COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: DENTAL TAC MEETING

February 13, 2019
9:00 A.M.
Public Health Building
Conference Room C
275 East Main Street
Frankfort, Kentucky

APPEARANCES

Dr. Garth Bobrowski
CHAIR OF TAC

Dr. John Gray
Dr. Matt Johnson
Dr. Phillip Schuler
TAC MEMBERS

Ms. Stephanie Bates
Ms. Sharley Hughes
Ms. Angie Parker
Mr. David Gray
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APPEARANCES
(Continued)

Dr. Julie McKee
STATE DENTAL DIRECTOR

Dr. Jerry Caudill
Ms. Nicole Allen
Ms. Shelly Grainger
Ms. Adrienne Bennett
AVESIS

Dr. Theresa Mayfield
DENTAQUEST

Ms. Jean O’Brien
ANTHEM KENTUCKY

Mr. Stuart Owen
WELLCARE

Ms. Amy Sinthavong
PASSPORT HEALTH PLAN

Ms. Jennifer Largen
AETNA BETTER HEALTH

Ms. Patti Smith-Glover
HUMANA-CARESOURCE
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DR. BOBROWSKI: Let’s call our meeting to order. Will folks just call in on this phone? Do we have to take that off the receiver?

MS. HUGHES: It doesn’t look like it’s working. I’m not getting a dial tone to call out on. So, I don’t think we’re going to be able to do that.

DR. BOBROWSKI: Okay. Thank you. Welcome, everyone, to beautiful Frankfort, Kentucky on a sunny day.

This is Ms. Sharley Hughes and she will be our coordinator, I guess, for the TAC. I’ve had numerous email conversations. And the good thing about that, she can’t slap my hands or stuff like that but you keep me in line to make sure I’m doing the right thing on some of this stuff here.

We will go around the room and introduce ourselves.

(INTRODUCTIONS)

DR. BOBROWSKI: I know he’s not here yet but David Gray is the new Public Relations’ person with Medicaid here in Frankfort and I’ve gotten to meet with him a few times.

We had a situation come up with some dentists in Eastern Kentucky and I wanted to
thank him for coordinating a resolution to that problem. And I don’t know exactly. Dr. Caudill, you all may have been involved - I don’t know - but it was a situation in Eastern Kentucky with some dentists. It was nothing illegal but just getting a new dentist in and getting him going and stuff like that.

So, if you all or, Dr. Mayfield, if you all had any involvement. I don’t know who all was helping with it but I got a hold of him and he was able to get some resolution to our problems.

DR. CAUDILL: He got a hold of me, yes.

DR. BOBROWSKI: Some things weren’t done right but no illegal intent but it was resolved and I just wanted to thank everybody for helping in that situation.

We need to approve the minutes from the last meeting and I’ve got a couple of things. Under B, Paragraph 2, and I don’t know if I said this - it doesn’t have my name beside it but I think the wording may have gotten twisted.

It says: Traditional Medicaid pays providers 10% less than the MCOs. I believe
that was to mean that there were two MCOs that pays providers 10% less than traditional Medicaid.

And, then, down under Paragraph C, it says: Dr. Brandon Taylor will have his wife look – we need to add the word into – the time it take to do a refund.

Are there any other changes, additions to the minutes? If not, can I hear a motion to approve the minutes?

DR. JOHNSON: So moved.

DR. SCHULER: Second.

DR. BOBROWSKI: All in favor, say aye. Thank you. The minutes are approved.

Now we will typically go through and ask the TAC members if they’ve got any questions or comments for our MCOs, Avesis, and, then, we’ll do DentaQuest.

DR. SCHULER: The only question I have, so, April 1st is coming along and I know we’re not dead positive that anything is going to happen on or about April 1st but we’re eternally hopeful. With the portals that the MCOs are setting up, do we have access to those portals currently the way they’re going to look on April 1st? What we see now is the way it’s going to be April 1st?
MS. ALLEN: With the exception of a few new items that DMS is now giving us access to, or I should say DMS and the MCOs are giving us access to, for example, identifying if the member is below the poverty level. That’s a new indicator that we currently don’t reflect in our system. So, we are updating our systems so that we can receive that information and then share that information with you on the portal.

But other than that, pretty much that’s it. The copays are there and that information is there.

Dr. Bobrowski, may we say something, if that’s okay?

DR. BOBROWSKI: Yes.

MS. ALLEN: We had two things that we wanted to talk about. The first is in regards to incarcerated members. Recently, DMS released a notice that there will be penalties held against the MCOs if we submit encounters for incarcerated members.

Services rendered to an incarcerated member should not be billed to Medicaid. Those services go through the federal government.

So, if we can please state here
for the minutes that as a friendly reminder, please
do not submit claims for incarcerated members to
Medicaid.

MS. BATES: So, correction.
Stephanie Bates. Sorry I’m late. Just to correct
you, the way that incarcerated coverage or
eligibility works is if someone is incarcerated,
generally their eligibility is suspended for Medicaid
and the Corrections’ folks pick up any kind of care
while they’re incarcerated.

However, if they come out for
twenty-four hours, like if they go to the hospital,
those claims, once they’re out for twenty-four hours,
come to fee-for-service, not the MCO. Does that make
sense?

MS. ALLEN: Yes. Thank you for
that clarification.

MS. BATES: So, just know that
that’s a clarification. Now, I would be shocked if
you would see an incarcerated member because they
would be inpatients most likely. It would be
something that happened, they had their appendix
rupture or they got into a fight or something like
that. They kept them in the hospital.

DR. GRAY: That’s actually when
we see them. So, how do we know? How do we know this? How do we know how to bill it?

MS. BATES: So, when would you see an incarcerated member?

DR. GRAY: They break their jaw and we see them in the hospital.

MS. BATES: So, that would be included in their hospital stay.

DR. GRAY: It would be while they’re in the hospital.

MS. BATES: Right. So, the hospital should know because they’re not going to be there alone.

DR. JOHNSON: But the surgeon bills the dental services directly.

DR. GRAY: We bill our entire services. So, how do we know as the surgeon?

MS. BATES: If you are seeing a patient that’s incarcerated, my guess is that——

DR. GRAY: Well, they’re not incarcerated. They’re in the hospital.

MS. BATES: Okay. If you don’t mind, let me finish. If someone is incarcerated and they go to the hospital, they won’t be alone. They will be escorted in some way. So, that facility will
know if they are incarcerated. So, they should be
communicating that with you. Corrections isn’t going
to let an incarcerated member just go to the hospital
by themselves.

    MS. ALLEN: And if I may help.
The member will have an “I” indicator on the portal.
So, the portal that you go into for fee-for-service,
towards the bottom middle, there’s a section that has
special indicators and they will have an “I”
indicator to identify that they are incarcerated.

    So, if your staff is looking at
the patients that you are rendering service to and
validating that they have coverage either before you
render the service or before they bill, please
educate them or ask them to look for that “I”
indicator. And if they do have the “I” indicator, as
Stephanie stated, then, the claim would go to fee-
for-service. Does that help?

    DR. GRAY: Not much because if
it’s not written down on how to do it, if there’s not
a flow chart on how to do it, we see the people. We
may or may not see that they’re with someone. We
have no way to do that. All we will get is whatever
their identifying data is.

