COMMONWEALTH OF KENTUCKY

CABINET FOR HEALTH AND FAMILY SERVICES

FOR MEDICAID SERVICES

IN RE: DENTAL TAC

EMERGENCY MEETING

HELD VIA ZOOM

DATE:

FEBRUARY 10, 2023

2:00 P.M.

A T T E N D E E S:

Garth Bobrowski, DMD, Chairman

Phil Schuler, DMD

Carol Braun, DMD

Joe Petrey, DMD

John Gray, DMD

(and many more were on ZOOM)

MS. SHEETS: Dr. Bobrowski, it looks like we have three of the five. I have you and Joe Petrey, John Gray. If I've missed anyone, please let me know, but it does look like we have a quorum.

DR. BOBROWSKI: Okay.

MS. SHEETS: And we will turn it over to you.

DR. BOBROWSKI: We do have a quorum. And I guess you have kind of officially done a roll call just now. Will that suffice okay, Ms. Kelli?

MS. SHEETS: (No response).

DR. BOBROWSKI: Kelli, can you hear me okay?

MS. SHEETS: Dr. Bobrowski, we cannot hear you.

DR. BOBROWSKI: Can you hear me now?

MS. LEE: I can hear you, Dr. Bobrowski. Can you hear me?

DR. BOBROWSKI: Yeah.

MS. LEE: I can hear you.

DR. BOBROWSKI: Yeah. Okay. All right.

DR. SCHULER: Yeah, I hear you.

DR. BOBROWSKI: Okay. Well, we'll call our

meeting to order of the Dental TAC. And this is Dr. Garth Bobrowski and I wanted to welcome everyone here today. And we want to -- hopefully, we have a very good and interesting meeting. And I just kind of wanted to kind of start us off -- and I've got just a brief report that I wanted to share with you-all. It's more or less as an example of things we can look at doing to help in a mechanism of preventive care, which could mean -- well, like doing fillings on teeth, help the patient, number one. Number two, I think it does help to minimize the cost to the state on future root canals and crowns and maybe even partial dentures down the road. The treatment of gum disease, the same thing. And I think I've mentioned this before at some meetings, but just the -- you know, dentistry is kind of in the -- well, I've got it down here on the report here. We are kind of in the healthy smile business and we -- a lot of the dentistry down here is, you know, we are trying to build a healthy foundation, you know, by treating

cavities, gum disease, occlusal disease, replacing teeth -- maintaining teeth positioning, but, you know, we want to try to help people. And I just wanted to -- was reading an article and other articles, but this one kind of caught my eye about the association of periodontal or gum disease with other systemic condition. That's the title of the article. It was a by directional relationship with other health issues. Kind of related to how the oral health relates to diabetes, rheumatoid arthritis, heart disease and other oral -- other related health issues related to oral health. This article came out of the National Center for Biotechnology information in association with the National Institute of Health through the National Library of Medicine and, also, in association with work being done by Boston University School of Dental Medicine.

One of the -- and I want to try to be quick and brief on this, but just to give you an example on things, but part of the article talked about probing depth is a good

indicator of the advance of the disease of gum disease. Of course, dentistry, also, you have to look at the X-rays. You look at the color texture of the tissues. You know, you count in the fact, are they diabetic or have other health issues that could advance the disease. This was a new item that they put out in this article, was this -- that clinically patients with periodontal pockets of four millimeters or more are now to be diagnosed with periodontitis. The gold standard used to be the five-millimeter pockets. And in some circles, it may still be five millimeters. But my question is, is why do we wait until there is bone loss to start treating this common disease?

Some form of periodontal or gum disease affects 75 to 90 percent of the global population. My wife said the other night -- I was kind of reading some of this to her, and she said, that's gross. And it can be. But left untreated, gingivitis progresses into an irreversible periodontitis, resulting in tooth loss and gum abscesses. And, again, we just -- we

got to stress it, we are in the healthy smile business and, you know, we want to just try to get people healthy.

Now, this is just an idea that I had on starting to treat gum disease in our Medicaid population, is to -- and I was looking at some of the criteria on some of our MCOs. And, you know, their -- some of their criteria is spot on. It's really good. But my idea would be to develop a -- with our patients, a one-year plan of action that the patient would sign as a treatment agreement. Now, you know, they will do -- I guess the signature would mean that we are trying to get them some buy in on their care. You know, this care would obviously include a full mouth X-ray series, periodontal charting, hard and soft tissue exams, diet, smoking counseling. And I think we need to add in a behavioral health component. Now, if this agreement is done, you have got your charting, but that -- to alleviate some of the paperwork that a lot of the dentists and dental offices have to go through is that if they are in this

agreement and sign this document, well, then no preauthorizations would be required through the MCOs or the fee for service patients. We would continue to use the same scale, root planing, appropriate codes like your D4341s and 42s, but we would also need to look at a robust code or adding a code in of a D4345, which is a full mouth debridement to enable an exam. Now, sometimes that examine I think is just used for pregnant lady. But when you deal with young people that come in and they have acute necrotizing ulcerative gingivitis, these people are sick. They have a fever, malaise, they are hurting, they can't eat, they don't feel well. And sometimes -- sometimes before you can even get your probe in -- well, number one, I wouldn't even start to probe somebody that's got this acute necrotizing ulcerative gingivitis. They can't stand it. But anyway, to look at this full mouth debridement, just to help them get out of pain and the disease process, starting to cure it, add in a code of D4921, gingival irrigation with a

medicinal agent, add in the code D4910, which includes -- which this would include a cleaning every three months for one year. This is a one-year plan.

Another behavioral component of this would be that the plan would have no failed appointments by the patient. And after one year, to reprobe and do a reevaluation of -- to see if those periodontal measurement numbers are getting better.

Now, other codes and some of these that I have already mentioned, they have already been added this year, but others could be added to just let us -- or just help us treat this disease.

Now, you know, an idea that I had, too, is, you know, instead of getting patients just to walk in the door and give them a gift card, let the patient earn that gift card now, after they have completed that year plan. Not just for showing up, but just to give them that reward, you know, if they complete the treatment plan. Also, I would recommend pay your providers a descent and fair fee, you know, that the MCO

can't go below. We have got to do some changes to move Kentucky from the 49th in the nation on oral healthcare. We got to move that up. We've got to do something different and we've got to just change the attitude of oral healthcare, you know, whether it be with administrations, administrators, the dentists, the public. And this is something that you don't do overnight, but just -- we want to just help our patients help us treat the disease. Now, that's -- I just want to give just some ideas of trying to get us out of this 49th position in American. I just put that out there as an idea and it -- it can be ignored, it can be modified -- and I know most ideas tend to get modified and that's okay, but I just want to get to us start thinking about ideas that we can do to move from 49th on up. I'll guarantee you, it will take a while to get to number one, but we got to start somewhere.

Now, are there any questions or comments about that brief report?

(No response).

DR. BOBROWSKI: I'll move on.

Now, I want to go to old business. And I put on the agenda, I said, please, don't shoot the messengers. Sometimes I feel like we as TAC member -- TAC members are -- you know, we bring questions from our self. We bring questions from a lot of our patients. We bring questions from other dentists and other healthcare providers that we need to bring before you and let the TAC look at it. And then make some resolutions to go before the MAC.

The -- and I wanted to, again, thank the Commissioner Lee, you know, for working with the TAC and others, and other groups to, you know, help increase our access to giving care. It is very well appreciated as she, you know, listens to us and has these concerns that we do.

One thing -- and I know -- I think the Commissioner said that she may have to leave early. And before I get into a lot of this other, I'd like to have the time if Commissioner Lee would like to speak now or after while, either way. So Commissioner,

would you like to have the floor for a few minutes?

MS. SHEETS: Dr. Bobrowski, this is Kelli Sheets. I'm sorry, the Commissioner did have to step away already.

DR. BOBROWSKI: Okay.

MS. SHEETS: So I apologize.

DR. BOBROWSKI: Okay.

MS. SHEETS: You also need to make sure you approve the minutes from the January Emergency Meeting and the November 4th meeting, so just a reminder of that.

DR. BOBROWSKI: Yes, yes, thank you so much.

MS. SHEETS: You're welcome.

DR. BOBROWSKI: Why don't we do that right now. We've got a quorum for our TAC members. Let me write this down here. Let me make a note here. Okay. Well, I'd like that just for the TAC members, I'd like to entertain a motion to approve the minutes, you know, from the November TAC meeting, and then also from the January meeting.

DR. PETREY: I second the motion.

DR. SCHULER: Did you do motion made first?

Yeah, that's okay. I'll make a motion to accept the minutes from the November meeting and the emergency January meeting. And, Joe, you can second or somebody.

DR. PETREY: Second.

DR. BOBROWSKI: All right. Thank you, Guys. All in favor say aye.

(All respond aye).

(Jean is in here, too)

DR. BOBROWSKI: Any opposed?

(No response).

DR. BOBROWSKI: Okay. I believe we got that, but I'm going to go on down. The -- we kind of wanted to look at the codes and reimbursement rates a minute here. And, boy, I hate to admit this, but I spent hours of time just going through the new 2023 FFS Fee Schedule. And I even expanded it out into Excel and I was making some -- you know, there was some typos in there. I was just going to go through and see what I could do to be helpful, and spent two or three days on it, several hours each day going through things. And I've got it all -- I sent it to the TAC and I sent it

to Commissioner Lee. And then somebody else later on said, well, where's your stuff? And somehow, I guess when I sent it, columns on me and then it stuck everything at the very bottom of the report instead of lined up with each code number. And it's -- you know, when you work on something like that for hours and hours and, boy, just -- and then that happened, and it just took the wind out of my sail. And it just like took somebody took my face and shoved it in the mud hole. But it just -- anyway, we are going to work on trying to update that and -- but I would encourage all the TAC members to kind of look over that fee list. And, of course, there's some typos in there that were in the previous years that just kind of got carried over. But I think since this is a state document, we can update it and...

