COMMONWEALTH OF KENTUCKY

CABINET FOR HEALTH AND FAMILY SERVICES

FOR MEDICAID SERVICES

IN RE: OPTOMETRIC TAC

HELD VIA ZOOM

DATE:

MAY 4, 2023

1:00 P.M.

A T T E N D E E S:

Dr. Karoline Munson, Chair

Dr. Matt Burchett

Dr. Gary Upchurch

Dr. Steve Compton

Dr. James Sawyer

(and many more were on ZOOM)

DR. MUNSON: Okay. So I'm Dr. Munson. Actually, Dr. Burchett is on the phone call, but he is not feeling terribly well, so he has asked me to go ahead and take the helm today. So I'm glad that he could at least join us, and I hope that you feel better, Dr. Burchett.

So looking here to make sure we've got our quorum. All right. So I think we are good on that.

So the first move for us will be for the approval of the minutes from the previous meeting. So I will call for a motion to approve those meeting minutes.

DR. UPCHURCH: I make a motion.

DR. COMPTON: Okay, go ahead. Steve Compton. I'll second.

DR. MUNSON: Thank you, Dr. Upchurch, and Dr. Compton, for the second.

Okay. So Item 4 on our agenda today is some Old Business. So, DMS, you get the floor pretty much our whole meeting today on this old business. So I'm just going to go ahead and pose these questions, and then whomever from the Department has the best

ability to answer them, just go ahead and chime in for us.

So does DMS have the no-show report to share with the TAC for the optometrists? I know we've had e-mail in the past, but I did not see one leading up to this meeting.

MS. BICKERS: Oh, he's logging in right now. Just one second.

Justin, have you gotten in yet?

MR. DEARINGER: Yes, thank you.

DR. MUNSON: Do you want me to repeat that question, then, so he can hear it?

MS. BICKERS: Yes, please.

DR. MUNSON: All right. So we are on No. 4 of our agenda under Old Business, and we are asking does DMS have the no-show report to share with the TAC for the optometrists? From last meeting we did have an update before our meeting, and I did not see one come through prior to this meeting.

MR. DEARINGER: No. I've still -- I've got that report pending. It's one that we have asked for. We are just waiting to get that information back. So I don't have that available today. We will have that

available very soon.

And, again, just kind of a reminder, we are currently working on and hoping to have available soon -- I know it was scheduled for an April release date that got pushed back again. Hopefully, it's going to be sometime this month for the no-show portal or the no-show dashboard. That will be a public access website and it's going to be -- anybody will be able to access that dashboard to be able to look at each provider type, each county, break it down several different dimensions to be able to look at the no-show list and what reasons were given for those no-shows. So that hopefully will be done within the next month or so. I've been kind of expecting it for the last several months, to be honest, and it's been delayed a few times. It's in production with our IT contractors. It has been for a little while. The actual report that we asked for, I think they misinterpreted that information of us asking for an update on the actual no-show dashboard. So we have not received that

yet. We have corrected that to let them know that we just needed a no-show for optometry to get that information to this TAC, so they should be sending that pretty soon.

DR. MUNSON: And then how will that be distributed? Just via e-mail to us on the TAC?

MR. DEARINGER: Right. I will send that to our staff that does the Technical Advisory Committees and they will e-mail each TAC member.

DR. MUNSON: Perfect. Okay, great. Thank you.

And then next for DMS, has there been any update on the Kentucky Board of Optometric Examiners electronically sending licenses to DMS?

MS. DUDINSKIE: Hello, this is Jennifer Dudinskie for Program Integrity. So as of February the 13th -- that was the last contact we had with Carson Kerr -- he stated there were still issues with the old system and that it was a holdup on their side. I had staff reach back out last

week, and there has been no response from their office at this time. That is all I have.

Any question, comments on that portion? I have the next portion, too, on the updated license piece. Okay. The next question -- I hope you-all can hear me. I'm getting messages that my internet is unstable.

So we do have 163 optometrists who have not updated their license. So typically we have a notice that's issued 30 days prior to give -- send a notification that provider you need to do this. I just found out this morning that for whatever reason that failed and that notification didn't go out. So I requested that they send a notification out today to those optometrists. As of noon that should have been issued, so, you know, just to give a little extra notification out there for those optometrists to update their license.

Any other questions for me?

DR. MUNSON: Not on that. Thank you.

MS. DUDINSKIE: Uh-huh (affirmative).

Sure.

DR. MUNSON: So moving along, we are continuing our discussion with the 2023 New Medicaid vision material benefit for adults and children. So first and foremost, is there any update on the CMS approval on these new enhanced benefits?

MS. LEE: Hello, this is Lisa Lee. I'm the Commissioner for the Department of Medicaid Services. We are continuing to work with CMS regarding those benefits. We had a few questions regarding responding to those and we are awaiting their approval.

DR. MUNSON: Okay. Have they given you any timeline on that?

MS. LEE: They have not given us a timeline right now.

DR. MUNSON: Okay, thank you.

And then if we could discuss the answers that we received from the Optometric TAC's recommendation to the MAC. And so I may I -- may have Sarah, if you're on here or Dinah, chime in with that so we can maybe be a little more specific with what we are asking DMS to clarify. That's what happens

when you put somebody in charge of a meeting like two hours before it starts.

