 tremendous amount of kids in that age category that
7 think they're doing well or they are phobic to the
8 possibility of having to wear glasses and they just
9 don't come in for the eye exams. They just drop out.
10 So, that's a good idea.

11 MS. HUGHES: Have you
12 considered, because I'm assuming you're not just
13 wanting this for Medicaid children. You would like
14 to have this for all children.

15 DR. COMPTON: Well, yes. I'm
16 not certain if the Primary Care TAC was proposing
17 because it was at the MAC, I don't know if they're
18 proposing that for all children. Whatever comes to
19 fruition there, I would just like to have it to
20 include eye exams.

21 MS. HUGHES: I was just going
22 to offer that you might want to go through the
23 legislative process as far as trying to get something
24 that all children, all high-schoolers, not just
25 Medicaid children.

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DR. BURCHETT: Sure.

DR. COMPTON: I wasn't certain, and I read the minutes again yesterday, if the Primary Care TAC meant Medicaid recipients only or all children. It would make more sense for all children.

MS. HUGHES: And right now, I know that our State Plan and our regulations talk about that we follow the - and I don't know all those names - but I know it's Grade A and Grade B of the something therapeutic----

MR. OWEN: U.S. Preventive Services Task Force.

MS. HUGHES: So, if it's recommended through that, it's covered. So, I don't know if they already cover that or not, if that's part of that.

DR. UPCHURCH: Well, these kids are covered now for routine eye exams if they have Medicaid. It's just a matter of whether or not they bother to come in. So, they're already covered.

DR. COMPTON: If that physical before high school is mandatory, this would be mandatory as well. It's all part of the package.

MS. HUGHES: But, see, I don't

1 know that we as Medicaid can make it a requirement
2 for a high school physical.

3 MS. UNGER: So, you have to
4 wait until Medicaid responds to the Primary Care's
5 recommendation.

6 DR. LEVY: Any way to help
7 educate the population through the PCP? So, when a
8 child goes in or to when they go in for their
9 physical before athletics, someone says, by the way,
10 did you get your eyes examined? Just simple
11 education may even help as well just in the interest
12 of time of trying to get something put through.

13 DR. COMPTON: Who seconded it?

14 DR. SAWYER: I did second.

15 DR. BURCHETT: We were having
16 discussion. So, we have a motion and a second.
17 We'll go ahead and take a vote on that. All in
18 favor? Any opposed?

19 I will say, Steve, since you're
20 our MAC representative, we've got that to bring
21 forth. I'll leave it to your discretion when to
22 bring it as far as if we want to wait until they say
23 they're going to do it for that population or if you
24 just want to do it and say we want this included.
25 How is that?

1 DR. COMPTON: We'll work on
2 making that sound good.

3 DR. BURCHETT: And I guess
4 you're the next one down, too.

5 DR. COMPTON: This is a
6 scenario that happened not in my practice but a
7 patient and a Medicaid recipient with papilledema.
8 The optometrist ordered an MRI to rule out a brain
9 tumor. That came back negative, so, she then tried
10 to refer the patient to neurology. The patient is
11 having bad headaches, in pain.

12 This was a month or two ago. I
13 think one neurologist could see her in October and
14 another one in December.

15 I'll tell you what happened
16 with this patient in a minute because it cost the
17 whole system a ton of money. Is there a time frame
18 that if you're a Medicaid provider, you've got to
19 make time available for patients within a certain
20 time frame or is that maybe some of my vision plans
21 require you've got to have a slot for those?

22 DR. HOAGLAND: I could be wrong
23 but I believe, except for primary care or in a
24 situation where there is an ongoing relationship with
25 the patient, and, so, it's for a continuity of care,

1 then, there are, depending on different contracts, I
2 think, that are probably let between the different
3 organizations, different expectations around
4 timeliness for appointments.

5 There is some kind of common
6 language in our contract with the Department around
7 timeliness of appointments for urgent and regular
8 care. But if I remember correctly, it's primarily
9 for when there's a relationship already established
10 or for primary care.

11 MS. O'BRIEN: There are some
12 guidance for specialists. If you're a specialist,
13 it's thirty days.

14 DR. HOAGLAND: Right, but I
15 don't think that it is if they don't have a
16 relationship.

17 MS. ALLEN: And if they don't
18 have a relationship, in certain specialties, it
19 doesn't apply to it, so, if you're an orthopedic
20 surgeon; but like family practitioners, GYNs, they
21 have to be available for urgent appointment within
22 forty-eight hours and for non-routine appointments, I
23 think it's within thirty days. So, there are time
24 frames that they do have to meet.