    So, somebody has to know that
it is fee-for-service as opposed to MCO, but where do they get that information? If it’s not on the portal, what I’m saying is there’s no way for us to figure that out.

MS. BATES: It is in KYHEALTH.Net. The indicator for incarcerated individuals is listed in KYHEALTH.Net.

DR. GRAY: And how to bill it, bill it as you said, bill it to fee-for-service?

MS. BATES: No, it probably won’t say that.

MS. ALLEN: But we do have a reminder on the Avesis portal that if it’s an incarcerated member, please bill to--actually we’ll update it to state to bill to fee-for-service. Right now we just state that incarcerated member services are not billed to Medicaid but we’ll add in the additional information to send that to fee-for-service.

And, then, we also did send out a letter. DMS sent out a letter - I know this is too far back - but it was August of 2016 that they sent out a letter and we’re in the process of drafting another letter that we’ll have to submit for approval.
Somewhere the twenty-four hours needs to be in there because that’s a caveat that if it’s not twenty-four hours, it’s not covered. Is that right?

MS. BATES: But it’s covered by Corrections.

DR. GRAY: Whether that’s county Corrections?

MS. BATES: Right and I can’t speak to Corrections obviously, but if they leave Corrections and go in to a hospital for whatever reason. So, that doesn’t necessarily mean your ER visit, but if they’re inpatient----

DR. GRAY: Our experience with Corrections is that they don’t cover it. So, it’s essentially not covered.

MS. BATES: So, the federal government does not allow Medicaid to cover services while they’re incarcerated.

DR. BOBROWSKI: Okay. That was number one. Now, you had a number two.

MS. ALLEN: Number two is the anesthesia notice.

DR. CAUDILL: A while back, DMS added expanded coverage for intravenous sedation,
moderate sedation. It used to be only for children and they expanded that to include adults so that oral surgeons especially weren’t forced to use a deep sedation general anesthesia code when maybe they were only doing moderate sedation.

However, an unforeseen side effect of that was all the general dentists out here that had a moderate sedation license suddenly started submitting claims for anesthesia to do two fillings and quite honestly crazy stuff, inappropriate stuff.

So, we did come up with some guidelines, basically the ones that were used in Pennsylvania. We met with anesthesiologists and some oral surgeons and, then, we met with both dental schools here in Kentucky and came up with some general guidelines as to when it would be appropriate to use moderate sedation in the private office.

And that was sent out by one of the MCOs already and I think we’re just pending the final approval on the others for them to go out but it’s all the same document.

So, we just wanted to make you all aware that that did go out, Humana-CareSource, it already went out to the network for them. So, we’re just trying to put some guardrails on so that it’s
used appropriately.

DR. SCHULER: Did letters go out to all the providers?

DR. CAUDILL: In Humana-CareSource, yes, and we’re just waiting on some final approvals for the other plans to go out.

MS. ALLEN: And that’s our two.

DR. BOBROWSKI: I had a gentleman about two weeks ago. Bless his heart, a lot of people don’t like going to the dentist. He was a rather portly young man but they’re so nervous. He is sweating just sitting in the chair.

Years ago, my office was one of ten in the state that was chosen to do a dental fear program through the University of Kentucky and a rather intense deal on how to handle fearful patients. It was kind of like a pilot program, but it does. It kind of makes you more aware of folks that have really got a true fear and how to help them.

So, I applaud efforts to see those people being seen through the Medicaid arena. Our only choice in our area, there’s a dentist about sixty-five miles away that will do sedation but it’s fee-for-service. It’s no Medicaid. Travel time is
hard. So, I applaud those efforts to make it realistic but still be able to see patients like that gentleman.

DR. CAUDILL: I was kind of the instigator of that because some oral surgeons came to me saying we feel like we’re in a box here. We don’t need to really take them all the way down to a deep sedation or a GA but that’s the only code we can use for these adults. And, so, we’re almost being forced to put the wrong code down in order to get any payment for what we’re doing.

And I proposed that through the plans and to DMS and they agreed and expanded it but, then, that opened the floodgates for all the other general dentists who had that certificate in the state to start doing it for everything which was not appropriate. And, so, that’s why this document was created and put out there.

DR. BOBROWSKI: I’ll let you have a three if you want it. Any other?

I won’t bring this up again but we mentioned it last time, but another patient brought these in to me from an MCO. I’ve got four letters to the same child in a family all on the same day stating that it’s time for checkups, not dental
but like their medical stuff. And the person that brought it in, they know I’m on the TAC. A lot of times, people see stuff like this and they say, well, here’s a good example of government waste and that’s what they tell me. So, I just wanted to make you aware.

And I know some of these things are not in your purview but, then, some of them are but I think it’s good for all of us. In our offices, sometimes we’re running on a tight budget on some things and we have to look at every penny that we expend. I know the public that we serve watches government spending also.

MS. BATES: So, just to speak to that. So, as you all know, we, Medicaid, DMS pay the MCOs on a capitated basis, so, a per member/per month and we only pay them for one. So, that’s their expense that they eat.

So, just know that when those types of things happen on the MCO side that the State dollars are going toward one notice and not the mistake that they may have made by mailing four. I don’t know if that helps but we pay on a capitated and all those actuarial calculations of rates are based on things that we require and that but it’s
based on one, not four.

And, so, if those administrative costs to the MCO or a subcontractor include mistakes like that, we don’t pay for those.

DR. BOBROWSKI: And I’m sure it’s probably just a glitch in the software or something that is pumping these things out in multiples instead of one but I just wanted to make the TAC aware and you all aware.

DR. JOHNSON: I understand that and that’s accurate, but from a member’s standpoint, they lump everybody together.

MS. BATES: Oh, no, I totally agree.

DR. JOHNSON: So, I’m saying I know that’s not DMS’--I mean, I know that--I understand and your point is well-received, but at the same time, from their perspective, you’re the same person. And, so, it’s kind of one of those things, if they’re doing it, it’s not DMS’ thing but they fall under the same place.

MS. BATES: Sure, and I agree, but for purposes of the TAC meetings, I’m more concerned that that person gets the care that they need than whether the MCO sent out three extra things.
because I know that we’re not paying for the three extras things. So, for purposes of this discussion where we know where those dollars go, I just want to put that out there.

Of course, for the whole state, I can’t explain everything to all 1.4 million people. If I could, I would, but, again, just know that those dollars are directed to one rather than the four.

DR. BOBROWSKI: That’s just good to know.

Medicaid fee-for-service, any comments, questions?

MS. BATES: I thought I would just go ahead and tackle the elephant in the room of the new TAC rules.

The Commissioner couldn’t be here, so, you get me. I’ll just tell you, I’ll just relay a message. How does that sound? But you all got the new TAC rules, so, just ask me any questions that you have about it and I will tell you what I know she will say and we can go from there.

DR. BOBROWSKI: And I got it down at the bottom.

MS. BATES: I’m afraid I’m going to be pulled, so, I just wanted to tackle this
I’ve got that on there, that Commissioner Steckel had formed an ad hoc committee for MAC members and TAC Chairs to look at the TAC and MAC operations. Is that a good term to use?

MS. BATES: Yes.

