COMMONWEALTH OF KENTUCKY

CABINET FOR HEALTH AND FAMILY SERVICES

FOR MEDICAID SERVICES

IN RE: OPTOMETRIC TAC

HELD VIA ZOOM

DATE:

FEBRUARY 2, 2023

1:00 P.M.

A T T E N D E E S:

Dr. Matthew Burchett, Chair

Dr. Karoline Munson

Dr. Gary Upchurch

Dr. Steve Compton

(and many more were on ZOOM)

DR. BURCHETT: Thank you all for joining us today. Once again, I think we all know each other fairly well by now, but I'm Dr. Matt Burchett, the Chair of the TAC and we will get things going. I think we've -- from earlier there, I think we said we have established we do have a quorum for the TAC members, so we'll go ahead and get the meeting underway here.

First order of business for us today, of course, is, as always, the approval from the previous two meetings that we have had of the minutes of those meetings. So we will start with the regular meeting from last year, the last regular meeting and then we will go to the special meeting. So if I can have a motion to approve the minutes for the last regular meeting of the TAC.

MS. BICKERS: Could I just ask that if you are a member, could you please -- could you please engage your camera, so that we can have a record of your votes.

DR. COMPTON: Mr. Chairman, Steve Compton, I move to approve.

DR. UPCHURCH: Gary Upchurch, second.

DR. BURCHETT: Thank you, Guys. Any discussion?

Hearing none, all those in favor of approval of the last regular meetings minutes say aye.

DR. UPCHURCH: Aye.

DR. COMPTON: Aye.

DR. BURCHETT: Good. And those opposed?

(No response.)

Now, since that's done, let's do the special meeting we called, there in December. I'll take a motion to approve the minutes of that meeting.

DR. COMPTON: Steve Compton. Mr. Chairman, I move to approve.

DR. UPCHURCH: Gary Upchurch, I second.

DR. BURCHETT: Thank you, Gentlemen. Any discussion on those minutes?

Hearing none, then I'll take all in favor say -- of approving those minutes of the special meeting say Aye.

DR. UPCHURCH: Aye.

DR. COMPTON: Aye.

DR. MUNSON: Aye.

DR. BURCHETT: And any opposed? (No

response).

Okay. So approval of both sets of minutes. That's good. That's got that out of the way, a little house cleaning.

Moving on to the No. 4 item there on our list is the old business. And let's just start at the top and work our way through. If you'll excuse me, my voice is a little crackly today. So at the November meeting, we talked about the optometrists reporting our no-show rates and asked if DMS would have any way to collect those numbers of no shows that we have report and share those with the TAC. I know talking with some of the TAC members about this, I think Steve and Gary said they had several no-shows that they reported. Does DMS have any total numbers across optometry to be able to report to us?

MS. KITCHEN: Yes. This is Kelly Kitchen. And I also apologize, my voice is still messed up. So we do have numbers and this was actually ran for you when you requested. It just did not get to you and I apologize for that. We do have here

showing that the overall total number of cancelled appointments -- and this, again, is up through November of '22, January 1st of '22 through November of '22. And those total cancelled appointments was 496 total. And then we have a total of missed appointments during that same time period of 1,947 missed appointments.

DR. COMPTON: Chairman, may I speak? Steve Compton.

DR. BURCHETT: Yes. Go ahead, Steve.

DR. COMPTON: I got that spreadsheet this morning and it shows Compton & Compton Eye Care, between the missed and the cancelled, of 285 in calendar year '22.

DR. BURCHETT: Yeah.

DR. COMPTON: We actually reported 575. I looked it up this morning. So these numbers are not -- they certainly don't reflect our practice.

MS. KITCHEN: Were those reported within the Kentucky HealthNet?

DR. COMPTON: Yes.

MS. KITCHEN: Okay. Is that only through November -- from January 1st through

November?

DR. COMPTON: No. It's January 1st through December 28th, I think.

MS. KITCHEN: Okay. So the report was ran up through November, and we actually ran that one when requested. So we do only have up through November.

DR. COMPTON: Okay. But I don't think I had 300 no-shows in December -- 290, I'm sorry.

MR. DEARINGER: This is just Justin Dearinger. We will definitely take a look at that and see if there is a discrepancy, and if it is, why. I did want to let you-all be aware that we are currently working on another initiative that has -- for no-shows in particular. That project has already been started, it's underway. We were hoping it would be completed by January 1st. However, it's -- it's not complete. Like most IT projects, it's taking a little time to develop. But basically, that project is going to be a tool for you-all to be able to go online and to be able to pull up any specific

provider type and look at the no-shows for the provider type based on year; can break it down by month. You can pull up the reason why, if there was a reason listed for the no-show. And, you know, that's a tool that we've just created -- or in the process of creating that hopefully is going to help, not only you-all, but will help us as we try to continue to solve this no-show issue. But we will definitely check on that numbers issue and see if there is anything that's not correct about it.