MS. BEVINGTON: Dr. Munson --

DR. MUNSON: I can hear you a little bit.

MS. BEVINGTON: Dr. Munson, this is Dinah. Can you hear me?

DR. MUNSON: Yeah. Yeah, I can. You're good now.

MS. BEVINGTON: Yeah. So the Optometric TAC, as you know, is a group devoted to submit some recommendations to the MAC. Those recommendations were received and we received a response from the MAC. I don't know if perhaps this is included on the agenda just to make sure that all of the TACs members know what response was received. I'm happy to go through that if there's any additional questions. We don't have any additional questions here at our office. I think this was just included just as a follow-up because last time we met we had not heard back, or we had voted to submit them and we had not heard back from our recommendations, but now we have and I believe everyone on the TAC has heard

that, has gotten that response, but I don't know if any other members wanted to ask questions about that.

DR. MUNSON: So do we have any other of our TAC members, Dr. Compton, Dr. Sawyer, Dr. Upchurch, Dr. Burchett -- anybody have any questions on what was submitted back?

DR. COMPTON: Dr. Munson, I was a little confused, especially on the medically-necessary contact lenses for children along with eyewear. Hasn't that been a benefit all along? Haven't we always been able to fit medically-necessary contacts on children?

DR. MUNSON: I believe that's correct.

DR. COMPTON: The response was that the Department would need what numbers that would affect, but they are already doing it, so I wasn't real clear as to what everybody needs to know about that.

MS. LEE: This is Lisa. Hi, Dr. Compton.

So our children's benefit, you're correct, we could always do contact lenses through the EPSDT. That's the Early Periodic Screening, Diagnostic, and

Treatment program or benefit. Those services could always be performed. So in the event that anything needs to be provided to children over and above that benefit, it just, you know, needs to be through the EPSDT benefit. We -- the language I think may have been -- with that may have been just a little bit confusing. We didn't need to know the number for children so much as we would have the adults, so I hope that we clarified that answer. I think that there were a couple of responses to those -- to those recommendations and I hope that's been clarified. But that has always been a benefited for children.

DR. COMPTON: Commissioner, thanks. I think there may be another disconnect that we all need to be on the same page when we talk about medically-necessary contact lenses, or I'm using the term luxury contact lenses, those folks that just want contact lenses because they don't want to wear glasses or what have you. There may be some confusion between all the parties involved and all these expanded benefits as

to what is what, so to speak. So just to me it's like, you know, maybe we are not all on the same page, but that could just be me.

MS. LEE: And I think maybe that's what the response was trying to state, that the contact lenses should be medically necessary. But I agree that we need to go back and look at the language to make sure that we clear up any confusion related to the coverage of the services that we are providing. I believe the expanded services we -- everything in Medicaid, of course, has to be medically necessary for us to deliver those services, but I believe that the intent is that we will cover contacts and/or glasses for individuals regarding their vision needs, that we would cover them and they have to be medically necessary, of course, the contact lenses.

So if somebody needs -- for example, somebody needs correction, vision correction, we would think that they could get either glasses or contact lenses, but I'll have to defer back to Justin and to see

if that was the intent in the regulation, that anyone could get either contact lenses or glasses, or was there special criteria for contact lenses.

MR. DEARINGER: This is Justin Dearinger. Thank you, Commissioner.

No, you are absolutely correct, the intent was -- has always been and currently is, even in the new reiteration, that contact lenses are for medical necessity only. And we spoke with multiple providers when we initially created the administrative regulations. They talked about instances where contact lenses were the preferred choice for certain instances and certain indications, and that's what we were trying to do was to give the provider the choice of exactly what type of corrective prescription that that individual needed based on that provider's assessment and that individual's needs. And so that's why it says they can have one or the other, and it is, you know, basically left to the discretion of the clinician that's prescribing those lenses.

If there's, you know, any thought that

clinicians in the state of Kentucky wouldn't be capable of making some of those choices or things like that, we could talk about that maybe with the Board. That might be a better discussion for them. But for us on our fee schedule, we only open that up to allow for prescribers -- clinicians, prescribers to prescribe exactly what they felt necessary for their individual patients based on their analysis and their expertise. And we show that on the fee schedule as well as the administrative regulation.

MS. LEE: And, for example, we would not cover contact lenses if someone did not have -- did not need vision correction and they just, for example, wanted to change the color of their eyes. Those contacts would definitely not be covered. That's an example of contact lenses that would not be medically necessary for individuals.

DR. MUNSON: So let me -- let me just make sure -- this is just Dr. Munson -- that when you talk about the medical necessity, it is actually defined by either their clinical diagnosis or their prescription.

So for someone who is, you know, just -- you are wearing reading glasses, so let's say they just want to have contacts so they can see to read, then that is not what it falls into medically necessary.

Now, if they are very, very nearsighted -- I believe the statute is minus eight and above -- then someone that falls into that would be considered medically necessary. So it is the same --

MS. LEE: Yes, that's correct.

DR. MUNSON: So I want to make sure that this isn't any different than what we have already been following for children.