At this time, I want to look at our -- I've got it on the agenda as old business of your fees and reimbursements. One of the things I noticed -- and I've already made the Commissioner aware of this when I sent

all this stuff in previously, but there's even some codes in there like a D2394, which is a four-surface composite filling code. There was nothing listed down in the new fee list. When I went back and compared it some of the older lists, it was there, but those are some things that we just need to tidy up our list. And if our TAC members could look at those and just see what else we could help work on that.

Now, TAC members, does anyone else have any comments on the fees and reimbursements so far?

TAC MEMBER: (Inaudible).

DR. BOBROWSKI: Whoever just spoke, I could not understand you. It was muffled.

TAC MEMBER: (Inaudible).

DR. BOBROWSKI: Okay. I still could not hear that. Can anyone else hear it better?

DR. SCHULER: I cannot hear it at all.

DR. BOBROWSKI: Okay. Phil, Dr. Phil, did you have any other comments so far on fees, reimbursements?

DR. SCHULER: Well, I know there's some confusion about some of the fluoride codes

and, you know, having to wait a number of weeks after we do a fluoride, but I think there was some confusion as to which fluoride codes we were looking at. I think one was diamine fluoride, which you don't want to do diamine fluoride on a tooth and then, you know, restore it, you know, a week later. But, you know, some of these -- some of the full-mouth fluoride treatments, there shouldn't be a restriction on doing restorative, you know, after that for -- I think the restriction was three months, if I remember correctly. And I don't have the code numbers in front of me. Sorry.

DR. BOBROWSKI: Let me see. I can look it up here.

DR. SCHULER: You know, there was a waiting period after restorative after fluoride treatment, which didn't make a whole lot of sense to me.

DR. BOBROWSKI: On the --

DR. SCHULER: And I had -- and I had the same question about the four-surface posterior composite missing.

DR. BOBROWSKI: On the fee list that I got up here, this was revised January 30th. On the fluoride there, I don't see anything. Are you finding that, Dr. Phil, in the MCO manual?

DR. SCHULER: No, I think it was on the one that was from -- I think it was it -- it may have gotten cleaned up on the next version.

DR. BOBROWSKI: Okay. It just shows on the fluoride, they say the exact same thing, whether it be a fluoride varnish or a topical application of fluoride. It's just limited to two per 12 months per member per provider. And that's the same -- I don't see any other restriction on there.

DR. SCHULER: Yeah.

DR. BOBROWSKI: And like I said --

DR. SCHULER: Did you -- did you talk to the Commissioner -- yeah, did you talk to the Commissioner about the prior authorization for the -- was it periodic exam code that was on there initially?

DR. BOBROWSKI: I did not. It's now -- yes, up there. It's the -- yeah, it's the

D0120 periodic oral exam. Oral evaluation requires prior authorization one per six months. I sent that in to her, but I did not talk with her about that particular one yet. And I believe --

DR. SCHULER: Well, I can't imagine that the MCOs are going to be...

DR. BOBROWSKI: Yeah, I don't even remember that being on...

DR. BRAUN: This is -- this is Carol Braun. I know I noticed that as well, because historically D0120 wasn't a covered service. You had to use the D0150 for each encounter. And so I just wasn't quite sure how to direct my staff to code out exams, so...

DR. SCHULER: Yeah, if we could get some clarity on that, Garth, that would be good, because obviously, the MCOs, you know, can't even handle -- I mean can you imagine having to preauthorize every periodic exam in the state?

DR. BRAUN: Well, and then also for the D0150 to be limited to one every 12 months, that's not something that had happened

before either. So I -- you know, it's a little bit confusing on that.

DR. CAUDILL: Garth, this is Jerry.

DR. BOBROWSKI: Yes, go ahead.

DR. CAUDILL: Avesis does not require a preauthorization for the D0120. And we made the same suggestion to DMS that you did.

MS. LOCKE: This is Loren --

DR. SCHULER: I know --

MS. LOCKE: Oh, I'm sorry.

DR. SCHULER: No. You're fine. Go ahead. I'll --

MS. LOCKE: I was going to go ahead. This is Loren from DentaQuest on behalf of Anthem. We are not requiring the prior authorization either.

DR. SCHULER: Yeah. But if everything on the new code list -- I'll be honest with you, that was the one that had everybody about as riled up as you could be, just because the amount of paperwork. And, obviously, we don't have the capacity and the MCOs evidentially either, so we got DentaQuest and, you know, Avesis are not

going to -- are not going to require that. So I guess we get -- United Healthcare will be in business.

DR. RICH: I don't know if you can hear me.

DR. BOBROWSKI: Yes, we can.

DR. SCHULER: Yeah, we got you.

DR. RICH: Yeah, we don't be requiring that.

DR. BOBROWSKI: Well, thank you all --

DR. SCHULER: Sounds like it's a moot point.

DR. BOBROWSKI: Cleared that up real quick. Thank you all so much. And, of course, basically on D0150, I mean that's -- is what I understand, that was one -- you could only use it once a year, which that's basically what it says out there in the notes is one per 12 months per member per provider.

DR. CAUDILL: What you can do there then is for the second one each year, you can use the 120, though.

DR. BOBROWSKI: Right. Yes. So Dr. Phil, that's how I do it, is I use the D -- the D0150, you know, like I said, at the

first of the year. And then -- or well -- for their first appointment. Then in six months, we just use the D0120. You just have to tell your front office staff, make sure they are doing that correctly.

There was some of the wording on these fee lists, is what I was looking at, sometimes it can be just a little un -- a little confusing or -- especially in this day and time when you have staff turnover, just training them on things to -- how to file things and not try to eliminate the refiling things and there -- and I know one of the questions was, why is there a different fee for like a upper denture as compared to a denture fee on the lower denture? And what I was told was that, statistically, when you -- when they look at the national trends of the payment on dentures, the upper denture typically was charged more by dentists than the lower denture. Now, I don't know, when I -- when I -- dentures to patients, I -- you know, I tell them, it's the same price for each denture. You know, I don't know why

dentists have two different prices for the -- basically the same procedure, just a different arch. If anybody knows that reason, chime in. But there was another one --

DR. SCHULER: We do it just like you described, Garth. I mean, it's the same --

DR. BOBROWSKI: Okay.

DR. SCHULER: -- it's the same teeth for the top or the bottom.

DR. BOBROWSKI: Yeah. See there -- here's just an example of one of the wording changes that I had recommended was under denture relines. Well, there's plenty of room to kind of spread those out, but it's a D5731. It says, denture reline complete mandible direct -- or it's spell -- they just put D-I-R. Well, the next code is a D5740 and it just says, reline maxillary. Well, that's a partial denture, but it's almost like -- and down there is the word for reline complete maxillary denture, a D5750, but just some of the wording, I think, you know, could just be matched up a little better. And I'm just looking at it

from helping to train staff and, you know, as we look through there on those codes. Let's see. Did John Gray ever get on the call? He's our oral surgeon. I was just going to ask if he had any questions on any of the oral surgery codes.

DR. SCHULER: I have not heard any comments coming from our oral surgeons, other than, thanks for the increase. I mean, that was -- that was nice, but I've not heard any confusion or anything that didn't make any sense from any of my folks.

DR. BOBROWSKI: Okay. Good. Now, I don't see it on this new code list. But on some of the previous ones, back earlier on in January, that was what I put on there. There was a column that was kind of -- it was marked in green out to the side. Is there anybody from the state -- I don't see it on the new one, but what was that for? I never could find out what that green column was for.

DR. SCHULER: The green column was -- the green column was for the codes and the fees that were going to be shared between oral

surgery and GP. So if it had a green code, that was the same code for oral -- for oral surgeons and GPs. If it didn't have a green column or a green square next to it, then that fee only applied to oral surgeons. That was my understanding.

DR. BOBROWSKI: Okay.

MS. KITCHEN: This is Kelly Kitchen with DMS. Can you hear me okay?

DR. BOBROWSKI: Yes.

MS. KITCHEN: Okay. So that is correct. The green column --

DR. SCHULER: You are breaking up a bit.

MS. KITCHEN: -- was put there for the oral surgeons. And we moved that piece to the lower portion of the fee schedule. As far as the wording that you are speaking of, DMS received a file from the AMA, from CMS that lists a short description of a code, and, also, it lists a -- I'm sorry, from the CD -- from the ADA. It lists a short description and a long description, so we -- most of the time, we use a short description, but we can definitely look at updating that to use the long description

that would make more sense.

DR. BOBROWSKI: Sometimes when you are just going down through there and -- you know, and looking at things, just on making stuff just easier to find.

MS. KITCHEN: Absolutely. Absolutely.

DR. BOBROWSKI: We'll just have to talk to that ADA about that stuff. No, I'm joking.

Now, are there any other comments or questions about anything of these other codes and things?

I think some of that has -- well, I guess the other thing is, like on -- and I did mention this to the Commissioner, on like dentures, partial dentures. Now, yes, some of the codes are -- the requirements or preauthorizations are done by the MCOs, but what are the guidelines, preauthorization requirements, et cetera for patients that are on the fee for service? Because some of those -- of course, those little squares don't have a lot of room, but how do we find out that information? Because we've got people calling every day wanting, you know, partial dentures or a denture or whatever

and we are a little hesitant to start something, because we don't have all the guidelines printed out somewhere yet that I can find.

MR. DEARINGER: This is Justin Dearinger Department for Medicaid services. And Kelli can correct me if I'm wrong. I thought we had covered this before multiple times, but, you know, you talk about something so much you forget exactly where you talk about it. And so we have -- maybe we should put out some guidance, I guess, on the website, because I think this has come up multiple times. But all of the requirements that we have are listed on the fee schedule. They are right there in that column. If there's not anything there, there are no requirements for that particular code. We do have prior authorizations where we use, you know, clinicians to review for appropriateness. And then all codes are open for auditing to look for medical necessity. But if it's not listed on that fee for schedule -- fee schedule or fee for service fee schedule,

then there's nothing for that particular code.

