CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
OPTOMETRIC
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
February 12, 2026
1:00 - 1:45 p.m.

Theresa Prokop
Certified Voicewriter

A P P E A R A N C E S

BOARD MEMBERS:

Dr. Matthew Burchett, TAC Chair
Dr. Steve Compton
Dr. James Sawyer
Dr. Gary Upchurch
Dr. Jason McCloud (not present)

MS. WASH: Okay, Dr. Burchett, this is Barbara Wash again, and it is 1:00. And no, I do not see Jason, but you do have Steve Compton, James Sawyer, and Gary Upchurch. So I think you'd meet quorum.

DR. BURCHETT: Okay. Well, if we've established a quorum, then I guess let's just get rolling to save everybody's time here.

I guess welcome to 2026. I am Dr. Matt Burchett from Richmond, Kentucky, Chair of the TAC.

I guess since Steve got tired of it, I have recently been appointed as the MAC representative too. So just to let you know what's going on with me and things like that.

As you say, we've got Dr. Steve Compton, Dr. James Sawyer, and Dr. Gary Upchurch on the call with us as well for the TAC.

I'm sure that we have a plethora. I can't see but a few people on my screen here, but I'm sure we have a plethora of attendees from the various insurance entities and from the department. So, do we want to go through and introduce everybody or just kind of get

rolling with the meeting? It doesn't matter to me either way if everybody wants to say hi.

Let's do that, because sometimes people change, and we haven't been on for a while. So let's do that. Who all's here?

MS. ELLIS: Hi, this is LeeAnn Ellis with March Vision.

DR. BURCHETT: Hey, LeeAnn.

MS. ELLIS: Hi. I'm the Kentucky Provider Relations Advocate.

DR. BURCHETT: Good.

MS. SANDLIN: Hi, this is Meranda Sandlin. I'm with Avesis, and I'm the Vision PR Manager.

DR. BURCHETT: Hello.

MS. LAWSON: This is Jesse Lawson. Director of Client Services for March Vision.

MS. MEDINA: Hi. Good afternoon. This is Christina Medina, the Associate Director at EyeQuest. And I am accompanied by Dr. Cummings, who is our EyeQuest Medical Director for Kentucky.

DR. BURCHETT: Hello.

MS. WRIGHT: This is Nicky Wright. I am the Senior Account Manager for Kentucky

with March Vision.

MARCH VISION REPRESENTATIVE: Hello. This is Vicky. I am also with March Vision Care. An Account Manager for Client Relations.

(Muffled speaking)

MS. VALL: With UHC.

MR. NYARKO: Good afternoon. My name is Mark Nyarko. I'm with Well Care of Kentucky.

DR. BURCHETT: Hello, Mark.

MS. TOLL: Cynthia Toll, and I'm on for DMS.

MS. VALL: And this is Tina Vall. I'm with UHC.

DR. BURCHETT: Good. Good. Anybody else out there?

MR. DEARINGER: Hi, my name is Justin Dearinger. I'm the Director for the Division of Healthcare Services in the Department for Medicaid.

DR. BURCHETT: Hey, Justin.

I think you're on mute, Wesley.

MS. PENN: I'm so sorry. Let's try again. I am in the Division of Physical

Management. I'm a Branch Manager for the Financial Management Branch. Great to be here. Thank you.

DR. BURCHETT: Thank you.

MS. WRIGHT: We also, for March Vision, have Jennifer Hicks on the line. She is the Associate Director of Provider Relations.

DR. BURCHETT: Okay. Good. Well, anybody else we're forgetting? If not, we'll get moving.

(No response.)

DR. BURCHETT: Okay. Well, hearing none, thank you everyone for taking time out of your day to be here and try to get some things moving forward with the Optometry TAC here.

And with that, I guess you have all seen and read through the minutes of the last meeting. I know it's been a while back, but any changes needed there, we think?

(No response.)

DR. BURCHETT: If not, I'll take a motion to approve the minutes from the last TAC meeting.