MS. LEE: That is correct.

DR. MUNSON: Okay, perfect. Thank you.

DR. COMPTON: That clears up the confusion.

DR. MUNSON: Absolutely. And then will that -- is that already now reflected on the new vision fee schedule, that it is medically necessary only for the reimbursement for the contact lenses?

MS. LEE: Yes, I believe that is -- it's definitely spelled out in the regulation.

DR. MUNSON: Okay. And then is that going

to be included on the fee schedule as well, annotated on that, or just in the regulation?

MS. LEE: We can -- we can go back and look at the fee schedule and see if it's annotated on there. If not, we could -- we could add that if the TAC thinks that's something that would be useful for the rest of the population.

DR. MUNSON: It would just -- it would make it easier to keep that kind of clean that way. Perfect. Thank you. And then -- go ahead.

MS. BEVINGTON: I'm sorry, one quick thing. So what we have heard from a number of providers is that the patient population believes that they have a choice between glasses or contact lenses. And then when you pull the vision fee schedule, that's the language that is utilized, it's a choice between contact lenses or glasses. The medically-necessary language to include on that vision fee schedule and any communication out to patients would be very helpful to help clarify that, because our

providers are on the front lines having to explain that not everyone gets contact lenses just because they prefer to have that as their method of vision correction.

MS. LEE: Okay. So would it be helpful then if the Department drafted up -- drafted a letter maybe, or some sort of a communication, and let the TAC review it to see if we could clear up some of this confusion, and are you saying you think it would be better for the members and the providers, or both?

MS. BEVINGTON: Absolutely, for both as well. Yeah.

MS. KLINGELHOFER: This is March Vision. This is Tyania from March Vision. We are using the language, elective contact lenses. And just recently we have been guided to tell our providers that it's eight units covered, and it's glasses or contacts, and that is what's specific on the benefits. So we -- we do need some clarify. Members need clarity, providers need clarity. This is just causing a bunch of chaos for us on the MCO side, and we're

in May. Let's just say we're -- you know, we are halfway through the year with these new benefits.

DR. DAVIS: This is John Davis from EyeQuest. I want to reiterate that statement that it's so confusing. Maybe I can ask just one maybe simple case in point. Maybe -- Dr. Munson, let's assume the patient comes into your office and they are, whatever, minus 1.25 sphere; right? They are 12 years old. They are at 1.25 spheres. They maybe have a little cell, whatever. It doesn't matter. Right? So they see with glasses 20/15 correctable. They say, no, I don't wants glasses this time; I'd rather have contact lenses. Is it our understanding that that patient now is allowed to have contact lenses instead of glasses at that visit? Let's assume, right, you don't have a contraindication to it. You just say, fine, that's what they want. Would that be part of the criteria for when we would cover contact lenses for the kids, do you think, based on your understanding?

DR. MUNSON: All right. So you are asking me based on my understanding in the clinical setting. No, because the regulations are written that for them to be medically-necessary contacts, that child needs to be a minus eight or higher. So, yes, clinically they could get them, but would the coverage come from them personally? Yes. Would it come from DMS? No.

And I'll ask Commissioner Lee if I'm interpreting that correctly, but I believe that is.

MS. LEE: I think I need to take this back to some of our policy folks and our medical director to make sure. I've been taking notes and got the information that you-all have asked. But I want to go back and just clarify, are we now saying that individuals can have contacts or glasses, and that if that's the case, then we need to clarify that, or are we saying that, no, they can only get contact lenses in the event that it meets medical-necessity criteria and here would be -- and here is the criteria.

MS. ALLEN: This is Nicole with Avesis --
MR. DEARINGER: I just want to say that the way that we currently interpret it in our regulation, at least in the last one that was filed and the current regulation that was filed, that it would have to meet medical necessity. We have said that in each regulation. In both places we have said that specifically that it had to meet medical necessity. And medical necessity would be if the clinician decided that it was medically necessary for that individual to have contacts.

It doesn't have to specifically be a medical issue, you know. It could be that the -- you know, maybe a child has some form of autism where they won't keep the glasses on their face and they decide that contacts are a better solution. There are a multitude of different areas and reasons why a clinician may choose to describe -- or prescribe medical contacts over glasses; however, it has to be a medical necessity and medically necessary for them to be able to do that. And I think we state that in

the regulation and in the previous regulation as well.

MS. LEE: Thanks, Justin. I still think there is some confusion based on the conversation that we are having. There still seems to be -- and I think Nicole from Avesis -- were you going to say something?

MS. ALLEN: Commissioner Lee, thank you. I just wanted to confirm that for Humana, for Aetna, and also for WellCare, based upon the 4/12 care revisions we reinstituted the medically-necessary criteria. So for the adults and for children, contact lenses are not in lieu of eyeglasses. They are covered under medical necessity. We are in the process of updating our plan sheets for the providers, so that will -- that will be released very shortly, or very soon, I should say. Thank you.

MS. LEE: And I think, Dr. Munson, that was -- what Nicole just said is your understanding, too, that contact lenses are not covered in lieu of, but must meet medical necessity.