And if you see something that you may, you know, think, well, I think there should be something there. You know, like we have said, feel free to reach out and submit that information -- along with all the other codes that you have talked about up to this point, submit that to us and we would be more than happy to look at that. And, you know, since this is a first time fee schedule, I know we are not making any changes for a while to it, because at some point we had to stop and say, this is the fee schedule. But we usually do change the fee schedule once per year. However, for this one, since it's new, we may consider doing something after six months or so, but we need to have all those -- all the information. And, absolutely, if it's a typo, we can change that, because it's already changed in the system one way.

Any time we make a change to the fee schedule, we have to make a change to the system as well, which usually takes a number

of months and is usually a price tag involved, also, but -- so anything that you feel like that's missing or been left off, we encourage you to write that, send that to myself or the Commissioner, either one, and we will review that and see what we can do. On this six months that rolls around, maybe we can do an update at that time.

DR. BOBROWSKI: Would you mind to give us your e-mail address then so we can send stuff -- we can send it to you and copy the Commissioner or vice versa?

MR. DEARINGER: Absolutely. I'll put it in the chat right now.

DR. BOBROWSKI: Okay. Good. Thank you very much, Justin.

MS. SHEETS: And, Dr. Bobrowski, I'll send that out to the TAC members as well following the meeting.

DR. BOBROWSKI: Okay. Great. Thank you. Let me make a note here. Well, just for sure, there's -- down under that D2394, there's no fee listed for four resin, four or more services posterior. And I know --

MR. DEARINGER: Yeah, I heard you -- yeah,

I heard you talk about that one earlier. That -- again, that may be a typo. We just --

DR. BOBROWSKI: Yeah.

MR. DEARINGER: -- have to go in and look and see. But get those together, we'll look at those. If it's anything that's a typo we have just accidentally left off on the fee schedule, we -- it's probably already in the system, so we just add that to the fee schedule and we are good to go. Any other suggestions we can look at possibly? Like I said, since it's a brand new -- I understand it's not a brand new fee schedule, but it's -- you know, it's a brand new fee schedule in the sense that we have created an additional, you know, additional group of people to be serviced. And we have also included a lot of additional codes and pricing. And because of all that, we may want to do a revision at the six-month mark, which is not something we normally do, but with this one, I think we might need to. But, yeah, absolutely send me that. I've got that one

already, but you can send me that one and all of them that we've talked about -- or any that you see after this, if you want to, you know, encourage the TAC to go back and relook at anything they may have a question about, any suggested improvements, anything like that, we are always -- and it's not just for this fee schedule.

It's something that I try to tell all provider types. We are always open. We get -- we constantly get e-mails from providers, from provider advocate groups, from TACs, from MCOs, asking about different codes or pricing or requirements. And so we are always looking at -- and doing research on requests we get and suggestions we get from the provider community about all types of different things. So this is something that is built into our process and our program and we look forward to it.

DR. BOBROWSKI: There's -- you know, in my little report this morning on treating the gum disease -- and I've already mentioned this to the Commissioner, but, you know, down there in treating gum disease, you

know, the -- I know the fee is a D4341. And I know the MCOs and the fee for service, it does require prior authorization. One thing that I know some of the MCOs require is, is that we can only preauthorize two quadrants at a time. This is a new change over the last few years, but instead of preauthorizing the -- and if somebody from one of the MCOs wants to chime in here in a minute, please do.

But it's just that by not being allowed to do all four quadrants at one time, then we get two done, then we got to go back and it just takes up more time from our front office staff to then, well, we got to send in two more quadrants to get done on you. It's kind of like the old way of just get in there and get it done. And most -- I don't know, the way we do it or in our office. We usually do two quadrants at a time. But I'd just like to decrease the paperwork time it takes the front office staff, so that -- if the MCOs would just consider doing one preauthorization would be nice, but on the other hand, looking at

those -- the 4342, sometimes to get somebody in and numb them, deep scale them, put a medicated caved rinse on them, and the fee for the adult is $26. I can't do it for that. Therefore, I can't treat the disease.

So, you know, these are -- to me, this is just as much of a preventive process, a preventive treatment code to help prevent the disease from getting worse. Yeah, it's not through their whole mouth, but it's in a section of one to three teeth. Typically, it's around the molars. But I can't do it for $26, so we need to -- we need to look at that fee on that one. And I have mentioned that to the Commissioner on that one.

MR. DEARINGER: Was that the 4341? Is that what you're...

DR. BOBROWSKI: Well, the 4341, that --

MR. DEARINGER: That was the prior authorization. So what was the code?

DR. BOBROWSKI: Right. Well, it's the D4341, that -- the fee on that one is only that $78, you know, for an adult. And it's paid at 101.40 for a child. I don't -- in all my years of doing dentistry, we don't

have to do much root planing on children or teenagers, but that -- that's another fee that needs to be looked at or, at least, raised up to the children's rate. And then the D4342, if you really want to get serious about treating gum disease, you got to get it to where, you know, it costs them that much just to do the paperwork for some of this stuff. And --

DR. SCHULER: Hey, Garth?

DR. BOBROWSKI: Yes, go ahead.

DR. SCHULER: Before we get, you know, off of fees, I was asked by some of our leadership on the oral surgery side about implant codes. I have not seen implant codes on the fee schedules, so is that -- I don't know if it's on the 130 revision that you had talked about, but patients are obviously asking a lot about implants. But at this point, I don't think we have got a lot of guidance on, you know, what's covered. And I mean, I've talked to Dr. Caudill about, you know, some of the clinical requirements, but I don't know if they are listed on that fee schedule or --

DR. BOBROWSKI: Yeah.
DR. SCHULER: -- even if the code was listed.
DR. BOBROWSKI: Yeah. There was an endosseous implant code. Right there, it's a D6010. Now, it -- endosteal implant is -- it says prior authorization required. Implant must be based on last resort. Dentures that are causing damage or not wearable due to medical reasons, once per tooth per lifetime. So somehow, if you get the preauthorization passed through, it would probably be like where the -- you would have to probably write a narrative where the denture is either causing damage to other tissues or just flat not wearable --
DR. SCHULER: Yeah.
DR. BOBROWSKI: -- due to a medical reason. And I guess the fact that there's no ridge left would be a medical reason and they have already tried a denture. Any of the MCOs got a comment on that part yet?
DR. SCHULER: I think as long as it has to be preauthorized, we'll -- I mean, these

are obviously going to be few and far between. I mean, the patients think that every time they have a tooth missing, they are going to be to get a -- you know, a free dental implant and that's not going to be the case.

DR. BOBROWSKI: Right.

DR. SCHULER: And as long as we got a preauthorization process to go through, you know, we'll work through it on a case by case. I just wanted to make sure it was on there.

DR. BOBROWSKI: Yeah. The -- and I know -- let's see the -- you know, and a while ago when I was giving my report, I know -- and I -- we do a -- and, Dr. Phil, it's just like the -- I know you all do a lot of gum treatments. We do, too. And they've added -- they have added in the code the D4910, which is a periodontal maintenance procedure. And if you are going to treat gum disease, I know it's standard of care to have a cleaning done at the -- and, typically, it's at the gum specialist, or sometimes they will alternate every three

months with the general practitioners office for just getting a good cleaning done, and then they do monitor the perio probing, so -- but now, this is -- what's on here is for the fee for service. And to be honest, I haven't looked at the new fee for service for the MCOs to make sure that the MCOs are going to follow through with that, too.

But those are -- those are some codes that are being added that I know as a practicing dentist, that those are appreciated because we can -- we can actually help our patients more by doing this follow-up care than we could in the past. So that is appreciated. And I wanted to say a thank you again.

DR. CAUDILL: Dr. Bobrowski?

DR. BOBROWSKI: Yes.

DR. CAUDILL: This is Bob Caudill. On the periodontal maintenance?

DR. BOBROWSKI: Yes.

DR. CAUDILL: Avesis did reach out to both the University of Kentucky College of Dentistry and University of Louisville

School of Dentistry. I spoke directly with the head of the periodontal department in both dental schools. Avesis is recognizing periodontal maintenance every three months.

DR. BOBROWSKI: Okay.

DR. CAUDILL: Following -- following --

DR. BOBROWSKI: Thank you very much.

DR. CAUDILL: -- following, you know, definitive periodontal therapy.

DR. BOBROWSKI: Yes, yes, yeah. But do you-all -- Dr. Caudill, in your research -- and I know you have been a practicing dentist, too. Am I correct in saying that that three-month followup is pretty much standard of care to help keep the disease process to a minimum?

DR. CAUDILL: That's what both dental schools said, yes. That is still the standard of care.

DR. BOBROWSKI: Good deal. Good deal.

DR. CAUDILL: And that's what they are still teaching at both dental schools.

DR. BOBROWSKI: I'm going to make a note here. Well, thank you all for that.