DR. SAWYER: So move.

TAC MEMBER: Second.

DR. BURCHETT: Good. With that, any discussion?

(No response.)

DR. BURCHETT: Without any, then all those in favor approving the minutes for the last meeting, say aye.

TAC MEMBERS: Aye.

DR. BURCHETT: And all those opposed?

(No response.)

DR. BURCHETT: Hearing none, then we'll say that the minutes were approved from the last TAC meeting.

Just like we always do, going down the list, old business. I don't see that we have any. Is there anything out there that we've forgotten to mention that comes to mind for you guys before we move on to the new business items?

(No response.)

DR. BURCHETT: I couldn't think of any off the top of my head when we were putting it together, so hearing none, we'll

just move on to the new business.

The first order of business is the March Vision Molina. We've had -- and I think this came from one of our TAC members, Jason, if I'm not mistaken.

Sarah, you can correct me on that if I'm wrong, but, anyway, we just need to have an explanation of the process for applying for additional glasses for a child through the EPSDT program if their benefits have been exhausted.

I'm sorry, that was Mary Beth Emmick, a member of KOA that sent that in to us. Not Jason.

MS. LAWSON: This is Jesse with March Vision. I can provide an overview of the process for UHC, and then I'll hand it over to Molina if they want to outline their process.

For March Vision, for United providers we need to contact the March Vision customer service for a clinical review. And then from there, our clinical team would review the case and reach out directly, work with the health plan for approval.

Once that's approved, we would update our system and forward all the information to customer service, who would then reach back out to the provider to confirm the approval and get billing instructions.

And then once that claim is received, March Vision would move forward with processing the claim.

DR. BURCHETT: Okay. Now would that be much like a prior authorization, I assume?

MS. LAWSON: Yeah, very similar.

DR. BURCHETT: Okay.

MS. LAWSON: Any questions on the United side before I hand it over to Molina?

(No response.)

MS. LAWSON: Okay. If there are any questions at any time, definitely reach out and we will provide that.

DR. BURCHETT: Sure. Molina?

(No response.)

DR. BURCHETT: Did we have a representative from Molina on?

(No response.)

MS. WASH: I'm looking through. Again, this is Barbara from DMS. I don't know

if I see anybody here from Molina.

DR. BURCHETT: Okay. Well, and I'm --

MR. PLEASANT: This is Sean Pleasant. I am on. I will make sure to get this back to leadership. I was asked to fill in, so I will go back and get a response to your question, Dr. Burchett, and get that submitted to you.

DR. BURCHETT: Okay. That's fair. I am going to ask Sarah Unger if she -- I think she's on, to -- we want to know the process for each individual group, because I think Dr. Emmick, if I'm not mistaken, tried to apply for the EPSDT and was told by each group that it was the other group that was supposed to be handling it. I could be mistaken in that, that's why I'm going to ask Sarah to speak to that if she could.

MS. UNGER: This is Sarah. Can you hear me?

DR. BURCHETT: Yes.

MS. UNGER: Okay. Hi, this is Sarah Unger with the Kentucky Optometric Association. I had sent this to the TAC, and

if LeeAnn Ellis wants to talk with March as well, because I know she and I communicated with this, but, Dr. Emmick went back and forth. And I know I helped as well. I know LeeAnn helped as well, between March and Molina, and I know March said Molina was responsible, and then Molina was saying March was responsible, and this went on for a great amount of time.

And I think we even reached out to DMS, and I think it was told, I'm just saying, this process needs to be clarified, because in the end, the children, there was like two or three children that had exhausted their benefit.

I think this started back in October, November, and so the office ended up -- they had broken their glasses again. And the doctor ended up paying out of pocket for these glasses, because they never could get it resolved for the childrens' eyewear.

So I would just stress that we figure out what the process is, because if this is one office, I assume others are discouraged as well, trying to help these

children who are vulnerable and need their glasses. And this is the group that you would think EPSDT is there for, are the ones that need their glasses and they're broken.