DR. MUNSON: Correct. And this is discussions in previous times with the TAC, and if the TAC members would like to chime in -- we had actually gone over this in detail in a special-called meeting, because initially I don't believe, and the other TAC members can bring their recollection, but I don't believe initially when this was presented that it was just contact lenses. There was no dialogue in there about medical necessity at all, and that was something that we brought. That was a recommendation that we brought to the MAC that it was medically necessary only.

It was already there in statute for children, but when this expanded benefit came out that it was expanded to adults, but it kind of became a free-for-all, and I feel like that's also what some of the MCOs on the call are talking about, is it has been kind of a moving target because that medical necessity wasn't -- wasn't hammered out and wasn't written out for people to understand. And in addition, Justin's scenario -- and I understand that you are not a doctor, but

I -- I almost cannot imagine getting a contact lens in an autistic child's eye that will not wear glasses. I can't imagine them letting us come and do that.

But when we talk about medical necessity, that is already defined in statute. I've been in practice 22 years. It has been in Medicaid to tell us when that is allowed and when it is not allowed. So it's not like I can say, oh, my, minus four, plays football, and he could potentially get hurt by having his glasses on under his helmet, so I'm going to deem that medically necessary. I as a practitioner don't have the leeway. The Department of Medicaid has told us what parameters is medically necessary and what is not. And so that is not something we need to reinvent the wheel. The Department has already done that. We just need to make sure that it is referenced across the board, and we as practitioners need to know, so we know which direction we are going, and also the recipients need to understand what benefits they do or don't have. So I think Dr. Upchurch has had

several instances of this, so I'm going to let him kind of give his background on it.

DR. UPCHURCH: Well, our understanding in -- and this has been horrible. I've talked with all the MCOs. They are in a bad position. I've talked to providers, multiple providers. We are all in the position where these patients are coming in and their understanding is, is that they can choose either contact lenses or they can choose glasses. And, you know, we are put on the front line and it's difficult.

So we've got some MCOs that -- several MCOs that are providing that, several that are not. And at this point I'm in total agreement with the TAC. We have guidelines, Medicaid does, on what is medically necessary. And I've been -- I've been going -- you know, I've been going against the grain on that because we have been told, or we have been implied that we could -- you know, people could get contacts. I'm all for making this plain that what exactly the stipulations are, and also getting that information to the patients, because it's --

it's killing us on the front line.

And to put contact lenses on children, especially when you're saying you are providing a year's supply, but you're not; you're providing one unit per eye, which is only one box, which is six lenses per eye, that's only six months' supply at maximum, then we are looking at potential major problems down the road as those people overwear those type of lenses.

I hope that helps. I hope that's what you were after, Karoline. I don't know.

DR. MUNSON: Yeah. Thank you, Dr. Upchurch.

MS. LEE: That helps me tremendously, too. And I think that there is a bigger conversation that needs to be had. I definitely appreciate this conversation. I understand the confusion. I understand what action we need to take and to get some clarity. So I will -- I will take this back to my medical team, to my policy, have a discussion. And what I'm hearing from this -- from the TAC is that we already have the medical-necessity criteria. If

the intent of the Department is to only apply medical-necessity criteria to contact lenses, we already have that in place. If the intent is to allow contacts in lieu of, we need to do some communication and some outreach to our provider community and our members, and our managed care organizations.

DR. UPCHURCH: Agreed.

MS. LEE: Thank you-all so much. This has been a great conversation and glad that I could join today, and hope to be able to join as many of these as I can in the future of the TAC meetings because always good information and good conversation.

DR. MUNSON: Great.

MS. BEVINGTON: In the meantime, you know, are we sticking to the medically necessary --

MS. LEE: Well, and it sounds like to me that there's providers that are sticking to the medical-necessity criteria and providers that are not. So I think in the meantime I would stick to the medical -- well, because everything in Medicaid has to

be medically necessary, so I would -- I would recommend sticking to the medical-necessity criteria that's outlined in the regulation.

MS. BEVINGTON: Okay. Thank you.

MR. IRBY: And, Commissioner Lee, this is Greg from UHC. And for our organization, I think the regulations are pretty clear that contact lenses must be medically necessary. The regs specifically say in 631, it says that these are not covered unless they meet the 632 guidelines, which require the medical necessity. So I'm not sure how all the MCOs are handling this, but we are handling it in alignment with the current regs. So if that question were posed to us as an MCO, the answer is yes, we have to have medical necessity. It is not a in-lieu-of benefit.

MS. LEE: Thank you, Greg.

DR. MUNSON: Do any of the other members of the TAC committee have any other comments on the contact lens issue?

DR. COMPTON: Other than just we are here to help, so just, you know, please run it

by us and we will maybe save everybody a lot of heartache.

DR. MUNSON: Okay. So next question was the discussion on balance billing with the -- anything that people get, and this is both children and adults. Is that something that is going to be allowed? I mean, I've had this question even this week. And so that would be something that if we could get some clarity on whether or not that would be allowed, that would be great.

MS. LEE: The federal rules do not allow balance billing of Medicaid members, so...

