COMMONWEALTH OF KENTUCKY

CABINET FOR HEALTH AND FAMILY SERVICES

FOR MEDICAID SERVICES

IN RE: OPTOMETRIC TAC

HELD VIA ZOOM

DATE:

NOVEMBER 9, 2023

1:00 P.M.

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2
3 **A T T E N D E E S:**
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5
6 Dr. Matt Burchett - Chair
7 Dr. Karoline Munson
8 Dr. Steve Compton
9 Dr. James Sawyer
10 Dr. Gary Upchurch
11
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14
15 (and many more were on ZOOM)
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1 DR. BURCHETT: Hello, Everybody.
2 MS. BICKERS: I count three of you. I see
3 yourself, Caroline and Gary. Did I miss
4 anyone else when they were logging in?
5 DR. BURCHETT: There should be Steve and
6 James.
7 MS. BICKERS: I don't see them yet. If I
8 they do log in, I'll let you know, but you
9 do have a quorum. I'll turn it over to
10 you.
11 DR. BURCHETT: Okay, sounds good.
12 Dr. Burchett here. I guess most of us
13 know each other by now.
14 So welcome to I guess the last TAC
15 meeting for this year. I'd like to open the
16 meeting up first off and just thank the
17 Department for fixing the limits that were
18 on the lower level 99 codes. I think they
19 were limited to two visits per provider per
20 year. And as we all know, sometimes that's
21 not good for treating various conditions to
22 have those limits, so we thank you for
23 taking care of that for us.
24 So we'll go on and start the meeting.
25 Let's approve the minutes from the last

1 meeting. I hope everyone has had a chance
2 to read them. But with that, I'll entertain
3 a motion to approve.
4 DR. MUNSON: I make the motion to approve
5 the minutes from the last meeting.
6 DR. BURCHETT: And do I have a second?
7 DR. ALBANY: Second.
8 DR. BURCHETT: Thank you-all.
9 Any questions on the minutes from the
10 last meeting? Any changes that you-all
11 noticed that might need to be made?
12 DR. MUNSON: No, I don't see any.
13 I'm going to try to help Steve. He's
14 having some trouble getting on the Zoom.
15 DR. BURCHETT: Yeah, I just saw that.
16 DR. MUNSON: He's going to try again, but
17 let me maybe send him the link again.
18 MS. BICKERS: And I believe James just
19 logged in. He might still be joining.
20 DR. MUNSON: Let's see if Steve can get on
21 then.
22 DR. BURCHETT: I'll hold for just a second
23 here to see if they can join in real quick.
24 MS. BICKERS: He's logging in now.
25 DR. BURCHETT: Good, good.

1 DR. MUNSON: Perfect.
2 MS. BICKERS: All of your TAC members are
3 logged in and on camera.
4 DR. BURCHETT: Good sounds good. I
5 appreciate that.
6 James, Steve, just getting ready to
7 approve the minutes from the last meeting.
8 We got a first and a second, and we're
9 talking is there any changes or anything
10 that you-all saw in there from what we
11 discussed last time?
12 DR. COMPTON: I don't see any changes.
13 DR. BURCHETT: Okay, good deal.
14 Well, with no discussion on that,
15 then, we'll go ahead and take a vote. All
16 in favor of approving the minutes from the
17 last meeting say, "Aye."
18 (Members vote saying "Aye.")
19 DR. BURCHETT: And those opposed?
20 (No response.)
21 DR. BURCHETT: Okay. So approve -- the
22 minutes have been approved.
23 And let's move on to -- we got a few
24 old business things to look -- like maybe
25 circle back around to. I'll just really

1 kind of go down the list here.
2 First, any word on the availability of
3 the no show report from DMS.
4 MS. BICKERS: I'm trying to see if anyone
5 from policy is on.
6 MS. KITCHEN: This is Kelly Kitchen. I
7 believe Justin had shared that in the past.
8 I don't -- I'm not sure if they still are,
9 or if they have ran a new report, but we
10 can find out and get back to you.
11 DR. COMPTON: This is Steve Compton.
12 Generally, Justin says we're still working
13 on it and we'll talk about it next month,
14 just to paraphrase.
15 DR. BURCHETT: I don't think we've ever
16 seen it, and I think that's why we keep
17 asking about it.
18 MS. KITCHEN: Okay. I know they were
19 creating a new system in order to be able
20 to pull the data, to ensure that it is all
21 the complete data. So that may be why it's
22 taking some time to get it. But I will
23 check with Justin to see where they are
24 with that.
25 MS. PARKER: This is Angie Parker with

1 Medicaid. It is my understanding that they
2 are able to right now to make the no-show
3 report public, but they were working on
4 getting it on Kentucky Health Net. And it
5 may be there. I don't know. But that is
6 the latest that I know about it, but Kelly
7 said she can get with Justin to get all the
8 ins and outs about it.
9 DR. BURCHETT: And then if we do that is
10 there any way we can get a communication
11 from you-all about that before next TAC
12 meeting?
13 MS. KITCHEN: Yes, absolutely.
14 DR. BURCHETT: Okay. Appreciate it.
15 Then I guess the next one is -- is
16 there any update on communication with the
17 Board of Examiners for electronically
18 sending the license updates?
19 MS. DUDINSKIE: Good afternoon. This is
20 Jennifer Dudinskie with provider
21 enrollment. We did make contact with the
22 new executive director, Christi LeMay, in
23 August, and she was working on a software
24 update that had to be completed first.
25 They were hoping to have that done by

1 October 1st. We haven't had any other
2 contact since that time, so I believe we
3 reached out when I got the notification of
4 the agenda for this meeting. We haven't
5 heard back from them yet, but we will make
6 contact again.
7 I know you-all are really waiting on
8 this. We -- we're trying. We are prepared
9 to do what we need to do on our end to
10 assist and get this completed, but I think
11 it's -- I think the problem has been the
12 software situation that they have had for
13 some time. They converted a system and then
14 they had a software change, so it just seems
15 like it's a technology issue that's
16 preventing it.
17 DR. BURCHETT: Right. Okay. Well, if
18 you-all reach back out to them in the near
19 future, just like the first item, is there
20 way any way we can have an update between
21 the TAC meetings?
22 MS. DUDINSKIE: Certainly. We'll do that
23 meetings.
24 DR. BURCHETT: Okay, sounds good.
25 MS. BICKERS: Dr. Burchett, Justin

1 Dearinger just joined. He might have an
2 update for you on that first item.
3 DR. BURCHETT: Yeah. Okay, sure. Yes.
4 MR. DEARINGER: Hello, how are you-all? My
5 computer just died on me, so I had to call
6 in on the phone so I don't have a video.
7 But I wanted to -- I see the first item you
8 talked about, the no-show report, and that
9 report is live and functional. So it's
10 available to all providers to be able to
11 get onto the payment system, the MMIS
12 payment and billing system, and it's under
13 reports and it says -- I think it says
14 no-show report or list of appointments
15 report. You can click on that and then
16 it's a whole little system there that lets
17 you search by provider, by -- it has all
18 the reasons for the missed appointments,
19 all that kind of stuff. So that's
20 available, it's up and running for all
21 providers to be able to search and look on
22 there. And one of the things that we're
23 trying to kind of highlight is that the
24 majority of those reasons, which is, you
25 know, a big part of what we're trying to

1 determine, is just undetermined or
2 unanswered. And so we're really trying to
3 reach out to providers to say, hey, if we
4 can get more individuals to answer and to
5 find out why, you know, that they didn't
6 show up, we can attack those reasons
7 through Department for Medicaid Services,
8 whether it's transportation, child care,
9 couldn't remember when the appointment was.
10 But that is up and running and available to
11 all providers currently.
12 DR. COMPTON: This is Steve Compton.
13 Justin, we have no idea why they don't
14 show up. They just don't show up, and then
15 their phone is disconnected. We can only
16 afford to spend so much timing tracking down
17 reasons. Most of them just don't show up.
18 They'll be here and not show up.
19 MR. DEARINGER: Yeah, and there's going to
20 be -- you know, we all know that the
21 majority of, you know, is going to be that
22 way. I mean, I don't think there's
23 anything that we can do about that right
24 now. That's kind of a larger issue. But I
25 want -- you know, I'm kind of hoping with

1 community health workers services, other
2 things like that, we can do a little more
3 outreach to ones who will respond and can
4 respond and who have actual, you know,
5 issues, reasons why they can't get -- to be
6 able to answer that and maybe we can assist
7 with that.
8 But I know what you're saying. I
9 understand that's going to be -- it's still
10 probably going to be the majority, but we're
11 hoping we can get at least maybe a larger
12 number.
13 DR. COMPTON: On the upside -- this is
14 Steve Compton again -- we did have one
15 patient call that Humana had contacted
16 about their no-show history and it seemed
17 to help. I think it was Humana. Right?
18 Yeah, okay. Anyway, that's one out of --
19 MR. DEARINGER: -- issue in all of our MCO
20 meetings, all of our provider meetings,
21 because it's a collaborative group effort
22 to attack the problem. And so hopefully
23 you'll see a lot more of that with all the
24 MCOs.
25 DR. BURCHETT: Well, it would be good.

1 Anybody have anything else on that
2 one? If not, we'll move on. Thanks for the
3 update. Hopefully we can put that to good
4 use and try to remedy some of that problem.
5 DR. MUNSON: Matt, can you hold on just a
6 second?
7 DR. BURCHETT: Yeah.
8 DR. MUNSON: Let me ask Justin to repeat
9 where that report is because I'm not able
10 to find it. So can you repeat like from
11 the -- like start to finish how you find
12 that report?
13 MR. DEARINGER: Sure. Kelly Kitchen is on
14 the call. She just asked me if I wanted
15 her to share her screen and I said --
16 DR. MUNSON: Yes. Like, walk us through
17 from the beginning until you get to that
18 report, because I think that --
19 MR. DEARINGER: Can you pull up --
20 DR. MUNSON: -- for members to know this --
21 we are not going to be able to just say,
22 oh, yeah, go on the portal and find it,
23 because it's not going to be conducive to
24 finding that information.
25 MS. BICKERS: Kelly, you're a cohost now.

1 You should be able to share your screen.
2 MS. KITCHEN: Great. Are you able to see
3 my screen?
4 DR. MUNSON: Yes.
5 MS. KITCHEN: Okay. So actually when you
6 log in, it is going to look a little bit
7 different for you-all, but when you log in
8 to Kentucky Health Net you're going to see
9 a place that says Missed Appointments
10 Dashboard. It does -- this is for all
11 provider types, so you do have the option
12 to pick for optician or for provider type
13 77. They are in order by provider type
14 number. You can select the reason code or
15 leave it as All. And as mentioned before,
16 a lot of times you don't know what the
17 reason is going to be, so you can click
18 unknown, but there are other -- other
19 reasons there, you know, no show, no reason
20 provided.
21 Obviously, when you're entering, you
22 are going to -- you know, you have a
23 Medicaid ID number. But this is just for
24 the actual report itself. You can choose a
25 month or you can do all, and you can choose

1 a year. Your chart type, so it's however
2 you want it to come out, if you want a bar
3 chart, column chart, line chart. And then
4 you have an option of a 3D chart or remove
5 grid lines, and then you would just generate
6 the chart.
7 So let me go ahead and generate -- I
8 guess it's telling me I have to generate --
9 let me see. So this is an actual bar chart
10 that will show you the amounts. You can
11 save it as a PDF also.
12 Does that help understand a little bit
13 more where to find it?
14 DR. MUNSON: Absolutely. Yeah, yeah.
15 That's fantastic. Thanks you so much for
16 doing that.
17 MS. KITCHEN: You're welcome. And let me
18 stop sharing here. Thank you.
19 DR. BURCHETT: Okay. Well, let's move on
20 then. The next item is the new vision
21 materials benefits from the Department.
22 Just the first one, when are you-all going
23 to release the contact lens fee schedule?
24 MR. DEARINGER: So we're still working on
25 the contact lens fee schedule. I think we

1 may be -- did we receive your all's
2 feedback from that?
3 DR. BURCHETT: I think probably. I know --
4 DR. COMPTON: I sent mine.
5 MR. DEARINGER: Yeah --
6 MS. KITCHEN: Actually, we were waiting on
7 the feedback on that before we actually
8 added it to the fee schedule, and we
9 haven't received a confirmation.
10 DR. BURCHETT: I think I sent mine, but I
11 will double check then. That's been more
12 than yesterday.
13 MR. DEARINGER: -- that we ran, that
14 you-all had a chance to review that before
15 we added it.
16 DR. BURCHETT: Sure. I think we might have
17 as a group sent responses in to Sarah from
18 the KOA, and she might have sent those in
19 to you, but I will check and make sure. I
20 think that's what I remember, but I -- like
21 I said, it's been more than yesterday.
22 So with our feedback then, what kind
23 of time frame would we be looking at?
24 MR. DEARINGER: Once we get that feedback,
25 we'll try to look at that, you know, within

1 a few days, and then we have to run that
2 up, you know, just to kind of clear that
3 with management. So maybe, you know, a
4 couple weeks, and we'll probably get back
5 with you-all if we have any questions or
6 anything like that, but no more than a few
7 weeks at most.
8 DR. BURCHETT: Okay, sounds good. And
9 we'll check and make sure we got that to
10 you. I think that would probably make
11 things go easier, if we haven't, but I
12 think -- I think we might have already sent
13 it. So if not, we can send again.
14 MS. UNGER: This is Sarah with KOA. We
15 sent an e-mail, I think back on
16 September 25th, Kelly and Justin, and I
17 sent the responses. And I don't think
18 there was any changes. They just had some
19 questions. And so I'm not sure if that's
20 what you-all are looking for still, or if
21 you want more confirmation. But if you
22 don't mind to go back, I can resend our
23 correspondence.
24 MR. DEARINGER: I may have -- I know I had
25 got something about -- I think it was a

1 question on one or two codes, but I wasn't
2 sure if that was the complete feedback on
3 the fee schedule. So just get with me,
4 we'll figure it out.
5 MS. UNGER: Okay. Thank you.
6 DR. BURCHETT: Sounds good. The next item
7 then is Medicare patients with Medicaid as
8 a secondary. And just how it states, if
9 the adult patient is covered by Medicaid,
10 non-MCO patients, how does billing for the
11 adult glasses work?
12 DR. ALBANY: I think that was my --
13 DR. BURCHETT: Yeah, I think so, too.
14 DR. ALBANY: So I might want to clarify
15 that for them, so that I don't throw them
16 into the weeds here.
17 So far on the Medicare patients
18 that -- the way I understood it is if they
19 have Medicare, Medicaid, we have to send the
20 glasses to Medicare first, it has to be
21 denied, and then we send it over to
22 Medicaid. Now I'm talking about -- I'm not
23 talking about MCOs here. Just straight
24 Medicare, medicaid. So far we've tried
25 that. We've not had any that got paid.

1 Traditionally, if Medicare denies
2 something, Medicaid is going to deny it, and
3 that's sort of what's been happening. My
4 question on that particular subject was all
5 of the MCO vision plans don't require
6 anything from Medicare because they know
7 Medicare is not going to pay for glasses for
8 Medicaid patients. So I was just wondering
9 if there wouldn't be a way for the straight
10 Medicaid patient -- or not the straight
11 Medicaid patients, but the Medicare with
12 straight Medicaid, why we have to send it to
13 Medicare to be denied to start with. I'm
14 sure that there's a reason for that, but it
15 causes tons of extra work to be done.
16 MS. KITCHEN: This is Kelly Kitchen. We
17 recently added all of the vision codes for
18 the V codes for the glasses and lenses to
19 the bypass list, Medicare bypass list. So
20 if you have a member that is dually
21 covered, Medicare, Medicaid, you do not
22 have to bill Medicare first. You can bill
23 straight Medicaid. Now, if we have QMB,
24 they would not be covered for their
25 glasses, and that's because Medicare is

1 primary and has to pay in order to cover
2 those. But we did recently do a bypass
3 list for that.
4 DR. ALBANY: Excellent. So the information
5 we got the last meeting that the QMB should
6 be covered, they're not; correct?
7 MS. KITCHEN: That correct. QMB cannot be
8 covered and that's per federal policy.
9 DR. ALBANY: Okay.
10 MS. KITCHEN: So in order to pay for
11 Medicare QMB, Medicare has to pay, and
12 Medicaid only pays the coinsurance and
13 deductible. So since Medicare doesn't pay,
14 there would be no Medicare insurance or
15 deductible to pay.
16 DR. ALBANY: Okay, great. The other thing
17 is, is on that -- to my knowledge so far,
18 and I look at most all these claims every
19 day as they come in, we're not getting paid
20 on dispensing on Medicaid adults. Do you
21 know anything about that or is anybody else
22 having that issue?
23 MR. DEARINGER: If you can send examples, I
24 can look at it and see what's going on with
25 those specific claims.