DR. COMPTON: My point being, I think the problem is a lot worse than maybe DMS realizes. It's -- it's an issue, at least in our practice. Thank you.

DR. BURCHETT: Thank you, Steve. Any other discussion from any of the other TAC members on that before we move on?

Okay. Hearing none, the next item is the update. Any updates from DMS on being able to electronically send our license renewals to the -- from the Board of Examiners to DMS?

MR. DEARINGER: Justin Dearinger again.

Unless anybody else has --
MS. DUDINSKIE: Justin?
MR. DEARINGER: Yeah, go ahead.
MS. DUDINSKIE: It's Jennifer. I have a little bit of an update on that, because my team had been working on that for some time.
DR. BURCHETT: Yeah.
MS. DUDINSKIE: And we thought we had it worked out. And then when we got the file transfer this past month, that -- we knew it wasn't correct. So we've taken a step back. We've recontacted them. We are still working on it. But whatever file that they sent to us, just -- it was not correct, so it is still a work in progress.
DR. BURCHETT: Okay. Thank you for that. Any thoughts or updates on timeframes of trying to upload another file to them or anything like that?
MS. DUDINSKIE: I need to check with my staff on that. I apologize, I don't have a date. But I will say if anybody on the TAC can help support us in any way with the Board, it might help a little bit to get a

nudge from you-all. They're responsive, but they are a little bit slow to respond to us.

DR. BURCHETT: Okay.

MS. DUDINSKIE: And so, you know, if we -- if there is anybody that has any influence in that way, we would greatly appreciate the help from you-all.

DR. BURCHETT: And if we did --

MS. DUDINSKIE: This is --

DR. BURCHETT: I was going to say if we did, who should they get in touch with, with you-all?

MS. DUDINSKIE: Best contact will be Sapna Sairajeev. I'll put her information in the chat since that might be a little challenging to spell.

DR. BURCHETT: Oh, come on now. That's fine, yes.

MS. DUDINSKIE: Certainly.

DR. BURCHETT: I guess moving on to the next -- thank you. I just saw that pop up in the chat.

Moving on to the next is, there was a question that arose from a couple of

optometrists across the state. And we all are supposed to abide by -- I think we established that numerous times with the TAC talking with DMS, but we're supposed to abide by the fee schedule; correct? And if there's a service that says it's covered on the fee schedule, then is it right if one of the MCOs or their vision providers reimburse that at a zero-dollar amount?

MS. PARKER: I think we need an example. I mean, provide us an example so that we could look at it. I mean, do you have a specific code or...

DR. BURCHETT: I think we probably could find one. But just in general, you know, say it was a 92014 and we bill it and it's on the fee schedule and they come back and say that their reimbursement is zero for that code or -- I don't have -- I don't have the actual codes off the top of my head for that example. I could probably look it up, but that would take a second.

MS. PARKER: It may be related to your contract with them. I mean, I think it depends on your contract with them if that

particular code would not be payable.
DR. BURCHETT: So then what you're saying is, even if it's on the fee schedule as a covered service, if the contract that was signed with the vision provider or the MCO, whichever in this case, if they had a zero-dollar amount for a code number that was a covered service, then that's a valid contract with them.
MS. PARKER: Well, you ask a very good question regarding that. Obviously, they are to cover medically necessary services --
DR. BURCHETT: Which I -- which I assume are the services on the fee schedule that have been deemed coverable.
MS. PARKER: Well, they are if they are medically necessary. I mean, I don't know if this particular code that you are talking about that -- I don't know if it's -- if you are just doing an in general question versus a specific code that you have, an MCO, I think that would be helpful. But, in general, they are to cover medically necessary services on the

fee schedule -- that are on the fee schedule. They can't cover something that is not unless it's a value add.

DR. BURCHETT: Sure. Yeah, and -- yeah, and we --

MR. DEARINGER: And something -- something else to think about --

DR. BURCHETT: -- understand that.

MR. DEARINGER: I think we've had that question a lot. Something else to think about is the MCOs are required to provide those services for their -- you know, for individuals. So if -- you know, but it doesn't have to -- every provider doesn't have to provide every service. So a lot of MCOs will have contracts with different providers that may exclude certain things because they -- for whatever reason, if that makes sense. So each contract can be different as long as they are provided somehow, somewhere, then they are still meeting that requirement. So there are a lot of detail -- you'd have to maybe send an example, you know, offline to somebody, one of the MCOs specialists that you are

concerned about, that works with that MCO. And they would have to look at your contract and look at that specific instance and that code to kind of see, you know, whether they were -- whether there's an issue or not.