DR. MUNSON: And so this is kind of where this is hard for us to thread the needle. So previously some of the MCOs have been generous enough to offer a value-added benefit of glasses, and in that value-added benefit if the patient chose to get something different, they were allowed to have an upgrade. And so if this benefit now flips to a benefit for all that is coming from DMS, they will not be allowed to do any of that balance billing from this

point further?
MS. LEE: That is correct, because it was not a covered benefit before, patients would have had -- and in the event that the Medicaid MCOs did not offer that benefit, the patients would have had to pay for that service themselves. Now that it is a covered service in the Medicaid program, it has to be -- we have to have -- the rules have to apply equally to everyone, and there would be no balance billing in the program.
DR. MUNSON: Okay. And then the last question refers to the contact lens fitting fee, which is code 92310.

In our last meeting DMS said that there would not be a limit on the use of that code. So some of the MCOs are not covering the contact lens fitting and others have confirmed that they will only pay for one fitting during the year. So if DMS has not put a limit on the vision Medicaid fee schedule, can the MCOs set their own limits and not follow the fee schedule limits?
MS. LEE: If the Medicaid fee schedule does

have a limit, the MCOs have to adhere to that limit. They can exceed that limit, but they could not reduce that limit.

DR. MUNSON: So if it does not have a limit on it, they cannot reduce that; is that what you're saying?

MS. LEE: If it does not have a limit, if we have no limits in place, then there's no limit, and I would -- I would look to see if it's something that -- you know, how many -- how many contact lens fittings a year would be appropriate. Is it something that the Department should consider a limit on, is what I would ask the TAC.

DR. MUNSON: So that really depends on what you're fitting. I mean, that -- and I'll let Dr. Upchurch speak to it, too, because specialty fittings are a different animal altogether.

DR. UPCHURCH: Well, in my office basic contact lens fitting, I cover it with just the one visit. That would not be a problem, but that's at a minimal charge. Then when you go up to lenses such as toric lenses, astigmatism lenses, you go up to

gas permeable lenses, you go up to bifocal contact lenses, typically those are going to require several visits, and our charge goes up to the private pay patient accordingly. And so one charge of 92310 per year would not even come close on a gas permeable bitoric contact lens, or, you know, a gas perm bifocal lens. We would -- we would essentially lose our shirts on that.

MS. LEE: I think that there was a conversation prior to this that talked about the type of lenses that Medicaid would cover and there was a -- there was some concern about the gas permeable. For example, there was some talk of concerns about the different types of lenses, and a recommendation was made that we only -- I think that the regulation right now -- I know the regulation says that we cover daily lenses rather than the gas permeable and the different types, the hard lenses.

DR. UPCHURCH: Well --

DR. MUNSON: If you don't mind here -- Dr. Upchurch, I'm going to jump in here

real quick.

So, Commissioner Lee, this is really -- you're really hitting the nail on the head, and I think it may be a good idea to review the December meeting, the emergency meeting that the TAC called, because you will hear a lot of this conversation and understand where some of the miscommunication or just misunderstandings are coming from.

So when you go back to talking about a medically-necessary contact lens, and I'll use keratoconus for example, probably the number one reason we would use a gas permeable lens. That is not something that can be corrected. It's a disease of the front part of the eye. You cannot correct it very well with glasses. You can only get the best visual acuity with a gas permeable contact lens. That is a medically-necessary specific reason that DMS would cover contact lenses.

When we were told initially, when this was brought to us, it was contacts for everybody, kids, adults, everybody. There

was medically-necessary not in the discussion at all, and that was where our frustration came in, because it was approved for one unit. When we initially had our discussion, one unit meant one soft contact lens per eye per year. Again, I've been in practice 22 years. I have not dealt with these lenses since I was a minor working in my doctor's office in high school. That is how antiquated that technology is. So we tried to bring this to DMS, and that was something that we tried to have that conversation that those lenses are not standard of care. Those lenses are going to end up in worse health for the front part of the eyes for the patients, and honestly ultimately more cost to DMS for visits to our office. So that discussion is all on, as Dr. Compton refers to them, luxury lenses, the I-want-contact-lenses, not I-need-contact-lenses.

So the materials that we're using when we talk about an I-need-contact-lenses are completely different, they are much more complex, they require a lot more chair time,

a lot more visits, and that's where the multiple use of that fitting fee code that Dr. Upchurch was explaining comes into play. And so there may be a daily lens that is necessary for someone in some -- in some respects, but more than likely there are very specialty lenses that we're talking about for someone that is having -- that actually has a disease of the eye. Somebody who is just incredibly nearsighted that literally can't see past, you know, two inches in front of their eyes and they have contact lenses, then, yes, daily lenses would appropriate for them to maintain the health of their eyes.

So this is a very nuanced conversation and this is just pointing to the reason why we as an Optometric TAC, since we are the doctors, this is our wheelhouse, we can provide all these answers, where folks at DMS, it's just that's not their thing. They didn't go to school for it. So it's very hard to work through these nuances if it's not something that you are incredibly familiar with.

So I didn't mean to jump right in there, Dr. Upchurch, but I feel like this really points to why this has been such a conundrum for all of us.

DR. UPCHURCH: You're good.

MS. LEE: I appreciate that. Dr. Munson, I appreciate that. I will go back and review those December emergency meeting minutes, and I think we've got -- the regulations were refiled on April the 12th. They will be up for review, reg review, on May the 9th. That's next Tuesday at 1:00. So we will talking about the regulations with reg review.