DentaQuest and United Healthcare, have

you-all had a chance to look at that code?
MS. MEDINA: This is Christy from DentaQuest. Yes, we are basically in agreement with Dr. Caudill and Avesis' approach there for those codes. Yeah.
DR. BOBROWSKI: Thank you very much.
DR. RICH: Yeah, this is Dr. Rich with United Healthcare. We are following the standard of care guidelines as well.
DR. BOBROWSKI: Okay. I hate to --
DR. SCHULER: Hey, Garth?
DR. BOBROWSKI: Yeah, go ahead.
DR. SCHULER: Could we maybe talk to the MCOs about that four-surface posterior composite. I mean, even though --
DR. BOBROWSKI: Yeah.
DR. SCHULER: -- even though it may not be on the -- you know, even though it may not be in the state fee for service fee schedule. Is that something that they will continue to cover? We can't -- because I mean if it was a typo, and it was like it was left off for real, we can't wait six months for that to be a covered procedure. We do a lot of for service posterior

restorations on this population.
DR. BOBROWSKI: Yes.
MS. MEDINA: So I know that for DentaQuest, you know, if something is not covered yet it's medically necessary, under EPSDT it is payable. So just kind of really depend -- you know, even though it's not on the fee schedule, there are those instances where it should be allowed.
DR. CAUDILL: And it could be allowed under children EPSDT, but that would not affect the adults. And actually, the state's fee schedule is showing -- I'm looking at it right now online. It's showing it's covered for children, but not for adults. It says N/C, so...
DR. BOBROWSKI: Right.
DR. CAUDILL: I guess we are all hoping that's just a typo that they can quickly fix.
DR. SCHULER: Yeah, because that's one, Garth, I mean, we need to -- we need to get an answer on that one pretty quick, because can you imagine how many four surface composites are done on Medicaid patients in

this state.
DR. BOBROWSKI: I do a ton of them, you know, and --
DR. CAUDILL: And the problem is, a lot of dental offices don't even have an amalgamator. They don't do silver fillings any more. They only do composites.
DR. BOBROWSKI: Yeah, right.
DR. SCHULER: Right.
DR. BOBROWSKI: Yeah. Now, Dr. Caudill, are you-all still just doing it under -- as a EPSDT at the --
DR. CAUDILL: Until the code is changed, you know, we are following exactly what's printed, yeah.
DR. SCHULER: But, I, mean to have to go through the EPSDT for every single one of these would be -- that's a burden.
DR. RICH: Yeah, but that's not -- my understanding -- this is Dr. Rich -- that code is always been covered for under 21. And EPSDT only cover under 21. It's the --
MS. MEDINA: YEAH.
DR. RICH: -- adult that it's not been on the fee schedule for and --

DR. SCHULER: There you.
DR. RICH: But UHC has been covering it for adults, but it's not on the fee schedule, the prior fee schedule or this one. It doesn't really make any sense. I don't understand that either. I think we are all in the same quandary as to why it's not covered, but it is covered for UHC members, I know that.
DR. BOBROWSKI: I'm going to put this down just a second. I'm going to look something up here.
DR. SCHULER: While Garth is looking that up, Dr. Caudill, did I understand that if it's not on the fee schedule, you are not covering it?
DR. CAUDILL: I believe that's what I was told on the last version of our fee schedule, that.
DR. SCHULER: Yeah.
DR. CAUDILL: You know, we are following DMS exactly.
DR. BOBROWSKI: Justin, I want to hopefully that -- I know it's Friday afternoon, but, boy, we've got to get this one figured out.

MR. DEARINGER: Yes, sir. Yeah, as I -- like I said, you know, I don't know if we will -- it's 3:00 on Friday afternoon. We'll do our best to try to get an answer for you-all as soon as possible.

DR. BOBROWSKI: Okay. Appreciate that, because --

MR. DEARINGER: Absolutely.

DR. BOBROWSKI: -- yeah, to follow up and see if it's a typo or it is just accidentally got left off. Because out here in our world, we have a lot of folks come in with, you know, whole sides of teeth busted out or decayed out and we do a lot of that type of repair. And it's -- and we are six weeks or so into the new year and it's untelling how many times that code has been used.

DR. SCHULER: Can we get a comment from DentaQuest? I think that's the only one that we really haven't heard from.

DR. BOBROWSKI: I think she said they use the EPSDT.

DR. SCHULER: But you can't do that on adults, right?

MR. DEARINGER: Yeah, EPSDT --
MS. MEDINA: Right. Sorry.
MR. DEARINGER: -- is children only.
MS. MEDINA: Yeah, it's children only, so it would just go down to medical necessity, you know, in the event there's like a true medical need. Sometimes they will be covered for adults.
DR. BOBROWSKI: Okay. I'm making a note here.
DR. SCHULER: I hope so. I'm making a big one.
DR. BOBROWSKI: Yeah.
MS. LOCKE: Hi, this is Loren from DentaQuest.
DR. SCHULER: Yeah, we're six months --
MS. LOCKE: Sorry. I was just going to add --
DR. SCHULER: Go ahead.
MS. LOCKE: -- that the -- they have been covered for adults. We just require the, you know, to show medical necessity, so just perio charting and X-rays.
DR. BOBROWSKI: See, that's -- see, that's the thing that bothers us practicing

dentists, is that, you know, historically you know, if something walks in the door, they have been up here at the restaurant at lunch time and broke the side out of a tooth and now you have got -- it's 1:00 in the afternoon and you got to fix it. Well, no, I may or may not have done a periodontal exam, but I can see on the X-ray that I don't see any bone loss. But, you know, if I've got to send in a preauthorization or a -- an X-ray and a perio charting, you know, just to fix that tooth and I can -- in my professional judgment, don't see a bone problem or a fracture that's going to cause the teeth to be weakened, that's what I have a problem with, is the paperwork that's involved with just treating people. We have got to figure this out. But the other thing is this, and it's down here in new -- well, no, it's here just in the next item. It's like we -- we as Medicaid providers, we've lost a ton of providers. And my question is, how do we get them back? And, boy, we -- you don't get them back by having a

bunch of paperwork and, you know, stuff to send in. If you got somebody in healthcare that's an outlier, you know -- you know, go after them. And I've talked to other practitioners and -- not even in dentistry that sometimes the paperwork involved is just denying treatment for people.

I mean, you take -- like if you have a broken tooth right after lunch and you did get into a dentist that afternoon, well, would you want the dentist to say, I can fix that but I got to wait until I get the authorization back from the -- from your insurance company or from your Medicaid company. When can I get that back? Well, how long does it take to get it sent in and get an authorization back. But that's -- that's my problem, is just a practicing provider. And that's the other problem, is as other dentists drop out or limit their services to the Medicaid program, then for the ones like me and some other dentists around and across the state, it's like we try to do everything we can, but that puts even extra burden on us as other people are

dropping out. And I'll tell you -- and it was shown by Dr. McKee's presentation and survey that, you know, these failed appointments was another problem. We talked to a dentist and he -- there's two dentists in another town close by, but they have limited their practice to like one four-hour segment a week. I think I may have mentioned this before, but he called me again the other day about -- well, about last week. They had 21 patients scheduled in that time block. 10 of them didn't show up. And, again, I think things we need to look at -- and I'm going to ask the MCOs and the State to kind of look at this, because it's a factor that's causing dentists to lose out. And I'm on the MAC. And this failed appointment problem, it's a problem across the State with multiple health providers. And I think we need to get creative and work with people. I understand a flat tire happens. The car won't start. I don't have a baby sitter. Life happens. But, boy, there's just -- yesterday afternoon, I had some other patients

scheduled and had three Medicaid patients. None of them showed up.

DR. COLEMAN: Dr. Bobrowski?

DR. BOBROWSKI: Go ahead, Ronny.

DR. COLEMAN: Yeah, I'm going to say that we have the same problem in every state. And, in fact, we just raised this issue in a legislative hearing yesterday in Indiana about what could be done. And I mean, people bounced it around and I -- it's just really hard, because some people want to be punitive against the patient. And then if you do that, then they are not never -- they are not going to want to go the dentist any way. They are not even going to try. It's like a really hard nut to crack, because it's everywhere. And, you know.

DR. BOBROWSKI: Yeah, yeah.

DR. COLEMAN: You are lucky if you are in a community where it's not a problem. The other thing I wanted to just mention while I'm on here is that you mentioned, you know, what do we to keep dentists? Well, just tell you, we closed our Broadway

office downtown Louisville, which we had open for -- I don't know, maybe 18 years or something like that. It served that downtown community. You know, rates are the main thing, but, you know, a lot of it was the no-show and -- and, really, the Pandemic. And then there's the crime down there, I think, on contributed to staffing not -- staff not wanting to work there. But I just wanted you to know that we did close that particular office about a month ago -- or less than a month ago.

DR. BOBROWSKI: Well, Ron, I sure do hate to hear that you had to close an office.

DR. COLEMAN: Me too. It's just hard to keep providers.

DR. BOBROWSKI: Yeah, I understand the -- you know, and staffing issue is another problem. Not only downtown Louisville, but out here in the country. I think I mentioned this before, I was talking with a hygienist the other day, a few weeks ago there, in the E-Town, with the Central Kentucky area, there was 22 offices looking for a hygienist. And I mentioned this to

the Commissioner. I'm down here in South Central Kentucky close by to Lindsey Wilson College in Columbia and Campbellsville University over here in Taylor County. And I'm kind of in between them, but I've been thinking about trying to develop a sales pitch and go to those universities and just see and talk to them about opening up a dental hygiene program. I know Campbellsville University is -- they are doing a lot of different types of program. They just opened up a cosmetology program. Lindsey Wilson just opened up a nursing program. Maybe it's time to talk to them about a dental hygiene program and get some of our local young people interested in the dental field, because with Covid -- Ronny, that's what you said. Covid, it just kind of knocked a lot of hygienists out of the system role.

DR. COLEMAN: Yeah, they just baled out.

DR. BOBROWSKI: And I talked to another dentist out in the western part of Kentucky, but -- he's not a Medicaid provider, but he said I went six months --

you know, he's been in practice 20 plus years, 25 years, but he said, I went for six months without a hygienist. So that can really slow down the whole process of treating patients when the dentist has to sit in there and do that procedure for half an hour to an hour. You know, you don't get any of their fillings done or you don't get that tooth pulled. So those are other factors involved.

I want to --

DR. PETREY: Garth, if I can interject on that real quick. I apologize --

DR. BOBROWSKI: Yeah.