So if we really can have Molina or March please get back to us on the proper process, really greatly appreciate it.

DR. BURCHETT: Thank you, Sarah.

MS. ELLIS: Hi, Sarah. It's LeeAnn. I am -- as you just said, you and I have communicated on this, and there are three children that we are aware of that are needing the materials.

I'll be reaching back out to the office today. I reached out two days ago to Christina and let her know that I was awaiting some more information, but we will make sure that the members have their materials.

And I will follow up with any additional information I receive on the process as well.

MS. UNGER: Thank you, LeeAnn. And I know you've helped with this whole process too. So I really appreciate your help, because I know you can only go so far also

until someone tells us exactly how the process is supposed to work. But the provider should not have to eat that out of their pocket when the children can't see and they need their glasses. So I appreciate your help. Thank you so much.

MS. ELLIS: Absolutely. Yes, my pleasure.

DR. BURCHETT: Yes, thank you, LeeAnn for that. We appreciate all the help you provide. I know you provided our office help several times on other things too. So thank you for being a good resource for us.

MS. ELLIS: Thank you.

DR. BURCHETT: You're welcome. I just wanted to throw in on this too. In talking to one of my billing clerks, we have a couple offices in Appalachia where we have people with somewhat special needs, but somewhat with high prescriptions, usually are the ones that seem to always be the ones that always break their glasses frequently.

Historically, we have tried since the MCOs have come into Kentucky to help manage the Medicaid population, to get EPSDT

benefits, and we were always told, fill out the prior authorization and they will be approved and then we can do it.

Well, initially, we always had trouble getting the prior authorizations approved, and then finally, we figured out what they hang up was there with everybody. And this goes across all the MCOs that we've been dealing with since the inception.

But the problem lies in, for us, we get the prior authorizations approved, but when we send them in to bill, we always are denied payment because it says that benefits have been exhausted. And when we ask, it says, yeah, we approved the prior authorization for them, but having a prior authorization does not guarantee payment.

So, for the last two-and-a-half, three years, we've quit doing EPSDT at all, and we're just footing the bill on all those glasses that come through. And it's a fair number.

So I would ask the department, what's our recourse if we follow the steps, get the prior authorization approved, and then

they deny payment for the EPSDT glasses?

MS. WASH: Dr. Burchett, this is Barbara Wash in DMS. Justin has his hand up. I think you might want to address that.

DR. BURCHETT: Sounds good.

MR. DEARINGER: Thank you. I absolutely do. So, I would like to know about it. So, you could send that to -- let me put an inbox here in the chat.

DR. BURCHETT: Okay.

MR. DEARINGER: And I don't know if there's anybody from health plan oversight on the call. Barb, Danni, do you all know?

I didn't see anybody, but Danni, will you please make sure to get with Chelsea after this meeting, and I would like for each of our MCO partners to put together their process and steps for applying for glasses for EPSDT services beyond a second pair.

MS. DAVIS: I'll do that.

MR. DEARINGER: And I want it to be detailed. And let's get them to have that to us by -- what is today? February 12th.

MS. WASH: Justin, Jeremy just got on. Just came on.

MR. DEARINGER: Hey, Jeremy. Thanks for joining. I appreciate it.

We're going to ask our MCO partners if they can get us a detailed process and explanation of how our vision providers in the state of Kentucky can apply for EPSDT -- or through EPSDT services for additional pairs of glasses for children above the two that they are allowed for through state plan services.

So if each of those entities could do that, each of our managed care organization partners could get us that. And if they could get us that, Jeremy, by I don't know, like February 27th, I think that would be appropriate.

And then we'll get Danni to send that to all the members of this committee. Does that sound something that would be doable, Jeremy?

MR. ARMSTRONG-DEROSSITT: Hey, Justin. Yes, absolutely. We can seek the due date of that 2/27 and get that information.