And, again, I think this is some good conversation. I think our intent -- of course, we do want to focus on services that are going to help our Medicaid members improve their vision, improve their sight. I think that is a first step. I think we have some more conversations to go and some more tweaks to make before we get it just right. But I do think it's vitally important for our Medicaid members, our adults, to receive glasses or contact lenses

in order to correct their vision so that they can, number one, be able to function in society, but, you know, help them get back into the workforce so that they can see as they go forward.

I think that we have -- you know, from some of the stats that I've been looking at maybe -- you know, preliminary maybe over 50,000 individuals who have received glasses. Not the contact lenses. Glasses. I've seen very view contact lenses. I think that's a large number and I think helping these individuals be able to see and regain some freedom in their life is very important.

I so appreciate this TAC, and I do look forward to conversations on how we can clear up some of this confusion and do what's right by our Medicaid members and our providers. So I think, you know, Dr. Munson, your conversation that you just -- very on spot and appreciate your candor. You are correct that the individuals here at Medicaid, we don't have the expertise that you have, and we will be

looking to you, to this TAC, to help us as we move forward.

DR. MUNSON: So we have 50,000 covered lives that received glasses since January with this expanded benefits?

MS. LEE: For adults. If the -- if the information that I am looking at, if I am interpreting it correctly, that's about 57 -- I can't -- 50 -- I can give you the specific code. Let's see, the code that I'm looking at, it's V2100 to V2399. Those are glasses, 58,000 individuals.

DR. MUNSON: And that's just in the adult component of it?

MS. LEE: Just the adult since January.

DR. MUNSON: And that includes all the codes within that or that's individual lives?

MS. LEE: That's 58 individual lives. 62,173 services delivered to those 58,000. And a little over $1.5 million.

DR. MUNSON: Wow.

MS. LEE: So, you know, we do know that there was a pent-up demand. And one of the things that I talk about when I talk about

our Medicaid members, I talk about, you know, the federal poverty level. We always throw out that federal poverty level number, and, you know, it's at 138 percent of the federal poverty level and below, and what does that really mean. You know, for a family of four, some of the information that I've looked at if you look at that 138, it's right around $40,000 a year, and the average cost to live in Kentucky is over 42,000. So individuals -- the bulk of these individuals that we are serving, Medicaid members, you know, they're working to put food on the table. And that 42,000 that I talked -- 40,000 is pre-tax. That's before taxes are even taken out of their income.

So having glasses is a luxury for some of them and it shouldn't be a luxury. It should be a benefit. They should be able to see and to read and to drive. So I think that 58,000 number is very telling about the pent-up demand that was out there, the individuals that did not have corrective glasses that needed them. So, again, I

think that it's something that's totally different. And we haven't covered glasses before, but I think it's something that is so necessary.

DR. COMPTON: Commissioner, it's Dr. Compton. On the 58,000, or whatever number you just quoted, you say it's V2100 through V- --

MS. LEE: 2399. It says lenses is what I've got the description --

DR. COMPTON: Most of the times there's two V codes filed per pair of glasses.

MS. LEE: So even if you halved it, it would be about -- it would still be about 30,000 individuals. Now, there's another V2020 --

DR. COMPTON: That's frames.

MS. LEE: -- that's 57,495 people.

DR. COMPTON: Then that would be accurate because that's only billed once. I just didn't want the wrong number getting out there.

MS. LEE: Yeah. 57 -- V2020 is 57,495. So, and I think that that's very telling on, you know, the pent-up demand that was

out there for individuals who needed to be able to see.

DR. COMPTON: It's a great, great benefit. We just need to get everything -- get us all on the same page.

MS. LEE: And I think we are getting there, you know --

DR. COMPTON: Today's made a big -- a lot of headway.

MS. LEE: I think we are getting there. I think that, you know, it's really important, and I always say that the Medicaid program was created for the member, but we can't take care of our members if we don't take care of our providers because you-all are the ones seeing these individuals, you know, so very vital to getting them the services they need. But I was really -- I was a big wow when I saw that number of glasses, of 57, just since January, so...

DR. MUNSON: Absolutely. And that is -- I mean, I will say for the MCOs that did cover that as a value-added benefit, it is -- I mean, at that point was wonderful

because for several years as a practitioner I just had to say, oh, you turned 21, you know, sorry, you don't get anything anymore, or have the conversation with the 20-year-old to be like, you know, we got to get this done before you turn 21. So the MCOs that offered that as a value-added benefit kind of cracked things open. But this benefit is fantastic. It is definitely something that I think can change the lives of the people in the Commonwealth.

I did get one question for you in the chat and I'm just going to read it from here. It's LeeAnn Ellis with March Vision, and it's, "Question for DMS to take back please: If there is no elective contact lens benefit, then why does the current revised 4/12/23 Kentucky Medicaid fee schedule indicate that codes V2500, et cetera show as available with 8 units? It specifically states, 'Adults and children may select eyeglasses or contact lenses per year but not both.'"