DR. BOBROWSKI: And I did bring a copy of the MAC bylaws. And correct me on this because this is new to us, too. It’s like some of the things that the Commissioner was suggesting goes - I’m going to say this as politely as I can - that goes against the MAC bylaws.

MS. BATES: Okay. She’s basically looking at the statutes and what’s ordered through the law. And if you read them, it’s basically that the TACs and the MAC will advise on policies and program development. There were three things. I can’t remember what the other is.

And, so, just in a nutshell, just know that she is wanting to get away from the one-off individual discussions; and by individual, I mean down to a person out there and to bring those back to you calling me or you calling the MCO or whatever.
It got a lot of attention, but at the end of the day, she wants you all to look at the program and say we really have these situations where individuals are terrified to get care. So, how can you all add a service that will help that that will result in more care for individuals like an IV sedation or something.

So, it’s more of she wants this and all TACs and the MAC to take an advisory role. That’s kind of the meat of what she is getting at. It’s just kind of gotten, depending on the day and the TAC and all the TACs are different.

DR. BOBROWSKI: And we agree. I understand that. To some of the folks, whether it be a patient calling me or another dentist calling me, it’s like yesterday morning, before I even got to work, I had like four texts and two phone calls and some of it is related to stuff that I think the TAC needs to be discussing or that maybe I can help them. I could call Jerry Caudill or I could call Stuart or something on some of these things.

Sometimes the dentist or the patient - and I’ve got it in my notes here somewhere - but they feel like they have tried all their appeals or they’ve tried their mechanisms that they
know about, but you all know, when you get into MCO and governmental language, it’s like you might call one person----

MS. BATES: It’s intimidating and you get the runaround.

DR. BOBROWSKI: You get the runaround. Sometimes they will call me or another dentist or the Kentucky Dental Association will help. So, I understand that we need to bring some of these things to individual MCOs but sometimes it’s like they feel like, sometimes I felt like that I can’t find out an answer, so, I just have to bring it up to the TAC and then we can discuss it or at least start a conversation on how to handle this situation.

Just like the sedation, it hadn’t ever come up before but now we’re working through that. We had the deal two or three years ago about the use of nitrous oxide. We brought it up here but we worked through it, and I believe it got more care, just what you were wanting, for the children.

So, I understand it. Just for an individual claim, we don’t need to waste our time here on stuff like that.

MS. BATES: I know that Avesis
and DentaQuest, the folks here will help if there’s a phone call but there are Call Centers and things like that. Just like at Medicaid, there are Call Centers and there’s miscommunication.

So, you know that you can always send me something and I will research it and that’s no problem; but for purposes of the time spent here, she really just wants things to be at a higher-level policy.

Now, if you get twenty people that have the same issue, then, you come here and say there’s this issue, I don’t know what’s going on but this happened, then, that’s appropriate.

And, then, the dentists or the folks here or KDA or whoever, I don’t know if you already have - she has mentioned this at other TACs - if you already have one-on-one meetings with the MCOs, but that is also something that the others do. Like, KHA is a perfect example. They have their own meetings with the MCOs separately and that’s when they go over the actual individual issues.

So, it might be a good idea for the MCOs to set those up. You can’t really meet as a TAC without it being open, but as an Association, you can. And, so, that might be another venue for you to
have regular meetings. A lot of the associations do that. The CMHC’s do it. KHA does it. The optometric folks do it. And I don’t think you all have those separately but----

DR. BOBROWSKI: We don’t.

MS. BATES: And I’m sure they would be happy to do that.

DR. BOBROWSKI: So far - you all chime in here - I feel like we’ve been able to most of the time get questions resolved by calling Nicole or Dr. Jerry or calling that MCO, Dr. Theresa. People have called, and for the most part, I believe things have gotten handled without those separate meetings. That’s what we need is one more meeting.

DR. GRAY: When you say higher level, could you be more specific what it is?

MS. BATES: It could be any kind of policy. Take back when we started with Kentucky HEALTH. You all brought your concerns about Kentucky HEALTH here and the policies that were being developed as we were getting ready to go live with My Rewards and all of that and the suggestions on the codes that should be in and out. Those are high-level policy decisions.

Now, I will tell you that the
Commissioner is very adamant about once we’ve made a policy decision, bringing it up at the next meeting isn’t going to work because we’ve made the decision, whether it goes in the favor of whoever has asked for it or not, but it is a higher level.

Remember back when we had address mismatch. It would be let’s talk about it and you all, as a TAC, here are the reasons why this is terrible. People need care.

So, it would be just those higher-level things, not - and I don’t mean this in any disrespect - but not bringing letters in to talk about the one person that got the letters. It might be here’s something I hear all the time. There’s all these letters that come in and we don’t understand why the State is spending all this money, and our response would be what I said and, then, that’s where it stays. And, so, that’s the kind of stuff that she would bring up if she were here.

Now, you all know, I’ve been at these meetings and I’ll answer anything but that’s her stance right now and that’s where she’s going with it.

Sharley, you all jump in if you want because Sharley is the leader and the organizer.
MS. HUGHES: One thing we are putting together for TACs and I’ve got it to the Commissioner and so forth for approval is we’ve asked every MCO to provide us contact names, phone numbers and emails.

I put together a list that we will distribute to each of the TACs so that you all will have that and it will be that person’s name and email and direct phone number for you to be able to reach them rather than going through a Call Center if you’re having some issues.

One of the members of a TAC last month had a call come in the day before that she was not able to get resolved, so, she brought it up, and my point to her was, what if you had gotten that call tomorrow. You would have waited two months to bring that to the TAC when you could have called us directly or called the MCO and gotten a resolution.

So, we are going to have that contact list out to you very soon. That should help.

DR. GRAY: With this idea of higher-priority decision-making and higher-priority program implementation, this is done at the higher level without input from the TAC. That’s what I’m hearing. Is that correct?
My problem is, where I’m going with this is you can we want this program. It’s a great program but we’re not going to fund it at all, zero funding, so, you really have no program.

At some point in time, there has to be boots on the ground to implement programs. And if you say this is a good idea but you don’t have anyone with boots on the ground that’s going to help assimilate this program, it’s never going to fly or it’s not going to fly well.

And I feel like as a member of this TAC that we have not had a voice and boots on the ground in most of these implementation processes, and this is not with this Commissioner. It’s ever since I’ve been on the TAC, no matter who has been here and no matter what administration.

We are a resource as boots on the ground, and it may not be important about the paper and how this patient is doing it or that patient is doing it but it goes to the boots on the ground, the people that are actually performing the services. Can we get it done? Is it realistic?

You mentioned earlier you can’t imagine about the twenty-four hour deal. That’s because you’re not an oral surgeon. That’s not what
you deal with. That’s what I deal with, so, that’s what I have to bring up.

And somewhere, when all these things are made, policies are formulated, there needs to be input from people who are actually going to be doing it. I don’t feel like we’ve had that input.

MS. BATES: I know it feels that way, but I assure you that all of the recommendations that came from everywhere but especially the dental community and the vision community we took into account and still—I mean, right now as I speak, there is a meeting about how the Kentucky HEALTH panel that you all look at looks to make it easier for you all based on the recommendations from the provider community.

So, just because a recommendation that’s made by the TAC or anywhere isn’t implemented, there’s a reason. It probably wouldn’t surprise you how many recommendations for changes we get and all the bases.