25 For optometrists and

1 ophthalmologists, I think you're another group that
2 is excluded from that unless it is, again, something
3 that's urgent or life-threatening but you probably
4 would refer them to the ER.

5 DR. COMPTON: Well, this
6 patient made four trips to the ER in one weekend
7 complaining with pain. I don't know who the MCO is
8 but there's four claims. The first time they gave
9 her Advil.

10 Finally, after the third or
11 fourth visit, they got the optometrist on the phone
12 and she finally got a lumbar puncture which is what
13 she needed and the pain is gone and that sort of
14 thing.

15 So, my next question is, and
16 maybe this is a question for the Board of Examiners,
17 can we order a lumbar puncture? That's what the
18 patient needed.

19 DR. LEVY: If that falls within
20 the scope within the state. You would know better
21 than I here.

22 DR. BURCHETT: Off the top of
23 my head, I couldn't answer that but it would be a
24 question for our Board of Examiners because they're
25 the ones to determine our scope.

1 DR. COMPTON: The O.D. could
2 have ordered the LP and saved four ER visits.

3 DR. HOAGLAND: Could you send
4 them to interventional radiology to have it
5 performed? Not every hospital has that service
6 available but many of them do and some of them now
7 are operating----

8 DR. COMPTON: This was done in
9 the ER finally.

10 DR. HOAGLAND: Some of the
11 radiology is almost open access now.

12 DR. THERIOT: But what about do
13 you have a neurologist, that you could have called
14 the neurologist and said I have this patient, can you
15 see them today in your office?

16 DR. COMPTON: She called three
17 different neurologists.

18 MS. HUGHES: Did the patient
19 call or did the optometrist?

20 DR. COMPTON: The doctor
21 called.

22 MR. LEVY: The O.D. did
23 everything possible to treat the patient.

24 DR. COMPTON: And knowing what
25 the patient needed. The O.D. ordered the MRI.

1 DR. THERIOT: Can she still
2 see?

3 DR. COMPTON: I don't know but
4 it cost the system. I think the Commissioner charged
5 us with finding a better way to do stuff and that
6 would be a better way. Those patients aren't common
7 but we all see them a few times a year.

8 DR. HOAGLAND: I guess, for
9 one, that would be a situation I would like to know
10 about firsthand and try to intervene, not that I
11 can't guarantee that I could pick up a phone and
12 someone would be able to see them that exact moment,
13 but I think it's something that we would try to exert
14 a little pressure within the network to try to get
15 them in.

16 DR. COMPTON: So, call the MCO
17 rep and see if they can put some pressure.

18 MR. LEVY: I have to ask this
19 because it would be upsetting. Did the neurologist
20 not see the patient because they were a Medicaid or a
21 government-sponsored patient?

22 DR. COMPTON: I have no clue.

23 MR. GRAY: I would just say
24 this as it relates to neurology only because I was
25 involved in helping a friend who has got Blue Cross

1 and Blue Shield, a great insurance plan, who spent
2 the prior weekend in an ER ruling out stroke, ruling
3 out MS. She suffers from Lupus, is right now bed-
4 bound. And the soonest her primary care doctor,
5 along with input from her rheumatologist, could get a
6 neurology appointment in the City of Louisville was
7 January.

8 DR. LEVY: You answered that.

9 MR. GRAY: It has nothing to do
10 with payor source.

11 MS. HUGHES: Neurologists I
12 have heard numerous times that it's impossible to get
13 in to them.

14 DR. HOAGLAND: It's the hardest
15 specialty to get in to see right now.

16 MR. GRAY: And that's across
17 the whole state.

18 DR. BURCHETT: Moving on, we've
19 got just a few more to cover. I'm going to skip down
20 to Other Business. I just had something pop into my
21 mind that I wanted to ask the Department about.

22 I know the comment period has
23 ended on the telehealth regs recently.

24 MS. HUGHES: I think so, yes.

25 DR. BURCHETT: Is there any

1 idea when those regs will be released?