1 DR. ALBANY: Do those examples need to be
2 sent to you directly, Justin?
3 MR. DEARINGER: Yeah, it would probably be
4 easier.
5 DR. ALBANY: Okay, we can do that.
6 The same -- along the same line, and
7 this may have been fixed with the bypass
8 that Kelly was talking about, I don't know.
9 If we billed two lenses, two units on the
10 same line, Medicaid was paying it for the
11 lenses. But a lot of those lenses don't go
12 on the same line because they have different
13 V code -- because of the power difference.
14 So we have to use one unit for one V code,
15 one unit for a different V code. And in
16 those cases on every claim that we've sent,
17 they denied one unit.
18 MS. KITCHEN: That should be fixed now. If
19 it is not, please send us examples.
20 DR. ALBANY: Okay. So on these that we've
21 gotten denied, do we need to resubmit those
22 or --
23 MR. DEARINGER: Again, you can send those
24 to us if they've been denied. They should
25 automatically go back and repay. But if

1 you haven't got payment for some, just send
2 them to us. We can look and see what
3 happened with those.
4 DR. ALBANY: Okay. All right. I
5 appreciate it. I think that you-all have
6 answered my questions. I did talk with my
7 insurance biller today, though, and just
8 recently within the last week we have --
9 they have denied some of our adult Medicaid
10 saying that we have to have it denied by
11 Medicare first. So you're sure Kelly, that
12 that -- do you know when that was fixed?
13 MS. KITCHEN: Yes, I'm sure that the bypass
14 list has been put in. I can go back and
15 verify the date for you and send that to
16 you.
17 DR. ALBANY: All right. Thank you so much.
18 I appreciate it.
19 DR. BURCHETT: Well, I think that answers
20 all of the other questions there on the
21 glasses and things that we had for Old
22 Business. So let's move on I guess to New
23 Business.
24 Once again, we'll just go down the
25 list, just some one-off items. The first

1 one, for the Eyequest Group. And I think
2 the code on there is wrong. I think the
3 code is 83516, not 95930. But it's a test
4 for inflammation for dryness in dry eye
5 testing. And I understand that you-all have
6 it as a once-per-lifetime occurrence. And
7 my question is why can't we -- why is the
8 limit once per lifetime?
9 DR. DAVIS: My name is John Davis. I'm
10 clinical director for Eyequest, if I could
11 offer to opine on that, give you our
12 rationale.
13 DR. BURCHETT: Sure.
14 DR. DAVIS: So you're correct, the code is
15 83516. That's just a typo you guys can
16 correct on your minutes.
17 So this particular test, it's called
18 an inflammadry. It's basically a test
19 looking, as Dr. Burchett has said, it looks
20 for inflammatory cells in the tear film.
21 Basically, it's an analysis of the tears.
22 And we feel like our guideline that limits
23 that to once per eye per lifetime is
24 reasonable. Mainly, the main reason we feel
25 it's reasonable is because this particular

1 test is a form of a diagnostic test, meaning
2 you do this test to determine if the
3 underlying cause of the dry eye is possibly
4 inflammatory, or autoimmune mediated maybe
5 is a better term for that, versus what we
6 they an aqueous-deficient dry eye, which the
7 doctors want to know that so that they can
8 decide which kind of mode of treatment they
9 might want to go with. Right?
10 You should also recognize too that
11 most dry eye management is done based on
12 symptomatology, though. Once it's
13 diagnosed, you treat it, there's only a
14 certain number of things you treat with.
15 There's a bunch of things now. But it's
16 managed based on symptomatic relief. You
17 try this drop, or this procedure, or this
18 whatever, and you -- and you find out if the
19 patient feels better.
20 I will say, too, that this test is not
21 really that commonly used nationally for us,
22 for our clients. It is potentially abused a
23 little bit by certain rare optometrists in
24 the country. We don't see that in Kentucky
25 at all. But it can be abused and it's

1 because everybody over 60 years old, every
2 woman in particular, probably has dry eyes.
3 So pretty much they test everybody and we
4 catch -- we identify those doctors, explain
5 to them why that's not appropriate.
6 But anyway, back to this question,
7 specific question is -- so we feel like it's
8 a diagnostic test. So you determine whether
9 the etiology is either inflammatory or is
10 aqueous-deficient, or at least you have a
11 guide, a little bit more of a guide to go
12 with to start your management. But we don't
13 feel like it's a monitoring test. That's
14 what the osmolarity test -- there's another
15 lab that's commonly done at the same time by
16 most doctors who do the 83516. They do the
17 838, I think it's 61, which is -- which is
18 another tear film analysis that sort of
19 helps monitor how the eye is doing, how the
20 tear film is doing, is it getting better.
21 And so that test doesn't have that same
22 limitation. That's a management test or a
23 monitoring test that we feel can be allowed
24 much more frequently to help monitor the
25 patient's condition, resolution, or their

1 symptoms, whatever.
2 But I say that -- I say, look, there
3 are always going to be extenuating
4 circumstances, too. Right? There are
5 patients where it's appropriate to do that
6 test again somewhere along the way, more
7 than once per lifetime. And that's what the
8 PA process is about, it's to identify those
9 one-off cases. So it shouldn't be done on a
10 routine basis, meaning everybody gets that
11 test every six months just as part of their
12 follow-up visits just to do it. We feel
13 like that's very wasteful and potentially
14 abusive. So that's our premise.
15 Again, the bottom line is if you have
16 extenuating circumstances, those are the
17 cases to present to us. I will say one more
18 thing quickly that's, I think, germane to
19 this particular group, is that you-all are
20 tuned into this stuff pretty well. We are
21 -- we do our -- our clinical guideline
22 policies, they are always annually reviewed
23 and sometimes more often. If you have
24 literature that supports the premise that
25 doing this test on an ongoing basis is

1 somehow contributory, we'd like to see that
2 literature, that peer-reviewed literature,
3 because we are always willing to change our
4 guidelines. We do all the time anyway, and
5 based on, you know, medical studies that are
6 done that are not equivocal, meaning they
7 are evidence based.
8 Dr. Burchett, do you got any questions
9 about that, or do you disagree?
10 DR. BURCHETT: Well, mildly, but in general
11 I don't disagree with you. What I'm
12 looking at it is patients that maybe got
13 tested, and a couple years down the road
14 they come back and, you know, they -- we
15 decide to retest because maybe something's
16 changed. Maybe they developed arthritis or
17 something like that, that could lead to an
18 inflammatory issue. And so I just, you
19 know, don't want to waste my time testing
20 if I'm not going to get reimbursed for it,
21 but it's in the best interest of the
22 patient at that point to retest.
23 DR. DAVIS: Right. Okay. That's, you
24 know, a simple, great example right there;
25 right? So what we -- we have a peer review

1 committee every couple of months, and we're
2 going to -- if you don't mind, I would like
3 to put this on the agenda for one of our --
4 we look at guidelines every time we meet as
5 a peer review committee. The peer review
6 committee is made up of optometrists --
7 practicing optometrists and practicing
8 ophthalmologists.
9 So we talk about -- again, we have
10 about 90 clinical guidelines that are --
11 that we deal with. So every year they all
12 get evaluated one way or the other. I --
13 since I saw this item, I have one of my
14 members, who's big on looking at literature
15 and going to all the sites for
16 ophthalmology, et cetera, or just the trade
17 peer-reviewed literature. And there's not a
18 lot on this inflammadry anymore going on out
19 there right now, and there's nothing real
20 current that he has told me. But we're
21 going to relook at it, and I'm going to cite
22 that example you just presented and we -- we
23 can look at that.
24 In the meantime, though, you're
25 welcome to, though, when you have patients

1 you feel like there's an extenuating
2 circumstance for approval, send that in.
3 Say, this is what we feel. Monitor in your
4 chart, or get a peer review directly with
5 one of our clinicians that looks at this
6 stuff. We have people you can call if you
7 have a -- if you want reconsideration of a
8 denial.
9 DR. BURCHETT: Sure. I would propose one
10 other instance to think about in your
11 discussions then.
12 DR. DAVIS: Okay.
13 DR. BURCHETT: You know, somebody that we
14 test and they're positive, so we start them
15 on a Restasis eye -- or whatever, you know,
16 we decide to treat with. And, you know,
17 we're treating, following, treating and
18 following, and then, you know, a year into
19 treatment they're saying, well, I don't
20 notice any difference. Well, I think it's
21 incumbent upon us to maybe recheck for the
22 inflammatory markers to see how that's
23 working.
24 DR. DAVIS: To see if you had a false
25 positive possibly? Maybe?

1 DR. BURCHETT: Yeah.
2 DR. DAVIS: Yeah, maybe reasonable. Right.
3 And, again, I think that policy was really
4 designed around what we see is we see
5 everybody gets both tests all the time.
6 They come back in six months, they get an
7 osmolarity test, they get another
8 inflammadry test. And, again, this is
9 optometry, period. I don't even have
10 corneal specialists that use this test that
11 treat dry eye. They don't do it. They
12 just treat these things more empirically
13 based on symptoms. But I think your
14 statement is not unreasonable. I'm going
15 to cite that as well.
16 You know, we don't want to make it
17 harder on you, and we don't even want to do
18 the PAs for this kind of thing, but it's an
19 area where we have to basically based on the
20 -- what's happening in the industry. It's
21 just one of those things.
22 So -- but I think that those are not
23 unreasonable and I will certainly -- and,
24 again, I think our next peer review
25 committee is I think around the 15th, middle

1 of December. I think the 15th actually. So
2 I'll have results for you for the next TAC,
3 which I believe is going to be in maybe
4 February. Can't remember the date. Is that
5 okay?
6 DR. BURCHETT: That's fine.
7 DR. DAVIS: Okay, good.
8 DR. BURCHETT: I appreciate it.
9 DR. DAVIS: Thanks for the -- I like those
10 -- thanks for those two kind of examples or
11 representative examples that do make sense
12 to me as a clinician. Okay.
13 DR. BURCHETT: Okay.
14 DR. DAVIS: I might still be up on that
15 next item.
16 DR. BURCHETT: I think the next two, they
17 are both from Steve, and I'm going to let
18 him talk about them because he's got more
19 direct knowledge of them.
20 And I will tell you-all this. I may
21 drop. I just realized my iPad is on about
22 two percent. So I may have to switch over
23 to the phone in just a minute. So if I drop
24 off, I'll be right back on.
25 DR. COMPTON: Okay. This is Steve --

1 DR. BURCHETT: Steve, you want to go ahead?
2 DR. COMPTON: Yes. And Dr. Davis called
3 our office this week, and it's my
4 understanding that both of these things
5 have been remedied. The different plans
6 with different benefits for Medicaid
7 members -- somebody on the frontline on the
8 phone and I guess didn't know what they
9 were talking about.
10 And then the 90-day waiting period for
11 replacement glasses, I think, Dr. Davis,
12 that's fixed?
13 DR. DAVIS: Yes, that was -- that was
14 removed a long time ago. I think the
15 specific situation was that -- had to do
16 with billing directly for 92370, versus
17 when the glasses are made the
18 replacement -- there's no waiting period at
19 all for that anymore, of course. I think
20 we resolved that a couple years back.
21 But I was worried about that. That's
22 why I called. I go, wait a minute, we don't
23 have that in place anymore, what else is
24 happening. And you have excellent staff. I
25 mean, you guys have experienced people that

1 know what they're talking about. And I
2 think that's what we determined, it was this
3 one particular thing where they were billing
4 us directly for this code versus having it
5 become automatically generated based on the
6 supply of the eyewear. Like, there was no
7 limit to getting the eyewear. I'm talking
8 about replacements for your members, for
9 your patients. Yeah, that's not a real
10 issue though.
11 DR. COMPTON: Okay. But the limits on the
12 dispensing fee, is that what I'm --
13 DR. DAVIS: Yeah, there is no limit. If
14 you make -- if you dispense them today and
15 the patient comes back tomorrow, says I
16 already lost my glasses, you get a
17 dispensing fee paid again tomorrow. And I
18 think the way we understand that is if
19 you're doing the work -- I mean,
20 replacements require work, too. You have
21 staff involved, whatever, and that was --
22 we felt like that was a reasonable premise,
23 which is why, again, going back about
24 almost two years now that 90-day waiting
25 period was removed.

1 DR. COMPTON: Well, thank you for your --
2 all your hard work. And I'm one of those
3 guys that's maybe using inflammadry too
4 much, so I'm going to reassess my --
5 DR. DAVIS: I don't think -- we don't --
6 those tests don't come up on my outlier
7 report for anybody in Kentucky, so you're
8 not -- otherwise you would show up.
9 DR. COMPTON: All right.
10 DR. DAVIS: But, obviously, you're saying,
11 you know, you like to practice as prudently
12 as you can, for sure, like the standard of
13 care.
14 Okay. So I think we're clear on that
15 one.
16 DR. COMPTON: Thank you.
17 DR. DAVIS: And the other one I think you
18 already mentioned, Dr. Compton, maybe was
19 also miscommunication about the different
20 plans. It had something to do with the
21 adult contact lens benefit versus the child
22 contact lens benefit, I think was the
23 misinterpretation. We consider them
24 exactly the same now. Adults and kids,
25 they both get contact lenses based on

1 medical necessity, period. No different
2 between the two, the way we understand it.
3 DR. COMPTON: All right. Okay.
4 DR. DAVIS: Good questions.
5 DR. COMPTON: There was a hiccup somewhere
6 along the line, so that's why we --
7 DR. DAVIS: That's okay. It's good.
8 DR. BURCHETT: Thank you, Dr. Davis, for
9 all of that.
10 DR. DAVIS: Sure.
11 DR. BURCHETT: Steve, I think the next one
12 might be yours too, if I'm not mistaken.
13 DR. COMPTON: Cindy is sitting in the room
14 with me, because she may have to help me
15 explain this.
16 This is Avesis. We had a patient in
17 the middle of the month -- back in June.
18 You know, we understand that the MCOs don't
19 have their portal updated for a few days
20 because Medicaid is month by month. But
21 this was the middle of the month. We
22 checked eligibility on the patient. Got
23 paid. And then a few months later they
24 recouped it, in September, saying the
25 patient wasn't eligible, and told us that at

1 least that month or some months it takes 30
2 days to update. 30 days is what they told
3 her. Well, that didn't work. It was the
4 next month by then. And if their portal
5 said they're eligible, I don't think we
6 should have the money recouped. So we
7 checked both -- you know, we checked both
8 Medicaid and MCO website and appealed it,
9 but it's still been denied.
10 ASSISTANT: KCI rep, she's supposedly
11 fixing it for me, and taking care of it
12 this week.
13 DR. COMPTON: So supposedly our rep is
14 taking care of that, but it's something
15 that shouldn't happen and we've spent a lot
16 more money on chasing it than we got paid.
17 Well, we haven't been paid. They took it
18 back.
19 It just needs -- if it's taking 30
20 days to update the website, it's the next
21 month by then.
22 MS. GRAY: Hi, Dr. Compton. This is Kim
23 Gray. I'm strategic client partner from
24 Avesis. Just wanted to address your
25 concerns there.

1 So in regard to the eligibility files,
2 we do receive monthly eligibility files from
3 the MCO, and then we receive daily change
4 files and updates from DMS. So we load that
5 information into our Avesis portal within
6 one business day. In regard to what you're
7 talking about, that has to do with, I guess,
8 a loss of eligibility for the member and
9 then they were reinstated. So we -- we
10 should be making those changes within a few
11 days. It shouldn't take 30 days, like what
12 you have discussed. And so -- and then we
13 would retrospective -- retrospectively move
14 their start date back to the first of the
15 month.
16 So this issue has been brought to our
17 attention by yourself and a couple other
18 providers, so we have put a halt on any
19 retro -- I'm sorry, any recoupment activity
20 until we get the eligibility situation
21 fixed. So I appreciate that you have
22 reached out to Casey. Casey is looking into
23 this concern for you and we will get this
24 remediated immediately.
25 DR. COMPTON: Okay. Thank you.

1 MS. GRAY: Sure. Thank you for bringing it
2 to our attention.
3 DR. BURCHETT: Thanks for all that
4 clarification there. That definitely can
5 be a problem for sure.
6 The next -- I'm going to throw in -- I
7 was going to have this for a general
8 discussion topic, but it's an Avesis-based
9 question as well. We have had some comments
10 from several providers about needing a prior
11 authorization for prism when it's put into a
12 glasses prescription. And I was just
13 wanting to ask Avesis if that is truly the
14 case, if we have to prior authorize prism in
15 glasses, because that seemed like it's part
16 of the prescription, just like a plus or
17 minus lens power would be part of the
18 prescription.
19 MS. GRAY: Hi, Dr. Compton. So according
20 to the KAR regulations, which it looks like
21 we are currently following, it states that
22 that would need to be a medically-necessary
23 item. So that's currently what we're
24 following in this case.
25 DR. BURCHETT: It seems to me that if it's

1 prescribed, it's going to be medically
2 necessary. We don't prescribe prism like
3 we would transition lenses or antiglare
4 coating. Prism comes because there's an
5 eye concern or double vision.
6 MS. GRAY: Is there anyone else on with
7 Avesis that can help explain this in more
8 detail?
9 MS. VERNIER: Kim, this is Dani. So I'm
10 going to go back and check the KAR again
11 just to make sure that I do have it listed
12 correctly. But I do believe that it is
13 listed under the non-covered section,
14 unless it is medically necessary.
15 DR. BURCHETT: I believe that just the need
16 of the prism in the prescription makes it
17 medically necessary.
18 DR. COMPTON: It's always medically
19 necessary.
20 DR. BURCHETT: We don't prescribe prism
21 because they have glare issues like we
22 would a transition lens, things like that,
23 tint for a lens, per se. If they're seeing
24 double or they've got an eye turn, that's
25 medical necessity and that's where a prism

1 comes in.
2 MS. GRAY: So do you currently submit those
3 to Avesis as a prior auth request to review
4 for medical necessity?
5 DR. BURCHETT: That's a question I don't
6 have the answer to for what I do, for my
7 billing staff. I would assume they do,
8 because they would know that it has to be,
9 but I just don't know that it should be a
10 prior auth because it's always medically
11 necessary when you prescribe prism.
12 MS. GRAY: Okay. We can certainly take
13 that question back to our clinical staff
14 here at Avesis and talk through that in
15 more detail. Would it be okay if we
16 followed up with you on that one?
17 DR. BURCHETT: That would be great. Much
18 appreciated.
19 DR. COMPTON: Dani, this is Dr. Compton
20 again. We will a lot of times give it away
21 because it is less expensive to give it
22 away than it is to jump through all the
23 hoops.
24 DR. BURCHETT: That is true, too.
25 DR. COMPTON: Writing prism, it's like a

1 bifocal or anything else. It's part of the
2 prescription and it's necessary, so...
3 DR. ALBANY: I think if you will confer
4 with Dr. Worth, he will agree that prism is
5 always medically necessary when it's
6 prescribed.
7 MS. GRAY: Absolutely. That's exactly who
8 I was going to confer with. I believe he
9 had to jump to another call today. So let
10 me connect with him offline and then get
11 back to you-all with an update.
12 DR. ALBANY: Thank you.
13 DR. BURCHETT: Much appreciated.
14 MS. GRAY: Thank you.
15 DR. BURCHETT: So the next item comes from
16 the Department, and we would like for
17 you-all to add some codes to the vision fee
18 schedule for the coming year. These are
19 codes that our Board of Examiners have
20 determined that are appropriate for
21 optometrists to use and bill for. And I
22 don't think that they're found on the
23 vision fee schedule, so we would like for
24 that to be updated.
25 MR. DEARINGER: Yes, sir. I received those

1 codes and we will do the research if we can
2 add them.
3 DR. BURCHETT: Okay. Which brings up
4 another point real quick for me to ask. I
5 know in this we always talk about the
6 vision fee schedule, and it's appropriate
7 because we're in the eye care business.
8 But also we are deemed physicians under
9 Medicaid in Kentucky, and as such, I think,
10 if I'm not mistaken, we are allowed to bill
11 for codes out of the vision fee schedule
12 that are on just the regular physicians'
13 fee schedule if our Board of Examiners
14 deems them appropriate to us, because I
15 know some of these codes are already on
16 that fee schedule. And I think the next
17 item is another example of that. It was on
18 the physicians' fee schedule, but not on
19 the vision. And when optometrists bill for
20 it, we get denied because it comes back to
21 the vision fee schedule. But I think by
22 law in Kentucky, as us being recognized as
23 physicians and our Board of Examiners
24 saying that these codes are appropriate for
25 optometry to use and bill for, then I think

1 that we are allowed to use other codes
2 besides the vision fee schedule codes.
3 MR. DEARINGER: So some codes are set up to
4 bill for -- it just depends on the code in
5 particular and the provider in particular
6 whether they're able to bill off the
7 physicians' fee schedule or not. So it
8 will have to be particular code. So I
9 looked down at 92066. That is a code that
10 we are adding to the vision fee schedule in
11 2024. I thought I had requested that, or
12 somebody had sent that in on your all's
13 behalf, and so we are going to add that for
14 2024.
15 The other ones, you know, like I said,
16 we are going to research and see if we can
17 add those to the vision fee schedule. But
18 as far as billing off the physicians' fee
19 schedule. It depends on your licensure
20 type, the particular code, and how it's set
21 up in the system. So you kind of have to
22 ask, you know, individually on those, so we
23 can look those up and see what edits and
24 audits are in place on there and what we can
25 do to -- if we -- you know, if we needed to