So, it’s hard to answer and give a reason for everything, but every single one of them down to why can’t we see the My Rewards’ dollars in KYHEALTH.Net. So, we understand the reason for asking for those things but some things we just can’t
do because of reasons, because of HIPAA or whatever they are, I don’t know, and that’s not a good example, but we do take those into account. But I hear you as far as things like the incarcerated. And I’ll tell you, that particular issue is not new but it’s newly arising in Medicaid and being looked at all the way down to connecting an incarcerated individual to care as soon as they get out and are released which is important which that hasn’t been happening because of eligibility things in the systems. DR. GRAY: The problem is we have to deal with the patient that drives two and a half hours that doesn’t even have the money to get there. And when they get to our office and they’re already upset because they’re hurting and they get there and they don’t have the money to have what they thought they were going to have done and, then, they’re yelling and I mean literally yelling and screaming at us. A doctor was shot in Eastern Kentucky because he wouldn’t give pain medicine. It’s real. It’s real. MS. BATES: I was yelled at for thirteen years. I know. I’ve been on that side. DR. GRAY: It’s yelling at a
higher pitch than ever before. It’s frightening to people when we can’t get that information. It’s just really important that we get it. That’s just one point that you brought up. We can’t tell them before they make that drive, we’re not going to be able to accomplish all this. It would be very helpful to do that.

MS. BATES: But back to this TAC, so, any policy type things, anything that’s higher level like that is kind of what she is looking at and not the individual scenarios, not that we don’t care about them but there’s a place for those and this is more supposed to be policy advice from the provider network.

DR. BOBROWSKI: See, the providers, a lot of them, they just feel like administration doesn’t care. I don’t mean to be blunt but that’s what we get on our side of it. Sometimes we get it back from them.

I think the relationship between a lot of the MCOs and the providers is getting better because of dialogue that we’re having and we’re working issues out.

I’m really concerned about the My Rewards Program, and I know what you all want, but
there’s logistical things that are going on that are
going to really make it hard for a general dentist
office to absorb the additional cost of checking
these people in.

Right now, the patient, when
they come in, we are able—in Medicaid, if you’re
doing fifty, sixty percent or more Medicaid,
sometimes it’s not that you’re trying to do illegal
treatment. The treatment that they need to have
done, it’s right there.

The patient has got five
cavities here. Well, instead of being able to come
in and do one, right now, we can do, hey, look, we
had a cancellation at ten o’clock. Do you want to
stay and get these other ones done? Yes, let’s get
them done. So, it helps us to be able to make $100
that hour instead of $39.

MS. BATES: Right.

DR. BOBROWSKI: We could talk
about this another day.

DR. McKEE: Well, on a higher
level, that’s better patient management, too, not
just the extra $71 or $61. That’s better patient
management.

MS. BATES: Well, because you
might not get them back, right? They might not come
back and there’s that.

DR. McKEE: True. It might not
be covered next month.

DR. GRAY: And the cost to the
patient driving in.

DR. SCHULER: So, let me ask
you this. When new policies are being formulated
because you’ve kind of stated once a policy is in
place, it’s going to be a challenge to get anything
undone, as those new policies are being formulated,
is it routine practice for those to be brought before
the TAC for comment and consideration before they are
implemented?

MS. BATES: I think it really
just depends on the policy. If it’s a policy that
we’re implementing because of a change in a federal
regulation or something that we have to do, we kind
of just have to do it.

DR. SCHULER: Sure.

MS. BATES: Now, how we
implement it or put it out there or how fast we have
to do it depends on whichever one.

Yeah, I mean, those are totally
open for comment. Regulations are always open for
comment. A lot of our policies come out of things that are changed in regulations and sessions like this. So, if you all are interested in that kind of thing, you really need to follow those types of open—open whatever they are, regs or whatever.

SPAs are a good one. Changes that are made through the State Plan Amendments, they’re put out there for comment. So, there’s so many changes that happen that may not just relate to the dental community.

We don’t necessarily reach out and say this is going to change. We try to use our MCOs as our arm to communicate things but a lot of times it’s when it’s already been decided.

So, as things happen, we can bring them to you all, but it’s usually going to be more of an implementation, but that doesn’t mean—I keep coming back to address mismatch. That doesn’t mean just because that policy was implemented whenever it was a few years back, we were able to do away with it.

And, so, if you come to us once that policy is implemented and lobby for it to not be and give us reasons why, which that particular policy, I was on board with all the providers on
that, but, seriously, that’s the kind of stuff. So, it isn’t that once a policy is implemented it can’t be changed, but the point is for purposes of the Commissioner and I’m just warning you on this is that if we said here is the answer to the question today and, then, the next Dental TAC, the same question is brought up like we don’t like copays or something, then, she’s going to say we’ve already answered this. And, so, that’s the kind of thing that I’m talking about. It’s kind of from one month to the next, the answer is not going to change but it may when you get a new Commissioner or a new administration or a new director over something or whatever it is.

DR. GRAY: My question would be if it’s the Dental Technical Advisory Committee, in what capacity - and this is a serious question - but in what capacity would they like our advice, would the Commissioner like our advice? At what point in all the processes would the Commissioner like our advice?

MS. BATES: I mean, and I’m speaking for myself and Sharley can kick me, but any advice that you have that is going to help the member community, the providers because we wouldn’t be here
without the members and the providers and I recognize
that very much so. So, anything that would help.

And, then, overall from a
fiscal standpoint, if you see something that’s going
to save the State money, that’s obviously always of
interest to us but we don’t want it to be at the
detriment of a provider or a member.

So, any advice that you all
have that you see out there because you are boots on
the ground would be welcomed.

DR. GRAY: Would there be any
advice appreciated in the development of higher-level
programs or is that done and, then, advice on how to
implement or would it be in the formative stages of
policy?

MS. HUGHES: One thing the
Commissioner did tell us was that we would need to do
a better job of bringing changes that we could bring
to you all to you before a decision is made.

Like Stephanie said, sometimes
those decisions are made a whole lot higher than my
level and even higher than her level. And once they
are made, then, at that point, it’s like, okay, how
do we implement it, but the Commissioner did
challenge us of bringing, if we can possibly do it,
bringing to you all this is what we want to do. Tell us, is it going to be a really bad idea or is it going to be a great idea but it’s going to be hard to implement and that type of stuff.

DR. SCHULER: And that’s really what I was talking about.

MS. BATES: A perfect example right now today would be the telehealth reg that’s out there and it’s wide open. It’s wide open.

DR. BOBROWSKI: And there’s some problems with some of that.

MS. BATES: And I sit here to tell you that we’ve gotten many recommendations from the provider community, from associations that every single question we either say, yes, we can do that and we’ve changed it but you just haven’t seen it yet.

So, things that are wide open, then, in my opinion, and the dental community should have a very high interest in the telehealth regulation, then, I would get your advice over and your questions because even if it’s not advice, if it’s a question that you have, it sparks in our mind, oh, wait, that doesn’t make sense, so, we do need to change that. And we received questions very specific
to dental from non-dental providers and not
necessarily we haven’t heard much from the dental
community. So, that’s a perfect example of where,
even in this meeting but even outside of it, where we
welcome comments because this is the time. 7/1 is
game on and we are making those changes.