DR. MUNSON: So Justin, this is Dr. Munson. I'm driving. Am I clear enough for you to understand me?

MR. DEARINGER: Yes, ma'am.

DR. MUNSON: Okay. So the question is, if it is a covered service on the Medicaid fee schedule, so the current schedule of medically necessary covered services, is that something that can be reimbursed at a zero-dollar rate, or is that something that has to be covered and reimbursed at something that is not a zero-dollar rate.

MR. DEARINGER: Again, I think it's -- you know, the question is a little -- they have to -- it has to be covered through -- by the MCO somehow, somewhere. It doesn't --

DR. MUNSON: Okay. Yeah, so we --

MR. DEARINGER: -- every single provider that they use as a provider for vision.

DR. MUNSON: So that's not what I'm asking. The zero-dollar rate, is what I'm asking. So if it is a covered service, like Matt's example, are they allowed to say a 92014, yes, we cover it, but the reimbursement is zero dollars. Is that still considered covered when there is a zero-dollar reimbursement?

MR. DEARINGER: Generally, no, but, again, it depends on the contract. So, for instance, if they had a contract with a -- you know, if they contracted with ten different vision providers and they covered that service through one provider and they pay that service at whatever that -- you know, there was a paid amount for that service, but the other nine providers, they paid zero on that service, they would still have that service covered, because whenever it was medically necessary they could send those individuals to that one provider. I'm not saying that's the case. I'm saying that's one of many possibilities.

DR. MUNSON: And what's the coverage area? Is it as the crow flies?

MR. DEARINGER: Well, I mean, again, there's specifics; right? It's something that we -- you would have to send us a specific instance off line or per e-mail and we would -- it would be something the MCO branch would have to look at.

MS. UNGER: Hi, this is Sarah with the Kentucky Optometric Association. Angie, I sent an e-mail on January 23rd with the information as an example, if you want to take a look at that. And I can resend it if needed.

MS. PARKER: Okay. Thanks, Sarah.

DR. BURCHETT: Well, let's move forward from that a little bit then in this train of thought. So say it is a covered service and say it's a medically necessary covered service, as we've said, and they are providing it at a zero-dollar co- -- or not copay, but zero-dollar reimbursement. And if that is established as not the right thing for them to be doing, how would an optometrist go about reporting this? Who would we report that to?

MR. DEARINGER: Angie, do you know the --

there's a complaint line or number.
MS. PARKER: Yes. Jeremy Armstrong-Derossitt is the branch manager over the Contract Compliance. And there is a link on our website that you can fill out a complaint form, but you can also just e-mail him directly. And, you know, Sarah has my contact information, too. And I'm always happy to assist when I can. I'm looking at this e-mail right now and, Justin, I'm sending it your way to kind of take a look at this.
DR. BURCHETT: So if --
MS. PARKER: I'm not a code -- I don't -- so we will need to look at this. We have an example for that.
DR. BURCHETT: So then moving a step forward, if they are in violation because it is supposed to be paid at a certain dollar amount -- and I understand dollar amounts can be negotiated between providers and -- and the MCOs, but it's some dollar amount, but they are trying to pay it at zero amount. If that's found in violation, does that make their contract with the

provider invalid then?
MR. DEARINGER: That's something that we would have to discuss. You know, if we find that to be the case, that's something we have to discuss between the provider and the -- and the contract branch.
DR. BURCHETT: Okay. Then taking that a step further, would that make the MCO's contract with the State invalid because they were providing -- or trying to provide zero-dollar reimbursements for covered services?
MR. DEARINGER: (Inaudible).
DR. BURCHETT: You said it would not?
MR. DEARINGER: Again, I think it's something we have to look at on a case-by-case basis, you know, kind of general questions we'd have to discuss and talk about to see if that -- if that is something that has occurred --
DR. BURCHETT: Sure.
MR. DEARINGER: -- but, you know, I think what you're asking overall maybe is -- and so I can't give you any general statements about anything you said really. The only

general statement I can say is that an MCO is required through their contract with us to be able to cover all the services that are listed on our fee schedule using whatever providers they have in their network. And they cannot reimburse -- something's not covered if it's reimbursed at a zero. That's not considered covered.

DR. BURCHETT: Okay.

MR. DEARINGER: However -- so I can say that, but, again, they can use different providers. They can have different plans for different procedures. You know, we can get deep into the weeds there about how far somebody has to travel before they -- to get certain procedures that they may cover with one provider versus another provider.

DR. BURCHETT: Well, let me give you this --

MR. DEARINGER: They may -- prior authorization.

DR. BURCHETT: Right. So let me give you this --

MR. DEARINGER: So we have to look at -- you know, we have to look at kind of a

case-by-case. But overall, in general, they have to cover it somehow, someway, not a zero-dollar amount. So, again, we will look at those examples and see.