MR. DEARINGER: Wonderful. And if you have a -- if you, anybody on this call or you hear from any of your other vision

providers that have an issue where you have sent in -- and just this specifically -- please don't send me something if you haven't billed it correctly or if they are asking you to do some type of modifier.

DR. BURCHETT: Right.

MR. DEARINGER: But if you have something where you have an approved prior authorization and they deny it because they have reached the limit, and you're trying to bill through EPSDT services, please submit that through that e-mail, and then I will get with Jeremy and we'll figure out what's going on. Does that sound like a plan?

DR. BURCHETT: That sounds good, Justin. I appreciate that. And in that, I would also ask, not just the process to get approved for it, because we've been approved numerous times, but past approval, submitting it for payment, is there anything special that we need to do that maybe we weren't doing. That kind of stuff.

MR. DEARINGER: Perfect. Does that make sense, Jeremy? Okay. Thank you.

DR. BURCHETT: Thank you.

DR. BURCHETT: Any of the other TAC members have anything to add to that particular point?

DR. COMPTON: Matt, Steve Compton. I'll just add that we quit trying to get approval. We haven't done that in a long time because it's just too much hassle.

DR. BURCHETT: Yeah. I mean that's what --

DR. COMPTON: No results.

DR. BURCHETT: Well, that's the same with us. You know, like I said, for two or three years now we have done the glasses and just given them to them, but because we'd get approval and then they would say they'd reached the limit. I mean, I can go back and see if we can recapture who some of those people were too, but, like I said, we don't have an example in our office, because we quit two or three years ago because of the hassle.

MR. DEARINGER: Yeah, any examples you might have. I mean, for me, that's extremely frustrating and disheartening. But that's why we have these TACs, so we're going to get that fixed.

DR. BURCHETT: Sounds good. We appreciate it.

MR. DEARINGER: There's no excuse if everything is billed correctly and all the processes are followed and steps are followed.

And again, each MCO may have their own procedure. They may have their own modifiers they ask for. They may have their own codes they ask you to bill, but if you follow all of those, there's no reason why you should not be getting payment for those. So, we can go back as far as we need to, to make sure to get this corrected and rectified.

DR. BURCHETT: Well, I'll check in with my billing staff and see if we can have some of that. Thank you, again, Justin.

MR. DEARINGER: Absolutely. Thank you for bringing it to our attention.

DR. BURCHETT: Moving on then, the next one is EyeQuest. And this one's yours, Steve, I think.

DR. COMPTON: It is.

DR. BURCHETT: If you want to speak to it, and then I've got something else to add for EyeQuest, but anyway, go ahead.

DR. COMPTON: Just curious if there's an option to opt out of using EyeQuest optical lab and use our own lab, like we do that with the rest of the MCOs, but I am told by my optical staff that that's not an option. And I just wanted to confirm if it is or isn't. And if it's not an option, why not?

DR. BURCHETT: Anybody from EyeQuest on would like to answer that, please?

MS. WASH: Dr. Burchett, I'm looking. I don't see anybody on.

MS. MEDINA: Hi, this is Christina from EyeQuest. And Dr. Cummings is on. I'm not sure if you saw his comment in the chat. I guess he was speaking and nobody can hear him.

Absolutely, we do have that option, offer that option for, you know, to opt out of the optical lab. You know, for those that have the ability to, you know, do their own glasses.

Dr. Cummings, are you able to -- let's see if he got his audio working again. Well, we definitely do have -- oh, there you go. I hear you now.

MR. ARMSTRONG-DEROSSITT: I think that might have been me. This is Jeremy with DMS.

MS. MEDINA: Oh, sorry.

DR. CUMMINGS: Can you guys hear me?

MR. ARMSTRONG-DEROSSITT: There he is.

DR. CUMMINGS: You got me?

MR. ARMSTRONG-DEROSSITT: Yes, sir.

DR. CUMMINGS: Okay. Sorry about that. I'm not used to the Zoom calls.