MS. LEE: And I think this goes back to the

conversation we had about the medical necessity that's in the regulation that's not on the fee schedule to cross-reference, so that's a very good question and something that we are going to take back and discuss.

DR. MUNSON: Okay. Excellent.

Now, does anyone on the TAC have any other questions about the 2023 New Medicaid vision material benefits?

DR. UPCHURCH: I just have a comment, Karoline. I just want to say to Director Lee how much I appreciate you, and you probably don't remember me, but we worked together so many years ago that you probably don't even want me to mention it, but I appreciate you and your team and you listening to us and hearing us out on this, because we on the front line, and the MCOs right behind us, have sort of been in a real predicament since this all came along. So I just want you to know we don't mean to cause you-all any problems, but we really appreciate what you are trying to do for the people of Kentucky, and I think we are

on the right track here.

MS. LEE: I appreciate that, Dr. Church. And I do remember you and I think -- I can't even remember how long ago it was.

DR. UPCHURCH: You don't want me to say.

MS. LEE: It was a while.

DR. UPCHURCH: Yeah.

MS. LEE: But I have over, you know, 20 years' experience in the Medicaid program, and Medicaid is a huge, huge program and you know, our resources are -- you know, just like many of you, our resources are stretched to the limit. And sometimes when we go down these paths of making changes to the program, it's very difficult because it's not just the Department and the TAC, it's CMS has to be involved, you know, other -- it's just, you know, our system changes, different things.

And we do agree with you, Dr. Upchurch, that we are going down the right path. We've got a few bumps in the road, but I think that we are going to get those straightened out and do what's best for our members and our providers as far as

the vision services goes, and this has been a really good conversation today, I believe.

DR. UPCHURCH: Thank you. That's all I wanted to say, Karoline.

DR. MUNSON: Okay. Thanks, Dr. Upchurch.

Okay. Well, if we don't have any other questions on that part, then we will go ahead and move on. I believe Ms. Dudinskie already answered our question under New Business about our optometrists about updating their license.

And then the other general discussion, a couple of things -- I know that Avesis had some questions. Again, getting told to lead the meeting two hours before it starts, I don't have those. But I do have one to lead up to that that kind of does tie in, Commissioner Lee, with what you said about the contact lens fee, the 92310, if there's no limit on the fee schedule, then there's no limit of those codes. Our regular just 99 codes, so 99211, 99212, 99213, those do not have limits on the fee schedule, so are those also something that would not be limited from the coverage from the MCO

perspective?

MS. LEE: Would you say those codes again, please? I'm sorry.

DR. MUNSON: So they do have -- excuse me. They do have limits of two, which is 99211, 99212 and 99213. And so they have a limit of two -- excuse me, I'm saying this backwards. So what we are asking, and I don't -- I don't know the correct direction for this to go or how this request to come through, but that's something -- like I have a guy that comes in and gets a foreign body in his eye. A 99213 would be very -- very correct to use for follow-ups. Well, if they don't follow my directions, they don't get their eyedrops, and I have to see them two or three times, I actually can only see him twice under that code, and that's -- you can ask the other doctors on this panel -- that's an incredibly commonly used code. It is not a long amount of time. It's not a terribly high reimbursement. And so that is something that if we can talk about that limitation being lifted, because, to be honest, 99211

isn't -- or 212 aren't even codes that would be billed. I mean, they are -- 99211 doesn't even require a doctor's presence, I don't think. And so that is something that from a care perspective does kind of bind us to be able to take care of patients appropriately with longer-term issues.

MS. LEE: I would think that that sounds like a great recommendation to look at lifting those codes, and if you made that recommendation maybe inserting what you think may be appropriate. I think that that is a good -- that would be a good recommendation for the TAC to make, is for us to talk about that limitation being lifted.

DR. MUNSON: And that doesn't -- that code does not affect just us. That's a -- that's a, you know, provider-wide code, so it's not optometry specific. So I'm actually kind of surprised that we would be the first ones recommending that to the MAC, but I feel that there would be providers across the board that would definitely be supportive of that change.

MS. LEE: And that would be one where we would have to go back and we could look at how many times that code has been billed and more than once. I'm not sure -- the only thing that we would have to go by would be under the EPSDT, if it was ever medically necessary, if it was ever under the EPSDT benefit, if it was lifted. But if you make that recommendation, I would suggest you also include maybe some sort of a recommended limit that you think would be reasonable.

DR. MUNSON: Okay.

MS. LEE: That would help us determine cost -- the cost of making that change.

DR. MUNSON: Okay.

MS. BEVINGTON: This is Dinah Bevington. After we had the special meeting in December we were asked to submit our recommendations to the Department, which we did December 29, 2022, and I'll send you a copy of this correspondence that we specifically requested that the limitation be removed on those codes at that time. So I'll send that to you so you've got a copy.