2 MS. HUGHES: Well, now, the
3 regs were already out there. So, this was the
4 Statement of Consideration.

5 DR. BURCHETT: Finalized.

6 MR. OWEN: Their response is
7 due September 15th.

8 MS. HUGHES: And I think they
9 can ask for it to be deferred a month but I think it
10 is like September 15th if they don't defer it that
11 the Statement of Consideration will come back out
12 with any changes to the regulation.

13 MR. GRAY: That's the E reg,
14 right?

15 MR. OWEN: The comment is on
16 the ordinary. If the reg stays as is, the comments
17 are on the ordinary. The ordinary could be changed.

18 DR. BURCHETT: So, September
19 15th is when we should start looking?

20 MR. OWEN: That's when it's due
21 to be filed. It might be published a couple of weeks
22 after that.

23 DR. LEVY: Was there something
24 specific you guys are looking at regarding the bill?

25 DR. BURCHETT: Just when they

1 were coming out. I think there are some optometrists
2 that are looking into doing electronic stuff.

3 MR. OWEN: I think the store
4 and forward was a concern because it's restricted to
5 radiology.

6 DR. LEVY: Right, because it's
7 synchronice or asynchronice.

8 MR. OWEN: So, the way it is
9 right now, that's only allowed for radiology. I know
10 there were concerns from other providers on that.

11 DR. BURCHETT: Okay. Thank
12 you.

13 Looking down my list, I think
14 the rest of it was stuff that you all wanted to be
15 excused.

16 MS. HUGHES: Can I do just this
17 just real quick?

18 DR. BURCHETT: I just wanted to
19 make sure I didn't skip over anything there. And if
20 I haven't, you all do this presentation.

21 MS. HUGHES: So, we've always
22 had a health insurance premium program but we've
23 never had a lot of participation in it. So, we're
24 really kind of excited to be able to start really
25 putting this forward more. Personally and as a

1 Medicaid employee, I think it's a great plan.

2 So, what it is, in a nutshell,
3 is if I have a Medicaid recipient that is working and
4 they have access to a group health insurance plan, if
5 it is cost effective for Medicaid, we will pay the
6 premium for them to enroll in that employer-sponsored
7 plan.

8 They will be pulled out of the
9 MCOs into the fee-for-service. So, what happens then
10 is just like anytime you have two different plans is
11 that the employer-sponsored insurance will pay first
12 and, then, Medicaid will come in and wrap around and
13 make the member whole back to--you know, they're
14 still going to have the \$3 copay.

15 So, we would come back in and
16 make the member whole. They're not losing any
17 benefits through Medicaid. So, if, for instance, the
18 employer-sponsored insurance doesn't have dental,
19 they're still going to have dental through Medicaid.
20 So, they're not losing anything.

21 We have I think the
22 Commissioner said yesterday like a hundred and forty
23 something that have enrolled since the beginning of
24 it July 1 and it's saving us like \$40,000 a month.

25 MR. GRAY: Potentially 85,000

1 people that are on Medicaid that are employed right
2 now.

3 MS. HUGHES: In May, we sent to
4 10,000 people that actually had indicated to us that
5 they had employer-sponsored insurance. So, August
6 5th, we sent about 35,000 letters out. And around
7 the first of September, we're going to send another
8 35 and those are to people that have just told us we
9 work. So, it's a letter saying if you have employer-
10 sponsored insurance, we can do this for you.

11 One of the good things about
12 this, and especially in our Waiver Program, it may
13 only be a child that's covered under Medicaid and say
14 the mother or the father works and has access to
15 employer-sponsored insurance.

16 If it is cost effective for us
17 to pay the family premium for them to have that child
18 also covered under that, we will cover the employer
19 premium for the entire family just to get that one
20 Medicaid child covered under there.

21 Now, the other family members
22 still won't have Medicaid but we'll pay that whole
23 premium for them. So, it helps them out in that
24 respect.

25 In some cases, it's actually

1 going to expand their provider network. Now, it's
2 always a choice. The wraparound payment is
3 contingent upon them going to a Medicaid provider but
4 they have the choice. Because they have the employer-
5 sponsored insurance, if there is a doctor there
6 that's in their employer-sponsored insurance that
7 they want to see and they're not participating with
8 Medicaid, they can see them. They would have to pay
9 the deductible and the coinsurance stuff with the
10 employer insurance.