Yes, we can definitely offer a provider supplied eyewear arrangement. Now, it would require recontracting, and so, we would just need to set you up with our provider services team, and then you would have to attest, you know, that you have a certain amount of frames that you can offer to the member at no cost. You know, there's some criteria there. So that's not an issue at all. We've just got to link you up with provider services.

DR. COMPTON: Re-credential, is that what you said?

DR. CUMMINGS: Recontract.

DR. COMPTON: Recontract. Is that like for two months we don't see patients until that paperwork goes through or does that work pretty smoothly?

DR. CUMMINGS: Timing wise, I don't know if I can speak to specifics on that, but you guys can definitely see patients. That's up to you, but until you are recontracted and can attest to meeting that criteria, you know, I don't know how we could work around that.

MS. MEDINA: Yeah, so from the operations perspective of it, you know, we do have that where we backdate it, so we will, you know, from the moment that we receive those documents, go ahead and honor that at the effective date for that new agreement. And we tend to wrap those up within 30 days. It's usually sooner than that, but it's always backdated to the date that you submitted the documents.

DR. COMPTON: Okay. Thank you.

MS. MEDINA: Yeah. No. Absolutely. You don't have to hold up care to get the load process in.

DR. CUMMINGS: Thank you, Christy.

DR. COMPTON: All right. Thanks.

MS. MEDINA: You're welcome.

MR. ELLIS: I had my hand up. Can I --

DR. BURCHETT: Go ahead, I'm sorry.

MR. ELLIS: No problem. This is Herb with Humana. Let me lower my hand.

And I was trying to get off mute on that prior issue about additional glasses. I noted in our policy, we do obviously cover additional glasses through the EPSDT. So if you're seeing that issue with Humana, absolutely send that to me so I can figure out why that's happening. But there shouldn't be any reason why they can't get additional glasses through EPSDT.

DR. BURCHETT: Okay.

Coming back around. This just came to my attention two days ago for EyeQuest. In one of our Appalachian offices, we have a little guy. He's eight years old. He's had congenital cataracts removed, I think, from what the provider told me. But his prescription is plus 14, minus three cylinder, and he's always been in a progressive bifocal

ever since he's had glasses, from what I've heard.

I've not seen the child myself. But our optical manager has been in contact with EyeQuest lab, and EyeQuest cannot make that prescription for him. They said they are not capable of making a lens that strong. And they looked and they worked. And I'm not trying to come down on the lab, because the lab did, they worked really well with our staff trying to get this kid taken care of. But at the end of the day, they said they cannot do a lens that strong for him.

And so, we can, out of the lab we use for our glasses, do that, but we were told that if we did the lens, it wouldn't be reimbursed to us because we are not, of course, contracted to do glasses out of our lab.

So, once again, it's a situation where a kid needs something that can't be provided, apparently, through the normal channels, and we're going to do the lens for the kid, because plus 14 minus three, a kid needs to see, but once again, that's something

that we are going to eat the cost on, which I don't care to, because I like for kids to be able to see.

But I just wondered, since we were told that we had no recourse for reimbursement for that, is that wrong? Do we have an avenue that that can be reimbursed to us since we can't do it?

MS. MEDINA: Absolutely, actually. So, you know, obviously, this is a very -- I don't want to say isolated case, but it is not a common occurrence, right?

DR. BURCHETT: Right, I agree with that.

MS. MEDINA: Yeah, so, and not just here. In a lot of these types of situations, right, where it is unique and you know, for whatever reason, you know, the lab or, you know, one of the providers aren't able to provide the necessary services, we can engage in what we call like a single case agreement. You know, just, you know, to ensure that you can get reimbursement for those services kind of outside of the scope of your current contract.

So, you know, just a little bit more documentation, but at the end of the day, absolutely, you know, it's never the intent to, you know, be a barrier to care. And this is just one of those situations.

And so we have a process to kind of account for, for these one-off cases. And we can go ahead and send that contact information, you know, to the group so that if something, you know, obviously so we can handle this case or if anything else were to come up in the future, we can go ahead and leverage that process to kind of handle it a little bit more proactively.