DR. BURCHETT: Sure. So let's think about this and maybe you can answer this, maybe you can't right off, but -- so say somebody comes to me and buys glasses and that's covered under their -- or my contract with them for me to provide glasses to them, but they say that they are not going to pay. It's a zero-dollar reimbursement for the dispensing of the glasses to me under my contract. So would they have to provide somewhere, somebody can dispense the glasses to them and be reimbursed? And if so, then what's the logic there for them to get glasses from me, but somebody else has to dispense them to them to get reimbursed for it?

MR. DEARINGER: I'm not sure. I'll have to kind of look into that. I can't answer right off the top of my head.

DR. BURCHETT: No, and that's fine. And we can revisit this later. If you-all want to

look at the example sent to you and we can come back to it next meeting --

MR. DEARINGER: Yeah, we can --

DR. BURCHETT: -- if we need to.

MR. DEARINGER: Let us do a little research and let us look at it. I think we have an e-mail that -- yes, some e-mail examples that we can look at and do some research on.

DR. BURCHETT: Sure. I appreciate it.

MS. PARKER: This is related to the dispensing fee and this one particular provider whose contract allowed that. So I understand that your overall question is, are they allowed to do that via contract; correct?

DR. BURCHETT: To provide the zero-dollar reimbursement, yes.

MS. PARKER: Yeah, right.

DR. BURCHETT: Yes.

MS. PARKER: Thank you.

MS. SHEETS: Please also note in a follow-up e-mail out to the TAC per this meeting, we will include that complaint e-mail where you can send those complaints

to as well, so that you will have that for your records.

DR. BURCHETT: Yes.

DR. COMPTON: Matt, I've been reading the August minutes. We've had discussions about this as far back as -- at least as far back as August --

DR. BURCHETT: Yeah.

DR. COMPTON: -- and we haven't got an answer yet.

DR. BURCHETT: That's why we are keeping it on the front burner, Steve.

DR. COMPTON: You and me.

DR. BURCHETT: Okay. Well, thank you for that. Hopefully, we will have maybe some clarity with it on the next meeting. I appreciate your-all's efforts there.

The next one, just a question to March Vision. Was there any updates or changes to billing refractions that are medically necessary?

MS. KITCHEN: This is Kelly Kitchen. I actually looked into that in the past when we spoke about refractions and DMS does not currently have any limitations on billing

for refractions. I'm not sure if that's coming from the MCOs on a limitation or if you are seeing that through the fee for service.

DR. BURCHETT: I think the question is more on, we were asking if March would consider covering refraction when medically necessary, because currently they don't pay any refractions.

MS. KITCHEN: You are saying that fee for service doesn't or no one does at all right now?

DR. BURCHETT: I'm saying that everybody but March Vision pays for refractions when medically necessary.

MS. PARKER: March Vision with United. Is anyone from March Vision and/or United on the call that can address this, please?

MS. RITCHEY: Good afternoon. This is Ann Ritchey with March Vision Care. I believe Dr. Edmonds was planning to be on the call. I'm not certain if he was, but I know he provided some guidance at the last meeting regarding refractions that were medically necessary. And I'm not a clinician, but I

believe the discussion was around when those refractions were done outside of the member's, you know, kind of routine or annual exam. And, Dr. Edmonds, I don't know if you have kind of any detail or were needing some examples on those?

DR. EDMONDS: Yeah, we've taken a look at what the contract is and I wasn't sure what the update was. So there -- it depends on how the contracts were. Generally speaking, refractions is a timed benefit available only once a year. It has not been paid for on interim outside of the annual amount. But if it is spelled out in the contract that it's paid as needed, when medically indicated, then we would pay it. We were going to do some contract research to see how that's -- how that's stated, because it does vary from state to state. Generally speaking, you know -- not speaking Kentucky, but speaking nationwide, it is a timed benefit. It's only paid as part of that annual exam and not paid -- but time -- if it's a -- considered a non-covered service, the time spent doing

the refraction would count as medical care and could be billed just -- you know, most medical care is billed based on time. You know, you would move it to a different level, if indeed you spent that time doing medical care that wasn't covered. If it's covered, just like fields and OCTs, the time, you -- when you bill those codes, you can't bill that time you spend on interpreting or doing an OCT or a field, because that's paid separately. But if it's not paid separately, then you can bill that time. So that's my understanding.

But if they have specific language in Kentucky that said, paid as needed, then we would pay as needed. I haven't gotten an answer back from legal on how that's worded for the state of Kentucky. So just want to be compliant with whatever their regs are based on the wording of the benefit.

MS. RITCHEY: Right. It's Ann, again. Scott, thanks for the update. I can work with you then to make sure we get some feedback and an update from legal, so we can close that issue. So thanks for the

reminder on that.

DR. BURCHETT: Any question from any of the TAC members on that?