11 But if they contact us and say
12 I really want to go to this doctor but he's not
13 participating with Medicaid, we will reach out to
14 that doctor and say would you be willing to
15 participate with Medicaid and try to get them to
16 enroll so it would help them that way as well. And
17 they can enroll for a one-time thing for that patient
18 only to take just for them to enroll.

19 So, to me, it's a win/win/win.
20 The Medicaid beneficiary is not losing anything.
21 We're saving money that we can put towards other
22 programs within Medicaid, and the employer obviously
23 - I mean, I worked for Anthem for years selling
24 employer insurance - if you've got more people on
25 your health insurance plans, sometimes that decreases

1 your rates.

2 So, if you know an employer or
3 if you all have employees that may qualify for
4 Medicaid, we've got stuff. I think I've sent all the
5 TAC members the website for the KI-HIPP Program.
6 We've now just last week added about six or seven
7 documents out there that are employer-driven.

8 We talked to the guy at
9 Owensboro Hospital this morning and he was saying
10 that they may have some employees that qualify. So,
11 we were telling him, go out there. There's
12 information for the employers to use to talk to their
13 employees about this plan.

14 So, we just wanted to touch
15 base. We think it's a great program. I know it
16 probably is not going to be a lot more because, also
17 having worked for Blue Cross, we know most health
18 insurance plans don't provide vision care very often,
19 but it is a good program and it can help the Medicaid
20 members.

21 DR. BURCHETT: A couple of
22 questions. So, say we've got an employee that is on
23 one of our plans and it's a high-deductible plan.
24 So, we bill to that and, then, it comes to Medicaid
25 second and will it still cover those costs for them?

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MS. HUGHES: Yes.

DR. BURCHETT: Okay. And when can they sign up because we just had our open enrollment and we're done with that for our insurance?

MR. GRAY: This is a qualifying event.

MS. HUGHES: This is a qualifying event for them to be able to----

MR. GRAY: Anytime. It's not tied to open enrollment.

MS. HUGHES: Right. So, they can come in at anytime when they sign up for this. There's a handbook out on the website that's just for KI-HIPP. There's the application and everything.

And even if their employer has five plans available to them, if they submit us the information on all five plans, we will run that plan through and look at the cost of the plan, the cost of what we would normally pay for that Medicaid beneficiary.

If it's cost effective, we're going to send back and say, okay, Plan A, C and D are plans we would pay your entire premium for if you signed up for it. So, we will tell them which one.

1 And if it's not cost effective, we will get back with
2 them and say, I'm sorry, but it's not cost effective
3 for us to do it.

4 DR. BURCHETT: Okay.

5 DR. HOAGLAND: Sharley and
6 David, didn't I hear the Commissioner say that right
7 now the numbers, it looks like there's maybe about
8 eighty thousand people around the Commonwealth that
9 could qualify?

10 MS. HUGHES: Yes. And we've
11 actually picked like the top ten employers in the
12 state and are reaching out to them to say we've got
13 this program available if you have Medicaid
14 beneficiaries or lower-income people that are
15 eligible for Medicaid working for you that we may pay
16 the premium for them.

17 The MAC members, when we talked
18 to them last month, they seemed to be very pleased.
19 Chris Carle, who is CEO of St. Elizabeth, was very
20 pleased and wanted information for him to be able to
21 give to his HR folks for some of their employees.

22 So, I think it's a pretty good
23 program. So, if you hear of anybody, have them call
24 us and we'll be glad to help them.

25 MR. GRAY: And to add, too, the

1 Medicaid piece would be considered fee-for-service.
2 That enrollee would come out of the MCO.

3 DR. BURCHETT: Would it just be
4 the employee's portion of the premium or the whole
5 premium?

6 MS. HUGHES: The whole premium.
7 Well, we'll look at it always, if the Medicaid
8 beneficiary is the policyholder, is the employee and
9 it wouldn't be cost effective for us to cover the
10 family but it would be to cover him, we would pay the
11 single plan.

12 DR. BURCHETT: But I'm saying
13 what if, say, like in our business, we pay a portion
14 of their premium for them. So, we still would pay
15 that?