DR. BURCHETT: That would be great. I figured there was something in place, but in talking to the lab after we figured that it was something they couldn't do, they said that they didn't think there was a way for us to seek reimbursement for us doing it. So that's where I was going with that.

MS. MEDINA: Yeah, and they might have just --

DENTAQUEST REPRESENTATIVE: -- in the chat so that they can get the member

information?

DR. BURCHETT: I'm sorry.

DENTAQUEST REPRESENTATIVE: Can we get your contact info so that we can get the member info?

DR. BURCHETT: Yes.

DENTAQUEST REPRESENTATIVE: Okay. Thank you.

DR. BURCHETT: Let me pull that up.

MS. MEDINA: Yeah, and I think just the lab might have -- they are not too close to that process and probably didn't want to, you know, misspeak, so I think that's probably where a little bit of that disconnect is.

DR. BURCHETT: Yeah. That's fine.

DR. CUMMINGS: Yeah, I'd like to personally look into that. I don't like hearing that a member's not taking care of and a provider's not taking care of.

DR. BURCHETT: Well, and like I said, I don't think it's the labs fault in particular. They weren't unhelpful, they just said the power of that lens they could not do. So that was where it was.

DR. CUMMINGS: I understand.

DR. BURCHETT: I just sent my e-mail in the chat.

MS. UNGER: So this is Sarah with the Kentucky Optometric Association. So, if the lab -- I just request that maybe that EyeQuest to go back and actually talk to the lab and say, when they have those type of issues, that maybe the lab reaches out to EyeQuest personnel also and say, hey, we've got this patient. I don't know how closely you all work together, but I think that would be helpful also if you all can take that back, so that they report those high indexes to you all, so that you can help take care of it even if it is that you have to go to a different lab or the doctor does it in-house. I don't know if that would be helpful or not.

DR. CUMMINGS: No, I totally agree, Sarah. Totally agree.

DR. BURCHETT: Okay. Thank you all for that.

Moving on, the next item looks like it is on Avesis, and this was from Dr. McCloud. Did Jason ever get on the call?

MS. WASH: Dr. Burchett, I still

don't see him on here, unless he's on a cell phone. I don't see him on here.

DR. BURCHETT: Okay. That's fine. I always just like the doctor, if it's one of ours, that can speak to it a little better than just us kind of talking about it.

Anyway, it says, when an internal quality review to analyze previous process claims to ensure appropriate processing occurs with Avesis, it says it will show on a current claim report. Is there a way that the claim is only showing up on the current claim for review since it has already been paid?

MS. SANDLIN: Hi, this is Meranda with Avesis. I know that Dr. McCloud isn't on right now, but I do want to thank him because he did send over an example to us to review.

DR. BURCHETT: Okay.

MS. SANDLIN: And had worked with Sarah as well. So, just to kind of recap, our system does run some internal reviews. We call those resubmissions. We run those on claims at random, and also as a member's coverage changes just to make sure that that claim is adjudicated appropriately.

When those processes -- was there a question?

Okay, when those processes happen, those do show on the next EOP that the providers receive, with the same claim numbers. That claim number doesn't change.

And it does list on there any previously paid amounts. And there is also a net pay for that particular run if there were any adjustments. If there were no adjustments, it would show $0 under net pay for that reprocessing.

So we do provide all the indicators that are required by the plan on the EOP, but there's not a special one that is called out that is was a resubmission on our side.

DR. BURCHETT: Okay.

Sarah, do you think that answers Jason's question?

MS. UNGER: I say maybe you keep it under old business so that if Dr. McCloud is on next time, he can respond to it, if that's okay with everybody.

MS. SANDLIN: Sure. And I can also reach out to Dr. McCloud and let him know that

this came up during the meeting today, and just give him a little bit of a synopsis and see if he has any additional questions as well.

DR. BURCHETT: That would be great. That would be great.