Hearing none, then thank you for the update. I'll be interested to hear what your final verdict is on that hopefully before the next TAC meeting.

Okay. So the next, I guess, looks like, if I'm not mistaken, deals with most of the stuff we talked about in the special-called meeting. And I'll turn this over to DMS, if they just want to go down each one of these follow-up questions and give us any kind of answers they can there, if that's okay with you-all.

MS. KITCHEN: This is Kelly Kitchen. So for the first question, has DMS approved the new enhanced benefits? That has not been approved by CMS yet, so we are still pending a response. And as far as how optometrists are supposed to be handling the billing of adult glasses, children/adult contacts with the new enhanced benefits right now, currently everything is paying based on the 2022 fee

schedule until we get the approval from CMS. Anything that is approved for 2023 will be backdated and there will be mass adjustments to claims that they have been billed with any codes that are on the new fee schedule and approved by CMS. Will the MCOs be giving optometrists and providers 30-days notice on the changes? I believe that's contractual.

DR. BURCHETT: And so if they are supposed to give a 30-day notice, then we should expect that as soon as CMS approves and you-all pass that along to us; right?

MS. PARKER: Correct.

DR. BURCHETT: Okay. Any discussion --

DR. UPCHURCH: I have a question, Matt.

DR. BURCHETT: Yes, I was getting ready to ask, any discussion here?

DR. UPCHURCH: So this is DMS's suggestions, that CMS has not approved this. We have patients coming into our office wanting these benefits now. If we go ahead and provide these benefits and for some reason CMS does not approve them, so are we just going to lose what we've

invested?

MR. DEARINGER: I don't know -- this is Justin Dearinger. We have had this happen several times, at least even since I've been here. I haven't been here that long, but it's -- we have never had an issue where -- where CMS didn't approve or didn't at least approve us to, you know, make payment. So I think, you know, we have to kind of -- and I understand what you're asking, but I don't think that's -- I don't think that that's ever happened that I know of. I don't think it's ever happened when we looked back and say -- in the history of what people have been here have known. So I don't think that's something that we have ever encountered. So I don't know if I can ask your question fully since none of us have ever experienced that.

As you-all know, or may not know, in the administrative regulation world, this happens a lot where an administrative -- where something has changed in policy, we have to operate out of a certain way based on time frames and system and then -- you

know, but it takes an administrative regulation a year to change. And so legally, you know, it might not be fully, you know, in operation for 12 months, but we may have to start something within six months. So that's just kind of how this process has went. Sometimes, like regulations, CMS is a little slow. That's, I guess, my response to that question.

DR. UPCHURCH: Well, having said that, Justin, so if we go ahead and start providing these services right away, is Kentucky DMS going to start paying us for those services right away or are we going to wait to see if CMS approves them before they pay them?

MR. DEARINGER: Those services will be reimbursed as soon as CMS approves. They wouldn't be paid now. They would be reimbursed when CMS gives approval.

DR. UPCHURCH: And you said that could take six months, could take a year?

MR. DEARINGER: No, no, no. I was using as an example the administrative regulation process. We don't anticipate -- you know,

I don't have an approximate date. I wouldn't anticipate it to be very much longer at all, but I don't -- you know, I can't -- I can't tell you. That six months to a year was just talking about sometimes we have to implement policy before a regulation is finalized. In a similar way, sometimes we have to implement fee schedules before CMS gives final approval. It was just an example comparison. But I don't anticipate it to be, you know, anywhere near that kind of time frame.

DR. BURCHETT: So do you-all have any mechanism in place to reimburse doctors that have gone ahead and started doing this if CMS says no to all or any of the benefits that you-all proposed?

MR. DEARINGER: Again, that is something that has never happened. I mean, that would have to be a bridge we would have to cross and figure out, you know, as -- you know, DMS has never -- that I can remember, and maybe you-all have some examples where we left providers hanging financially. So I don't -- I don't think it would -- you

know, but I can't give you any kind of definite answers. It's never happened. That's just kind of how -- it's kind of how things are done -- I don't know -- with fee schedule.

DR. BURCHETT: Well, sure.

MR. DEARINGER: We don't get asked that question a lot, but --

DR. BURCHETT: Well, you know, it's -- I can speak -- I can speak for myself. I don't know about any of the other providers across the state, but I don't get the warm and fuzzies to provide services knowing that they may or may not be reimbursed to me.

MR. DEARINGER: I understand that. I get it.