    DR. McKEE: What is the date of
closure for the comments for the telehealth?

    MS. BATES: I knew you were
going to ask.

    MR. OWEN: It’s the end of this
month.

    DR. CAUDILL: But I can give
you an example of what she talking about because I’ve
been sitting on committees with the Telehealth Board
to make recommendations to DMS, and one of their
thought patterns was, well, we’ll designate a
telehealth encounter or treatment with a modifier.
And I had to say, well, excuse me. Dental claim
forms don’t have modifiers.

    Well, the other people on the
committee had no clue. So, if you’re not at the
table, you’re on the menu. If you’re not there to
make these things happen, then, you’ve got to try to
unwind it after it’s already taken place and that’s a
whole lot harder to do.

MS. BATES: So, when we revise this regulation, dental providers in our minds are absolutely in there. It’s any Medicaid provider that’s acting within their scope of service and that covers obviously a dentist.

But to Jerry’s point, if at the end of all of this, all the questions haven’t been asked and the operationalizing of it doesn’t work, then, come 7/1, you can’t get paid for a telehealth, right, and then we’ve got to figure all that system stuff out. So, that’s a good example.

DR. BOBROWSKI: I’ve got a question for you, then. On the telehealth bill, why is there language in there that it pays a certain rate the first year, but after the first year, your payment is cut in half?

MS. BATES: It wasn’t cut in half. I think it was eighty something.

MR. OWEN: Five.

MS. BATES: Eighty-five.

MR. OWEN: I think it says to allow providers time to acclimate and build the technology and related infrastructure to do it more efficiently. I think that’s actually what the reg
actually says but that’s the reason why.

DR. GRAY: I think that’s helpful and I think it would be helpful for us without you all to meet with the MCOs to say, hey, where do we need to go.

MS. HUGHES: And what the Commissioner has offered, if you all want to do this immediately following your TAC, we can extend the time that we have this room reserved for, if it’s available at the same time you all have your meetings, and, then, you all can sit around and if you’ve got a bunch of claims issues and that type of stuff, that you can meet one-on-one with Avesis and DentaQuest and hash that out.

That is something that we’ve offered every one of the TACs is that if you all want to get down to the claim level and have claims discussions, we can extend your time here. I don’t know if you all have your offices closed or whatever, but if you wanted to do that, you can.

DR. CAUDILL: So, after the official meeting is adjourned.

MS. HUGHES: Yes. After we’ve closed the TAC meeting.

MS. BATES: And that way, you
don’t have to have a separate meeting and you can
kind of go over these one-offs.

    DR. BOBROWSKI: I think a good
policy thing that was started here a year or a year
and a half ago was the silver diamine fluoride. We
brought that and I think you all had some good
information and background data to bring that in and
it helps children with that need and sometimes it can
even help folks in the nursing homes, the two ends of
the spectrum there of age groups.

    DR. CAUDILL: And Red Bird
Mission is doing that right now. They’re going to
nursing homes and senior citizen centers and they’re
using silver diamine fluoride because that’s a non-
ambulatory population that can’t get to the dentist.
So, they’re going to them.

    DR. BOBROWSKI: And that’s a
policy change through DMS that’s been helpful to the
citizens out there.

    MS. BATES: But, anyway, so, as
far as fee-for-service goes, outside of that, we do
not have a Dental Director yet but we’re working on
that. So, Dr. Liu for a minute was Dental Director,
Medical Director and Pharmacy Director but we have a
Pharmacy Director now. So, now the next is a Dental
Director.

DR. BOBROWSKI: Okay. Good deal.

Under Old Business, the eligibility check-ins has gotten better. I just wanted to thank everybody for working together on that and getting that mostly resolved.

Under Old Business, we had sent in a question to the State on age and claims paid information. And we did get a response back but it had nothing about ages in there.

MS. HUGHES: See, I didn’t know what kind of data you were actually requesting.

MS. BATES: What is that question?

DR. BOBROWSKI: We had through the portal which we’re supposed to go through----

MS. BATES: So, it was a data request? You’re talking about the data request?

DR. BOBROWSKI: Yes.

MS. BATES: And you all got the data.

DR. BOBROWSKI: And it wasn’t right.

MS. BATES: Wasn’t right in
DR. BOBROWSKI: Well, we had asked for an age breakdown of claims paid. We used to get the geo maps where it showed where a dentist was providing services, but we asked to get a little bit more information on that of what age group of dentist is providing “x” number of paid claims across the state so that we could see who is providing services.

DR. JOHNSON: Nicole, wasn’t she going to help do that stuff?

MS. ALLEN: Yes. I sent you that information, the specs for how we generated the report previously. I did send that, I think, like within two days after our meeting.

DR. JOHNSON: You did?

MS. ALLEN: Yes.

DR. CAUDILL: It was how to fashion the request.

DR. JOHNSON: I don’t know how to process it to send it to you so you can get the data that you want. Basically what we’re looking for is paid claims on how much is, you know, a breakdown of zero to $1,000, $1,000 to $500, whatever per provider and, then, we want to know age breakdowns of
how many providers are providing claims mainly so
that we can tell if 80% of the claims are done by
people who are 55 or 60 or older, what is going to
happen in ten years.

MS. HUGHES: So, you want the
age of the dentist.

DR. JOHNSON: Of the provider.

DR. BOBROWSKI: We had that
information sent in through the portal and it just
wasn’t the correct information that was requested.
And, Nicole, I----

DR. JOHNSON: I can still find
that information----

DR. BOBROWSKI: I’ll have to
look. I’m sorry. I didn’t see it.

DR. JOHNSON: ----that we were
looking for.

MS. SINTHAVONG: I think it’s
just ensuring that the TAC Committee asks for the
appropriate specs and that’s when Nicole was going to
send that because we used to provide it as MCOs and,
then, we were told we were not supposed to, and I
think that we were previously told just make sure you
have exactly the data that you’re requesting.

So, maybe if that’s not
correct, they can speak to somebody that can tell
them, okay, this is what you need to request.

MS. BATES: Let me talk to the
Commissioner about this because she hasn’t really
even talked about data requests with our new
procedure for TACs and stuff.

So, let me ask her how she
wants to handle those. She may ask that you all send
them through open records and that way you can
explain exactly what you want since you’re not going
to know the specs that are in the system, but let me
go back and talk to her about the data requests and
see if she wants to do something. That system and
stuff, that was before her. That was when Veronica
was here. So, I will look and I’ll talk to her.

Will you send me what you sent
him just so I have the specs in case she says, yeah,
go ahead and do it and we’ll see if we can do it?

MS. ALLEN: Yes, I will send it
to you.

MS. BATES: Thank you.

DR. BOBROWSKI: You asked us
really not to bring up copays.

MS. BATES: No, I didn’t. I
said don’t ask us to not implement copays because we
already said that we were.

DR. BOBROWSKI: Okay. I understand the difference. I got this. We’ve been told children do not have copays.

MS. BATES: Correct. That is the way it’s supposed to be as of 1/1.

DR. BOBROWSKI: Even at my office, we had another 13-year-old that did have a copay on their portal information. And I copied off, are services exempt from copays? Exceptions may apply but are not limited to emergency services, preventive services. Providers should reach out to the MCO for specific codes.