1 research it to make a change to that and put
2 that on the vision...
3 DR. BURCHETT: Okay. So then how many
4 times a year can we update the vision fee
5 schedule if codes come up that we're not
6 aware of, or new codes come out, per se?
7 MR. DEARINGER: We only update any fee
8 schedule once a year. That's my official
9 answer. However, if we find that there
10 are, you know, opportunities and options,
11 if we feel like it's something that's
12 needed immediately where we can change it
13 at any time in the year. And you-all have
14 seen that, you know, with the changes that
15 we have done so far in 2023. I don't know
16 how many times we've updated the fee
17 schedule, the vision fee schedule in
18 particular, in 2023, but it's been several.
19 So officially we do it once a year and
20 we -- you know, that's how it kind of has to
21 work. But all year long we're reviewing
22 codes. So when you-all send us stuff, we
23 immediately start researching, looking into
24 it, and seeing if it's something we can add,
25 do we have the budget for it, how does it

1 impact, what are other states are doing, all
2 that kind of stuff. And then once we make a
3 decision, if it's something we feel like is
4 impactful, you-all feel like is impactful,
5 something that needs to happen, we always
6 have that option to be able to add it
7 immediately if we have to. But in general,
8 it's once per year.
9 DR. BURCHETT: Okay. Any questions on any
10 of that?
11 MS. GRAY: Yeah, this is Sarah from -- oh,
12 sorry.
13 DR. MUNSON: That's okay. You go ahead,
14 Sarah.
15 MS. UNGER: Well, I was going to say the
16 same thing.
17 Well, I just had a question because I
18 sent -- this is Sarah with the KOA. I sent
19 e-mails back in February of 2023, asking for
20 the 92066 to be added, and told that
21 you-all -- that the Department has the --
22 you know, would not add the code all during
23 that time, that you only add it once a year.
24 But from what you're saying, Justin, I mean,
25 it's kind of like you-all are picking which

1 codes to add. So I don't understand how
2 you-all can pick codes what you want to add,
3 what you don't want to add when it's been
4 requested. And that actually now that I
5 have found out that that code was put on the
6 physician fee schedule, but that the
7 Department did not put it on the vision fee
8 schedule.
9 So it kind of goes back to what
10 Dr. Burchett is saying, if it's on there,
11 why can an optometrist then not bill for the
12 code even though it's not on the vision fee
13 schedule? If you-all are not going to add
14 it to the vision fee schedule, could you
15 have not gone in and put on the physicians'
16 side that the optometrist provider type
17 could still bill that code for this year
18 until it was added to the 2024 fee schedule?
19 MR. DEARINGER: That's a great question.
20 So if we had the opportunity to add codes
21 freely and then that would be a much easier
22 process for us to do, and we wouldn't have
23 to do any kind of -- you know, there
24 wouldn't be any thought process in it.
25 Once we approved that, the request, we

1 could go ahead and add it.
2 The unfortunate part is that every
3 time we add a code on the fee schedule, that
4 is a change order that we have to put in
5 with our billing providers, and it goes
6 through a whole set of systems that charges
7 us money, right. And it's not cheap. It's
8 expensive. Every time we add a code, it's
9 very expensive because all the programmers
10 have to go in and rewrite the program, reput
11 in limitations, and edits and audits, and
12 all that stuff.
13 So it's really a money issue.
14 There's -- financially we have to evaluate
15 on, you know, based on a lot of factors
16 based on, you know, how much it's going to
17 cost to make that change versus the impact
18 to members and providers.
19 DR. MUNSON: But here's a question that I
20 have. This is Carolyn, Dr. Munson. We
21 have in Kentucky what's called a pay peri
22 (phonetic) law, which says that we as
23 optometrists are able to bill and be paid
24 at the same rate for a service as an
25 ophthalmologist that's within our scope of

1 practice. So if you have this 92066 on the
2 physician fee schedule, which an
3 ophthalmologist can be bill and be paid
4 for, then by our statutes, by our state
5 laws, then that is something then as
6 optometrists that we should have been able
7 to bill for since the beginning of the year
8 when this was added to the physician fee
9 schedule. And so I'd like for you to speak
10 to that or help me understand how Medicaid
11 is able to have this in direct
12 contradiction to a law that has been
13 passed?
14 MR. DEARINGER: Sure. So I think the
15 contradiction would be if we had the same
16 code on the physicians' fee schedule and
17 the same code on the vision fee schedule,
18 and we paid one price for one and one price
19 for the other. The difference is there are
20 certain codes that are -- ophthalmologists
21 are able to bill that optometrists are not,
22 and so that's kind of the difference.
23 We have to, you know, vet that, make
24 sure that's okay to be able to put on the
25 vision fee schedule, and then that's, you

1 know, the way we are able to do that and to
2 put that on there. So it's not that you-all
3 are being paid a different rate for a code.
4 It's just you're not able to bill that code.
5 We have to make sure that, you know, that it
6 goes through the process of making sure it's
7 okay and going through all the licensure --
8 all that kind of stuff to be able to put on
9 that -- that vision fee schedule.
10 DR. MUNSON: Right. But what you're
11 telling me is this code -- and I understand
12 that you know these numbers, these codes.
13 You don't actually know what that means in
14 a practice setting as a doctor's
15 perspective. You can't pay ophthalmology
16 for something that is within our scope of
17 practice. So the law states that if it's
18 within our scope of practice as
19 optometrists, as decided by the Kentucky
20 Board of Optometric Examiners, then that
21 has to be paid -- number one, paid, but,
22 number two, paid equally to optometrists.
23 So I understand the point that you're
24 saying about if there were two different
25 fees that were being paid, but it's paying

1 period. I can't bill cataract surgery
2 because I can't do that within my scope of
3 practice, but I can bill a visual field
4 because I can do that within my scope of
5 practice. So this code, this 92066, is
6 within the scope of practice of an
7 optometrist and an ophthalmologist. But
8 the way that these fee schedules are out
9 are discriminatory against optometrists for
10 something that they legally are able to do
11 and licensed to be able to do.
12 So that's I think where my question
13 is. It's not about the amount of
14 reimbursement. It's the fact that we are
15 being discriminated against and have been
16 this entire calendar year.
17 MR. DEARINGER: Well, I think it's a valid
18 argument. I think it's a good point. I
19 need to research it a little more. So let
20 me get back with you on that, and maybe we
21 can figure something out. I definitely
22 don't want anything that we do to be
23 discriminatory. We value all of our
24 providers equally. So, you know, let's
25 have some more conversation about it. Let

1 me look into it just a little bit more and
2 I'll get back with you-all. Maybe we can
3 figure something out. You know, it's not
4 done intentionally, I can promise you that.
5 DR. MUNSON: Well, and it's not a
6 high-dollar code and it's not something
7 that is done in every office. It's
8 actually quite specific. And so for those
9 few providers that this does affect, that
10 is something that since it's been on the
11 fee schedule since beginning of the year,
12 if we could get that, A, changed and, B,
13 have those few providers back-paid for that
14 discriminatory period, that would be a
15 fantastic solution. So I look forward to
16 your response to that.
17 MR. DEARINGER: All right. Thank you for
18 bringing that up. Like I said, it's -- you
19 know, for sure we already added it to the
20 2024 fee schedule, but let's keep talking
21 about, you know, looking at the 2023, when
22 we only added it to the physicians as well.
23 DR. MUNSON: Absolutely. That sounds
24 fantastic. Thank you.
25 MS. UNGER: And this is Sarah with KOA

1 again. I guess then my follow-up question
2 to this is -- you know, it was added
3 January 21st, 2023 to the physician -- is
4 there a way that the Department goes
5 through -- I mean, I know we're not the
6 only other -- I know there's lots of
7 different fee schedules. So how does the
8 Department determine like what other fee
9 schedule that code should go to? Are they
10 waiting on the provider groups, or does the
11 Department go through and say, oh, this
12 code could be billed here, here, and here
13 on these different fee schedules, or how
14 does that work exactly?
15 MR. DEARINGER: So the process goes both
16 ways. There are multi-faceted levels of
17 review. You know, whenever we get a --
18 there's two ways we add codes. So the
19 first way we add codes is when CMS makes
20 their updates, federal Medicaid, they send
21 those updates to us, and we can add codes
22 that way. The other way we add codes is if
23 a provider reaches out and asks for a code
24 to be added. In that case the -- that code
25 is researched. We have to look at federal

1 Medicaid standards, we have to -- and it
2 goes to different groups of people to do
3 different research to all come back.
4 So we look at what federal Medicaid's
5 doing. We look at what surrounding states
6 are doing, because not only do we have to
7 look at and determine the -- I'm sorry, did
8 I go on mute there for a minute? Can
9 you-all hear me?
10 DR. BURCHETT: Yes.
11 MR. DEARINGER: I'm sorry. So I'm not sure
12 what you-all heard and what you didn't, so
13 I'll kind of start back from the beginning.
14 So when we get those codes from a
15 provider, we look at federal CMS, Medicaid
16 rules. Then it goes out to other different
17 individuals to do research for other states.
18 We look at the licensure for those codes,
19 who can bill for those codes, who can't bill
20 for those codes. We look at all the
21 different limitations, how it impacts all
22 the different provider types. And so there
23 are a lot of different layers to it before a
24 code is added.
25 And then once all that information is

1 gathered back in, we have to do a fiscal
2 analysis to see how that -- you know, if we
3 have the money to add it, what rate should
4 be on the code, what limitations, all those
5 different types of things, before we do
6 recommendation on whether to add the code or
7 not. And if management approves that, then
8 it gets added to the fee schedule in the
9 next year.
10 And, again, if it's something that
11 they feel like is impactful immediately to
12 the health and would be worth the extra
13 money to add before the first of the year,
14 you know, we have the ability to do that.
15 Not that we like to do that very much
16 because, like I said, it's very expensive
17 and that's extra funds, taxpayer funds, we
18 are spending to add that sooner.
19 DR. THERIOT: Justin, this is Dr. Theriot.
20 Would a good example of that be the RSV
21 codes, because they don't come out in a
22 timely manner, so because we needed them on
23 the vaccination schedule it needed to be
24 done off cycle?
25 MR. DEARINGER: That's exactly right. So

1 we added -- you know, we had -- and Dr.
2 Theriot can probably speak better than I
3 could about it. We had RSV codes. They
4 are vaccines that came out late. And so
5 there was a public health, you know,
6 possible -- you know, some large public
7 health implications to be able to cover
8 those vaccines, because for -- in the
9 vaccine world, a lot of times a vaccine
10 code will only last a year or two years and
11 they will replace it with a different
12 vaccine code. So then you don't have any
13 coverage for vaccines for that particular
14 illness or disease. And so in order to
15 cover that, you know, we have to do that
16 outside of the normal annual timeframe to
17 make sure that everybody gets those in the
18 appropriate season when you would normally
19 get -- same way with the flu vaccine or
20 Covid vaccine. And most of the time those
21 come out in a timely manner and we can add
22 those the first of the year.
23 But Dr. Theriot is exactly right. We
24 had to do that with the RSV vaccines this
25 year. And in that case it was worth the

1 extra money we had to pay to get those added
2 outside of the normal yearly fee updates.
3 It's definitely -- it's not cheap.
4 DR. BURCHETT: Justin, this is
5 Dr. Burchett --
6 MR. DEARINGER: Really quick. You know, a
7 lot of times fiscal will come back and say
8 this is going to cost this amount to add
9 the code and this is the amount that it's
10 going to cost if we don't add the code.
11 And so in the case of the RSV vaccines, you
12 know, there was data from some other states
13 that showed an increase in emergency room
14 visits, an increase in hospital stays, an
15 increase in individuals on respirators.
16 And so that code -- that cost greatly
17 exceeded the cost of adding the codes. So
18 that's -- I mean, that's another -- you
19 know, fiscal always gives us that report of
20 the cost of adding them outside of that
21 annual update versus the cost of not adding
22 it.
23 DR. BURCHETT: Dr. Burchett here again,
24 Justin. My question then is -- maybe I
25 misheard. If I did, please -- please tell

1 me. But you said that, you know, each year
2 new codes and things come out and you-all
3 review them and you kind of look at
4 licensure type and you look at what
5 surrounding states are doing, things like
6 that, before we decide to add or not add
7 codes to fee schedules. Was that a correct
8 synopsis?
9 MR. DEARINGER: Yes.
10 DR. BURCHETT: Make sure I understood that
11 correctly.
12 So then in my mind what you're telling
13 me is the Department is trying to set the
14 scope of practice for each profession by not
15 allowing them to bill certain codes that
16 they use in that profession.
17 MR. DEARINGER: No. I mean, that's
18 absolutely not the case. It's -- you know,
19 any code that is, you know, billed in the
20 traditional course of providing care for
21 our recipients, you know, we try to make
22 sure is added on our fee schedule. We
23 get -- I guess you -- you know, when you're
24 talking about -- and I think right now you
25 and I are talking about codes that are

1 requested by providers. And so when we
2 look at codes that are requested by
3 providers, those codes come through --
4 there's a lot of codes out there. And so
5 some of those codes come through of cases
6 where a provider would -- you know, has
7 never billed before, no other states cover
8 that, private insurance doesn't cover it.
9 You know, those codes aren't covered at all
10 under any insurance. And so we get those
11 requests, and we have to look at is that
12 something that is just new and innovative
13 and maybe Kentucky can be a leader in
14 adding those codes, or is that something
15 that is just not covered under insurance
16 for whatever reason.
17 But as far as what provider types can
18 do what codes, as long as it's in their
19 licensure, it goes on the fee schedule. I'm
20 sure there are times where maybe we've left
21 a code off by mistake from one fee schedule
22 to another preventive -- one clinician or
23 another of doing that, and that's kind of
24 when we rely on you-all to be able to tell
25 us, hey, this is in our scope of practice,

1 too, you-all didn't add this. And maybe
2 that's the case with the, you know, 92066.
3 I don't know.
4 MS. UNGER: And I guess -- this is Sarah
5 with KOA. So what you're saying, though,
6 that is what's happened in the past. If
7 there is a code that is added, because the
8 92066 was a new code starting in 2023, as
9 of January 1st. So when we found out that
10 it had not been added to the vision fee
11 schedule, you would think that Medicaid,
12 when CMS has added it, all MCOs, all
13 insurances are adding it, that you-all
14 would go back and add it, because it does
15 affect the office that is billing it
16 because it has changed the way -- because
17 in the past the code was a 92065 and the
18 doctor or their staff, they could bill that
19 code. Well, now it's been restricted and
20 they split the code into the 92065 can be
21 billed one way, or the 92066.
22 So when Medicaid didn't add the code
23 since it was a new code, but you added it to
24 the physician fee schedule, then the
25 optometrists have been left out all year.

1 Does that -- I mean, I understand what
2 you're saying, your explanations, but to me
3 this is one way of saying it should be added
4 from what you're explaining, because it
5 wouldn't be on any other fee schedule.
6 MR. DEARINGER: It's very possible. I
7 mean, I have to, again, go back and look to
8 make sure, like we said earlier, but that
9 absolutely is possible. We do that all the
10 time where we backdate codes and add codes.
11 Not all the time. We try not to make
12 mistakes all the time, but those things do
13 happen. This is case where that could have
14 happened.
15 Like I said, I have to just kind of go
16 back and look just a little bit more at it,
17 but we are always open to your all's -- you
18 know, you-all are the ones that catch that.
19 You know, we can't catch that. We have -- I
20 have at least 10 to 20 code requests a day
21 from providers. So, you know, if we add
22 something to a fee schedule, but it relates
23 to another group and we've forgotten to add
24 it to that fee schedule, then that's
25 something that, you know, we definitely need

1 your all's help to reach out to us and say,
2 hey, this should have been on the vision and
3 not just the physicians to get added, so...
4 MS. UNGER: Okay. Well, this is Sarah.
5 I'll forward my email request that I
6 started back in February asking for this.
7 So I'll send it after this. Thank you so
8 much. I appreciate it.
9 MR. DEARINGER: Thank you. I appreciate
10 it.
11 DR. BURCHETT: I'll jump back into asking
12 the TAC, is there anything else that
13 you-all have to discuss that we might not
14 have touched on here?
15 DR. COMPTON: Matt, Dr. Compton. This
16 happened yesterday. And maybe this is
17 still a policy and I'm mistaken. Avesis.
18 Once we finally got through to a
19 representative, they tell us they can only
20 help with three claims at a time. I know
21 that was a policy at one time. I thought
22 that had been rescinded, but I can't
23 remember. But it takes a while to get to
24 them and then you get cut off after three
25 and you got to get back in line.

1 MS. GRAY: Hi, this is Kim Gray again with
2 Avesis. I will have to check on that for
3 you. I'm not exactly sure what the process
4 is as far as, you know, how many claims
5 that they will look at at a time. I can
6 certainly get back to you.
7 DR. COMPTON: Okay. Thank you. This guy
8 was named Danny. I don't know if they use
9 their real names. I wouldn't.
10 MS. GRAY: I'm sorry, what was the name?
11 DR. COMPTON: Danny, I think is what I'm
12 hearing. Yeah.
13 Maybe he's misinformed or I don't
14 know. It'd be nice if we didn't have to
15 call at all, if there weren't so many --
16 MS. GRAY: And are you calling to check on
17 claims or eligibility or both?
18 DR. COMPTON: All the above. It was claims
19 yesterday, denied claims.
20 MS. GRAY: Okay. There shouldn't be a
21 limit, but I will certainly check on that
22 for you and get back.
23 DR. COMPTON: (Speaking to assistant.)
24 Yeah. Did you hear that? She asked why.
25 He said, well, there's other people waiting

1 in line, so...
2 MS. GRAY: Yeah, I understand that. If
3 there is a limit, I will certainly share
4 that with you.
5 DR. COMPTON: If there is, there is. You
6 know, we'll learn to deal with it.
7 MS. GRAY: And then you also have a
8 provider relations rep. I think you had
9 mentioned Casey that you are working with.
10 So Casey is always available any time you
11 need assistance.
12 DR. COMPTON: I'm going to strongly
13 disagree. She's hard to get ahold of. We
14 don't get a very prompt response. Is that
15 correct, Cindy? We've had to go over her
16 head more than once to get some answers.
17 So nothing against Casey, but we get the
18 "out of the office" -- you know, the auto
19 reply and all that sort of thing and it
20 takes a while before they get back.
21 MS. GRAY: Yeah, I believe she is out in
22 the field more often now, which is why
23 you're probably receiving that. But I
24 appreciate the feedback and I will
25 certainly connect with our provider

1 relations leadership team to share that
2 feedback.
3 DR. COMPTON: -- if you need her, how long
4 it takes before she got back.
5 MS. GRAY: I'm sorry, I missed that last
6 part.
7 DR. COMPTON: We have the dates we've
8 contacted and the dates she got back to us
9 if you need those dates.
10 MS. GRAY: Yeah, I will certainly have her
11 get in touch with you. If you've got some
12 unresolved issues that need addressed, I
13 will ask her to give you a call tomorrow if
14 that's okay.
15 DR. COMPTON: Except we won't be here.
16 MS. GRAY: Will you be in on Monday?
17 DR. COMPTON: Be here on Monday.
18 MS. GRAY: Okay. I will have her call you
19 on Monday.
20 DR. COMPTON: Thank you so much.
21 MS. GRAY: Yeah. No problem. Thank you.
22 I'll get back to you with the claims
23 information or the customer service number.
24 DR. BURCHETT: Any other discussion from
25 the TAC?