DR. PETREY: -- for interrupting.

DR. BOBROWSKI: No problem.

DR. PETREY: I completely understand the sentiment on no-shows and the worries about no-shows. It is a critical issue, but I think -- and I love your -- your concept that we can -- we need to get creative on how to address those. I think, however, though, we are dealing with a patient population that has a lot of constraints against them, socioeconomically

specifically. And for us to anticipate them to be in the same show rate as every other individual, I think is a farce. I also think that when we -- when we focus and compare our patients, we need to be very careful of that and what they are able to achieve and what they are not able to achieve. I think those of us that are on this committee see high rates of these patients. I think we get a lot of complaints by from -- from individuals, practitioners that do not see high rates of the Medicaid population. And they complain when comparing no-show rates of their Medicaid population to their non-Medicaid population. You get no-shows from every economic status.

DR. BOBROWSKI: Yeah, yeah, yeah.

DR. PETREY: But when you compare the two, it's unfair to the individuals that do have a more difficult time in completing those appointments.

For me, it all goes back to, how do we get more practitioners to want to see more patients? Why do we have so many no-shows?

Some of the no-shows, because they wait for treatment, they have difficulty getting treatment because there's not enough providers. And so to address the problem, I think we need to increase our providers and increase the pay for those providers so that each provider understands there will be a higher no-show rate. In our clinics, we have an 18 to 20 percent no-show rate daily. We factor that in. When everybody shows, we love it. It's a very difficult day when they do, but we --

DR. BOBROWSKI: Yeah.

DR. PETREY: -- we factor that in. Why do we factor that in? Because we want to see our patients. And it is increasingly more of a challenge, acutely becoming more increasing and more of a challenge because one of the very few orthodontic providers in Eastern Kentucky that does accept Medicaid, will close his practice in 10 days. That's going to add another difficulty for those of us out there that are trying to see his population. But if we factor in that no-show, and we

understand that this population is going to have that, but we are appropriately compensated for the work that we are doing, then we as practitioners need to accept that no-show rate, try to improve it, but understand it and be very careful. And I know that you are not, but many blame the patient when it's not always their situation.

DR. BOBROWSKI: Right.

DR. PETREY: And if we could -- if we could improve things such as the compensation for the providers, we can improve the system, we can increase the number of providers. And we all will not have the worry. I love treating the population. Would I like it to be less of a percentage of the people that I treat? Absolutely. But I'm going to see who needs to be seen. And we are going to have to factor in that no-show rate. But we are not going to get young dentists, young orthodontists, young periodontists or oral surgeons to jump into this game if they don't have an appropriate compensation for what they are doing,

especially with the understanding that they are the negative aspect such as no-show.

DR. BOBROWSKI: Yeah. Good -- good comments. Thank you, Dr. Joe. Appreciate them.

Any other ideas or -- on how do we get providers back? I just call it, you know, rebuilding our network. And, you know, developing plans of care with patients and I -- I put down same thing, fees and I -- and you worded that really well on, you know, just to acknowledge that there's going to be a failed appointment problem. And -- but -- and just go into it knowing that. But you're right, we've got to take care of people. That's our job. That's our oath.

DR. SCHULER: Well, Garth, another --

DR. BOBROWSKI: Go ahead.

DR. SCHULER: Another big component to this is the hygiene shortage. So --

DR. BOBROWSKI: Yeah.

DR. SCHULER: -- I mean, like you mentioned, there's not nearly enough hygienists to service, you know, the needs of the population that's out there. And,

you know, you -- form an economic standpoint, you just have to look at it and go, I can see one population of patients at a certain fee schedule. Maybe that's Medicaid, which is, you know, half to a third what we are -- you know, what we are getting compensated for, you know, for fee for service or, you know, PPO or any of those other things. And I mean, you know, we -- I can't imagine being, you know, an experienced doctor without hygiene support and, you know, your day if filled up with Medicaid hygiene. I mean, you are just -- you are going to just lose money all day long.

DR. BOBROWSKI: Yeah.

DR. SCHULER: And Joe is right. I mean, you are going to have higher no-show rates. It's not like -- you know, people think the only folks that no-show are Medicaid patients. I mean, I have been no-showed by every population there is. You know, it happens, but it is higher with Medicaid. And, you know, if reimbursements were higher, it would be less painful because

you would, you know, recoup it on the ones that did show up. And you do have -- so I mean, if you're having a 20 percent no-show rate, you overbook by 20 percent, and like Joe said, some days are real interesting, but for the most part they are not. I mean, you end up having kind of a regular day, but you got to overbook and, you know, patients are waiting forever for treatment. It takes forever to get into oral surgeon's office. And I mean, I appreciate, you know, everybody who had a part in elevating the oral surgery fees because it kept the oral surgeons in the system. Now, how do we keep the GPs in the system? Just look at what we had to do to keep the oral surgeons in the system, by bumping up these oral surgery codes. Look at all the other codes and that's what we are going to have to do if we want to not only expand the system, but if we want to keep the ones in here. You know, as the economy gets tighter and tighter, it gets harder and harder. You know, compensation is up. Supplies are up. Lab bills are up.

Everything is up. But, you know, if you are seeing a large percentage of Medicaid patients, you are just -- you are going in the hole deeper and deeper every day and that is a tough sell job for any provider to, you know, hey, come join us and, you know, you can lose a lot of money. That's not really a good thing. I mean, even with, you know, even with our cost structure -- and I mean we have a lot of offices. Even with our cost structure, there's only so much Medicaid we can see. I was really -- I hated to hear that, you know, we are closing an office on 18th street because that usually means our Dixie Highway office is going to blow up with Medicaid patients. You know, and that's why I know there's such a poor network out there. We can close new patients off at an office. And I'll see an office 20 miles away, 30 miles a way, that's where all those patients are going. And what that tells me is there's nobody in between there, you know, seeing Medicaid, because people don't want to drive any more than

they have to. So, I mean, we got a poor system and this -- while this increase in the oral surgery fees and some of the other fees is helpful, it's a step in the right direction. You know, we are not -- the reason Indiana has got so many Medicaid providers is because their reimbursement rates are so much higher. You know, our Indiana offices -- all of our Indiana offices see Medicaid. And they don't complain about Medicaid and, you know, they don't even complain about the no-shows with Medicaid. I mean, they have them and nobody likes them. But the reimbursement rates are so much higher than Kentucky, it takes some of the edge off, you know, the no-show issues and just some of the, you know, the behavioral stuff and -- I mean, you know, it's -- it's sometimes a difficult population to take care of. But it all comes down to fee schedules. I mean, we can dance around it all day long, but, you know, it is what it is.

DR. COLEMAN: Dr. Schuler, I agree with you. It's all about the fee schedule. And

I know in Indiana, they say that's the number one reason dentists don't take Medicaid. But I will tell you that the Dental Association is having a big problem. In fact, I testified in front of the Ways and Means Committee last night, specifically on a bill that we are trying to pass that would get the Medicaid dental rates up to the 50 percentile of ADA. And so -- and the legislatures get it. A lot of them visit our offices and they are hearing it from their constituent dentists and they are hearing it from their constituents who are patients, so -- but you are right. I mean, we have to do something in Kentucky. And the problem is, in some states they can make changes without legislation, just like Medicaid did this time with the oral surgery stuff and by covering this additional adult population in a way that nobody knew they could do. But when you say talk about make a wholesale improvement in a way that's going to be meaningful for like the general population, that almost requires

legislative action. And the problem is, we can only do that every two years. So I think we are going to have to gear up this summer in preparation for next year to try to get the legislative leaders to buy into it.

And this is the other thing -- and I shared this with Dr. Bobrowski, in Virginia, we were able to get a 30 percent across the board rate increase last legislative session. We had by partisan support for it in legislature. And everybody was excited, we thought it was going to make a big difference. And for those of us who are primarily Medicaid, yeah, it was helpful. But, again, you are starting at a lower base. And so that 30 percent -- I used this example last night. You use a couple swimming pools. But you got a swimming pool that's 12 feet and a swimming pool that's four feet, which is where we are in Kentucky. You increase reimbursements 25 percent, you just go up to 5 feet. Where as if you have a ten foot --

DR. BOBROWSKI: Yeah.

DR. COLEMAN: -- you know, and so it has to be meaningful. And the longer they wait, the harder it's going to get. So we're going to have to ask for something substantial. And I think the time to start on it is this summer. Otherwise, it's just going to feel completely deteriorate in the next three years before the following budget session.

DR. BOBROWSKI: Justin, I will call your attention there to these -- just like these adult -- they call them prophylaxis or a cleaning codes. It's a D1110. And this has just been up to -- you know, I know you got your fee for service set rate, but some of the MCOs take, you know, 10 percent off of that fee. And the adult code pays 46.25, according to this new fee list. Well, you know, Dr. Phil, I don't know what you-all have to pay for a hygienist, but, you know, it's anywhere from, oh, around 30 to $35 an hour, you know, around our area, give or take on that just a little, but it -- you can see right there, you're already almost starting off in the hole.