MS. BATES: So, the blanket answer to your 13-year-old question is no 13-year-old should have a copay that’s on Medicaid regardless of what you read on that document because those copay rules about like emergencies and all that stuff, like, a child should not have a copay anyway.

So, I would like to have an example of where, if you have that actual child because I need to see who the MCO was.

DR. BOBROWSKI: Okay. And, then, the same thing like here. Just kind of the way things are worded, it just leaves it open for
ambiguity. And like I said, this one here, I got this and they called the MCO and I’ve got a reference number for it and the MCO said, yes, there is a copay on the children.

MS. BATES: No. I’d have to see the example.

DR. BOBROWSKI: That’s where we’re getting mixed messages.

MS. HUGHES: Did I send you an email asking for the example so we could look at that one?

DR. BOBROWSKI: Yes, and I didn’t have access to that specific one. That’s why I didn’t get back with you on that one.

MS. BATES: And do you have the provider copayment logic that was sent out?

MS. HUGHES: That was sent to all the TACs.

DR. BOBROWSKI: Here it is. I’m up with you. I’m trying to stay on top of this stuff.

MS. BATES: I’m not interpreting that for you today. I’m being off the cuff but we’d be here all day long.

DR. BOBROWSKI: It’s just like
on here, copay is not deductible when maximum cost
share levels are met and, then, it’s got 5% out there
at the end of that sentence. Are you all trying to
throw me off? What is that 5% on there for?

MS. BATES: That’s how we
calculate the—so, a Medicaid recipient, once they
hit 5% of their income or whatever for what they pay
out in copays or whatever they’re paying out, then,
they no longer have to pay the copay or the premium
if we get to Kentucky HEALTH.

And, so, in your Kentucky
HEALTH portal, so, just imagine your portal and it’s
not a child, so, we’re going back to an adult and it
says copay indicator, yes, so, they have a copay,
but, then, you go down to cost share and it will say
no if they’ve already hit their 5%.

But all of that, what I just
said, is why they’re having a meeting right now to
look at those screens because there’s also the caveat
if they’re under 100% of the FPL, you can’t deny them
services. So, we’re trying to make all of that more
user friendly instead of just saying—I think it says
poverty indicator right now for the FPL and we’re
just going to say under 100% or over 100%.

DR. GRAY: When you say can’t
deny services, what does that mean?

MS. BATES: That means if they are standing in front of you and they can’t pay a copay, you still have to see them.

DR. BOBROWSKI: See, some of the wording in some of this, it talks about the pregnant ladies and children, that they don’t have copays anyway, so, why is there language in there that we can’t deny them services? We weren’t going to deny them anyway because they don’t even have a copay.

MS. BATES: Well, it’s doubly you can’t deny them, so, you really can’t deny them.

DR. CAUDILL: So, it’s all children including KCHIP’s don’t have a copay, right?

MS. BATES: Yes. KCHIP III did have copays before like in the fee-for-service waiver world but we actually took those out, so, that way we could say all children have no copays.

DR. GRAY: What if they don’t have any money left on their----

MS. BATES: Now, My Rewards is a totally different story. We’re getting into some weeds but I’m talking about in today’s world of copays outside of the waiver, you can’t deny them
services if they can’t pay. My Rewards and Kentucky HEALTH are totally different.

DR. CAUDILL: Is that only if they’re under 100%, though?

MS. HUGHES: Yes.

DR. GRAY: Will there be a can’t deny services to My Rewards if they don’t have any----

MS. BATES: Our Rewards’ services are not necessarily covered services. That’s a different story. We can’t get into all this here, and I understand you have the questions and we are happy to have a meeting with you all separately. I mean, we’ve been doing this now for over two years and all of those policies on things really haven’t changed much.

And, again, I thought that David Gray, but we’ve met with KDA. We’ve been at the table. So, if there are unanswered questions that we haven’t already answered, I’m happy to answer them or answer them again but please send them to me and we’ll do that.

DR. BOBROWSKI: I know that David Gray came to the KDA and I was there and it was a good introductory meeting.
MS. BATES: Well, he’s not going to know all the policies and that’s fine. His role is to say, all right, so, I met with them and they don’t know anything, so, you all need to meet with them. I mean, that’s basically what it comes down to and we’re happy to do that to get in the weeds, but, again, I don’t know that we need to do that here.

DR. BOBROWSKI: We need to bring some of these things up so that we can dig deeper into them because, like you said, even yesterday, I had numerous texts and phone calls. It’s not like that every day but I get a lot of emails, texts, messages, phone calls and sometimes I can’t answer all of this.

MS. BATES: Right. Right.

DR. BOBROWSKI: And I’ve got ladies out at my front desk that have been with me for twenty, twenty-five years doing Medicaid and this stuff is confusing to them.

MS. BATES: It’s confusing to us honestly sometimes. I’m just being real honest.

DR. BOBROWSKI: Thank you.

MS. BATES: We’re all human beings, right?
DR. BOBROWSKI: You take an office that’s got a new receptionist and----

MS. BATES: Well, if you take a Call Center at the MCOs or DMS that you have a new person. So, if you get an answer like you did, those things happen but we want to try to keep them from happening.

DR. CAUDILL: And when you call Provider Relations or call me, I call Phoenix and they re-coach that person who gave the wrong information. As Stephanie said, we have a constant turnover of employees just like you have a front desk person change or a system change. Well, so do we and we train them but sometimes new trainees make errors and, then, they have to be re-coached.

DR. BOBROWSKI: Well, my staff says call Dr. Caudill. Don’t call Phoenix.

DR. CAUDILL: And that’s why I give my cell phone to everybody.

DR. BOBROWSKI: Before you have to leave, I need to bring up one other thing. I know right now, one of my staff is going through the webinar trainings for the MPPA project and it’s an hour and a half a day for four days. She printed this stuff off just in case she had to make notes.
Now, this is two days of webinar information.

My question is, why could the State not have—a lot of dentists are already signed up with a national clearinghouse, ProView Administrators, CAQH. Why could the State not have used that because all of our information is already on there and the dentists can click buttons? Do you want to allow all insurance companies that are requesting data from you to get this data or you can select which insurance company or entity like that to use your data.

Why could the State not have used a system that is already set up nationally? I know he has already had his staff under training. That’s just two days of information right there.

MS. ALLEN: Dr. Bobrowski, is the MPPA, is that the new credentialing portal for credentialing?

MS. BATES: No, no, no. It’s the provider portal.

MS. Oh, okay, just the provider portal. All right. Thank you. Sorry.

MS. BATES: So, the provider portal is enrollment and credentialing is separate. So, those are two separate things, and House Bill 69
has told us that we have to do one credentialing verification organization, that we have to have one of those. And, so, right now, we’re in a procurement status where we are procuring for that one entity which will be combined with the provider portal to try to--it’s basically an automated process for enrollment and credentialing but where you as a provider will only have to do it one time.

So, back to the provider portal, everything that Medicaid does is tied back to some sort of permission and funding from the feds. And, so, if we start something and say we’re going to do “x”, whatever it is, a provider portal, then, we have to follow through that in order to still receive the federal funding for that. And, so, that’s part of the reason.