1 DR. COMPTON: Are the meeting dates for
2 next year -- were those all suitable? Erin
3 sent out, I think.
4 DR. BURCHETT: Yeah, for me they are, but,
5 you know, I don't know what I'm doing
6 tomorrow, Steve. So they're fine for me.
7 We'll make them work.
8 DR. COMPTON: We're staying with the Zoom
9 for the year like that said?
10 DR. BURCHETT: Well, that's another
11 question. I mean, I think we now have the
12 ability to come face-to-face if you want
13 to. You are the ones that have to travel.
14 I mean, Caroline and I are fairly close to
15 Frankfort.
16 DR. COMPTON: I feel the same way about the
17 MAC. Zoom is certainly more convenient and
18 doesn't take as much time out of my daily
19 schedule. I think face-to-face is more
20 effective sometimes. So I don't know if we
21 need a -- I'm okay either way, but, you
22 know, just face-to-face sometimes, it seems
23 like we can get more done, but I'll...
24 DR. BURCHETT: Let me ask this question to
25 the Department people. If we -- do we have

1 to make that decision now or can we make
2 that kind of as we go to say, hey, this TAC
3 meeting we would prefer to be in person?
4 Would there be any kind of time that we
5 would have to let you know before the TAC
6 meeting started?
7 MS. BICKERS: This is Erin with the
8 Department. You absolutely have the right
9 to meet in person if you'd like. You don't
10 have to make that decision right now. The
11 only thing I ask is that you give me more
12 than a few weeks' heads up. One, I do have
13 to let the public know on the website that
14 we are doing that in person, and also too,
15 our building is under construction, and so
16 I would just need a little more time to
17 make sure we have a meeting space that can
18 accommodate as many people that would like
19 to show up.
20 LRC no longer lets us use their
21 recording equipment, so we can't use the
22 Capitol Annex anymore, but I've been given
23 some information for our local public
24 library, and we do -- I'm reaching out to
25 Public Health. About six, eight months ago

1 they had water pipes burst in all of their
2 big conference rooms, but they should be
3 getting closer to being functional again.
4 So I just ask you to give me a couple weeks'
5 heads up so that I can make sure that we
6 have a secure location.
7 DR. BURCHETT: Sure, sure. So then we can
8 do that at any time. So say the next one
9 in February, if we let you know mid January
10 that we wanted to meet in person, that
11 would be fine?
12 MS. BICKERS: Yes, sir.
13 DR. BURCHETT: Okay, okay. Sounds good.
14 DR. COMPTON: At one time we said we'd
15 follow the lead of the MAC, but that was
16 back during the pandemic. I don't know if
17 the MAC is going to return to in person or
18 not.
19 Erin, you may have some indication of
20 that.
21 MS. BICKERS: So far they have stayed with
22 Zoom. Now, we do have a meeting at the end
23 of the month and they may decide one day
24 next year they want to meet in person.
25 A lot of the TACs have stated they

1 feel kind of like you, Dr. Compton, they
2 don't have to travel, it makes a little bit
3 easier for them to attend. But we do have a
4 couple of TACs about once a year -- the
5 physicians' TAC I believe this past July, I
6 believe met in person for once a year. So
7 it's really up to what the TAC would like.
8 And as long as you give me a couple weeks'
9 notice so I can work on getting a room and,
10 you know, kind of put it out on the website
11 so people do realize -- and it can also be
12 hybrid.
13 If, say, Dr. Compton and everybody
14 else wants to meet in person, but you can't
15 make it into town, there will always still
16 be the Zoom link, so I just find a room that
17 I can accommodate as many folks as possible.
18 DR. COMPTON: I just thought I'd throw it
19 out there. I'm good either way.
20 DR. BURCHETT: Okay. I don't disagree,
21 Steve. Sometimes in person is a little
22 easier to accomplish some things. We'll
23 just take it meeting by meeting and see
24 what we think.
25 DR. COMPTON: All right. Thank you.

1 DR. BURCHETT: Sounds good. Any other
2 discussion?
3 Well, and, Steve, you will be at
4 the -- attending the next MAC meeting at the
5 end of the month?
6 DR. COMPTON: I will by Zoom. And we have
7 no recommendations; is that correct?
8 DR. BURCHETT: Well, that's what I was
9 getting ready to say. If you're going to
10 attend, is there any recommendations that
11 the TAC has that we might want to take to
12 the MAC?
13 DR. COMPTON: I think since DMS is looking
14 at all these codes, I think we're good.
15 You're chairman for the MAC too, so...
16 DR. BURCHETT: So I think waiting to hear
17 some of the answers on some of these things
18 we've asked is fine for now to hold on
19 recommendations, unless somebody else feels
20 different.
21 DR. MUNSON: Yeah, Matt, this is Carolyn.
22 The only thing that I would definitely
23 think about recommending, depending on the
24 resolution of these codes, is that if
25 they -- if there are codes that are added

1 to the physician fee schedule that are
2 within our scope of practice, that they are
3 automatically added to the vision fee
4 schedule, so this debacle does not happen
5 again and our patients don't lose out on
6 care because a code is not added, or
7 inadvertently left off. But we'll see how
8 the resolution goes. But I think that the
9 next meeting we have we may consider making
10 that recommendation to the MAC to make that
11 a more seamless process.
12 DR. BURCHETT: That sounds good to me.
13 We'll see how the resolution is.
14 DR. COMPTON: The MAC will meet twice
15 before the TAC meets again. So it would be
16 March.
17 DR. BURCHETT: Well, and what we can do,
18 you know -- and I think we can have a
19 special-called TAC meeting any time we need
20 to. So if we run into any issues, then we
21 might consider that option if need be
22 before the MAC meets again. Does that
23 sound fair to everyone?
24 DR. MUNSON: Absolutely.
25 DR. COMPTON: Yes.

1 DR. ALBANY: Yes.
2 DR. BURCHETT: Good deal. Well, I think
3 like you said, the next meeting will be in
4 February. I don't have the date right off,
5 but I think Erin has sent that out to us so
6 we all have that.
7 And then if nobody has anything else,
8 I will take a motion to adjourn.
9 MS. BICKERS: February 1st. If you didn't
10 get the invite, let me know and I can
11 resend it to everybody.
12 DR. BURCHETT: February 1st you said?
13 MS. BICKERS: Yes, sir.
14 DR. BURCHETT: Okay. Good deal.
15 So unless something comes up before
16 then, we'll see you-all February 1st. And,
17 like I said, I'll take a motion to adjourn.
18 DR. MUNSON: I make the motion we adjourn.
19 DR. COMPTON: Second.
20 DR. BURCHETT: All in favor, "Aye."
21 (All Members vote "Aye.")
22 DR. BURCHETT: You-all have a good
23 afternoon. Talk to you later.
24 * * * * * * *
25 THEREUPON, the TAC Meeting was concluded.

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 5th day of January 2024.

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

ASSISTANT: [1] 35/10
DR. ALBANY: [14] 4/7 17/12 17/14 19/4 19/9 19/16 20/1 20/5 20/20 21/4 21/17 40/3 40/12 70/1
DR. BURCHETT: [74]
DR. COMPTON: [42] 5/12 6/11 10/12 11/13 15/4 30/25 31/2 32/11 33/1 33/9 33/16 34/3 34/5 34/13 35/13 36/25 38/18 39/19 39/25 60/15 61/7 61/11 61/18 61/23 62/5 62/12 63/3 63/7 63/15 63/17 63/20 64/1 64/8 64/16 66/14 67/18 67/25 68/6 68/13 69/14 69/25 70/19
DR. DAVIS: [17] 22/9 22/14 26/23 28/12 28/24 29/2 30/7 30/9 30/14 31/13 32/13 33/5 33/10 33/17 34/4 34/7 34/10
DR. MUNSON: [19] 4/4 4/12 4/16 4/20 5/1 12/5 12/8 12/16 12/20 13/4 14/14 44/13 46/19 48/10 50/5 50/23 68/21 69/24 70/18
DR. THERIOT: [1] 53/19
MR. DEARINGER: [28] 9/4 10/19 11/19 12/13 12/19 14/24 15/5 15/13 15/24 16/24 19/23 20/3 20/23 40/25 42/3 43/7 45/19 47/14 49/17 50/17 51/15 52/11 53/25 55/6 56/9 56/17 59/6 60/9
MS. BICKERS: [13] 3/2 3/7 4/18 4/24 5/2 6/4 8/25 12/25 65/7 66/12 66/21 70/9 70/13
MS. DUDINSKIE: [2] 7/19 8/22
MS. GRAY: [21] 35/22 37/1 37/19 38/6 39/2 39/12 40/7 40/14 44/11 61/1 61/10 61/16 61/20 62/2 62/7 62/21 63/5 63/10 63/16 63/18 63/21
MS. KITCHEN: [12] 6/6 6/18 7/13 13/2 13/5 14/17 15/6 18/16 19/7 19/10 20/18 21/13
MS. PARKER: [1] 6/25
MS. UNGER: [6] 16/14 17/5 44/15 50/25 58/4 60/4
MS. VERNIER: [1] 38/9

1

10 [1] 59/20
15th [2] 29/25 30/1
1:00 [1] 1/16
1st [5] 8/1 58/9 70/9 70/12 70/16

2

20 [1] 59/20
2023 [8] 1/15 43/15 43/18 44/19 50/21 51/3 58/8 71/13
2024 [5] 42/11 42/14 45/18 50/20 71/17
21st [1] 51/3
24 [1] 71/13
25th [1] 16/16

3

30 [4] 35/1 35/2 35/19 36/11
3D [1] 14/4

5

5th [1] 71/16

6

60 [1] 24/1
61 [1] 24/17

7

77 [1] 13/13

8

83516 [3] 22/3 22/15 24/16
838 [1] 24/17

9

90 [1] 27/10
90-day [2] 31/10 32/24
92065 [2] 58/17 58/20
92066 [7] 42/9 44/20 47/1 49/5 58/2 58/8 58/21
92370 [1] 31/16
95930 [1] 22/3
99 [1] 3/18

A

ability [2] 53/14 64/12
able [23] 6/19 7/2 9/10 9/21 11/6 12/9 12/21 13/1 13/2 42/6 44/6 46/23 47/6 47/11 47/21 47/24 48/1 48/4 48/8 49/10 49/11 54/7 57/24
about [40] 6/13 6/17 7/6 7/8 7/11 9/8 10/23 11/16 16/25 17/22 17/23 19/21 20/8 25/8 26/9 27/9 27/10 28/10 30/18 30/21 31/9 31/21 32/1 32/8 32/23 33/19 36/7 37/10 41/5 48/24 49/13 49/25 50/21 54/3 56/24 56/25 64/16 65/25 67/4 68/23
above [1] 61/18
absolutely [8] 7/13 14/14 40/7 50/23 56/18 59/9 65/8 69/24
abused [2] 23/22 23/25
abusive [1] 25/14
accommodate [2] 65/18 67/17
accomplish [1] 67/22
according [1] 37/19
accurate [1] 71/10
activity [1] 36/19
actual [3] 11/4 13/24 14/9
actually [7] 13/5 15/6 15/7 30/1 45/4 48/13 50/8
add [35] 40/17 41/2 42/13 42/17 43/24 44/6 44/22 44/23 45/1 45/2 45/3 45/13 45/20 46/1 46/3 46/8 51/18 51/19 51/21 51/22 53/3 53/6 53/13 53/18 54/21 55/8 55/10 56/6 56/6 58/1 58/14 58/22 59/10 59/21 59/23
added [24] 15/8 15/15 18/17 44/20 45/18 47/8 50/19 50/22 51/2 51/24 52/24 53/8 54/1 55/1 56/22 58/7 58/10 58/12 58/23 59/3 60/3 68/25 69/3 69/6
adding [6] 42/10 55/17 55/20 55/21 57/14 58/13
address [1] 35/24
addressed [1] 63/12
adjourn [3] 70/8 70/17 70/18
adult [4] 17/9 17/11 21/9 33/21
adults [2] 19/20 33/24
Advisory [1] 71/11
affect [2] 50/9 58/15
afford [1] 10/16
after [2] 60/7 60/24
afternoon [2] 7/19 70/23
again [26] 4/16 4/17 8/6 11/14 16/13 20/23 21/24 25/6 25/15 27/9 29/3 29/8 29/24 32/17 32/23 38/10 39/20 51/1 53/10 55/23 59/7 61/1 66/3 69/5 69/15 69/22
against [3] 49/9 49/15 62/17
agenda [2] 8/4 27/3
ago [2] 31/14 65/25
agree [1] 40/4
ahead [5] 5/15 14/7 31/1 44/13 46/1
ahold [1] 62/13
all [103]
all's [4] 15/1 42/12 59/17 60/1
allowed [3] 24/23 41/10 42/1
allowing [1] 56/15
almost [1] 32/24
along [3] 20/6 25/6 34/6
already [5] 16/12 32/16 33/18 41/15 50/19
also [7] 14/11 23/10 33/19 41/8 62/7 65/14 67/11
always [12] 25/3 25/22 26/3 38/18 39/10 40/5 41/5 44/5 55/19 59/17 62/10 67/15
amount [3] 49/13 55/8 55/9
amounts [1] 14/10
analysis [3] 22/21 24/18 53/2
Angie [1] 6/25
Annex [1] 65/22
annual [2] 54/16 55/21
annually [1] 25/22
another [11] 24/14 24/18 29/7 40/9 41/4 41/17 55/18 57/22 57/23 59/23 64/10
answer [4] 10/4 11/6 39/6 43/9
answered [1] 21/6
answers [3] 21/19 62/16 68/17
antiglare [1] 38/3
any [35] 4/9 4/10 4/12 5/9 5/12 6/2 7/10 7/16 8/1 8/20 16/5 16/18 17/25 26/8 28/20 36/18 36/19 43/7 43/13 44/9 44/9 45/23 45/24 54/12 56/19 57/10 59/5 62/10 63/24 65/4 66/8 68/1 68/10 69/19 69/20
anybody [3] 12/1 19/21 33/7
anymore [4] 27/18 31/19 31/23 65/22
anyone [3] 3/4 6/4 38/6
anything [10] 5/9 10/23 12/1 16/6 18/6 19/21 40/1 49/22 60/12 70/7
anyway [3] 11/18 24/6 26/4
appealed [1] 35/8
appointment [1] 10/9
appointments [3] 9/14 9/18 13/9
appreciate [9] 5/5 7/14 21/5 21/18 30/8 36/21 60/8 60/9 62/24
appreciated [2] 39/18 40/13
appropriate [7] 24/5 25/5 40/20 41/6 41/14 41/24 54/18
approval [1] 28/2
approve [5] 3/25 4/3 4/4 5/7 5/21
approved [2] 5/22 45/25
approves [1] 53/7
approving [1] 5/16
aqueous [2] 23/6 24/10
aqueous-deficient [2] 23/6 24/10
are [83]
area [1] 29/19
aren't [1] 57/9
argument [1] 49/18
around [3] 5/25 29/4 29/25
arthritis [1] 26/16
as [43] 3/20 13/15 13/15 14/11 15/17 17/7 19/19 22/6 22/19 25/11 27/4 29/15 30/12 33/11 33/12 37/9 39/3 41/9 41/22 41/22 42/18 42/18 46/22 46/24 47/5 48/14 48/18 48/19 50/22 57/17 57/17 57/18 57/18 58/8

A

as... [9] 61/4 61/4 64/18 65/2 65/18 67/8 67/8 67/17 67/17
ask [8] 12/8 37/13 41/4 42/22 63/13 64/24 65/11 66/4
asked [3] 12/14 61/24 68/18
asking [4] 6/17 44/19 60/6 60/11
asks [1] 51/23
assist [2] 8/10 11/6
assistance [1] 62/11
assistant [1] 61/23
assume [1] 39/7
attack [2] 10/6 11/22
attend [2] 67/3 68/10
attending [1] 68/4
attention [2] 36/17 37/2
audits [2] 42/24 46/11
August [2] 7/23 71/13
auth [2] 39/3 39/10
authorization [1] 37/11
authorize [1] 37/14
auto [1] 62/18
autoimmune [1] 23/4
automatically [3] 20/25 32/5 69/3
availability [1] 6/2
available [4] 9/10 9/20 10/10 62/10
Avesis [10] 34/16 35/24 36/5 37/8 37/13 38/7 39/3 39/14 60/17 61/2
Avesis-based [1] 37/8
aware [1] 43/6
away [2] 39/20 39/22
Aye [4] 5/17 5/18 70/20 70/21

B

back [45] 5/25 6/10 8/5 8/18 16/4 16/15 16/22 20/25 21/14 24/6 26/14 29/6 30/24 31/20 32/15 32/23 34/17 35/18 36/14 38/10 39/13 40/11 41/20 44/19 45/9 49/20 50/2 50/13 52/3 52/13 53/1 55/7 58/14 59/7 59/16 60/6 60/11 60/25 61/6 61/22 62/20 63/4 63/8 63/22 66/16
back-paid [1] 50/13
backdate [1] 59/10
bar [2] 14/2 14/9
based [11] 23/11 23/16 26/5 26/7 29/13 29/19 32/5 33/25 37/8 46/15 46/16
basically [3] 22/18 22/21 29/19
basis [2] 25/10 25/25
be [93]
because [39] 11/21 12/9 12/18 12/23 18/6 18/25 20/12 20/13 22/25 24/1 26/3 26/15 30/18 34/14 34/20 37/15 38/4 38/21 39/8 39/10 39/21 41/7 41/14 41/20 44/17 46/9 49/2 49/4 52/6 53/16 53/21 53/22 54/8 58/7 58/14 58/16 58/16 59/4 69/6
become [1] 32/5
been [24] 5/22 8/11 15/11 15/21 18/3 20/7 20/24 21/14 31/5 35/9 35/17 36/16 43/18 45/3 47/6 47/12 49/15 50/10 58/10 58/19 58/25 60/2 60/22 65/22
before [15] 7/11 13/15 15/7 15/14 52/23 53/5 53/13 56/6 57/7 62/20 63/4 65/5 69/15 69/22 70/15
beginning [4] 12/17 47/7 50/11 52/13
behalf [1] 42/13
being [5] 41/22 48/3 48/25 49/15 66/3
believe [10] 4/18 6/7 8/2 30/3 38/12 38/15 40/8 62/21 67/5 67/6
benefit [2] 33/21 33/22
benefits [2] 14/21 31/6
besides [1] 42/2
best [1] 26/21
better [4] 23/5 23/19 24/20 54/2
between [2] 8/20 34/2
bifocal [1] 40/1
big [3] 9/25 27/14 66/2
bill [21] 18/22 18/22 40/21 41/10 41/19 41/25 42/4 42/6 45/11 45/17 46/23 47/3 47/7 47/21 48/4 49/1 49/3 52/19 52/19 56/15 58/18
billed [5] 20/9 51/12 56/19 57/7 58/21
biller [1] 21/7
billing [8] 9/12 17/10 31/16 32/3 39/7 42/18 46/5 58/15
bit [7] 13/6 14/12 23/23 24/11 50/1 59/16 67/2
Board [5] 7/17 40/19 41/13 41/23 48/20
both [8] 29/5 30/17 31/4 33/25 35/7 35/7 51/15 61/17
bottom [1] 25/15
bringing [2] 37/1 50/18
brings [1] 41/3
brought [1] 36/16
budget [1] 43/25
building [1] 65/15
bunch [1] 23/15
Burchett [8] 2/6 3/12 8/25 22/19 26/8 45/10 55/5 55/23
burst [1] 66/1
business [5] 5/24 21/22 21/23 36/6 41/7
bypass [5] 18/19 18/19 19/2 20/7 21/13