16 MS. HUGHES: Yes, you would
17 still pay that. We would pay what the employee had
18 to pay.

19 MR. GRAY: The employer still
20 pays their portion.

21 DR. BURCHETT: Okay. Fair
22 enough.

23 MR. SMITH: Because I know like
24 if a member, if they become a KI-HIPP beneficiary,
25 they'll be pulled out of the MCO and put in the fee-

1 for-service. Let's say my employer offers medical,
2 again, I'll have my primary covered by my employer.
3 Fee-for-service will cover any medical.

4 Now, vision, how does that
5 work? Will that still be fee-for-service?

6 MS. HUGHES: Yes.

7 MR. SMITH: Let'S say they
8 don't offer vision coverage.

9 MS. HUGHES: Yes, it's still
10 going to be fee-for-service.

11 MR. SMITH: Okay. That makes
12 sense. With the vision and dental both, it would
13 still be fee for service if it wasn't offered through
14 the employer insurance.

15 DR. COMPTON: But the glaucoma
16 and diabetic and all that will go to medical.

17 MS. HUGHES: Yes. That would
18 be medical and would go to their employer insurance.
19 And, then, once that paid, then, you would turn
20 around and file it to Medicaid.

21 So, what should happen is that
22 that Medicaid beneficiary, when they come to your
23 office, will give you their employer-sponsored card
24 and their Medicaid card, but we're also going to have
25 that information in our system.

1 And if it comes back as being
2 cost effective, we'll notify the member and say, yes,
3 you can go ahead if you want to and sign up for this
4 plan and we'll pay the premium. Now, it will still
5 come out of the employee's paycheck, their portion,
6 and, then, they submit to us the proof that it was
7 paid and we pay them back.

8 DR. UPCHURCH: So, our HR
9 person, they just need to call this number or visit
10 this website and figure all that out?

11 MS. HUGHES: Yes. And if you
12 have any questions, just let me know and I can get
13 our folks here that are working on it to call you.
14 Be glad to help you. If it's cost effective, it's
15 going to really be good for everybody.

16 DR. UPCHURCH: Well, it's going
17 to be good for you all, Medicaid, but it's also going
18 to be good for that employee big time.

19 MS. HUGHES: Right, big time
20 for the employee if we're going to pay that premium
21 for them. And, also, if they've just got a child
22 that's eligible for Medicaid, then, we may pay that
23 whole family premium just to get the Medicaid
24 recipient covered.

25 And, then, also, unless it's

1 like what the dentists told us yesterday, the
2 employer-sponsored insurance, if you all are seeing
3 them and it's covered under there, if their
4 reimbursement is higher than Medicaid, then, you all
5 are going to receive additional money rather than it
6 just being a Medicaid recipient.

7 DR. UPCHURCH: There's a lot of
8 employees that even though they're working, they
9 still meet the criteria for Medicaid.

10 MS. HUGHES: Yes. People think
11 that Medicaid recipients don't work, but just for
12 those that have indicated to us on our system, we
13 show about 80,000 that currently have indicated to us
14 in some way they're employed.

15 DR. BURCHETT: Thank you all.

16 (Ms. Hughes and Mr. Gray leave at this time)

17 DR. BURCHETT: Let's finish up
18 real quick. The WellCare/Aetna recoupment stuff,
19 we're going to table that for today. We're not going
20 to talk about that. So, I think that's been
21 discussed previously already and worked out somewhat.
22 So, we'll go with that for now.

23 And, then, the only other one
24 is the Aetna Better Health incentive being offered to
25 members for diabetic eye exams, and I think Steve is

1 going to talk about that.

2 DR. COMPTON: That was
3 something else that was presented at the MAC. Aetna
4 Better Health, for their diabetic patients that get a
5 dilated eye exam, they get a Walmart card----

6 MS. ALLEN: A gift card, yes.

7 DR. COMPTON: ----that they can
8 go charge at Walmart. I have three questions. I may
9 or may not want the answer.

10 One, how much is it? What is
11 it worth? Number two is why Walmart? And number
12 three what do we have to give that patient or how
13 does that work? What is the process?

14 DR. LEVY: I'll just say it's a
15 dilated exam. They put a bunch of non-majoritic
16 cameras in the Walmart and it's just that. So, it's
17 a retinal screen. It's not even a fundus photo.

18 DR. COMPTON: That's not the
19 way it was presented at the MAC.

20 DR. LEVY: I know but I know
21 the program that they're doing and they're not doing
22 it through us that they're doing the program, but
23 from what I have seen and understood, it's a non-
24 majoritic camera in Walmart in that environment.
25 False positive is huge.