Now, to your point, when this CVO, one CVO becomes a thing, we’re hoping that then you won’t have to do all that. That’s the whole point; but right now, this training is meant for providers that need to use it and work through that now.

As far as the amount of information, if we didn’t give that amount of information, then, we didn’t give enough. If we gave
more, we gave too much. So, we’re kind of in a
win/lose situation with those types of things, but
there is a current development right on the edge of a
procurement for this uniform, centralized
credentialing verification organization which will
kind of integrate with the enrollment process to make
it easier for you as a provider so you don’t have to
enroll with us, go to Avesis, go to DentaQuest, blah,
blah, blah.

DR. GRAY: As an advisory
committee, I would support your all’s looking at that
and specifically looking at what most of the dentists
in the state are doing. Just as a matter of
information, when we bring on a new person in the
practice, it costs us $5,000 to get them credentialed
with hospitals, with insurance companies, with
Medicaid. When we use an outside credentialing
source, it’s a $5,000 process. And if they’re
credentialed next door, it doesn’t make any
difference. It has to be redone and it’s $5,000 per
click and that’s just a tremendous amount when you
can go to a central.

So, if you guys can make that
happen, we would support that a lot. If there’s one
that’s for pharmacy and one that’s for medicine and
one for dental, I don’t know that any one meets all the needs and it would be nice to look at that.

MS. BATES: I think it will be more of a here’s all of it. And, then, depending on your provider type, this is what we need kind of thing and you check off the boxes, but we definitely just by law have to go to the centralized CVO and that is happening. It’s moving forward.

DR. BOBROWSKI: Well, that’s just what we were wondering was if you have to do it, did the State look at systems that are already set up to do all of that?

MS. BATES: And if I remember, wasn’t there some issue with - and I’m not with Provider Enrollment - but wasn’t there a system issue between the dental database or whatever and getting that automated information over to us? I thought there was at one time.

I’ll ask Kate and Carl about it just in case because I thought there was at one time, but I suspect this will be remedied through this centralized CVO but I’ll make sure that I bring it up to them.

DR. BOBROWSKI: See, even on the back of this cover page here, another thing, it
just says Tips for Success. Stay in Touch with your Kentucky Department of Medicaid Services, your Technical Advisory Committee, the TACs, licensing boards or professional associations for updates and information.

So, when I see that word TAC on here, we’ve got to be up to par on all this stuff, too.

DR. SCHULER: I’m not up to par on it.

DR. BOBROWSKI: You’re not up to par?

DR. SCHULER: No, I’m not.

DR. BOBROWSKI: Well, I’ve got to read this tonight and there will be another stack when I get home because she’s listening to another webinar today.

MS. BATES: We’re full of information.

DR. BOBROWSKI: Any other questions?

DR. SCHULER: So, back to the copays and the portal changes that you all are talking about, do you have any idea when that will be done or will we be notified when that is done? Will
the providers be notified if there’s like a change in
how that looks?

MS. BATES: So, yes, and I’ll
tell you one change that’s definitely getting ready
to come up in March is currently providers can’t see
the medically frail status anymore because medically
frail is not an active status right now because we’re
not on with the waiver; but in anticipation of our
4/1 go live, we’re going to start making that visible
like the first week of March, but everything aligns
with big, huge system uploads. They take days, days
at a time for these changes to take place.

So, like the system changes
they’re talking about in that meeting right now, it
will probably take two, three months for them to go
in because, one, we’re loading all this stuff for
Kentucky HEALTH to go live 4/1.

So, it kind of takes a little
bit of a back burner, but on KYHEALTH.Net or when you
sign into that portal, it should say system changes
or you can now see medically frail or whatever,
whatever the change is.

DR. SCHULER: When you log in,
the changes will be there.

MS. BATES: It should be.
That’s what we’ve asked.

DR. SCHULER: As opposed to just logging in one day and it’s a different screen.

MS. BATES: And saying what is this, yes, because I know from a provider’s standpoint, if you’re looking at an EHR, if you get one little system change where it even changes the font, it freaks everybody out.

So, I understand if you’re changing words and it’s the same concept, yes, I totally understand.

DR. SCHULER: Thank you.

DR. GRAY: When will we be able to find out what medically frail means? Is there a definition? I’m sure there is somewhere for medically frail.

MS. BATES: Yes. Medically frail has been talked about for two-plus years now. So, that’s all out there on the KYHEALTH site.

DR. GRAY: I’ve seen it but I can’t determine. Is an insulin-dependent diabetic? We just have to look on the portal and see.

MS. BATES: So, medically frail is determined in a few different ways. One is there was a medically frail tool that was developed by
actuaries that uses already the MCO claims data that’s out there. So, it looks at services and diagnosis codes. And, so, that spits out a bunch of people that are medically frail. That’s a simple way of saying it. So, it spits out that list.

Then there’s the medically frail attestation. So, you as a Medicaid provider, if you know that someone by way of whatever record that you have is insulin dependent or has this or has that, you can complete that medically frail attestation and sign off as a Medicaid provider attesting to medical frailty.

Now, in that instance, that form is sent back to the MCO and is, we call it scored. It’s scored. So, it still has to meet by their scoring whatever, their rubric or whatever you want to call it, their own tool, their paper tool, it still has to meet medical frailty because you could say I’m medically frail but I still have to have something, right?

And, then, the only other ways are through the automatic type systems which would be SSDI, like a disability, if you’re on disability or the Ryan White Program, those type of things.

DR. GRAY: I’ve never seen a
list that says if you’re on Suboxone, you’re medically frail.

MS. BATES: There’s not going to be.

DR. GRAY: So, there’s not going to be a list.

MS. BATES: No.

DR. CAUDILL: Is that only sent from the physicians, like an oral surgeon?

MS. BATES: Any Medicaid provider that wants to put their name on they’re attesting to it can do that.

DR. CAUDILL: Based on history and medications being taken.

MS. BATES: So, you know as a provider that when you see someone, it’s very relevant to you as an oral surgeon to know and get the medical records on someone who has diabetes and how severe the diabetes is.

So, if you have that in front of you and you can attest to what you see, that doesn’t mean that their diabetes doctor has to sign off on it. You can sign off on that because you have the proof right there, right? And you don’t have to send that in. That’s not required to send in to the
MCO but you are signing off with your name. So, if it ever came back to you, you could say, well, here it is. We had it in the medical record. Does that make sense?

DR. CAUDILL: Yes. Thank you.

MS. PARKER: It has to go through an algorithm to determine medically frail.

MS. BATES: No. We’re talking about the attestation. The algorithm is the automatic.

MS. PARKER: Okay.

DR. BOBROWSKI: Since you brought up copays again, in this literature, there is a sentence in there----

MS. BATES: Which literature, the one I did? My work has never been referred to as literature.

DR. BOBROWSKI: One of the statements in here somewhere says that April 1st, the copays will end when My Rewards starts.

MS. BATES: I’d like to see that literature. So, we’re going live 4/1, right? So, everyone who is in Kentucky HEALTH that is assessed a premium will be assessed a premium.

There’s still a handful of

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folks that are in Medicaid, like a fee-for-service, like your 1915(c) and long-term care and those type of things, if a copay applies to them, if they’re not exempt from a copay, they will still have a copay; but if you’re assessed a premium, then, you’re assessed a premium.