By the time you pay the hygienist and then pay her social security and withholding -- not her withholdings, but her social security taxes and stuff and -- of course, we did get it allowed to clean, you know, like once every six months, but the -- for a lot of our adults, man, it -- you -- it's -- those a lot of times have patients that haven't been to the dentist in years. We have had two or three yesterday. You can't even clean them in an hour. They have got that much tartar and stuff. So I mean, that adult fee -- I mean, the child fee is $60. Even if it was raised to the child's fee helps, but those are fees that -- you can't keep doing them. And it's like Dr. Phil said a while ago, you have paid a hygienist all day long and you have gone in the hole --

MR. DEARINGER: Yes, sir. This is Justin Dearinger. And I -- like I said, I encourage you-all to put together a list of fees that you think, you know, could be incorrect, that are too low to -- you know, you-all are having a hard time actually

doing the services because they are so low, and then send me that on an e-mail, because it takes time for us to research that. I know we had a discussion before we created this fee schedule and we looked at the top ten fees that were billed by dentists. And we looked at every state that touched the state of Kentucky. And the state of Kentucky was higher than the average for each of those states, for those ten codes. So we know those codes in particular, you know, there's no pricing or fee schedule issue with, but you look -- that's a large fee schedule. So I'm sure there are codes on there that need some help. But in order to do that, we have to make sure we do the research. We have to do the research on our end to see what every other state's paying, to see what private insurance is paying. And so we have to put all that work in and then we have to run that through the budget to see if we can get the codes. I know you-all know that we attempted to move all of the child fees and adult fees to be the same. That was not in

our budget. We were unable to do that budgetarily. So I think, like somebody said earlier, that is something that is taking up and fixed by legislation, because we don't have that kind of money in the fee schedule -- or in our budget to be able to make those kind of changes to the fee schedule. I know there are a lot of providers that have a gotten no change in their fee schedule this year at all, no increases, and we were able to increase as many things as we could for this 2023 fee schedule.

But, you know, one of the things that we make sure that we do is, if you find a code that you feel like this is -- you know, I can't do this procedure because this code is too low and, you know, we can't afford to do it, make sure to include that in the list that you send me and we will make sure to research that according to other states and, again, private insurance pay.

DR. BOBROWSKI: There's another code there that -- it's a new code. It's a -- and I know you-all have done this research,

but -- and I don't have to do this code very often, but it's the D5621 and D5622, but it says to repair a cast partial frame, which is the metal, the metal work of a partial denture to -- my -- the last one I sent for repair, the lab bill was like $98. And, I mean, and you are going to pay 72.60. See, that's what I mean. It doesn't even cover our lab bill to repair one of those, so, I mean, those -- I know you said you done your research, but -- and even when we use our lab -- I mean, we don't necessarily try to find the cheapest lab, but we try to find labs that are reasonable and -- but the main criteria is when we use a lab is that, they do good work. You don't have to refit. We don't have to redo things. You want that partial to fit perfect. Now -- but anyway, that's just another one of those codes that we might need to look at.

All right, TAC Members. Let's get our -- if you-all want to look at those -- that fee list and, you know, maybe just send them to me or send them -- we can either do

one list or send them individually. Might be better to do one list of the codes and maybe possible revisions that we need to look at and then we can get that to them here ASAP and get to going on this.

Now, is there any other old business? (No response).

DR. BOBROWSKI: Okay. The new business, I got the MLR stands for Medical Loss Ratio. And -- and some of these we can put on here just for, you know, helping us learn your acronyms and stuff, but right now, the MCOs -- and correct me if I'm wrong, but I think it's a 90 percent of the capitation monies that you receive go towards patient care.

And then the next question I had down is, who's exactly in charge of the MCO dental contracts? And I'll have to pose that question to someone from the state, please, or at MCO.

MS. SHEETS: Angie, are you still on?

MR. DEROSSETT: This is Jeremy --

MS. PARKER: Yes. Jeremy can answer.

MR. DEROSSETT: This is Jeremy Armstrong

DeRossett. I am the branch manager of the contract monitoring branch that oversees the state MCO contracts. And so I would be, for the state side, the person who oversees and in charge in a sense, but if any of the MCOs dental contracts that they have with any of their subcontractors, that responsibility would still be on the MCOs.

DR. BOBROWSKI: But now you -- your division -- I mean, like who drafts the language for those contracts? Is that your division?

MR. DEROSSETT: Yes, sir.

DR. BOBROWSKI: Okay.

MS. PARKER: Not for the dental contractors. This is Angie Parker with Medicaid. The dental contracts are subcontracts of the MCO and they are the ones who develop the language in the subcontract.

DR. BOBROWSKI: Okay.

MS. PARKER: The MCOs directly contract with the dentist -- the dental -- Avesis, that's through them, but we do monitor their subcontracts as well.

DR. COLEMAN: From my standpoint, I think the reason for asking this question is -- might not be for Dr. Bobrowski, but the problem we have is that the MCOs are taking money off of the exceedingly low fee for service schedule. And I know that happens in some other states, but it doesn't happen in other states. I go back to what Dr. Schuler said about Indiana, about maybe people not complaining as much. They haven't increased rates there in a long, long time either, but their MCOs don't take money off the top of what the state sets as the fee schedule. Now, I know United Healthcare doesn't do that, which is helpful in Kentucky, but others do. And it's -- over the years, it's been significant. Let's just put it that way. And, I mean, it would be one thing if we were all getting paid at all like usual and customary. But when you are like 150 to 200 percent below usual and customary, and then somebody takes an additional however much off, that's not good. And the reason this is important is because, in your

contracts with the MCOs in the future, it might be a good idea to require reimbursement, at least, at the state fee schedule, as they do in Indiana. That way, if we do legislative activism and we have money put towards the dental program to get rate up like we did in Virginia, some money would go straight through to the providers. In fact, in Texas right now, they put language in the budget as they are trying to increase rates so that the money will do exactly that. So that's -- I'm glad you raised this question, Dr. Bobrowski.

DR. BOBROWSKI: Well, it's just -- it's one of those things that, you know, we've just got to look at getting our providers back. And I know the MCOs do a lot of great work for us, but, you know, we have all got to get in on this together or I'm just afraid this -- I'm going to age out here one of these days. I still got 25 or 30 good years left in me, I believe, but -- that's a joke, Phil. It -- but, you know, we like to try to help people as long as we can. But we will work on that one. But I know

Dr. -- Senator Alvarado did have a bill that was going to be presented this year and may have to work on it this summer again to -- you know, to have the MCOs pay at the fee for service rate as a minimum, but...

All right. Any other questions on that or comments?

MS. LOCKE: Yeah, this is Loren, again, for DentaQuest for Anthem. I was just going to add that we are currently paying at or above the current fee schedule and that went into effect -- we backdated it to 1/1 -- well, we always have. But for the new fees, they were updated and we reprocessed all of those for 2023.

DR. COLEMAN: Thank you. That's great.

DR. BOBROWSKI: Thank you. All right.

Now, on this next item is reports -- the report requests for the state and the MCOs. I know we've been kind of working on this. And if we've got anything to -- and that we can include this, what to go into the report to go to the MAC, you know, on some of these requests, but -- I know in the

past we used to get a multi-page document from each MCO and had all kinds of reports in those. And there's one that has been particular of interest is the development of the -- I guess, you-all correct me if I'm not using the correct term, but I think they were called the GEO maps, and kind of coordinating that with a claims paid sheet. And then it may actually be required to have -- in that report, more than one sheet. But I'm not at statistician. I don't do a lot of grafts and things like that and charts, but you-all can do this. But one of the things I was looking at was to do a GEO map of the -- across the state of the numbers or the providers that are doing anywhere from $1 to $1,000. And I put down here just in my thoughts was, like $1 to $1,000 per quarter; $1,001 -- another page of $1,001 to $3,000 per quarter; $3001 to $5,000 per quarter; $5001 to $10,000 per quarter; and $10,001 on up per quarter. I didn't know if -- I picked quarter, we could change it to monthly, but I think in the past we have gotten something like that

to -- and by using the GEO maps, I think that kind of helps to see where there are shortage areas in the state. Any discussion from TAC members?

DR. SCHULER: Well, I think you've got -- you know, you kind of got -- the state is, you know, tasked with taking care of its people. So there is a need to have an adequate provider network. The MCOs are mandated to have a certain amount of coverage in the state. So -- I think it's provider of 50-mile radius or something like that. I think there is an urban and suburban limitation. So, I mean, the state would gather based on reimbursements, like you said -- because there's a big difference between somebody being a Medicaid provider, you know, and seeing, you know, a couple patients a week, as opposed to somebody who's Medicaid provider and they are seeing 20 or 30 patients a day. I mean, that's a huge difference. And either one of those count as a provider in the network, but they are not the same level of provider. And we know that. So,

you know, if you've got a bunch of -- if you've got a bunch of, you know, providers that are barely doing any dentistry -- I mean, we need them. I mean, thank goodness for them. But that doesn't really show the picture. So you know, if you had some sort of cutoff where -- where you just kind of in your own mind think, okay, somebody's doing, you know, 10 to 15,000 bucks, you know, a quarter in Medicaid, they are maybe putting a dent in it a little bit, you know, I'd like to see that map compared to just anybody who is a Medicaid provider. I mean, a lot of our offices, a whole heck of a lot more than 10 or 15,000 bucks a quarter. It's a month, and some of them, probably a week.

DR. BOBROWSKI: Yeah.

DR. SCHULER: But still, you know, it would be nice to see that correlated to reimbursement levels.

DR. BOBROWSKI: Would you rather see this on a monthly basis instead of a quarter basis?

DR. SCHULER: Well, I think quarterly is

fine. I mean, we don't need to get too granular with it, but --

DR. BOBROWSKI: Right.

DR. SCHULER: -- I think quarterly -- quarterly would certainly paint as clear a picture as monthly. And, I mean, you could even do it on a trailing 12-month -- you know, rolling 12-month basis so you'd catch any -- I mean, if we got that report quarterly, you know, on a rolling 12-month, you know, that would probably do it.

DR. PETREY: Garth, yeah, we will want to break this down as well by GP and then by the specialties, too --

DR. SCHULER: Yeah, yeah, yeah.

DR. PETREY: -- I mean, to make sure that's in there.

DR. BOBROWSKI: Okay. Sure.

DR. SCHULER: Yeah.

DR. PETREY: Because that's what's really going to scare you, when you see the specialty. I think we've got the only -- there can't be hardly anybody else seeing pediatric patients in Louisville Metro, pediatrician -- ped-odontic, you know,

providers. There's a lot of people seeing kids, but, you know, they are not -- you know, they are not pedodontists.