MS. LEE: And did that go to the MAC, too? That went to the MAC and then --
MS. BEVINGTON: Yes, it also went to the MAC as well.
MS. LEE: Okay. So we have it. I can look it up, Dinah. There's no sense in sending it to me. I can get it. And I'm assuming that we responded to that?
MS. BEVINGTON: No, there was no response to that specific -- that recommendation, it looks like.
MS. LEE: Okay. I'll go back and take that -- but if you have made that recommendation, then I'll look -- I'll go back and look at that and we'll take that into consideration.
MS. BEVINGTON: Wonderful.
MS. LEE: Sorry for that oversight.
MS. BEVINGTON: That's all right. Thank you very much.
DR. UPCHURCH: Most of your MCOs are paying that code more than once because they realize -- I've got one lady that has recurrent iritis and I may see her ten or 12 times in a year. So most of the MCOs

are paying it more than once, but it's sort of got their hands tied, too.

MS. LEE: And that is a good thing about the MCOs, you know. They do have more flexibility to provide some of those services and exceed some of those limitations. But that's good to know, too, Dr. Upchurch. That gives us a little bit more information that we can look in the system about how many times that code has been billed and paid with those limitations lifted.

DR. MUNSON: Okay. Thank you for that. And I apologize for presenting that kind of backwards, but I appreciate you looking into that for us.

And then I'm going to let Nicole from Avesis -- I'm going to put you on the hot seat. Avesis had some questions as well.

MS. ALLEN: Hello, Dr. Munson.

Actually, we presented -- we did discuss the main one that we had questions with, so thank you so much. We do appreciate you bringing that forward.

DR. MUNSON: Oh, you're so welcome. Well,

excellent. That is fantastic.

Okay. So is there any other general discussion from any members of the TAC committee today?

DR. COMPTON: Is this part of New Business? May I chime in?

DR. MUNSON: Yeah, we are ready for New Business.

DR. COMPTON: Okay. Earlier this week or late last week, I don't know, a colleague of mine called -- called billing and coding employee to let us know that the -- I can't think of the code right now off the top of my head.

MS. LEE: 66030?

DR. COMPTON: Yes, yes. And, Commissioner Lee, I thank you ahead of time for helping us. That that had been termed, I guess is a word from -- I don't know if it's Medicaid didn't pay anybody that, or just a term for -- that's fixed. But my bigger question is, is how does DMS decide what codes they will pay, what codes they will stop paying? Is there a process? Is it -- just to kind of avoid this issue again, or

at least have a heads up.

MS. LEE: We do have a process for the bulk of our procedure codes. It's typically based on Medicare. There are some things that Medicare does not cover, but typically our codes are -- we base our fee schedules on Medicare, and our rates are developed on a Kentucky-specific Medicare fee schedule.

With this particular code, Dr. Compton, what happened is the Department received some communication from an association, and this is not uncommon. We receive these sorts of communications all the time. And we received a communication that said that this code that we were probably -- that we could be operating outside of, or be in violation of KRS 320.210 specifically Section 2(b)3, which relates to -- which relates to procedures that were excluded from the scope of practice of optometry. And the third one is a nonlaser surgery, and it goes on to -- it says requiring full thickness incision or excision. So we interpreted that. What we did is when we received that communication,

we went to the KRS and our interpretation was, well, this code was not allowable. But we have since had some communications, and specifically we had some conversations with Dinah, and she had pointed out that that was not a correct interpretation, that the Board of Optometric Associations actually -- in 2020 the Board of Examiners included that code in the list of services, so we have since reversed that code. We have put it back on the fee schedule. We will be reprocessing any claims that have come in.

So typically if it is -- you know, if it's a change in scope or something like that, we would definitely, you know, want to reach out before we made a change. But this, actually our interpretation led us to believe that we were in violation of the KRS, which was something that we would want to change, you know, a lot sooner. And we did do some research before we discontinued this code on the fee schedule. We did do some research and it showed that in the last two years there were less than $400 in claims that were paid for that code. So

that, again, led to our interpretation as this may not be, you know, a valid code for the optometric fee schedule.

DR. COMPTON: Thank you for the explanation. You have been a big help.

Probably the lower utilizations we are dealing in our office, most of them are Medicare, have commercial insurance. There are very few Medicaids. It's generally an older population that needs these injections, so that may explain part of the utilization. But you have been a huge help on this entire meeting today and I really appreciate it, so thank you.

DR. MUNSON: I definitely second that, Dr. Compton.

So does anybody else have any general discussion for today on the TAC committee?

Okay. So seeing none, Dr. Compton is our MAC meeting representative. And so the next MAC meeting is on May 25th, and he will be in attendance for that.

I don't believe today that we have any recommendations for him to take to that. If anyone does, speak now or forever hold your

peace. And if not, we will be having our next meeting on August 3rd at 1:00 p.m. I'm not sure if that will be Zoom or in person. That is above my pay grade. But that is something that we will discuss coming closer to that.

And so if there is no other discussion, then I will entertain a motion to adjourn.

DR. UPCHURCH: I'll make a motion.

DR. COMPTON: I'll second. I'm good at that today.

DR. MUNSON: All right. Thank you-all so much for being here. And, Commissioner Lee, I really appreciate you being on the call with us today. You have been incredibly helpful and we appreciated your support of all the patients in the Commonwealth of Kentucky.

MS. LEE: Thank you. And I appreciate everything you-all are doing for the Medicaid population.

DR. MUNSON: Thank you so much. Everyone have a great day.

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THEREUPON, the Optometric TAC 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 30th day of July 2023.

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