C

CABINET [1] 1/3
calendar [1] 49/16
call [8] 9/5 11/15 12/14 28/6 40/9 61/15 63/13 63/18
called [5] 22/17 31/2 31/22 46/21 69/19
calling [1] 61/16
came [1] 54/4
camera [1] 5/3
can [80]
can't [11] 11/5 22/7 30/4 48/15 49/1 49/2 52/19 59/19 60/22 65/21 67/14
cannot [1] 19/7
Capitol [1] 65/22
care [8] 3/23 10/8 33/13 35/11 35/14 41/7 56/20 69/6
Caroline [2] 3/3 64/14
Carolyn [2] 46/20 68/21
case [8] 37/14 37/24 51/24 54/25 55/11 56/18 58/2 59/13
cases [4] 20/16 25/9 25/17 57/5
Casey [5] 36/22 36/22 62/9 62/10 62/17
cataract [1] 49/1
catch [3] 24/4 59/18 59/19
cause [1] 23/3
causes [1] 18/15
CCR [1] 71/20
cells [1] 22/20
certain [4] 23/14 23/23 47/20 56/15
certainly [9] 8/22 29/23 39/12 61/6 61/21 62/3 62/25 63/10 64/17
certify [1] 71/9
cetera [1] 27/16
Chair [1] 2/6
chairman [1] 68/15
chance [2] 4/1 15/14
change [7] 8/14 26/3 36/3 43/1 43/12 46/4 46/17
changed [3] 26/16 50/12 58/16
changes [6] 4/10 5/9 5/12 16/18 36/10 43/14
charges [1] 46/6
chart [8] 14/1 14/3 14/3 14/3 14/4 14/6 14/9 28/4
chasing [1] 35/16
cheap [2] 46/7 55/3
check [8] 6/23 15/11 15/19 16/9 38/10 61/2 61/16 61/21
checked [3] 34/22 35/7 35/7
child [2] 10/8 33/21
choose [2] 13/24 13/25
Christi [1] 7/22
Cindy [2] 34/13 62/15
circle [1] 5/25
circumstance [1] 28/2
circumstances [2] 25/4 25/16
cite [2] 27/21 29/15
claim [1] 20/16
claims [8] 19/18 19/25 60/20 61/4 61/17 61/18 61/19 63/22
clarification [1] 37/4
clarify [1] 17/14
clear [2] 16/2 33/14
click [2] 9/15 13/17
client [1] 35/23
clients [1] 23/22
clinical [4] 22/10 25/21 27/10 39/13
clinician [2] 30/12 57/22
clinicians [1] 28/5
close [1] 64/14
closer [1] 66/3
CMS [3] 51/19 52/15 58/12
coating [1] 38/4
code [48] 13/14 20/13 20/14 20/15 22/2 22/3 22/14 32/4 42/4 42/8 42/9 42/20 44/22 45/5 45/12 45/17 46/3 46/8 47/16 47/17 48/3 48/4 48/11 49/5 50/6 51/9 51/12 51/23 51/24 52/24 53/4 53/6 54/10 54/12 55/9 55/10 55/16 56/19 57/21 58/7 58/8 58/17 58/19 58/20 58/22 58/23 59/20 69/6
codes [48] 3/18 17/1 18/17 18/18 40/17 40/19 41/1 41/11 41/15 41/24 42/1 42/2 42/3 43/5 43/6 43/22 45/1 45/2 45/20 47/20 48/12 51/18 51/19 51/21 51/22 52/14 52/18 52/19 52/20 53/21 54/3 55/17 56/2 56/7 56/15 56/25 57/2 57/3 57/4 57/5 57/9 57/14 57/18 59/10 59/10 68/14 68/24 68/25
cohost [1] 12/25
coinsurance [1] 19/12
collaborative [1] 11/21
column [1] 14/3
come [15] 14/2 19/19 26/14 29/6 33/6 43/5 43/6 52/3 53/21 54/21 55/7 56/2 57/3 57/5 64/12
comes [6] 32/15 38/4 39/1 40/15 41/20 70/15
coming [1] 40/18
comments [1] 37/9
commission [1] 71/13

C

committee [5] 27/1 27/5 27/6 29/25 71/11
commonly [2] 23/21 24/15
COMMONWEALTH [1] 1/2
communication [2] 7/10 7/16
community [1] 11/1
complete [2] 6/21 17/2
completed [2] 7/24 8/10
Compton [11] 2/8 6/11 10/12 11/14 33/18 35/22 37/19 39/19 60/15 67/1 67/13
computer [1] 9/5
concern [2] 36/23 38/5
concerns [1] 35/25
concluded [1] 70/25
condition [1] 24/25
conditions [1] 3/21
conducive [1] 12/23
confer [2] 40/3 40/8
conference [1] 66/2
confirmation [2] 15/9 16/21
connect [2] 40/10 62/25
consider [3] 33/23 69/9 69/21
construction [1] 65/15
contact [8] 7/21 8/2 8/6 14/23 14/25 33/21 33/22 33/25
contacted [2] 11/15 63/8
contradiction [2] 47/12 47/15
contributory [1] 26/1
convenient [1] 64/17
conversation [1] 49/25
converted [1] 8/13
corneal [1] 29/10
correct [7] 19/6 19/7 22/14 22/16 56/7 62/15 68/7
correctly [2] 38/12 56/11
correspondence [1] 16/23
cost [7] 46/17 55/8 55/10 55/16 55/17 55/20 55/21
could [10] 22/10 26/17 45/14 45/17 46/1 50/12 51/12 54/3 58/18 59/13
couldn't [1] 10/9
count [1] 3/2
country [1] 23/24
COUNTY [1] 71/5
couple [8] 16/4 26/13 27/1 31/20 36/17 66/4 67/4 67/8
course [2] 31/19 56/20
cover [5] 19/1 54/7 54/15 57/7 57/8
coverage [1] 54/13
covered [8] 17/9 18/21 18/24 19/6 19/8 38/13 57/9 57/15
Covid [1] 54/20
creating [1] 6/19
current [1] 27/20
currently [4] 10/11 37/21 37/23 39/2
customer [1] 63/23
cut [1] 60/24
cycle [1] 53/24

D

daily [2] 36/3 64/18
Dani [2] 38/9 39/19
Danny [2] 61/8 61/11
Dashboard [1] 13/10
data [3] 6/20 6/21 55/12
date [5] 1/14 21/15 30/4 36/14 70/4
dates [4] 63/7 63/8 63/9 64/1
Davis [4] 22/9 31/2 31/11 34/8
day [7] 19/19 31/10 32/24 36/6 59/20 66/23 71/16
days [7] 16/1 34/19 35/2 35/2 35/20 36/11 36/11
deal [5] 5/13 27/11 62/6 70/2 70/14
Dearinger [1] 9/1
debacle [1] 69/4
December [1] 30/1
decide [5] 23/8 26/15 28/16 56/6 66/23
decided [1] 48/19
decision [3] 44/3 65/1 65/10
deductible [2] 19/13 19/15
deemed [1] 41/8
deems [1] 41/14
deficient [2] 23/6 24/10
definitely [5] 37/4 49/21 55/3 59/25 68/22
denial [1] 28/8
denied [10] 17/21 18/13 20/17 20/21 20/24 21/9 21/10 35/9 41/20 61/19
denies [1] 18/1
deny [1] 18/2
Department [12] 3/17 10/7 14/21 40/16 44/21 45/7 51/4 51/8 51/11 56/13 64/25 65/8
depending [1] 68/23
depends [2] 42/4 42/19
designed [1] 29/4
detail [2] 38/8 39/15
determine [5] 10/1 23/2 24/8 51/8 52/7
determined [2] 32/2 40/20
developed [1] 26/16
diagnosed [1] 23/13
diagnostic [2] 23/1 24/8
did [10] 3/3 7/21 11/14 15/1 19/2 21/6 45/7 52/7 55/25 61/24
didn't [8] 10/5 31/8 35/3 52/12 58/1 58/22 61/14 70/9
died [1] 9/5
difference [4] 20/13 28/20 47/19 47/22
different [20] 13/7 20/12 20/15 31/5 31/6 33/19 34/1 48/3 48/24 51/7 51/13 52/2 52/3 52/16 52/21 52/22 52/23 53/5 54/11 68/20
direct [2] 30/19 47/11
directly [4] 20/2 28/4 31/16 32/4
director [2] 7/22 22/10
disagree [4] 26/9 26/11 62/13 67/20
disconnected [1] 10/15
discriminated [1] 49/15
discriminatory [3] 49/9 49/23 50/14
discuss [1] 60/13
discussed [2] 5/11 36/12
discussion [4] 5/14 37/8 63/24 68/2
discussions [1] 28/11
disease [1] 54/14
dispense [1] 32/14
dispensing [3] 19/20 32/12 32/17
DMS [3] 6/3 36/4 68/13
do [71] 3/8 3/9 4/6 7/9 8/9 8/9 8/22 10/23 11/2 13/11 13/25 18/21 19/2 19/20 20/1 20/5 20/21 21/12 23/2 24/16 24/16 25/5 25/12 25/21 26/4 26/8 26/9 29/11 29/17 30/11 31/15 33/20 36/2 36/7 38/11 38/12 39/2 39/6 39/7 41/1 42/25 43/19 43/25 45/22 45/23 48/1 49/2 49/4 49/10 49/11 49/22 52/2 52/6 52/17 53/1 53/5 53/14 53/15 54/15 54/24 57/18 59/9 59/12 64/25 65/12 65/24 66/8 66/22 67/3 67/11 69/17
doctor [1] 58/18
doctor or [1] 58/18
doctor's [1] 48/14
doctors [3] 23/7 24/4 24/16
does [12] 13/10 14/12 17/10 43/25 50/9 51/7 51/10 51/14 58/14 59/1 69/4 69/22
doesn't [4] 19/13 24/21 57/8 64/18
doing [12] 14/16 24/19 24/20 25/25 32/19 44/1 52/5 52/6 56/5 57/23 64/5 65/14
dollar [1] 50/6
don't [59] 3/7 4/12 5/12 6/8 6/15 7/5 9/6 10/13 10/14 10/17 10/22 13/16 16/17 16/22 17/15 18/5 20/8 20/11 23/24 24/12 26/11 26/19 27/2 28/19 29/9 29/11 29/16 29/17 31/22 33/5 33/5 33/6 34/18 35/5 38/2 38/20 39/5 39/9 40/22 43/15 45/1 45/3 48/13 49/22 53/21 54/12 55/10 58/3 61/8 61/13 62/14 64/5 64/20 65/9 66/16 67/2 67/20 69/5 70/4
done [11] 7/25 18/15 23/11 24/15 25/9 26/6 43/15 50/4 50/7 53/24 64/23
double [3] 15/11 38/5 38/24
down [5] 6/1 10/16 21/24 26/13 42/9
Dr [9] 2/6 2/7 2/8 2/9 2/10 35/22 54/1 54/23 55/5
Dr. [18] 3/12 8/25 22/19 26/8 31/2 31/11 33/18 34/8 37/19 39/19 40/4 45/10 46/20 53/19 55/23 60/15 67/1 67/13
Dr. Burchett [6] 3/12 8/25 22/19 26/8 45/10 55/23
Dr. Compton [6] 33/18 37/19 39/19 60/15 67/1 67/13
Dr. Davis [3] 31/2 31/11 34/8
Dr. Munson [1] 46/20
Dr. Theriot [1] 53/19
Dr. Worth [1] 40/4
drop [3] 23/17 30/21 30/23
dry [6] 22/4 23/3 23/6 23/11 24/2 29/11
dryness [1] 22/4
dually [1] 18/20
Dudinskie [1] 7/20
during [2] 44/22 66/16

E

e-mail [1] 16/15
e-mails [1] 44/19
each [3] 3/13 56/1 56/14
earlier [1] 59/8
easier [5] 16/11 20/4 45/21 67/3 67/22
edits [2] 42/23 46/11
effective [1] 64/20
effort [1] 11/21
eight [1] 65/25
either [3] 24/9 64/21 67/19
electronically [1] 7/17
eligibility [6] 34/22 36/1 36/2 36/8 36/20 61/17
eligible [2] 34/25 35/5
else [10] 3/4 12/1 19/21 31/23 38/6 40/1 60/12 67/14 68/19 70/7
email [1] 60/5
emergency [1] 55/13
empirically [1] 29/12
end [3] 8/9 66/22 68/5
enrollment [1] 7/21
ensure [1] 6/20
entering [1] 13/21

E

entertain [1] 4/2
entire [1] 49/16
equally [2] 48/22 49/24
equipment [1] 65/21
equivocal [1] 26/6
Erin [4] 64/2 65/7 66/19 70/5
et [1] 27/16
et cetera [1] 27/16
etiology [1] 24/9
evaluate [1] 46/14
evaluated [1] 27/12
even [3] 29/9 29/17 45/12
ever [1] 6/15
every [10] 19/18 20/16 24/1 25/11 27/1 27/4 27/11 46/2 46/8 50/7
everybody [8] 3/1 24/1 24/3 25/10 29/5 54/17 67/13 70/11
everyone [2] 4/1 69/23
evidence [1] 26/7
exactly [6] 33/24 40/7 51/14 53/25 54/23 61/3
Examiners [5] 7/17 40/19 41/13 41/23 48/20
example [4] 26/24 27/22 41/17 53/20
examples [5] 19/23 20/1 20/19 30/10 30/11
exceeded [1] 55/17
excellent [2] 19/4 31/24
Except [1] 63/15
executive [1] 7/22
expensive [4] 39/21 46/8 46/9 53/16
experienced [1] 31/25
expires [1] 71/13
explain [3] 24/4 34/15 38/7
explaining [1] 59/4
explanations [1] 59/2
extenuating [3] 25/3 25/16 28/1
extra [4] 18/15 53/12 53/17 55/1
eye [11] 22/4 22/23 23/3 23/6 23/11 24/19 28/15 29/11 38/5 38/24 41/7
Eyequest [2] 22/1 22/10
eyes [1] 24/2
eyewear [2] 32/6 32/7

F

face [6] 64/12 64/12 64/19 64/19 64/22 64/22
faceted [1] 51/16
fact [1] 49/14
factors [1] 46/15
fair [1] 69/23
fairly [1] 64/14
false [1] 28/24
FAMILY [1] 1/3
fantastic [3] 14/15 50/15 50/24
far [8] 17/17 17/24 19/17 42/18 43/15 57/17 61/4 66/21
favor [2] 5/16 70/20
FAYETTE [1] 71/5
February [8] 30/4 44/19 60/6 66/9 70/4 70/9 70/12 70/16
February 1st [1] 70/16
federal [5] 19/8 51/20 51/25 52/4 52/15
fee [54] 14/23 14/25 15/8 17/3 32/12 32/17 40/17 40/23 41/6 41/11 41/13 41/16 41/18 41/21 42/2 42/7 42/10 42/17 42/18 43/4 43/7 43/16 43/17 45/6 45/7 45/12 45/14 45/18 46/3 47/2 47/8 47/16 47/17 47/25 48/9 49/8 50/11 50/20 51/7 51/8 51/13 53/8 55/2 56/7 56/22 57/19 57/21 58/10 58/24 59/5 59/22 59/24 69/1 69/3
feedback [7] 15/2 15/7 15/22 15/24 17/2 62/24 63/2
feel [14] 22/22 22/24 24/7 24/13 24/23 25/12 28/1 28/3 43/11 44/3 44/4 53/11 64/16 67/1
feels [2] 23/19 68/19
fees [1] 48/25
felt [1] 32/22
few [9] 5/23 16/1 16/6 34/19 34/23 36/10 50/9 50/13 65/12
field [2] 49/3 62/22
figure [3] 17/4 49/21 50/3
files [3] 36/1 36/2 36/4
film [3] 22/20 24/18 24/20
finally [1] 60/18
financially [1] 46/14
find [9] 6/10 10/5 12/10 12/11 12/22 14/13 23/18 43/9 67/16
finding [1] 12/24
fine [4] 30/6 64/6 66/11 68/18
finish [1] 12/11
first [16] 3/16 5/8 6/2 7/24 8/19 9/2 9/7 14/22 17/20 18/22 21/11 21/25 36/14 51/19 53/13 54/22
fiscal [3] 53/1 55/7 55/19
fixed [5] 20/7 20/18 21/12 31/12 36/21
fixing [2] 3/17 35/11
flu [1] 54/19
folks [1] 67/17
follow [3] 25/12 51/1 66/15
follow-up [2] 25/12 51/1
followed [1] 39/16
following [4] 28/17 28/18 37/21 37/24
forgotten [1] 59/23
form [1] 23/1
forward [2] 50/15 60/5
found [3] 40/22 45/5 58/9
frame [1] 15/23
Frankfort [1] 64/15
freely [1] 45/21
frequently [1] 24/24
frontline [1] 31/7
functional [2] 9/9 66/3
funds [2] 53/17 53/17
future [1] 8/19

G

Gary [2] 2/10 3/3
gathered [1] 53/1
general [3] 26/10 37/7 44/7
Generally [1] 6/12
generate [3] 14/5 14/7 14/8
generated [1] 32/5
germane [1] 25/18
get [50] 4/20 6/10 6/22 7/7 7/7 7/10 8/10 9/11 10/4 11/5 11/11 12/17 15/24 16/4 17/3 26/20 27/12 28/4 29/6 29/7 32/16 33/25 36/20 36/23 40/10 41/20 49/20 50/2 50/12 51/17 52/14 54/19 55/1 56/23 57/10 60/3 60/23 60/24 60/25 61/6 61/22 62/13 62/14 62/16 62/17 62/20 63/11 63/22 64/23 70/10
gets [4] 25/10 29/5 53/8 54/17
getting [9] 4/14 5/6 7/4 19/19 24/20 32/7 66/3 67/9 68/9
give [7] 22/11 39/20 39/21 63/13 65/11 66/4 67/8
given [1] 65/22
gives [1] 55/19
glare [1] 38/21
glasses [11] 17/11 17/20 18/7 18/18 18/25 21/21 31/11 31/17 32/16 37/12 37/15
go [27] 3/24 5/15 6/1 12/22 14/7 16/11 16/22 20/11 20/25 21/14 21/24 23/9 24/11 31/1 31/22 38/10 44/13 46/1 46/10 51/9 51/11 52/8 58/14 59/7 59/15 62/15 65/2
goes [9] 45/9 46/5 48/6 51/4 51/15 52/2 52/16 57/19 69/8
going [44] 4/13 4/16 10/19 10/21 11/9 11/10 12/21 12/23 13/6 13/8 13/17 13/22 14/22 18/2 18/7 19/24 25/3 26/20 27/2 27/15 27/18 27/21 27/21 29/14 30/3 30/17 32/23 33/4 37/6 37/7 38/1 38/10 40/8 42/13 42/16 44/15 45/13 46/16 48/7 55/8 55/10 62/12 66/17 68/9
gone [1] 45/15
good [26] 3/11 3/21 4/25 4/25 5/4 5/4 5/13 7/19 8/24 11/25 12/3 16/8 17/6 30/7 34/4 34/7 49/18 53/20 66/13 67/19 68/1 68/14 69/12 70/2 70/14 70/22
got [19] 5/8 5/23 8/3 16/9 16/25 17/25 19/5 21/1 26/8 26/12 30/18 34/22 35/16 38/24 60/18 60/25 63/4 63/8 63/11
gotten [1] 20/21
Gray [2] 35/23 61/1
great [5] 13/2 19/16 26/24 39/17 45/19
greatly [1] 55/16
grid [1] 14/5
group [5] 11/21 15/17 22/1 25/19 59/23
groups [2] 51/10 52/2
guess [10] 3/12 3/14 7/15 14/8 21/22 31/8 36/7 51/1 56/23 58/4
guide [2] 24/11 24/11
guideline [2] 22/22 25/21
guidelines [3] 26/4 27/4 27/10
guy [1] 61/7
guys [3] 22/15 31/25 33/3