MS. BICKERS: Dr. Burchett, this is Erin with DMS. And sorry to cut you off, Justin. So Kelli Sheets and I are also the SPA coordinators. Just a little bit of feedback -- DMS is working with us to try to make sure all the language is as it should be so that everything that we want to cover is covered under what federal

regulation, law allows. And so that's just within -- there's a lot of questions back and forth, and that's the only reason I -- I believe, since I've been doing this, that they haven't been able to move forward, just to make sure that they are understanding what we are trying to do, and ever -- and my learning, training history at SPA has never been rejected. They try very, very hard to work with us. Now, as far as the billing aspect goes, that's a little out of my wheelhouse. But that's just a little bit of background about the SPA process. There has just been a lot of questions going back and forth, because we had not altered these services in a year. So they are just trying to make they are understanding what we want to do, how we want to do it. And we just recently got some more questions that we answered, so we're -- we are working very diligently with DMS to get this approved as quickly as possible.

DR. BURCHETT: Sure.

MR. DEARINGER: We're the government. Just

trust us.

DR. UPCHURCH: That's what we're afraid of.

DR. BURCHETT: That don't make me feel good. Sorry.

Anyway, going back to the first bullet point there, you-all have any response to the letter that the TAC sent you with recommendations from our meeting we had in December? And, if so, were there any changes that you-all decided to make from those recommendations?

MS. KITCHEN: At this time we are going to keep the B Schedule as we have it until we get through the approval process with CMS, get the regulations updated and get the system changes put in. Once that has happened, then we may come back and revisit those requests for changes. But until the actual CMS approval happens and policy or the regulation gets updated, we are going to keep everything as is, and then we will come back and rereview to make any additions that's been requested.

DR. BURCHETT: Okay.

MR. DEARINGER: And this is Justin again.

We do have that -- those recommendations. Some of those are very good. And, you know, when we talk to all the different provider types that had this expanded coverage -- this is the first time we've ever done anything like this and, you know, we have changed those fee schedules I don't know how many times up until about the time that it was CMS. And that's another reason why it's taken so long. We made a lot of adjustments to the fee schedule based on stakeholder feedback there at the very end, because we realized we missed some stakeholder groups and there were some other groups we wanted feedback from. And so we made a lot of changes deep into, you know, when we should have already had these things posted. So a lot of that is on us for not including, you know, all the stakeholders that needed to be included and having such a time crunch. But we are -- as always, we have those suggestions. And, you know, being a new expansion like that there are going to be a lot of changes to that fee schedule -- not changes, but

improvements, not from us, from you-all, from stakeholder input and feedback. So we will make those throughout the year. And whether we do a -- you know, a special June or July change to the fee schedule or whether we wait until January 1st, 2024 fee schedule, we are definitely going to make some changes and a lot of that's going to come from input that you-all provided. So I thank you very much for that.

But at some point we had to stop and -- with CMS and say, this is it, this is where we are at for now, in order to get this thing moving.

DR. BURCHETT: Okay. Thanks for that input. Any other discussion on any of that from other TAC members?

DR. UPCHURCH: I guess my question, Matt, too, for that would be for the MCOs. Is it going to be the same situation where -- are they going to start paying for these new enhancements right now or is that also going to be held back until all this is approved and then the 30-day notification? So where are we sort of at with the MCOs?

MR. RANDALL: Hi, this is Jeremy Randall with Anthem. I want to assure you that we are paying for these currently and ready to receive claims and process them.

MS. ALLEN: Hello, Dr. Upchurch. This is Nicole with Avesis. The Avesis administered plans are also configured and are paying at the DMS released fee schedule.

DR. UPCHURCH: I appreciate that, Nicole. I knew that yours was. I didn't know about any of the others. Jeremy, I appreciate that input on yours.

What about the March and --

MS. RITCHEY: Yeah. Good afternoon. This is Ann again at March Vision Care. We are in the proses of finishing up our configuration, so we should be set to pay those, I would say, by early next week.

DR. UPCHURCH: And will you-all have grids for different -- the different MCOs as to what their reimbursements and things are that will either come out to us or be on your website?

MS. RITCHEY: For March Vision Care, I

believe it will -- you know, the reimbursement to the providers will be based upon the contract that those providers have with March and the Medicaid fee schedule that was published. So I don't know that there's going to be anything additional that will be published on our website, but I'll certainly be happy to confirm that.

DR. UPCHURCH: Okay.

DR. BURCHETT: Any other questions on that, clarifications? (No response.)

Okay. Thank you to the Department for -- thanks for that clarification from DMS. I am going to move on to the new business portion. And I think this is something Steve brought to our attention, so I'm going to turn it over to Steve to discuss this one.

DR. COMPTON: Yes. We have an issue -- or had an issue. I thought I had it. Here it is in my hand. Cindy is in here, but she said please don't make me talk. Anyway, we had a recoupment on a patient that we went back and looked. And on the DMS website,

the patient is eligible on the date of service, and on the vision subcontractor website it said they are eligible and we saw the patient and we got paid. And then some point later -- I don't even remember who -- they recouped the money, so, you know, then what do you do? You looked everywhere you could look. It says they are eligible and then you provide the service, and then they take their money back.