And, I guess the next item is also for Avesis. It looks like during a time of recredentialing, letters were sent to patients stating the provider is no longer a provider for Avesis Medicaid.

Many instances when the recredentialing is fixed, the patients are not notified by Avesis that the recredentialing issues were resolved.

So we would like to request an option for providers to request additional notices be sent to patients by Avesis that the provider is once again credentialed with them.

MS. SANDLIN: Sure. This is Meranda again. Those member termination letters, those are triggered once a provider is termed in our system. However, it's not part of our process to send those letters out if we are aware that that provider is actively working

on sending updated information to us due to that failure to recred term.

So if someone has some examples that they can send to us, we are more than happy to take a look at those and address those, and potentially work to send out those letters.

DR. BURCHETT: Sarah, did you have an example of that?

MS. UNGER: Yes. And I can send it to Meranda.

DR. BURCHETT: Okay. Thank you. I couldn't remember -- I was going to say I could remember who that was that had that issue.

MS. UNGER: Meranda, it's Dr. Dwight Avery.

MS. SANDLIN: Okay. Sorry. Sarah, I didn't know that that was you speaking. Yeah, Sarah, if you want to send that over to myself or the Kentucky provider mailbox, I can definitely take a look at that and see what happened there and see if we can work with them to get letters.

MS. UNGER: Will do.

DR. BURCHETT: Thank you.

Moving on, the next item it looks like for DMS themselves. With all the changes that are possibly coming out there, we just had a few questions that hopefully maybe you can address. Request that DMS review the possible process rules of cost sharing and co-payments for Medicaid patients under the Big Beautiful Bill.

And some questions that we have, of course, it's listed there, but which Medicaid patients would be excluded from having to pay co-pays? And if a Medicaid patient comes to an office and decides not to pay the co-pay, does the provider still have to provide the services or materials to the patients?

And our example there would be, would an office have to order or release glasses or contacts if the patient does not pay the co-pay?

And I will add too, and I know sometimes our hands are tied with whether or not some of these things happen, but when we had a $2 co-pay several years back, I can tell you that zero patients paid the $2 co-pay. Which is just, you know, cutting our fees for

one, but also it hinders service, because when we start asking them or reminding them that they have a $2 co-pay, patients quit coming in, because they didn't want to have to say, well, I don't have the co-pay.

So, anyway, any clarifications that could be given there from the department, we would appreciate it.

MR. DEARINGER: Sure. Hi, this is Justin Dearinger. I wanted to start by saying that it's February, so it's early. We do not have full direction from CMS on the implementation of HR 1. We are working to obtain that.

We have submitted a large document full of questions. As have all the other states. So we are all awaiting CMS's direction on exactly how to implement this. And, you know, how to proceed.

So, we will have a very extensive training and outreach for our providers as soon as we have everything from CMS.

In addition to that, as you all may or may not know, there is current legislation, in our Kentucky state legislature, House Bill

2 would be an example of that, that also changes what is in House Resolution 1 adds to it.

And so we have to wait until this legislative session is over and that statute has been codified to kind of put all that into place as well.

So, a lot of unknowns. A lot of uncertainty. For right now, when we look at House Resolution 1, it exempts enrollees that are not enrolled in the Medicaid expansion population. It exempts anybody below 100% of the federal poverty level. It also exempts members that are receiving primary care services, mental health services, substance use disorder services, services provided by FQHC or behavioral health clinic or rural health clinic.

There is also some exempt Medicaid members if they fall under like individuals under the age of 18 would be exempt. Pregnant women receiving pregnancy services would be exempt. Terminally ill individuals receiving hospice care. Individuals in an ICF, intermediate care facility. Individuals

receiving emergency services, and American Indians and Alaska natives that were receiving Indian Health Services.

So all those people under House Resolution 1 would be exempt from that.

Now, HB 2, House Bill 2, which is in our state legislature currently, again, that is subject to change, and will probably change many times, if it is adopted. It may or may not be.