H

had [33] 4/1 6/7 7/24 8/1 8/12 8/14 9/5 11/15 15/14 16/18 16/24 17/25 21/21 28/24 31/15 33/20 34/16 37/9 40/9 42/11 42/12 44/17 45/20 47/15 54/1 54/3 54/24 55/1 58/10 60/22 62/8 62/15 66/1
halt [1] 36/18
hand [1] 71/16
happen [4] 35/15 44/5 59/13 69/4
happened [4] 21/3 58/6 59/14 60/16
happening [3] 18/3 29/20 31/24
hard [2] 33/2 62/13
harder [1] 29/17
has [23] 4/1 8/11 9/17 17/20 19/1 19/11 21/14 22/19 24/2 27/20 36/7 36/16 39/8 43/20 44/21 47/12 48/21 57/6 58/12 58/16 68/11 70/5 70/7
have [140]
haven't [6] 8/1 8/4 15/9 16/11 21/1 35/17
having [3] 4/14 19/22 32/4
he [6] 4/19 9/1 27/20 40/4 40/8 61/25
he's [5] 4/13 4/16 4/24 30/18 61/13
head [1] 62/16

H

heads [2] 65/12 66/5
health [8] 1/3 7/4 11/1 13/8 53/12 54/5 54/7 65/25
hear [3] 52/9 61/24 68/16
heard [2] 8/5 52/12
hearing [1] 61/12
HELD [1] 1/11
Hello [2] 3/1 9/4
help [9] 4/13 11/17 14/12 24/24 34/14 38/7 47/10 60/1 60/20
helps [1] 24/19
her [8] 12/15 12/15 35/3 62/15 63/3 63/10 63/13 63/18
here [15] 3/12 4/23 6/1 10/18 14/18 17/16 17/23 39/14 51/12 51/12 51/12 55/23 60/14 63/15 63/17
here's [1] 46/19
hereunto [1] 71/15
hey [4] 10/3 57/25 60/2 65/2
Hi [3] 35/22 37/19 61/1
hiccup [1] 34/5
high [1] 50/6
high-dollar [1] 50/6
highlight [1] 9/23
him [3] 4/17 30/18 40/10
history [1] 11/16
hold [3] 4/22 12/5 68/18
hoops [1] 39/23
hope [1] 4/1
hopefully [2] 11/22 12/3
hoping [3] 7/25 10/25 11/11
hospital [1] 55/14
how [23] 9/4 12/11 17/8 17/10 24/19 24/19 28/22 42/20 43/3 43/16 43/20 43/25 45/1 46/16 47/10 51/7 51/13 52/21 53/2 61/4 63/3 69/7 69/13
however [2] 14/1 43/9
Humana [2] 11/15 11/17
hybrid [1] 67/12

I

I'd [3] 3/15 47/9 67/18
I'll [15] 3/8 3/9 4/2 4/22 5/25 30/2 30/24 50/2 52/13 60/5 60/7 60/11 63/22 64/23 70/17
I'm [40] 4/13 6/4 6/8 10/25 12/9 16/19 17/22 17/22 18/13 21/13 22/9 26/11 26/20 27/21 29/14 30/17 32/7 32/12 33/2 33/4 34/12 35/23 36/19 37/6 38/9 41/10 52/7 52/11 52/11 57/19 60/17 61/3 61/10 61/11 62/12 63/5 64/5 64/21 65/24 67/19
I've [1] 65/22
ID [1] 13/23
idea [1] 10/13
identify [2] 24/4 25/8
illness [1] 54/14
immediately [5] 36/24 43/12 43/23 44/7 53/11
impact [2] 44/1 46/17
impactful [3] 44/4 44/4 53/11
impacts [1] 52/21
implications [1] 54/7
inadvertently [1] 69/7
increase [3] 55/13 55/14 55/15
incumbent [1] 28/21
indication [1] 66/19
individually [1] 42/22
individuals [3] 10/4 52/17 55/15
industry [1] 29/20
inflammadry [4] 22/18 27/18 29/8 33/3
inflammation [1] 22/4
inflammatory [5] 22/20 23/4 24/9 26/18 28/22
information [6] 12/24 19/4 36/5 52/25 63/23 65/23
innovative [1] 57/12
ins [1] 7/8
instance [1] 28/10
insurance [5] 19/14 21/7 57/8 57/10 57/15
insurances [1] 58/13
intentionally [1] 50/4
interest [1] 26/21
invite [1] 70/10
involved [1] 32/21
iPad [1] 30/21
is [182]
is month [1] 34/20
issue [8] 8/15 10/24 11/19 19/22 26/18 32/10 36/16 46/13
issues [4] 11/5 38/21 63/12 69/20
it [164]
It'd [1] 61/14
it's [89]
item [10] 8/19 9/2 9/7 14/20 17/6 27/13 30/15 37/23 40/15 41/17
items [1] 21/25
itself [1] 13/24

J

James [4] 2/9 3/6 4/18 5/6
January [4] 51/3 58/9 66/9 71/17
January 1st [1] 58/9
January 21st [1] 51/3
Jennifer [1] 7/20
John [1] 22/9
join [1] 4/23
joined [1] 9/1
joining [1] 4/19
JOLINDA [2] 71/7 71/20
July [1] 67/5
jump [3] 39/22 40/9 60/11
June [1] 34/17
just [63] 3/16 4/15 4/18 4/22 5/6 5/25 6/14 8/14 8/19 9/1 9/5 10/1 10/14 10/17 12/5 12/14 12/21 13/23 14/5 14/22 16/2 16/18 17/3 17/8 17/23 18/8 21/1 21/7 21/24 21/25 22/15 25/11 25/12 26/18 27/16 27/22 29/12 29/21 30/21 30/23 35/19 35/24 37/12 37/16 38/11 38/15 39/9 41/12 42/4 44/17 48/4 50/1 57/12 57/15 59/15 59/16 60/3 64/22 65/16 66/4 67/16 67/18 67/23
Justin [13] 6/7 6/12 6/23 7/7 8/25 10/13 12/8 16/16 20/2 44/24 53/19 55/4 55/24

K

KAR [2] 37/20 38/10
Karoline [1] 2/7
KCI [1] 35/10
keep [2] 6/16 50/20
Kelly [8] 6/6 7/6 12/13 12/25 16/16 18/16 20/8 21/11
KENTUCKY [12] 1/2 7/4 13/8 23/24 33/7 41/9 41/22 46/21 48/19 57/13 71/4 71/9
kids [1] 33/24
Kim [3] 35/22 38/9 61/1
kind [26] 6/1 9/19 9/23 10/24 10/25 15/22 16/2 23/8 29/18 30/10 42/21 43/20 44/2 44/25 45/9 45/23 47/22 48/8 52/13 56/3 57/23 59/15 65/2 65/4 67/1 67/10
Kitchen [3] 6/6 12/13 18/16
know [110]
knowledge [2] 19/17 30/19
KOA [5] 15/18 16/14 44/18 50/25 58/5
KY [1] 71/20

L

lab [1] 24/15
large [3] 54/6 71/9 71/20
larger [2] 10/24 11/11
last [11] 3/14 3/25 4/5 4/10 5/7 5/11 5/17 19/5 21/8 54/10 63/5
late [1] 54/4
later [2] 34/23 70/23
latest [1] 7/6
law [4] 41/22 46/22 47/12 48/17
laws [1] 47/5
layers [1] 52/23
lead [2] 26/17 66/15
leader [1] 57/13
leadership [1] 63/1
learn [1] 62/6
least [4] 11/11 24/10 35/1 59/20
leave [1] 13/15
left [3] 57/20 58/25 69/7
legally [1] 49/10
LeMay [1] 7/22
lens [7] 14/23 14/25 33/21 33/22 37/17 38/22 38/23
lenses [6] 18/18 20/9 20/11 20/11 33/25 38/3
less [1] 39/21
let [15] 3/8 4/17 12/8 14/7 14/9 14/17 30/17 40/9 49/19 49/25 64/24 65/5 65/13 66/9 70/10
let's [7] 3/25 4/20 5/23 14/19 21/22 49/24 50/20
lets [2] 9/16 65/20
level [1] 3/18
levels [1] 51/16
library [1] 65/24
license [1] 7/18
licensed [1] 49/11
licensure [5] 42/19 48/7 52/18 56/4 57/19
lifetime [4] 22/6 22/8 22/23 25/7
like [55] 3/15 5/24 8/15 8/19 11/2 12/10 12/11 12/16 15/20 16/6 22/22 24/7 24/13 25/13 26/1 26/17 27/2 28/1 30/9 32/6 32/22 33/11 33/12 36/11 37/15 37/16 37/20 38/2 38/21 38/22 39/25 40/16 40/23 42/15 43/11 44/3 44/4 44/25 47/9 50/18 51/8 53/11 53/15 53/16 56/5 59/8 59/15 64/9 64/23 65/9 65/18 67/1 67/7 70/3 70/17
limit [5] 22/8 32/7 32/13 61/21 62/3
limitation [1] 24/22
limitations [3] 46/11 52/21 53/4
limited [1] 3/19
limits [4] 3/17 3/22 22/22 32/11
line [8] 14/3 20/6 20/10 20/12 25/15 34/6 60/25 62/1
lines [1] 14/5

L

link [2] 4/17 67/16
list [7] 6/1 9/14 18/19 18/19 19/3 21/14 21/25
listed [2] 38/11 38/13
literature [5] 25/24 26/2 26/2 27/14 27/17
little [12] 9/16 11/2 13/6 14/12 23/23 24/11 49/19 50/1 59/16 65/16 67/2 67/21
live [1] 9/9
load [1] 36/4
local [1] 65/23
location [1] 66/6
log [3] 3/8 13/6 13/7
logged [2] 4/19 5/3
logging [2] 3/4 4/24
long [5] 31/14 43/21 57/18 63/3 67/8
longer [1] 65/20
look [27] 5/24 9/21 13/6 15/25 19/18 19/24 21/2 25/2 27/4 27/23 42/23 50/1 50/15 51/25 52/4 52/5 52/7 52/15 52/18 52/20 56/3 56/4 57/2 57/11 59/7 59/16 61/5
looked [1] 42/9
looking [9] 15/23 16/20 22/19 26/12 27/14 36/22 43/23 50/21 68/13
looks [3] 22/19 28/5 37/20
lose [1] 69/5
loss [1] 36/8
lost [1] 32/16
lot [12] 11/23 13/16 20/11 27/18 35/15 39/20 46/15 52/23 54/9 55/7 57/4 66/25
lots [1] 51/6
lower [1] 3/18
LRC [1] 65/20

M

MAC [9] 64/17 66/15 66/17 68/4 68/12 68/15 69/10 69/14 69/22
made [3] 4/11 27/6 31/17
mail [1] 16/15
mails [1] 44/19
main [1] 22/24
Mainly [1] 22/24
majority [3] 9/24 10/21 11/10
make [30] 4/4 7/2 7/21 8/5 15/19 16/9 16/10 29/16 30/11 32/14 38/11 43/1 44/2 46/17 47/23 48/5 54/17 56/10 56/21 59/8 59/11 64/7 65/1 65/1 65/10 65/17 66/5 67/15 69/10 70/18
makes [3] 38/16 51/19 67/2
making [3] 36/10 48/6 69/9
managed [1] 23/16
management [5] 16/3 23/11 24/12 24/22 53/7
manner [2] 53/22 54/21
many [7] 2/15 43/3 43/16 61/4 61/15 65/18 67/17
March [1] 69/16
markers [1] 28/22
materials [1] 14/21
Matt [4] 2/6 12/5 60/15 68/21
may [11] 6/21 7/5 15/1 16/24 20/7 30/20 30/22 34/14 66/19 66/23 69/9
maybe [23] 4/17 5/24 11/6 11/11 16/3 23/4 26/12 26/15 26/16 28/21 28/25 29/2 30/3 33/3 33/18 49/20 50/2 55/24 57/13 57/20 58/1 60/16 61/13
MCO [5] 11/19 17/10 18/5 35/8 36/3
MCOs [4] 11/24 17/23 34/18 58/12
me [33] 4/17 9/5 12/8 12/14 14/7 14/8 14/9 14/17 17/3 27/20 30/12 34/14 34/14 35/11 37/25 40/10 41/4 47/10 48/11 49/20 50/1 52/9 56/1 56/13 59/2 64/4 64/6 64/24 65/11 66/4 67/8 69/12 70/10
mean [11] 10/22 31/25 32/19 44/24 51/5 55/18 56/17 59/1 59/7 64/11 64/14
meaning [3] 23/1 25/10 26/6
means [1] 48/13
meantime [1] 27/24
mediated [1] 23/4
medicaid [30] 1/4 7/1 10/7 13/23 17/7 17/9 17/19 17/22 17/24 18/2 18/8 18/10 18/11 18/12 18/21 18/23 19/12 19/20 20/10 21/9 31/6 34/20 35/8 41/9 47/10 51/20 52/1 52/15 58/11 58/22
Medicaid's [1] 52/4
medical [4] 26/5 34/1 38/25 39/4
medically [7] 37/22 38/1 38/14 38/17 38/18 39/10 40/5
medically-necessary [1] 37/22
Medicare [19] 17/7 17/17 17/19 17/20 17/24 18/1 18/6 18/7 18/11 18/13 18/19 18/21 18/22 18/25 19/11 19/11 19/13 19/14 21/11
meet [6] 27/4 65/9 66/10 66/24 67/14 69/14
meeting [24] 3/15 3/16 3/24 4/1 4/5 4/10 5/7 5/17 7/12 8/4 19/5 64/1 65/3 65/6 65/17 66/22 67/23 67/23 68/4 69/9 69/19 70/3 70/25 71/11
meetings [4] 8/21 8/23 11/20 11/20
meets [2] 69/15 69/22
member [2] 18/20 36/8
members [8] 5/2 5/18 12/20 27/14 31/7 32/8 46/18 70/21
mentioned [3] 13/15 33/18 62/9
met [1] 67/6
mid [1] 66/9
middle [3] 29/25 34/17 34/21
might [13] 4/11 4/19 9/1 15/16 15/18 16/12 17/14 23/9 30/14 34/12 60/13 68/11 69/21
mildly [1] 26/10
mind [3] 16/22 27/2 56/12
mine [2] 15/4 15/10
minus [1] 37/17
minute [3] 30/23 31/22 52/8
minutes [7] 3/25 4/5 4/9 5/7 5/16 5/22 22/16
miscommunication [1] 33/19
misheard [1] 55/25
misinformed [1] 61/13
misinterpretation [1] 33/23
miss [1] 3/3
missed [3] 9/18 13/9 63/5
mistake [1] 57/21
mistaken [3] 34/12 41/10 60/17
mistakes [1] 59/12
MMIS [1] 9/11
mode [1] 23/8
Monday [3] 63/16 63/17 63/19
money [7] 35/6 35/16 46/7 46/13 53/3 53/13 55/1
monitor [3] 24/19 24/24 28/3
monitoring [2] 24/13 24/23
month [12] 6/13 13/25 34/17 34/20 34/20 34/21 35/1 35/4 35/21 36/15 66/23 68/5
monthly [1] 36/2
months [6] 25/11 27/1 29/6 34/23 35/1 65/25
more [31] 2/15 10/4 11/2 11/23 14/13 15/11 15/21 16/6 16/21 24/11 24/24 25/6 25/17 25/23 29/12 30/18 35/16 38/7 39/15 49/19 49/25 50/1 59/16 62/16 62/22 64/17 64/19 64/23 65/11 65/16 69/11
most [7] 3/12 10/17 16/7 19/18 23/11 24/16 54/20
motion [5] 4/3 4/4 70/8 70/17 70/18
move [5] 5/23 12/2 14/19 21/22 36/13
much [14] 10/16 14/15 21/17 24/3 24/24 33/4 39/17 40/13 45/21 46/16 53/15 60/8 63/20 64/18
multi [1] 51/16
multi-faceted [1] 51/16
Munson [2] 2/7 46/20
mute [1] 52/8
my [29] 7/1 9/4 13/3 17/12 18/3 19/17 21/6 21/6 22/7 22/9 26/19 27/13 30/21 31/3 32/16 33/4 33/6 39/6 43/8 49/2 49/4 49/12 51/1 55/24 56/12 60/5 64/18 71/13 71/16

N

name [2] 22/9 61/10
named [1] 61/8
names [1] 61/9
nationally [1] 23/21
near [1] 8/18
necessary [8] 37/22 38/2 38/14 38/17 38/19 39/11 40/2 40/5
necessity [3] 34/1 38/25 39/4
need [16] 4/11 8/9 20/1 20/21 37/22 38/15 49/19 59/25 62/11 63/3 63/9 63/12 64/21 65/16 69/19 69/21
needed [4] 42/25 43/12 53/22 53/23
needing [1] 37/10
needs [2] 35/19 44/5
Net [2] 7/4 13/8
never [1] 57/7
new [10] 6/9 6/19 7/22 14/20 21/22 43/6 56/2 57/12 58/8 58/23
next [22] 6/13 7/11 7/15 14/20 17/6 29/24 30/2 30/15 30/16 34/11 35/4 35/20 37/6 40/15 41/16 53/9 64/2 66/8 66/24 68/4 69/9 70/3
nice [1] 61/14
no [22] 4/12 5/14 5/20 6/3 7/2 9/8 9/14 10/13 11/16 13/19 13/19 16/6 19/14 31/18 32/6 32/13 34/1 56/17 57/7 63/21 65/20 68/7
no-show [4] 7/2 9/8 9/14 11/16
nobody [1] 70/7
non [2] 17/10 38/13
non-covered [1] 38/13
non-MCO [1] 17/10
normal [2] 54/16 55/2
normally [1] 54/18
not [67] 3/21 6/8 10/18 12/2 12/9 12/21 12/23 16/13 16/19 17/22 17/25 18/7 18/10 18/21 18/24 19/6 19/19 20/19 22/3 23/20 24/5 26/6 26/20 27/17 29/14 29/22 32/9 33/8 34/12 41/10 41/18 42/7 43/5 44/22 45/7 45/11 45/12 45/13 45/15 46/7 47/21