MR. DEARINGER: Can you send me an e-mail with all that information? We have had a couple of cases like that. We are trying to track down exactly why this --

DR. COMPTON: Okay. I've sent it --

MR. DEARINGER: -- I think --

DR. COMPTON: I think you've got it, right, Sarah Unger?

MS. BEVINGTON: This is Dinah. Sarah's audio is not working, so we are in the same office and she told me to tell you, yes, she has got it and she will send that on.

DR. COMPTON: Okay.

MR. DEARINGER: Yeah, we'll -- we'll --

and, again, we are aware that it's -- it's not happening a lot, but it is happening and we are going to get that taken care of. I think we've got it kind of narrowed down, but any extra cases I can get to look at helps us to make sure that it's only happening in certain instances and -- but we are aware of that and we'll take care of that.

DR. COMPTON: And they will forward that to you. It was Humana and Avesis. I guess an FYI thing. All right. Thank you.

DR. BURCHETT: Any other questions or discussion there? I think it sounds like we got that one figured out a little bit. We will get that information in there, Steve, and see what we come up with.

Going back, I've got just a -- to the previous No. 4. We were talking with the Department on some of the stuff that was sent to CMS. I just had a follow-up. I've been trying to run it around in my head here for just a second, but -- so say if CMS improves the enhancement to the plans for the patients. And the Department, like you

said, currently, you don't think you will change anything on the fee schedule. You said you thought that would stay the same for now. As a provider, what happens between myself and the patients if I don't feel comfortable giving them one soft contact lens for a year to wear, then am I in violation of my agreement, my contract with any of the MCOs that are providing that, or to the Department for fee for service if I don't decide to do that yearly contact?

MS. KITCHEN: You are not. And, actually, I think we spoke on this before was, the items that are on the fee schedule are items that DMS will pay for. If you provide that service to a member, that they are not services that DMS says you have to provide these services to that member. It is an option based on medical necessity and what the provider feels that particular patient may need, may or may not work for them or that patient may need.

DR. BURCHETT: Okay. So then if we don't feel comfortable doing that, then it's a

service that we can just say we don't provide, basically?

MS. KITCHEN: Yes, that is correct.

DR. BURCHETT: Okay. What about the MCOs? Would that be the same through the MCOs?

MS. ALLEN: Hello, Dr. Burchett. This is Nicole with Avesis. Yes, that is true.

MR. RANDALL: This is Jeremy with Anthem. Yes.

MS. HUGHES: Kimberly with Passport. Yes.

DR. BURCHETT: Okay. Well, I guess that answers that for us then. I appreciate the clarification, again. I thought we talked about that stuff, but I just wanted to make sure that I understood it the right way. Thank you-all.

Moving on, next is a general discussion topic and I've got something to throw out to the TAC on this. And some of it stems from, I think, what Steve had talked about, that the MAC had come, talked about maybe a little bit from time to time. But would there be any -- this is a question really for the Department to start with. Is there any possibilities for us to increase

reimbursement for codes that we provide service for that would improve the quality of the outcomes for the patients? Maybe not all fees, because I know some fees won't make a lot of difference in the quality of outcomes that happened and the exam that we give, but there's some testings that we can do and things like that, that if we have that information, then maybe we can provide a better outcome for that particular patient. Would there be any thought about looking at a fee increase for some things like that, that we might be able to provide you a list of those codes?

MR. DEARINGER: Yeah, absolutely. This is Justin again. We are always open for providers to send us code or codes that they feel like are underpaid or not utilized because payment is too low. And what we do with those codes is we will research those. We will look at the Medicare rate, if there is one. And if there is not one, we will look at other states and see what they are paying, all the surrounding states. And then we will

come up with a report and announce report comparing and contrasting. And then we will go look at our budget and see what we got, you know, there. So it's a multi-stage process, but we are constantly doing that with all provider types with the variety of codes. So we always encourage providers if you see some codes that you feel like, you know, are not paid enough or -- to be used or, you know, those codes aren't used because the payment is too low, then send us those and we will research those. And, you know, we always get back to you and let you know, you know, if there's something we can do or not. Or if the research shows that those need to be upgraded or not and, you know, we are always doing that. So absolutely send us -- send us those codes.

MS. PARKER: Dr. Burchett, are you talking maybe about value based-contracting as it relates to quality as well?

DR. BURCHETT: Possibly. I haven't really dug really deep into it. Just thinking about some of the things we do in office

that maybe if we were reimbursed more, we could start to utilize better. Like he was saying, under-utilized codes because the reimbursement is so low --

MS. PARKER: Okay.

DR. BURCHETT: -- that we could improve outcomes for some population. But now, no, we are open to looking at anything just about.