DR. BOBROWSKI: There was another office close by me that was a Medicaid office. It was a younger guy even and -- but he just recently dropped seeing all adults, so that throws them -- I mean, I don't mean this a in a bad way, but that pushes them over here to me. And I don't mind, but the -- and then another office west of here, they are -- they are down to -- oh, and the one -- did I say that he -- he just -- he dropped all adult. He's only seeing children now. And then another office west of here, they have got another office in another town. They do not see any Medicaid there in that town. The only -- one office, they -- they're down to only seeing children, too.

DR. SCHULER: Some of the state can actually do any -- you know, any of that work. I mean, I know it's -- I mean, it's somewhat labor intensive, you know, to come up with that, but --

DR. BOBROWSKI: What I'll have to do --
DR. SCHULER: -- it will be helpful.
DR. BOBROWSKI: Yeah. Some of these, we can ask through the Commissioner's office to see if this would need to go to them or do it by MCO. And if we go through the state, they may be only able to give us information from the fee for service part of it, where if we really need to get that report from the MCOs to see what they cover in their territories. So did somebody want to the ask something else?
DR. COLEMAN: I was just going to say, you might see what the dental benefit administrators have to say. I know in Virginia, DentaQuest actually pulls that information and shares it with Medicaid and certain people in the community. So I don't know, maybe Dr. Caudill or somebody could speak to that. If not, I mean, I've found that sometimes you are better off just going to a legislator and having them request the information. And then generally, everybody jumps in line and they get it for them, especially if it's a

legislative leader.

MS. ALLEN: Hello, Dr. Bobrowski. This is Nicole with Avesis. We would be more than happy to provide that information, but we will have to receive the direction from DMS if they give us the authorization to do that. As I understand, the reporting requests go through DMS. But if you, you know, would like us to provide that level of information, we do have availability to provide that. Or I should say capabilities to provide that.

DR. BOBROWSKI: Great. Thank you, Ms. Nicole. Appreciate that.

MS. SHEETS: Dr. Bobrowski, this is Kelli Sheets, again.

DR. BOBROWSKI: YEAH.

MS. SHEETS: If you would e-mail us and let us know exactly what you want in writing in a report, we can send that on for you.

DR. BOBROWSKI: Okay. Thank you.

Now, and like I said at the start of this, I'm not one to develop graphs and charts and stuff. I know you all in the past have done those GEO maps and can maybe

include, you know, methods to put the numbers with that, that -- you know, those amounts of claims paid. It would probably be helpful if we came up with kind of the same type of design. So that way, the reporting matches each other pretty close. And Ms. Kelli, I'll e-mail you about that one. And then we will get that one on the -- on the road here.

MS. SHEETS: Okay. Sounds good. Thank you.

DR. BOBROWSKI: Thank you.

DR. PETREY: Yeah, Dr. -- let's -- let's work on -- let's work on that. But, also, I'd like to -- if feasible, I would like to see if that can be at our next meeting, that we have that prior to, so we can review it and then be able to discuss that at our next meeting.

DR. BOBROWSKI: I'll make a note there. Okay. We will get that one done. You know, when I've gone to some of those MAC meetings, you know, we have received, you know, some support from other health care providers. And I don't -- I don't know

that this has to be any kind of a resolution or vote on or anything, but we can if we want to, just -- I think it's good to, you know, the Dental TAC, you know, work with other health care providers. You know, we are all in this together on -- and even healthcare providers to continue to deal with our and work with our straight state administrators and lawmakers and each other, you know, to -- it's all about taking care of patients, is our number one goal. And sometimes, we've got to figure out the fine details of getting patients seen, but we just got to work together on that. Like I said, we are all in this together.

And then here's another item that -- you know, TAC Members, we can all encourage our own dental office administrators or our office managers and our staff, you know, for their input on policies and getting this care delivered, you know, to our patients. So that might be just something to -- and I'm sure you-all do, too. I know I try to listen to my office folks, because they

handle the paperwork. They see what works, what doesn't work and what we might need to tweak.

But here's another possible report -- let me make a note here -- is to maybe get a report from the MCOs on a list of the prior authorization codes -- or the codes that require a prior authorization and the percentage of denials compared to the percentage of approvals. And it may be interesting, too, to find out, well, what is the reason of the denials. And I know sometimes it's just, well, maybe an X-ray got sent in that maybe wasn't readable or wasn't -- or was the wrong tooth. You know, I know when I send in things, I try to tell my front office people exactly which picture to send in, but sometimes -- I'm not sure, sometimes -- and I don't have -- personally I don't have much trouble with any of that, but I'm not saying that they couldn't -- by the time of the phone rings and they are checking somebody in or checking somebody out that they will say, which -- now which tooth was it I got to send? Or the X-ray

and which -- I think it was this one and they punch the send, but I can see where that sometimes can happen. But I don't know. Is that a -- an informative piece that any of the TAC Members would be interested in or are we okay with that one?

DR. CAUDILL: Garth, if I can point out one thing.

DR. BOBROWSKI: Okay.

DR. CAUDILL: As you know, you know, there's clinical criteria out from the various MCOs and their TPAs.

DR. BOBROWSKI: Right.

DR. CAUDILL: And quite often, a doctor will know that a prior authorization will not be approved. But in order to then offer a payment plan, or there was an aunt or an uncle willing to pay for that treatment, even though it doesn't qualify under Medicaid criteria, they still need denial in writing from us before they are allowed to do that. Orthodontics is a very good example of that, where, you know, the orthodontics will check no to every single box saying, I know this case does not meet

medical necessity as outlined in the KAR regulations. However, it's more of a cosmetic issue and maybe there's a grandmother that's willing to pay for this, but I can't bill them until I get that denies from you. So those kinds of things can actually skew the number of denials, just because they are sending in, knowing they don't need criteria.

DR. BOBROWSKI: Okay. That's a good point. I know -- you know, I've got that list of criteria for orthodontics close by here and -- and I'll -- sometimes I'll do that. I'll just tell the parents or grandparents, I'll say, from what I can see, I don't believe you are going to get this approved, you know, because they just -- you know, it's just a couple of -- you know, a couple of rotated maxillary interiors and that doesn't hardly meet any of the criteria. But like you said, that's a good point Dr. Caudill, that they might just want that denial, but I try to -- and if they insist, well, I will give them a referral to an orthodontist, but I'll -- I don't know what

else to do. You know, just let them get the denial and -- but does any TAC Member --

DR. SCHULER: Garth?

DR. BOBROWSKI: -- do we need anything else on that one or we can let it go or -- go ahead.

DR. SCHULER: Garth, I think I'd rather focus on the -- let's get some data wrapped around the provider network, and, you know, let's focus on that and, you know, see where we are at there --

DR. BOBROWSKI: Okay.

DR. SCHULER: -- as opposed to kind of layering this on top of it.

DR. BOBROWSKI: Okay. Here's another question that might go with that then, Dr. Phil. It's just like, well, how many dental providers are in the fee for service network? How many are in each MCO? Would that be of any benefit?

DR. SCHULER: We can usually pull the data by reimbursement levels internally. I'm not sure if that would help understanding the full network, unless there were gaps.

If we are getting reports from each MCO, then, you know, we will be able to -- basically each MCOs network. I think that might be give us similar information.

DR. BOBROWSKI: Okay. Now, here's another question that might go in with that, the GEO maps one, was, would it be helpful to have a map or chart showing where the Medicaid population is in relation to the number of providers for Medicaid?

DR. SCHULER: When getting an address on these people?

DR. BOBROWSKI: No, no, no. I'm just going -- just --

DR. SCHULER: That's going to be tough.

DR. BOBROWSKI: Like I say, I'm not a statistician, so I -- these are just some questions that I've had posed -- some of these are just things I've had posed to me and --

DR. SCHULER: Well, I think if you -- I think if you have a pretty clear picture of the provider network -- because we know people are driving hours, you know, to be seen.

DR. BOBROWSKI: Yeah, yeah.
DR. SCHULER: I mean, that's -- we hear that over and over again, especially from, you know, a lot of our specialists, especially the oral surgeons. You know, I think if we had -- I think if there's more information that we want to kind of layer on top of the initial data, I think that we can ask better questions once we know a little bit more.
DR. BOBROWSKI: Okay.
DR. SCHULER: Just my thought.
DR. BOBROWSKI: That's great. Here's another thing. And I know -- and I think it was DentaQuest, last meeting mentioned some work they were doing -- and again, I think this is stiff we need to work with each MCO and the Commissioner, the MCOs, to decrease the emergency room visits. Last year there was over nine million dollars the state had to spend on dental related ER visits. And I just wanted to put that out there that, you know, that's a big chunk of change. And I told the Commissioner once there that, you know, I had a patient from

another county, you know, a smoker that didn't follow our directions and developed a dry socket. You know, we treated it, you know, once here and we said, well, come back tomorrow and we will treat this again, if it's needed. Well, she didn't show up the next day. And then she came back later for another appointment a week or two later, but we asked, well, did that get better or what happened? And -- we didn't see you the next day. She said, oh, I just went to the emergency room and had them treat it. You know, now, the emergency rooms, I don't know exactly what the charge is, that they charge the MCO or they charge the state, but I think it's hundreds of dollars per visit. And I told the Commissioner I said, well, typically, you know, if somebody's got a dry socket, we normally don't charge for that. You know, and -- I mean, but whereas if they go to the emergency room, that's -- it's usually several hundred dollars. So I think we need to work with our MCOs and the Commissioner on seeing what can be done to

decrease these emergency room -- of course, a lot of times, it's, you know -- from what I see, it's patients either won't go or can't go -- for a number of reasons, they won't go to the dentist. Because I know none of the emergency rooms around here do fillings. Don't see very many emergency rooms that pull teeth. So they kind of doctor them up, you know, 'til -- they say, well, you go see a dentist tomorrow, so -- but I would kind of think we all just need to work together on decreasing the emergency room visits. I don't have any ideas to give you today, but is that something we want to talk any more about today or I can move on?