N

not... [26] 48/2 48/4 49/13 50/3 50/5 50/6 51/5 52/6 52/11 53/7 53/15 55/3 55/21 56/6 56/14 56/18 57/15 58/10 59/11 59/11 60/3 60/13 61/3 66/18 69/4 69/6
Notary [2] 71/8 71/20
nothing [2] 27/19 62/17
notice [2] 28/20 67/9
noticed [1] 4/11
notification [1] 8/3
NOVEMBER [1] 1/15
now [21] 3/13 4/24 7/2 10/24 12/25 17/22 18/23 20/18 23/15 27/19 32/24 33/24 45/4 56/24 58/19 62/22 64/11 65/1 65/10 66/22 68/18
number [7] 11/12 13/14 13/23 23/14 48/21 48/22 63/23
numbers [1] 48/12

O

obviously [2] 13/21 33/10
occurrence [1] 22/6
October [1] 8/1
October 1st [1] 8/1
off [11] 3/16 21/25 25/9 30/24 42/6 42/18 53/24 57/21 60/24 69/7 70/4
offer [1] 22/11
office [5] 31/3 50/7 58/15 62/18 71/16
official [1] 43/8
officially [1] 43/19
offline [1] 40/10
often [2] 25/23 62/22
oh [3] 12/22 44/11 51/11
okay [48] 3/11 5/13 5/21 6/18 7/14 8/17 8/24 9/3 11/18 13/5 14/19 16/8 17/5 19/9 19/16 20/5 20/20 21/4 26/23 28/12 30/5 30/7 30/12 30/13 30/25 32/11 33/14 34/3 34/7 36/25 39/12 39/15 41/3 43/3 44/9 44/13 47/24 48/7 60/4 61/7 61/20 63/14 63/18 64/21 66/13 66/13 67/20 70/14
old [3] 5/24 21/21 24/1
once [18] 15/24 21/24 22/6 22/8 22/23 23/12 25/7 43/8 43/19 44/2 44/8 44/23 45/25 52/25 60/18 62/16 67/4 67/6
once-per-lifetime [1] 22/6
one [41] 7/15 9/22 11/14 11/18 12/2 14/22 17/1 20/14 20/14 20/15 20/17 21/25 22/1 25/9 25/17 27/3 27/12 27/13 28/5 28/9 29/21 32/3 33/2 33/15 33/17 34/11 36/6 39/16 47/18 47/18 47/18 48/21 57/21 57/22 58/21 59/3 60/21 65/12 66/8 66/14 66/23
one-off [2] 21/25 25/9
ones [4] 11/3 42/15 59/18 64/13
ongoing [1] 25/25
only [12] 10/15 19/12 23/13 43/7 44/23 50/22 51/6 52/6 54/10 60/19 65/11 68/22
open [2] 3/15 59/17
ophthalmologist [3] 46/25 47/3 49/7
ophthalmologists [2] 27/8 47/20
ophthalmology [2] 27/16 48/15
opine [1] 22/11
opportunities [1] 43/10
opportunity [1] 45/20
opposed [1] 5/19
optician [1] 13/12
option [4] 13/11 14/4 44/6 69/21
options [1] 43/10
OPTOMETRIC [3] 1/7 48/20 71/11
optometrist [3] 45/11 45/16 49/7
optometrists [12] 23/23 27/6 27/7 40/21 41/19 46/23 47/6 47/21 48/19 48/22 49/9 58/25
optometry [2] 29/9 41/25
order [6] 6/19 13/13 19/1 19/10 46/4 54/14
osmolarity [2] 24/14 29/7
other [26] 3/13 8/1 11/1 13/18 13/18 19/16 21/20 27/12 28/10 33/17 36/17 42/1 42/15 44/1 47/19 51/6 51/8 51/22 52/16 52/17 55/12 57/7 59/5 61/25 63/24 68/1
otherwise [1] 33/8
our [40] 8/9 11/19 11/20 15/22 16/22 21/9 22/11 22/22 23/22 25/14 25/21 25/21 26/3 27/3 28/5 29/24 31/3 35/13 36/5 36/16 37/2 39/13 40/19 41/13 41/23 46/5 46/25 47/4 47/4 48/16 48/18 49/23 56/21 56/22 57/25 62/25 65/15 65/23 69/2 69/5
out [36] 6/10 8/3 8/18 10/3 10/5 11/18 14/2 17/4 23/18 27/18 36/22 41/11 43/6 45/5 49/8 49/21 50/3 51/23 52/16 53/21 54/4 54/21 56/2 57/4 58/9 58/25 60/1 62/18 62/21 64/3 64/18 65/24 67/10 67/19 69/5 70/5
outlier [1] 33/6
outreach [1] 11/3
outs [1] 7/8
outside [3] 54/16 55/2 55/20
over [5] 3/9 17/21 24/1 30/22 62/15

P

P.M [1] 1/16
PA [1] 25/8
paid [15] 17/25 19/19 32/17 34/23 35/16 35/17 46/23 47/3 47/18 48/3 48/21 48/21 48/22 48/25 50/13
pandemic [1] 66/16
paraphrase [1] 6/14
Parker [1] 6/25
part [7] 9/25 25/11 37/15 37/17 40/1 46/2 63/6
particular [12] 18/4 22/17 22/25 24/2 25/19 32/3 42/5 42/5 42/8 42/20 43/18 54/13
partner [1] 35/23
PAs [1] 29/18
passed [1] 47/13
past [4] 6/7 58/6 58/17 67/5
patient [9] 11/15 17/9 18/10 23/19 26/22 32/15 34/16 34/22 34/25
patient's [1] 24/25
patients [10] 17/7 17/10 17/17 18/8 18/11 25/5 26/12 27/25 32/9 69/5
pay [9] 18/7 19/1 19/10 19/11 19/13 19/15 46/21 48/15 55/1
paying [2] 20/10 48/25
payment [3] 9/11 9/12 21/1
pays [1] 19/12
PDF [1] 14/11
peer [7] 26/2 26/25 27/5 27/5 27/17 28/4 29/24
peer-reviewed [2] 26/2 27/17
people [7] 28/6 31/25 52/2 61/25 64/25 65/18 67/11
per [11] 3/19 3/19 19/8 22/6 22/8 22/23 22/23 25/7 38/23 43/6 44/8
percent [1] 30/22
Perfect [1] 5/1
peri [1] 46/21
period [7] 29/9 31/10 31/18 32/25 34/1 49/1 50/14
person [9] 65/3 65/9 65/14 66/10 66/17 66/24 67/6 67/14 67/21
perspective [1] 48/15
phone [4] 9/6 10/15 30/23 31/8
phonetic [1] 46/22
physician [6] 45/6 47/2 47/8 51/3 58/24 69/1
physicians [4] 41/8 41/23 50/22 60/3
physicians' [7] 41/12 41/18 42/7 42/18 45/15 47/16 67/5
pick [2] 13/12 45/2
picking [1] 44/25
pipes [1] 66/1
place [3] 13/9 31/23 42/24
plans [3] 18/5 31/5 33/20
please [3] 20/19 55/25 55/25
plus [1] 37/16
point [4] 26/22 41/4 48/23 49/18
policies [1] 25/22
policy [5] 6/5 19/8 29/3 60/17 60/21
portal [4] 12/22 34/19 35/4 36/5
positive [2] 28/14 28/25
possible [4] 54/6 59/6 59/9 67/17
possibly [2] 23/3 28/25
potentially [2] 23/22 25/13
power [2] 20/13 37/17
practice [11] 33/11 47/1 48/14 48/17 48/18 49/3 49/5 49/6 56/14 57/25 69/2
practicing [2] 27/7 27/7
prefer [1] 65/3
premise [3] 25/14 25/24 32/22
prepared [1] 8/8
prescribe [3] 38/2 38/20 39/11
prescribed [2] 38/1 40/6
prescription [5] 37/12 37/16 37/18 38/16 40/2
present [1] 25/17
presented [1] 27/22
pretty [2] 24/3 25/20
preventing [1] 8/16
preventive [1] 57/22
price [2] 47/18 47/18
primary [1] 19/1
prior [4] 37/10 37/14 39/3 39/10
prism [10] 37/11 37/14 38/2 38/4 38/16 38/20 38/25 39/11 39/25 40/4
private [1] 57/8
probably [8] 11/10 15/3 16/4 16/10 20/3 24/2 54/2 62/23
problem [5] 8/11 11/22 12/4 37/5 63/21
procedure [1] 23/17
process [7] 25/8 45/22 45/24 48/6 51/15 61/3 69/11
profession [2] 56/14 56/16
Professional [1] 71/8
program [1] 46/10
programmers [1] 46/9
promise [1] 50/4
prompt [1] 62/14
propose [1] 28/9
provided [1] 13/20
provider [17] 3/19 7/20 9/17 11/20 13/11

P

provider... [12] 13/12 13/13 42/5 45/16 51/10 51/23 52/15 52/22 57/6 57/17 62/8 62/25
providers [14] 9/10 9/21 10/3 10/11 36/18 37/10 46/5 46/18 49/24 50/9 50/13 57/1 57/3 59/21
providing [1] 56/20
prudently [1] 33/11
public [8] 7/3 54/5 54/6 65/13 65/23 65/25 71/8 71/20
pull [2] 6/20 12/19
put [14] 12/3 21/14 27/3 36/18 37/11 43/1 45/5 45/7 45/15 46/4 47/24 48/2 48/8 67/10

Q

QMB [4] 18/23 19/5 19/7 19/11
question [16] 17/1 18/4 22/7 24/6 24/7 37/9 39/5 39/13 44/17 45/19 46/19 49/12 51/1 55/24 64/11 64/24
questions [8] 4/9 16/5 16/19 21/6 21/20 26/8 34/4 44/9
quick [3] 4/23 41/4 55/6
quickly [1] 25/18
quite [1] 50/8
quorum [1] 3/9

R

ran [2] 6/9 15/13
rare [1] 23/23
rate [3] 46/24 48/3 53/3
rationale [1] 22/12
RE [1] 1/7
reach [3] 8/18 10/3 60/1
reached [2] 8/3 36/22
reaches [1] 51/23
reaching [1] 65/24
read [1] 4/2
ready [2] 5/6 68/9
real [5] 4/23 27/19 32/9 41/4 61/9
realize [1] 67/11
realized [1] 30/21
really [8] 5/25 8/7 10/2 23/21 29/3 46/13 55/6 67/7
reason [6] 13/14 13/17 13/19 18/14 22/24 57/16
reasonable [4] 22/24 22/25 29/2 32/22
reasons [6] 9/18 9/24 10/6 10/17 11/5 13/19
reassess [1] 33/4
reassess my [1] 33/4
receive [3] 15/1 36/2 36/3
received [2] 15/9 40/25
receiving [1] 62/23
recently [3] 18/17 19/2 21/8
recheck [1] 28/21
recipients [1] 56/21
recognize [1] 23/10
recognized [1] 41/22
recommendation [2] 53/6 69/10
recommendations [3] 68/7 68/10 68/19
recommending [1] 68/23
reconsideration [1] 28/7
record [1] 71/10
recording [1] 65/21
recouped [2] 34/24 35/6
recoupment [1] 36/19
regard [2] 36/1 36/6
Registered [1] 71/7
regular [1] 41/12
regulations [1] 37/20
reimbursed [1] 26/20
reimbursement [1] 49/14
reinstated [1] 36/9
relates [1] 59/22
relations [2] 62/8 63/1
release [1] 14/23
relief [1] 23/16
relook [1] 27/21
rely [1] 57/24
remediated [1] 36/24
remedied [1] 31/5
remedy [1] 12/4
remember [4] 10/9 15/20 30/4 60/23
remove [1] 14/4
removed [2] 31/14 32/25
rep [3] 35/10 35/13 62/8
repay [1] 20/25
repeat [2] 12/8 12/10
replace [1] 54/11
replacement [2] 31/11 31/18
replacements [2] 32/8 32/20
reply [1] 62/19
report [13] 6/3 6/9 7/3 9/8 9/9 9/14 9/15 12/9 12/12 12/18 13/24 33/7 55/19
Reporter [1] 71/8
reports [1] 9/13
representative [2] 30/11 60/19
reput [1] 46/10
request [3] 39/3 45/25 60/5
requested [4] 42/11 45/4 57/1 57/2
requests [2] 57/11 59/20
require [2] 18/5 32/20
rescinded [1] 60/22
research [6] 41/1 42/16 43/1 49/19 52/3 52/17
researched [1] 51/25
researching [1] 43/23
resend [2] 16/22 70/11
resolution [4] 24/25 68/24 69/8 69/13
resolved [1] 31/20
respirators [1] 55/15
respond [2] 11/3 11/4
response [3] 5/20 50/16 62/14
responses [2] 15/17 16/17
Restasis [1] 28/15
restricted [1] 58/19
resubmit [1] 20/21
results [1] 30/2
retest [2] 26/15 26/22
retro [1] 36/19
retrospective [1] 36/13
retrospectively [1] 36/13
return [1] 66/17
review [9] 15/14 26/25 27/5 27/5 28/4 29/24 39/3 51/17 56/3
reviewed [3] 25/22 26/2 27/17
reviewing [1] 43/21
rewrite [1] 46/10
right [26] 7/2 8/17 10/23 11/17 21/4 21/17 23/9 25/4 26/23 26/24 26/25 27/19 29/2 30/24 33/9 34/3 46/7 48/10 50/17 53/25 54/23 56/24 65/8 65/10 67/25 70/4
road [1] 26/13
room [4] 34/13 55/13 67/9 67/16
rooms [1] 66/2
routine [1] 25/10
RPR [1] 71/20
RSV [4] 53/20 54/3 54/24 55/11
rules [1] 52/16
run [2] 16/1 69/20
running [2] 9/20 10/10

S

said [17] 7/7 12/15 15/21 22/19 35/5 42/15 50/18 53/16 56/1 59/8 59/15 61/25 64/9 66/14 70/3 70/12 70/17
same [13] 20/6 20/6 20/10 20/12 24/15 24/21 33/24 44/16 46/24 47/15 47/17 54/19 64/16
Sarah [8] 15/17 16/14 44/11 44/14 44/18 50/25 58/4 60/4
save [1] 14/11
saw [3] 4/15 5/10 27/13
Sawyer [1] 2/9
say [16] 5/17 10/3 12/21 23/20 25/2 25/2 25/17 28/3 44/15 51/11 55/7 60/1 65/2 66/8 67/13 68/9
saying [13] 5/18 11/8 21/10 28/19 33/10 34/24 41/24 44/24 45/10 48/24 58/5 59/2 59/3
says [6] 6/12 9/13 9/13 13/9 32/15 46/22
schedule [49] 14/23 14/25 15/8 17/3 40/18 40/23 41/6 41/11 41/13 41/16 41/18 41/21 42/2 42/7 42/10 42/17 42/19 43/5 43/8 43/17 43/17 45/6 45/8 45/13 45/14 45/18 46/3 47/2 47/9 47/16 47/17 47/25 48/9 50/11 50/20 51/9 53/8 53/23 56/22 57/19 57/21 58/11 58/24 59/5 59/22 59/24 64/19 69/1 69/4
schedules [4] 49/8 51/7 51/13 56/7
scope [9] 46/25 48/16 48/18 49/2 49/4 49/6 56/14 57/25 69/2
screen [3] 12/15 13/1 13/3
screen and [1] 12/15
se [2] 38/23 43/6
seal [1] 71/16
seamless [1] 69/11
search [2] 9/17 9/21
season [1] 54/18
second [6] 4/6 4/7 4/22 5/8 12/6 70/19
secondary [1] 17/8
section [1] 38/13
secure [1] 66/6
see [28] 3/2 3/7 4/12 4/20 4/23 5/12 6/4 6/23 9/7 11/23 13/2 13/8 14/9 19/24 21/2 23/24 26/1 28/22 28/24 29/4 29/4 42/16 42/23 53/2 67/23 69/7 69/13 70/16
seeing [2] 38/23 43/24
seemed [2] 11/16 37/15
seems [3] 8/14 37/25 64/22
seen [2] 6/16 43/14
select [1] 13/14
send [14] 4/17 16/13 17/19 17/21 18/12 19/23 20/19 20/23 21/1 21/15 28/2 43/22 51/20 60/7
sending [1] 7/18
sense [1] 30/11
sent [14] 15/4 15/10 15/17 15/18 16/12 16/15 16/17 20/2 20/16 42/12 44/18 44/18 64/3 70/5
September [2] 16/16 34/24

S

September 25th [1] 16/16
service [2] 46/24 63/23
services [4] 1/3 1/4 10/7 11/1
set [5] 42/3 42/20 46/6 56/13 71/15
setting [1] 48/14
several [2] 37/10 43/18
share [4] 12/15 13/1 62/3 63/1
shared [1] 6/7
sharing [1] 14/18
she [9] 7/7 7/23 12/14 15/18 34/14 61/24 62/21 63/4 63/8
she's [2] 35/10 62/13
should [15] 3/5 13/1 19/5 20/18 20/24 23/10 35/6 36/10 39/9 47/6 51/9 53/3 59/3 60/2 66/2
shouldn't [4] 25/9 35/15 36/11 61/20
show [14] 6/3 7/2 9/8 9/14 10/6 10/14 10/14 10/17 10/18 11/16 13/19 14/10 33/8 65/19
showed [1] 55/13
side [1] 45/16
simple [1] 26/24
since [8] 8/2 19/13 27/13 47/7 50/10 50/11 58/23 68/13
sir [3] 40/25 66/12 70/13
sites [1] 27/15
sitting [1] 34/13
situation [3] 8/12 31/15 36/20
six [3] 25/11 29/6 65/25
so [162]
software [3] 7/23 8/12 8/14
solution [1] 50/15
some [24] 4/14 6/22 8/13 12/4 16/18 21/1 21/9 21/25 35/1 37/9 40/17 41/15 42/3 49/25 54/6 55/12 57/5 62/16 63/11 65/23 66/19 67/22 68/17 68/17
somebody [4] 28/13 31/7 42/12 68/19
somehow [1] 26/1
something [22] 16/25 18/2 26/17 33/20 35/14 43/11 43/24 44/3 44/5 47/5 48/16 49/10 49/21 50/3 50/6 50/10 53/10 57/12 57/14 59/22 59/25 70/15
something's [1] 26/15
sometimes [5] 3/20 25/23 64/20 64/22 67/21
somewhere [2] 25/6 34/5
sooner [1] 53/18
sorry [6] 36/19 44/12 52/7 52/11 61/10 63/5
sort [3] 18/3 24/18 62/19
sound [1] 69/23
sounds [9] 3/11 5/4 8/24 16/8 17/6 50/23 66/13 68/1 69/12
space [1] 65/17
speak [2] 47/9 54/2
Speaking [1] 61/23
special [1] 69/19
special-called [1] 69/19
specialists [1] 29/10
specific [4] 19/25 24/7 31/15 50/8
spend [1] 10/16
spending [1] 53/18
spent [1] 35/15
split [1] 58/20
staff [5] 31/24 32/21 39/7 39/13 58/18
standard [1] 33/12
standards [1] 52/1
start [8] 3/24 12/11 18/13 24/12 28/14 36/14 43/23 52/13
started [2] 60/6 65/6
starting [1] 58/8
state [4] 47/4 71/4 71/9 71/20
stated [1] 66/25
statement [1] 29/14
states [9] 17/8 37/21 44/1 48/17 52/5 52/17 55/12 56/5 57/7
statutes [1] 47/4
stayed [1] 66/21
staying [1] 64/8
stays [1] 55/14
Steve [15] 2/8 3/5 4/13 4/20 5/6 6/11 10/12 11/14 30/17 30/25 31/1 34/11 64/6 67/21 68/3
still [11] 4/19 6/8 6/12 11/9 14/24 16/20 30/14 35/9 45/17 60/17 67/15
stop [1] 14/18
straight [5] 17/23 18/9 18/10 18/12 18/23
strategic [1] 35/23
strongly [1] 62/12
studies [1] 26/5
stuff [7] 9/19 25/20 28/6 43/22 44/2 46/12 48/8
subject [1] 18/4
submit [1] 39/2
such [1] 41/9
suitable [1] 64/2
supply [1] 32/6
supports [1] 25/24
supposedly [2] 35/10 35/13
sure [34] 6/8 9/3 12/13 15/16 15/19 16/9 16/19 17/2 18/14 21/11 21/13 22/13 28/9 33/12 34/10 37/1 37/5 38/11 47/14 47/24 48/5 48/6 50/19 52/11 54/17 56/10 56/22 57/20 59/8 61/3 65/17 66/5 66/7 66/7
surgery [1] 49/1
surrounding [2] 52/5 56/5
switch [1] 30/22
symptomatic [1] 23/16
symptomatology [1] 23/12
symptoms [2] 25/1 29/13
synopsis [1] 56/8
system [6] 6/19 8/13 9/11 9/12 9/16 42/21
systems [1] 46/6