MS. PARKER: Well, I mean, the value-based contracting would be through the MCOs subcontractor or contractor or whoever provides the optometric provider network and who you contract with those, that that could be something you could have a discussion with them about contracting for value-based programs.

DR. BURCHETT: Sure. Sure. Thank you.

So then if the Department is up for that, I'd say the TAC will put together a list of those codes and send over to you, much like we did with the information on the fee schedule stuff from the last meeting, if that's okay.

MR. DEARINGER: Yes, sir. Thank you.

DR. COMPTON: Matt, I have a question. This is Steve Compton.

DR. BURCHETT: Yes.

DR. COMPTON: For my clarification, at the MAC meeting, I think it was stated that the MCOs by contract have to spend 90 percent of their income on patient care and -- I'm paraphrasing here -- and the other 10 percent is on administrative costs for them to administer their program. My question is, are all these value-added services, like laptops and phones and electric toothbrushes and what have you, is that part of that 90 percent? Is that -- is that considered 90 percent that they have to spend or is that coming out of the 10 percent administrative portion? And I may have misunderstood what was said at the MAC meeting as well.

MR. DEARINGER: Angie, do you know the answer to that?

MR. OWEN: Well, this is Stuart --

MS. PARKER: Well, I started talking before, but go ahead, Stuart. You can probably answer a lot clearer than me.

MR. OWEN: Well, I was going to say -- this is Stuart Owen -- I'm 99 percent certain that it comes out of the 10 percent, not the 90 percent for healthcare. It's extra from the MCO, that 10 percent, not from what's paid for member benefits, the 90 percent.

DR. COMPTON: Thank you.

MS. PARKER: Yeah, because the 90 percent and the 10 percent, it's a medical loss ratio that they have to meet and -- where that administrative versus healthcare dollar. So I'm with Stuart as the 99 percent -- as it falls in the administrative as well.

DR. COMPTON: All right. Thank you.

MS. PARKER: But if not, I'll definitely let Erin or Kelli know and they can pass that along.

DR. COMPTON: Okay. Thank you.

DR. BURCHETT: Thank you for that clarification, Everyone. Steve, that's a good question. I didn't know the answer to it either.

So any more from any of the other TAC

members on the general discussion? Any other general things we want to talk about or have on your minds?

DR. COMPTON: No, but what Justin said is encouraging to me, to at least look at it.

DR. BURCHETT: Yes.

DR. COMPTON: Yeah. That's a whole lot better than no.

DR. BURCHETT: Right. Well, hearing no others there, I'm going to move on to No. 7. And I would like to go ahead and make a motion that the TAC send the recommendations that we sent to the Department on 12/28/22 to the MAC as a recommendation from the TAC.

DR. COMPTON: I concur with that, Matt, if you need a second.

DR. BURCHETT: That's what we are looking for.

Any other discussion on that from the TAC members?

Hearing none, then I will take a vote on a the motion for us to send those recommendations to the MAC from the TAC. All in favor?

DR. UPCHURCH: Aye.
DR. COMPTON: Aye.
DR. MUNSON: Aye.
DR. BURCHETT: Any opposed?
Hearing none, then we will put that together in the form of a recommendation to send on to the MAC for their next meeting. I think that's in March, Dr. Compton?
DR. COMPTON: Yes. It will be a bit before we meet again. I'll have it ready.
DR. BURCHETT: Yeah.
DR. COMPTON: All right.
DR. BURCHETT: So, and that way maybe you can talk a little bit on it there as well, so...
DR. COMPTON: -- part of the public record, too, so...
DR. BURCHETT: Right. Appreciate it.
Any other business to discuss from the TAC?
We have got our next meeting dates there. I think it's May 4th, looks like. So, hopefully, we will hear back on some of these questions that we have talked about today to get some clarity and maybe put the

issues to bed once and for all and -- that would be good. Past that, I would entertain the meeting to adjourn.

DR. UPCHURCH: Motion to adjourn.

DR. COMPTON: Second.

DR. BURCHETT: All in favor?

DR. COMPTON: Aye.

DR. UPCHURCH: Aye.

DR. MUNSON: Aye.

DR. BURCHETT: Thank you. Thank you, Everyone.

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THEREUPON, the Meeting was concluded.

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STATE OF KENTUCKY)
COUNTY OF FAYETTE)

I, JOLINDA S. TODD, Registered Professional Reporter and Notary Public in and for the State of Kentucky at Large, certify that this transcript is a true and accurate record of the Optometric Technical Advisory Committee meeting.

My commission expires: August 24, 2023.

IN TESTIMONY WHEREOF, I have hereunto set my hand and seal of office on this the 16th day of April 2022.

JOLINDA S. TODD, RPR, CCR(KY)
NOTARY PUBLIC, STATE AT LARGE