DR. SCHULER: Well, I think a lot of that would help by having a more robust provider network.

DR. BOBROWSKI: Yeah, yeah.

DR. SCHULER: I mean, the fact that somebody would sit six or eight hours in an emergency room to get something looked at, you are not going to get treated, just get it looked at, as opposed to going to a

dental office is crazy. I mean, I can't imagine how the ER would be your top choice unless you knew you were going to get, you know, six or eight, you know, Hydrocodone to get you through, so...

DR. BOBROWSKI: Right. Yeah.

DR. SCHULER: And from the Commissioner's annual report put out, what this state spends on opioids could quadruple, you know, what -- ten times what we get reimbursed for dental care. It's incredible what we spend on opioids in this state. And they don't even get treatment, so, no, I think that kind of goes back to data collection from the MC0s and the state as far as provider network. We need a better provider network. You are going to -- drop.

(Zoom audio problem).

DR. BOBROWSKI: On that one --

MS. ALLEN: Dr. Bobrowski?

DR. BOBROWSKI: Yes, go ahead.

MS. ALLEN: I'm sorry. This is Nicole again with Avesis. We do offer an emergency department innovative program

that we are currently administering with some of our MCOs and have seen significant results in the decrease of patients re -- are going to the emergency department multiple times. So just as an FYI, we are looking at -- kind of outside the box to identify ways to encourage members to stay with their dentists, utilize Telehealth services, as opposed to utilizing the emergency department.

DR. BOBROWSKI: Great. Okay. Thank you. I've got -- of course, more and more this last year than even this year, I've got more and more patients that will -- on -- I guess it's Facebook Messenger. They will send me messages about this or about that. And, of course, I've heard some dentists saying that they will tell their patients, don't do that, but sometimes folks that they have gotten rid of their home phones and a lot of home phones are not in any phone books any more. But I know at our office here, we try to leave a phone number that -- and a lot of offices do, too, just an after-hours contact phone number, so --

but the last question I've got is -- this was asked by another physician's group or something. On pregnant ladies and oral healthcare, I -- in my mind, I didn't think there was any way using our codes to see if -- you know, how many of the pregnant ladies were -- like for instance, getting an exam and cleaning. Because I think the -- most of the time, we just use our regular exam and pro fee codes. Be don't differentiate whether they are, you know, pregnant or not. But this was just a question asked and -- about, you know, pregnant moms and oral healthcare. Anybody got any ideas on that or just -- I don't -- I couldn't think of any way to really, you know, develop any kind of report on that one. All right. I'm going to move on here.

MR. OWEN: Dr. Bobrowski, it might be a little dangerous for me to guess here, but is there perhaps an ICD 10 code that would show pregnancy? I don't know. That's just a thought.

MS. O'BRIEN: Yeah, I think so, Stuart. I

was thinking the same thing and looking to see if they had a -- you know, identify those members and then see if they have had a dental visit.

MR. OWEN:

MS. O'BRIEN: Probably is a way to do that, yeah.

DR. BOBROWSKI: Yeah, you would have to look at the ICD 10 codes --

MS. O'BRIEN: Uh-huh (affirmative), uh-huh (affirmative).

DR. BOBROWSKI: -- to see pregnancy status.

MS. O'BRIEN: Correct.

DR. BOBROWSKI: Then use that patient name or that number and then go to the dental record.

MS. O'BRIEN: Right.

DR. BOBROWSKI: That's a lot of work -- that's a lot of work -- I don't know --

MS. O'BRIEN: Well, I think --

DR. BOBROWSKI: -- I'm just trying to.

DR. BRAUN: Yeah, it would have to be more at the MCO level instead of it being at the sub -- you know, not the subcontractor. It would have to be like Anthem and WellCare

and Molina and --
DR. BOBROWSKI: Right.
MS. O'BRIEN: -- to be able to pull that data together.
DR. BOBROWSKI: Is that something that would help us on any kind of treatment planning or -- I mean, the -- the -- to be honest, the pregnant ladies that come to our office, we don't see a lot of -- I mean, yeah, every now and then, we might have to pull a tooth or do some fillings, but I really don't see anything different than any other patient.
DR. BRAUN: Right.
DR. CAUDILL: I think that stipulation was removed in the new iteration of the KAR.
MS. O'BRIEN: Uh-huh (affirmative).
DR. BOBROWSKI: Okay. Let's move on, on that one there. Are there any other reports that the TAC Members would move on to the MAC? I believe the main thing is just developing our -- what we first talked about on that. And then I can get that to Ms. Kelli. And then I believe our folks there can work on that one. I'm not seeing

anything that we need to report to the MAC, unless you-all have got something else.

All right. I'm going to move on real quick to -- usually in the past, I would -- you know, we would have election of the chair and vice chair for the TAC at the first meeting of the year. Now, I was researching that with one of our helpers there from Frankfort. And they were talking about, well, maybe through the MAC regulations that's done through the first meeting of the fiscal year, you know, which would put that up in the summer. Now, we could have -- we could do -- by that, we could have nominations made, you know, either like at our meeting today or at our meeting in May. And then our meeting there -- August meeting, we would have our vote. But we do have to probably have the nominations, you know, maybe a meeting before, and then that would be put on the next agenda to actually vote on. That's just kind of what I was going by on the MAC rules.

MS. BICKERS: Dr. Bobrowski, this is Erin

with DMS.
DR. BOBROWSKI: Yes.
MS. BICKERS: We ask -- like to make your recommendations or the nominations in this meeting. And I would think your May meeting would be close enough to the fiscal year that you guys can make your vote on that, so you don't have to wait until August.
DR. BOBROWSKI: Okay.
MS. BICKERS: But that's completely up to the TAC.
DR. BOBROWSKI: Okay. Well, let's get our nominations in and then we will -- we can do our vote in May. We are just kind of going by the rules of what are stipulated in the MAC rules, but let's have the nominations in for the chair and nominations for the vice chair for the TAC. And the floor is opened.
DR. PETREY: If you do it again, I nominate you would be the chair.
DR. BOBROWSKI: Okay.
DR. SCHULER: Me too.
DR. PETREY: You said you number two, Phil?

You -- vice chair, is that what you were saying?

DR. SCHULER: No, I said me too on Garth as the chair. I mean, I'd be vice chair. I don't care.

DR. BOBROWSKI: Okay. Well, we've got nominations --

DR. SCHULER: Me and Garth talk often enough any way.

DR. BOBROWSKI: Yeah. We could -- is there any other nominations?

(No response).

DR. BOBROWSKI: All right. Hearing none, we'll just vote on both at the same time for me being the chair and for Phil being the vice chair. And then we will -- well, I guess we will have to just have those nominations and actually vote on it in May, but...

DR. PETREY: Yes.

DR. BOBROWSKI: We will vote. I guess everybody in favor aye, we will just put those two names on the ballot then in May.

DR. PETREY: Aye.

DR. BRAUN: Aye.

(All voted Aye).
DR. BOBROWSKI: All right. Thank you-all.
Now, is there -- the one thing that's very important that I do not want to leave off today is we want to wish Ms. Erin the very best, because she's getting ready to go on maternity leave.
MS. BICKERS: Thank you, Dr. Bobrowski.
DR. BOBROWSKI: So we --
MS. BICKERS: 24 days.
DR. BOBROWSKI: Oh, boy. Well, we truly do want to wish you the best and -- is it a boy or girl?
MS. BICKERS: It's a boy.
DR. BOBROWSKI: Okay. Well, I've got --
MS. BICKERS: I appreciate that. Thank you.
DR. BOBROWSKI: Yes. Is there any other new business that we need to bring up?
DR. SCHULER: I know we have had a spot at the end for any public comment. I looked on the participant sheet. I couldn't tell if there was any private dentists out there, but we probably leave a little gap at the end to -- you know, if any private

dentists or any other providers are on the call, if they have anything that they'd like to say to the TAC.

DR. BOBROWSKI: The floor is open now for -- if anybody on the call list would like to make a comment or have an opportunity to make the recommendation or for something for the TAC to look into or whoever.

DR. SCHULER: Doesn't sound like we got any takers, but just wanted to throw it out there.

DR. BOBROWSKI: Yes. Thank you. Well, A lot of times, if you will notice on the agendas, I will try to put on there either -- like you said, public comments or other comments or other, especially like in old business, just so I don't forget something. And I did today. I forgot to put on there about approving the minutes. And then I swear, inevitably, if that -- I'll try to get the agenda out at least -- I try to do for two weeks, but the last two it's been a week. But, inevitably, there's always been something that will come up

that's like, oh, man, we need to talk about that. You know, we can't really wait another three months on that. So that's why I put that other on there, is just to kind of help speed up the process on things, but...

Our next meeting will be May the 12th, 2:00 Eastern Time.and I really appreciate everybody's input and thoughts and comments. All we can do is just kind of keep working together and try to do what we can to help our patients and then we -- just to work on our provider network. I think it's critical, because we work on our provider network, it really helps our patients. But that's all I've got. Thanks everybody. Hope everybody has a good weekend. And do not forget that next Tuesday is Valentine's Day. Treat your Valentine extra special.

DR. SCHULER: Most important holiday of the year.

DR. BOBROWSKI: That's right. Well, thanks everyone.

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THEREUPON, the Meeting was concluded.

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STATE OF KENTUCKY)

COUNTY OF FAYETTE)

I, JOLINDA S. TODD, Registered Professional Reporter and Notary Public in and for the State of Kentucky at Large, certify that this transcript is a true and accurate record of the Dental 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 4th day of April 2023.

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