1 I don't know the success rate
2 but I do and I've heard a little bit about it. I
3 don't know what the gift card is but it's not
4 dilated, it's not comprehensive and it's being
5 offered as a screening.

6 DR. BURCHETT: So, they can't
7 get this through us, then? It's coming straight
8 through Walmart?

9 DR. LEVY: It's part of an
10 incentive program through Aetna through Walmart
11 specifically, yes.

12 MS. UNGER: Is anyone here from
13 Aetna?

14 MS. ALLEN: Yes, but I'm not
15 sure if you can speak to this. Can you speak to this
16 program?

17 MS. GUNEY: No.

18 MS. ALLEN: Okay. So, if you
19 can give us an opportunity to talk with Aetna, I will
20 get the details on the program and we'll give that
21 information to Sarah to disseminate to you. Is that
22 acceptable?

23 DR. HOAGLAND: I know that
24 there is a third party----

25 DR. LEVY: There is.

1 DR. HOAGLAND: ----that
2 packages this program. We've been approached by I
3 suspect it's the same group. I don't know that to be
4 100% true but we were approached by it as well. We
5 had some questions.

6 DR. COMPTON: One more
7 question. What happens to that patient that's a
8 positive?

9 DR. LEVY: All of your
10 questions are founded and those are my questions as
11 well. I will tell you that I listened to the program
12 that they're providing, and by no means it is
13 absolutely nothing more than a screening. There is
14 no review. The patient takes the image. They get
15 maybe a prick Alc on their finger and they're trying
16 to get them through a gamut of different things, but
17 that's a good question and that wasn't shared on if
18 there is any review, if I'm not mistaken.

19 MS. ALLEN: So, let us take it
20 back.

21 DR. HOAGLAND: I think there
22 was tied to a relationship that Walmart has or is
23 growing with vision providers within their bricks and
24 mortar. Off the record.

25 OFF THE RECORD

1 MS. ALLEN: So, I will talk
2 with Aetna. We'll get the details on the program and
3 answer your four questions and we'll follow up with
4 Sarah.

5 DR. COMPTON: If I think of
6 more questions, I will send them to you.

7 DR. UPCHURCH: I've got a
8 question and you may not know the answer to this, but
9 are they just taking the pictures and handing them to
10 them or are they giving them some kind of device at
11 all?

12 DR. LEVY: No, I don't think
13 they're doing that and I don't know the total process
14 but I don't think they're getting the picture or the
15 image. I think it's just taking a shot.

16 And to the doctor's point. I'm
17 not sure. It's surprising because, if I'm not
18 mistaken, a lot of the Walmarts have full
19 capabilities and fungus cameras to be able to and a
20 practitioner, an optometrist on staff there. So,
21 it's surprising.

22 I think it was really more to
23 get them to do some of the other things based on
24 other comorbidities that they may have and this was
25 just one of the ways to do a screening, but I'm

1 familiar with the camera they're using and it's more
2 than challenging on a dilated eye with the camera
3 there using the technology they're using.

4 DR. UPCHURCH: You're always
5 concerned about the possibility of them saying, oh,
6 this looks good and, then, the patient getting the
7 false impression that they're fine and they're not.

8 DR. LEVY: My feedback is that
9 if a patient does that and to break to my partner,
10 it's this is not in any means an eye exam. This is
11 just a screening and that's that.

12 So, I had some pause and some
13 concern that in the mind set of that member, it would
14 stop right there for eye care services and that's
15 exactly what we're not about.

16 MS. UNGER: Who are they going
17 after? So, you're just walking in?

18 DR. BURCHETT: Are they
19 marketing to them?

20 MS. UNGER: I guess there's a
21 lot of questions.

22 MS. ALLEN: Yes. So, we'll
23 talk.

24 DR. UPCHURCH: Well, we're
25 thankful that you're going to be on top of this as an

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O.D. because that's scary. It's a little scary.

DR. LEVY: Absolutely.

DR. BURCHETT: Any other questions? We thank you all for all the information and all the information to come.

DR. UPCHURCH: I make a motion we adjourn.

DR. COMPTON: Second.

DR. BURCHETT: We're adjourned.

MEETING ADJOURNED