T

TAC [16] 1/7 3/14 5/2 7/11 8/21 30/2 60/12 63/25 65/2 65/5 67/5 67/7 68/11 69/15 69/19 70/25
TACs [2] 66/25 67/4
take [8] 5/15 36/11 39/12 64/18 67/23 68/11 70/8 70/17
takes [4] 35/1 60/23 62/20 63/4
taking [5] 3/23 6/22 35/11 35/14 35/19
talk [7] 6/13 21/6 27/9 30/18 39/14 41/5 70/23
talked [1] 9/8
talking [11] 5/9 17/22 17/23 20/8 31/9 32/1 32/7 36/7 50/20 56/24 56/25
taxpayer [1] 53/17
team [1] 63/1
tear [3] 22/20 24/18 24/20
tears [1] 22/21
Technical [1] 71/11
technology [1] 8/15
tell [4] 30/20 55/25 57/24 60/19
telling [3] 14/8 48/11 56/12
term [1] 23/5
test [21] 22/3 22/17 22/18 23/1 23/1 23/2 23/20 24/3 24/8 24/13 24/14 24/21 24/22 24/23 25/6 25/11 25/25 28/14 29/7 29/8 29/10
tested [1] 26/13
TESTIMONY [1] 71/15
testing [2] 22/5 26/19
tests [2] 29/5 33/6
than [9] 15/12 15/21 16/6 25/7 35/16 39/22 54/2 62/16 65/12
thank [21] 3/16 3/22 4/8 14/18 17/5 21/17 33/1 33/16 34/8 36/25 37/1 40/12 40/14 50/17 50/24 60/7 60/9 61/7 63/20 63/21 67/25
thanks [5] 12/2 14/15 30/9 30/10 37/3
that [386]
that's [59] 3/20 6/16 8/15 9/19 10/24 11/9 11/18 14/15 15/11 15/20 16/19 18/3 18/25 19/8 22/15 24/5 24/13 24/15 24/22 25/7 25/13 25/14 25/18 26/23 28/22 30/6 31/12 31/21 32/2 32/9 33/3 34/6 34/7 37/23 38/24 38/25 39/5 40/7 43/8 43/11 43/20 44/13 45/19 46/25 47/22 47/24 47/25 49/12 53/17 53/25 55/18 55/18 56/17 57/23 58/2 59/24 63/14 64/10 68/8
their [14] 10/15 11/16 18/24 24/25 25/11 34/19 35/4 36/14 51/20 57/18 58/18 61/9 65/20 66/1
them [23] 3/7 4/2 8/5 8/18 10/17 17/15 17/15 21/2 24/5 28/14 30/18 30/19 32/14 33/23 41/2 41/14 53/22 55/20 56/3 56/15 60/24 64/7 67/3
then [50] 4/21 5/15 7/9 7/15 8/13 9/15 10/14 14/3 14/5 14/20 15/11 15/22 16/1 17/7 17/21 28/11 28/18 31/10 34/23 35/4 35/21 36/3 36/9 36/12 40/10 41/25 43/3 44/2 45/11 45/21 47/4 47/5 47/5 47/25 48/20 51/1 52/16 52/25 53/7 54/12 55/24 56/12 58/24 59/24 60/24 62/7 66/7 69/20 70/7 70/16
there [53] 3/5 5/9 5/10 7/5 7/10 7/16 8/19 9/16 9/22 13/18 13/19 16/18 18/9 19/14 21/20 22/2 25/2 25/4 26/24 27/19 32/6 32/13 34/5 35/25 37/4 38/6 42/24 43/9 45/10 45/23 47/19 48/2 48/24 51/4 51/16 52/8 52/22 54/5 55/12 57/4 57/20 58/7 60/12 61/15 61/20 62/3 62/5 62/5 65/4 67/15 67/19 68/10 68/25
there's [16] 10/19 10/22 18/14 23/13 23/15 24/14 27/17 27/19 28/1 31/18 38/4 46/14 51/6 51/18 57/4 61/25
THEREUPON [1] 70/25
Theriot [3] 53/19 54/2 54/23
these [14] 19/18 20/20 29/12 31/4 40/18 41/15 41/24 48/12 48/12 49/8 51/13 68/14 68/17 68/24
they [80]
They'll [1] 10/18
they're [9] 19/6 28/14 28/19 32/1 35/5 38/23 40/22 42/6 64/6
they've [2] 20/24 38/24
thing [8] 19/16 25/18 29/18 32/3 44/16 62/19 65/11 68/22
things [17] 5/24 9/22 11/2 16/11 21/21 23/14 23/15 29/12 29/21 31/4 38/22 53/5

T

things... [5] 56/2 56/5 59/12 67/22 68/17
think [74]
this [97]
those [49] 3/22 5/19 9/24 10/6 15/18 19/2 19/25 20/1 20/11 20/16 20/21 20/23 21/3 24/4 25/8 25/16 29/21 29/22 30/9 30/10 33/2 33/6 36/10 39/2 40/25 42/17 42/22 42/23 50/8 50/13 51/21 52/14 52/18 52/19 52/20 53/4 54/8 54/17 54/20 54/22 55/1 57/3 57/5 57/9 57/10 57/14 59/12 63/9 64/2
though [7] 21/7 23/12 27/24 27/25 32/10 45/12 58/5
thought [4] 42/11 45/24 60/21 67/18
three [3] 3/2 60/20 60/24
through [12] 10/7 12/16 39/14 39/22 46/6 48/6 48/7 51/5 51/11 57/3 57/5 60/18
throw [3] 17/15 37/6 67/18
time [29] 5/11 6/22 8/2 8/13 15/23 24/15 26/4 26/19 27/4 29/5 31/14 43/13 44/23 46/3 46/8 54/20 59/10 59/11 59/12 60/20 60/21 61/5 62/10 64/18 65/4 65/16 66/8 66/14 69/19
timeframe [1] 54/16
timely [2] 53/22 54/21
times [7] 13/16 39/20 43/4 43/16 54/9 55/7 57/20
timing [1] 10/16
tint [1] 38/23
today [3] 21/7 32/14 40/9
TODD [2] 71/7 71/20
told [4] 27/20 34/25 35/2 44/20
tomorrow [4] 32/15 32/17 63/13 64/6
tons [1] 18/15
too [11] 17/13 23/10 23/20 25/4 32/20 33/3 34/12 39/24 58/1 65/14 68/15
took [1] 35/17
topic [1] 37/8
touch [1] 63/11
touched [1] 60/14
town [1] 67/15
tracking [1] 10/16
trade [1] 27/16
traditional [1] 56/20
Traditionally [1] 18/1
transcript [1] 71/10
transition [2] 38/3 38/22
transportation [1] 10/8
travel [2] 64/13 67/2
treat [5] 23/13 23/14 28/16 29/11 29/12
treating [3] 3/21 28/17 28/17
treatment [2] 23/8 28/19
tried [1] 17/24
trouble [1] 4/14
true [2] 39/24 71/10
truly [1] 37/13
try [7] 4/13 4/16 12/4 15/25 23/17 56/21 59/11
trying [6] 6/4 8/8 9/23 9/25 10/2 56/13
tuned [1] 25/20
turn [2] 3/9 38/24
twice [1] 69/14
two [13] 3/19 17/1 20/9 20/9 30/10 30/16 30/22 32/24 34/2 48/22 48/24 51/18 54/10
type [6] 13/12 13/13 14/1 42/20 45/16 56/4
types [4] 13/11 52/22 53/5 57/17
typo [1] 22/15

U

unanswered [1] 10/2
under [6] 9/12 38/13 41/8 57/10 57/15 65/15
underlying [1] 23/3
understand [12] 11/9 14/12 22/5 32/18 34/2 34/18 45/1 47/10 48/11 48/23 59/1 62/2
understanding [2] 7/1 31/4
understood [2] 17/18 56/10
undetermined [1] 10/1
unfortunate [1] 46/2
unit [3] 20/14 20/15 20/17
units [1] 20/9
unknown [1] 13/18
unless [3] 38/14 68/19 70/15
unreasonable [2] 29/14 29/23
unresolved [1] 63/12
until [3] 12/17 36/20 45/18
up [28] 3/16 9/20 10/6 10/10 10/14 10/14 10/17 10/18 12/19 16/2 25/12 27/6 30/14 33/6 33/8 39/16 41/3 42/3 42/21 42/23 43/5 50/18 51/1 65/12 65/19 66/5 67/7 70/15
Upchurch [1] 2/10
update [11] 7/16 7/24 8/20 9/2 12/3 35/2 35/20 40/11 43/4 43/7 55/21
updated [3] 34/19 40/24 43/16
updates [5] 7/18 36/4 51/20 51/21 55/2
upon [1] 28/21
upside [1] 11/13
us [24] 3/12 3/23 12/16 20/19 20/24 21/2 23/21 25/17 28/21 32/4 34/25 41/14 41/22 43/22 45/22 46/7 51/21 55/19 57/25 60/1 60/19 63/8 65/20 70/5
use [10] 12/4 20/14 29/10 40/21 41/25 42/1 56/16 61/8 65/20 65/21
used [1] 23/21
using [1] 33/3

V

vaccination [1] 53/23
vaccine [5] 54/9 54/9 54/12 54/19 54/20
vaccines [5] 54/4 54/8 54/13 54/24 55/11
valid [1] 49/17
value [1] 49/23
various [1] 3/21
verify [1] 21/15
versus [6] 23/5 31/16 32/4 33/21 46/17 55/21
very [6] 25/13 46/9 53/15 53/16 59/6 62/14
vet [1] 47/23
VIA [1] 1/11
video [1] 9/6
vision [25] 14/20 18/5 18/17 38/5 40/17 40/23 41/6 41/11 41/19 41/21 42/2 42/10 42/17 43/2 43/4 43/17 45/7 45/12 45/14 47/17 47/25 48/9 58/10 60/2 69/3
visits [3] 3/19 25/12 55/14
visual [1] 49/3
vote [3] 5/15 5/18 70/21

W

wait [1] 31/22
waiting [8] 8/7 15/6 31/10 31/18 32/24 51/10 61/25 68/16
walk [1] 12/16
want [18] 10/25 14/2 14/2 16/21 17/14 23/7 23/9 26/19 28/7 29/16 29/17 31/1 45/2 45/3 49/22 64/12 66/24 68/11
wanted [4] 9/7 12/14 35/24 66/10
wanting [1] 37/13
wants [1] 67/14
was [50] 7/23 10/9 11/17 16/18 16/25 17/2 17/12 18/4 18/8 20/8 20/10 21/12 29/3 31/13 31/13 31/15 31/21 32/2 32/6 32/21 32/22 32/25 33/18 33/22 34/5 34/21 35/3 37/7 37/12 40/8 41/17 44/15 45/5 45/18 47/8 51/2 54/5 54/25 55/12 56/7 58/8 58/17 58/23 60/21 61/8 61/10 61/18 66/15 68/8 70/25
wasn't [2] 17/1 34/25
waste [1] 26/19
wasteful [1] 25/13
water [1] 66/1
way [23] 7/10 8/20 8/20 10/22 17/18 18/9 25/6 27/12 32/18 34/2 48/1 49/8 51/4 51/19 51/22 51/22 54/19 58/16 58/21 59/3 64/16 64/21 67/19
ways [2] 51/16 51/18
we [274]
we'd [2] 26/1 66/14
we'll [16] 3/24 5/15 6/13 8/22 12/2 15/25 16/4 16/9 17/4 21/24 62/6 64/7 67/22 69/7 69/13 70/16
we're [20] 5/8 6/12 8/8 9/22 9/25 10/2 11/10 14/24 19/19 27/1 27/20 28/17 33/14 37/23 41/7 43/5 43/21 51/5 64/8 68/14
we've [12] 6/15 17/24 17/25 20/16 20/20 35/15 43/16 57/20 59/23 62/15 63/7 68/18
website [4] 35/8 35/20 65/13 67/10
weeds [1] 17/16
week [3] 21/8 31/3 35/12
weeks [2] 16/4 16/7
weeks' [3] 65/12 66/4 67/8
welcome [3] 3/14 14/17 27/25
well [27] 5/14 8/17 11/25 14/19 21/19 25/20 26/10 28/19 28/20 29/15 33/1 35/3 35/17 37/9 44/15 44/17 49/17 50/5 50/22 58/19 60/4 61/25 64/10 68/3 68/8 69/17 70/2
were [14] 2/15 3/4 3/17 3/19 6/18 7/3 7/25 15/6 31/9 32/3 36/9 48/24 48/25 64/2
weren't [1] 61/15
what [57] 5/10 8/9 9/25 11/8 13/16 15/20 15/22 16/20 21/2 23/5 24/14 25/7 26/11 26/25 28/3 29/4 31/8 31/23 32/1 32/2 32/12 35/2 36/6 36/11 37/23 39/6 42/23 42/24 44/1 44/24 45/2 45/3 45/9 48/10 48/13 51/8 52/4 52/5 52/12 52/12 53/3 53/4 56/4 56/12 57/17 57/18 58/5 59/1 59/4 61/3 61/10 61/11 64/5 67/7 67/24 68/8 69/17
what's [5] 18/3 19/24 29/20 46/21 58/6
whatever [5] 23/18 25/1 28/15 32/21 57/16
when [27] 3/4 8/3 10/9 13/5 13/7 13/21 14/22 21/12 27/25 31/17 37/11 39/11 40/5 41/19 43/22 45/3 47/8 50/21 51/19 52/14 54/18 56/23 57/1 57/24 58/9 58/12 58/22
whenever [1] 51/17
where [13] 6/23 12/9 14/13 25/5 29/19

W

where... [8] 32/3 38/25 43/12 49/12 57/6 57/20 59/10 59/13
WHEREOF [1] 71/15
whether [4] 10/8 24/8 42/6 53/6
which [13] 9/24 23/6 23/8 24/17 24/17 30/3 32/23 37/20 41/3 44/25 46/22 47/2 62/22
while [2] 60/23 62/20
who [6] 11/3 11/4 24/16 40/7 52/19 52/19
who's [1] 27/14
whole [2] 9/16 46/6
why [15] 6/16 6/21 10/5 10/13 11/5 18/12 22/7 22/7 24/5 31/22 32/23 34/6 45/11 61/24 62/22
will [34] 6/22 8/5 11/3 14/10 15/11 15/19 23/20 25/17 29/23 30/20 36/23 39/20 40/3 40/4 41/1 42/8 54/10 54/11 55/7 61/2 61/5 61/21 62/3 62/24 63/10 63/13 63/16 63/18 67/15 68/3 68/6 69/14 70/3 70/8
will make [1] 8/5
willing [1] 26/3
within [11] 15/25 21/8 36/5 36/10 46/25 48/16 48/18 49/2 49/4 49/6 69/2
woman [1] 24/2
won't [1] 63/15
wondering [1] 18/8
word [1] 6/2
work [10] 17/11 18/15 32/19 32/20 33/2 35/3 43/21 51/14 64/7 67/9
workers [1] 11/1
working [6] 6/12 7/3 7/23 14/24 28/23 62/9
world [1] 54/9
worried [1] 31/21
worth [3] 40/4 53/12 54/25
would [40] 11/25 14/5 15/23 16/10 18/24 19/14 20/3 27/2 28/9 33/8 36/13 37/17 37/22 38/3 38/22 39/7 39/8 39/15 39/17 40/16 40/23 44/22 45/21 47/15 50/14 53/12 53/20 54/18 57/6 58/11 58/14 65/3 65/4 65/5 65/16 65/18 66/11 67/7 68/22 69/15
wouldn't [5] 18/9 45/22 45/24 59/5 61/9
Writing [1] 39/25
wrong [1] 22/2

Y

yeah [24] 4/15 9/3 10/19 11/18 12/7 12/22 14/14 14/14 15/5 17/13 20/3 29/1 29/2 32/9 32/13 44/11 61/12 61/24 62/2 62/21 63/10 63/21 64/4 68/21
year [29] 3/15 3/20 14/1 27/11 28/18 40/18 43/4 43/8 43/13 43/19 43/21 44/8 44/23 45/17 47/7 49/16 50/11 53/9 53/13 54/10 54/22 54/25 56/1 58/25 64/2 64/9 66/24 67/4 67/6
yearly [1] 55/2
years [5] 24/1 26/13 31/20 32/24 54/10
Yes [14] 7/13 9/3 12/16 13/4 21/13 31/2 31/13 40/25 52/10 56/9 66/12 69/25 70/1 70/13
yesterday [4] 15/12 15/21 60/16 61/19
yet [2] 3/7 8/5
you [278]
you'd [1] 65/9
you'll [1] 11/23
you're [24] 11/8 12/25 13/8 13/21 14/17 21/11 22/14 27/24 32/19 33/7 33/10 36/6 44/24 48/4 48/10 48/23 56/12 56/23 58/5 59/2 59/4 62/23 68/9 68/15
you've [1] 63/11
you-all [37] 4/8 4/10 5/10 7/11 8/7 8/18 9/4 13/7 14/22 15/14 16/5 16/20 21/5 22/5 25/19 30/20 40/11 40/17 43/13 43/22 44/4 44/21 44/25 45/2 45/13 48/2 50/2 52/9 52/12 56/2 57/24 58/1 58/13 59/18 60/13 70/16 70/22
your [20] 5/2 13/1 14/1 15/1 22/16 24/12 28/3 28/10 29/13 32/8 32/9 33/1 33/2 35/24 42/12 42/19 50/16 59/2 59/17 60/1
yours [1] 34/12
yourself [2] 3/3 36/17

Z

ZOOM [8] 1/11 2/15 4/14 64/8 64/17 66/22 67/16 68/6