If it went into effect today, the way it's written, it would -- there would be additional cost sharing provisions for a lot of the list I just mentioned. For anybody that exceeded 100% of the Federal poverty level. Although, again, there are some of those individuals like the ones I read there at the end that would still be exempt under federal law. But a lot of the other ones I mentioned in the front would not be, according to that house bill.

So, that's kind of the answer to the first question.

The second question -- again, it's just still up in the air.

The second question about co-pays, House Resolution 1 leaves it up to the state on whether the state requires providers to see the patient regardless of whether they pay the co-pay are not. So that still has not been 100% decided. We do have that option.

Or we have the option of allowing providers not to see the member if they can't provide that copayment. So both options are on the table in House Resolution 1.

I think the state of Kentucky hasn't made a definitive decision on that one. It will be up to Kentucky to decide whether to implement that part of it.

There's nothing in House Resolution 1 that talks about the amount of the copayments, however, and House Bill 2, again, if it was to go into effect today as currently written, there would be an $8 co-pay for anybody for glasses and contacts. And then I don't remember exactly the price for just the visit, but for glasses and contacts, I think the co-pay was $8 in House Bill 2.

So, again, House Bill 2 is going to the legislative process. It's going to

probably go through several amendments and rewrites.

And House Resolution 1, we have a multitude of questions and clarifications that will come from CMS. And so, hopefully some time, I mean, as soon as possible, as soon as we get those clarifications from our state legislature and from CMS, we will put together all of our provider education materials and notifications, and we will send that out to each one of our provider types on exactly how much co-pay amounts are. If you have to see a patient or you don't have to, collection procedures, all of those types of things.

Cleared everything up? Not at all, right?

DR. BURCHETT: Thanks, Justin. We knew that things are still up in the air, and we just kind of wanted to know if you all had any insights coming up to when things might actually be in place and what it might start to look like. But knowing that stuff is just starting to be helpful, but as soon as we could know that stuff would be great. And I know you all are working to work through all

that.

MR. DEARINGER: Absolutely. We'll try to -- because I think January 1st would be the start date, so we're going to try to get everything to our providers as soon as possible. As soon as we have some definitive answers, we can clarify and move forward.

DR. BURCHETT: Any questions from the TAC? Comments?

(No response.)

DR. BURCHETT: Seeing none, moving on to -- thank you, Justin, once again.

Moving on to general discussion, does anybody have any other items that have come to light?

(No response.)

DR. BURCHETT: Any recommendations from the TAC at this point?

(No response.)

DR. BURCHETT: None?

As I said earlier then, I was appointed the new Optometric MAC representative. And Steve, I have a newfound appreciation for you, I'll say that. I've been to two meetings and it's been

interesting.

DR. COMPTON: Well, it is interesting.

DR. BURCHETT: To see the scope of everything else going on outside just the world of optometry, right?

DR. COMPTON: Exactly.

DR. BURCHETT: Yeah. So. Thank you for your service on the MAC, Steve, I know you've served for several years.

DR. COMPTON: You're welcome. I'm still trying to get off of the e-mail lists. I still get e-mails.

DR. BURCHETT: Well, knowing that, I'll just keep forwarding them to you so you don't feel left out.

DR. COMPTON: All right. Thanks.

DR. BURCHETT: So, next meeting looks like May 7th. Same time. And then August 13th and November 5th is what we have on the calendar here.

So if nothing else is going on, then I will say, we'll see everybody on May 7th. And I'll entertain a motion to adjourn.

DR. UPCHURCH: I make a motion to

adjourn.

TAC MEMBER: Second.

DR. BURCHETT: All in favor?

TAC MEMBERS: Aye.

DR. BURCHETT: Thank you all, once again, for your service. We'll see you in May.

MS. SANDLIN: Thank you. Bye.

(Meeting adjourned at 1:45 p.m.)

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C E R T I F I C A T E

I, THERESA PROKOP, Certified Voicewriter, hereby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 27th day of February, 2026.

Theresa Prokop

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Theresa Prokop, Certified Voicewriter