So, those who aren’t assessed a premium and who aren’t exempt from copay, cost-sharing basically will have a copay. So, there are a handful of people out there that that could apply to.

Now, fast forward. When people start like not paying their premium and those that are under 100% of the poverty level, so, you go a few months and you don’t pay your premium, well, we can’t discontinue your Medicaid because you’re under 100% of the poverty level, those folks are the ones that will also be assessed a copay.

None of that policy has ever changed the two years we’ve been doing it.

DR. CAUDILL: Was there an announcement that they were going to have a moratorium on the premium for a month or two?

MS. BATES: That’s separate.

Why are you trying to confuse them?

DR. CAUDILL: Because I think
it goes to saying that if there’s no copay, it’s going to be assumed they’ve made a premium payment even if they didn’t, right, and I think maybe that’s where he’s getting that information.

MS. BATES: But if you’re assessed a premium, then, you don’t have to pay a copay.

So, 4/1, if Garth gets a letter in the mail that says he’s going to have to pay a $1 premium on 4/1 or whatever and that’s not a letter--like, the Notice of Eligibility says this, that you have to pay a premium - but we as a state have decided to waive the premium for the first month because we don’t know if we’re going to get a judgment basically - then, you still don’t have to pay a copay because you still have to pay a premium. We’re just telling you you don’t have to pay it for April 1st. Does that make sense?

DR. BOBROWSKI: Right. I read that, yes. There’s the part about the pregnant women.

I’ll just have to get with you on some of these other questions.

MS. BATES: That’s fine. You can come in and we’ll knock them all out.
DR. BOBROWSKI: Okay. Still back on Old Business, I know that Jessica was going to look into a couple of things. One was they were going to look into DMS developing U-Tube instructionals, and the other thing was like on prescription filling policies.

MS. HUGHES: What prescription filling policy? She didn’t----

DR. BOBROWSKI: She didn’t pass on anything?

MS. HUGHES: No.

DR. BOBROWSKI: In the sake of time, I’ll get with you on that.

MS. HUGHES: But I know Stephanie has told you all a number of times to email her. If you want to email me also because she is extremely more busy than I am and I can follow up and help her get your answers back.

DR. BOBROWSKI: Okay. Is there any other Old Business?

Hearing none, New Business. I put some of these questions on here. How are persons notified that they are not active? How are patients notified that they are being moved into the My Rewards Program? How are patients from another state
receiving Kentucky Medicaid? I know sometimes there
are certain situations on the borders.

    MS. BATES: I can answer some
of these offline for you. There are compacts that
states have with each other when someone needs a
service in another state but they still live here.
There are rules which allow for those types of
things.

    Sometimes the other agency
might be responsible for paying for things, but there
are very few but there are instances where we do have
compacts and they’re written agreements between
states. And that’s a lot of times because we don’t
have whatever the service is where they had to go.

    But, then, for Kentucky
residents obviously on the borders, they can receive
services across the borders because those are
Medicaid providers.

    DR. BOBROWSKI: I’m pretty far
up in the state but we’ve got people from Nashville,
Tennessee that show up as Medicaid eligible.

    MS. HUGHES: For Kentucky
Medicaid?

    DR. BOBROWSKI: Yes.

    MS. BATES: Well, so, but you
have to--and, again, we don’t want to get into specifics here. So, if you send me some of these, but a lot of times, so, Vanderbilt is a big Medicaid provider. And, so, sometimes the address might because of the care that they’re getting there because we don’t have it here, that might be why the address change.

There’s different reasons for everybody and it’s very HIPAA-specific. So, I don’t want to get into a lot of this here, but, yes, there are instances where some people - not very many - but some people do have out-of-state addresses.

DR. BOBROWSKI: The reason I was asking about the not active, boy, we’ve just had a - and, again, not just me - I mean, I’m getting phone calls on this - that people are showing up for their dental appointments or their oral surgery like at eight or nine o’clock in the morning and we have to check eligibility that morning.

Well, they’re not eligible.

They’re driving two or three hours to get to this oral surgery appointment or this dental appointment or they’re driving an hour.

I’ve gotten calls from dentists in Louisville that are Medicaid providers that are
seeing patients from Western Kentucky because there’s not very many Medicaid providers in Western Kentucky. So, people are driving to Louisville.

They get there, can’t be seen, are not active in the rolls. So, how does the patient not know that ahead of time?

And, then, I’ve done a little non-scientific test in my office. A lot of the adults - I’ve asked them - have you gotten any literature on April 1st being moved to My Rewards Program? And I said, I know there’s different qualifications.

DR. McKEE: They haven’t gotten it.

DR. BOBROWSKI: They haven’t.

Now, I saw a thing that said something like the State was advertising - not advertising but announcing that there had already been $70 million accrued in My Rewards, but people in my area don’t even know what My Rewards is and this is supposed to go live on April 1st.

So, what I’m asking, how are they going to earn points to be available April 1st for dental treatment?

DR. McKEE: Isn’t this what the
Foundation is supposed to be doing?

MS. BATES: What?

DR. McKEE: Informing potential My Rewards’ recipients on how to work the system.

MS. BATES: That’s part of it, but My Rewards is not a secret. All of this same stuff went out last year and we have as a State made a policy decision to allow all the way back to the beginning of last year folks that will eventually have a My Rewards’ account to accrue money, even all the way down to at the end of the year last year, we allowed them to accrue money those that never went to the ER the whole year to accrue money and it pushed the amount of money up a lot.

We did that because we didn’t want anybody to go without services April 1. So, if a Medicaid recipient has been going for their preventive visits and doing all the things that allows them to accrue points, their HRA and all that stuff, then, they should have money in their accounts.

So, their Notice of Eligibility will tell them where they are, like what plan they’re in, if they have to access My Rewards or if they don’t and that won’t go out until May because we
won’t know the eligibility file. It’s all very
technical but the eligibility file that we use to run
to know exactly who is going to have that on 4/1
doesn’t even happen until March. And, so, we don’t
want to notify you. That’s mistakenly notifying you.

But as far as the amount, you
know, what do you? So, you make a choice. Do you go
ahead and just throw everything at them right now and
confuse the heck out of them because they don’t
understand, and, then, we get a judgment and, then,
everything happens like it did in July? Which one is
less confusing is kind of where we are as a state.
We have to make a decision - go all in or whatever.

So, all the information is out
there that has been out there about My Rewards and
what it means, all of the information that went out
from the MCOs before it went out and it was not
mailed back from the recipients. So, they have it.

And I understand that Medicaid
recipients, they don’t understand. A lot of them do
actually understand and there’s a lot of questions
out there, but I think that as of right now, the
folks that make those decisions have decided to be
very sensitive to making a mass notification once,
twice, now we’re on number three. And, so, we’ve
just got to be really careful about how we implement this going forward.

DR. BOBROWSKI: Well, I’ve been asking adults, probably three to five a day over the last month and a half. I’ve had one lady, at first she said no. Then she said, well, you know, I think I am getting some points because I’ve been taking my children to doctors’ appointments, but I’ve had one adult.

So, what I’m worried about is come April 1st or April 5th, whatever, we’re going to have patients that are going to want dental services and are expecting to receive them like they always have and, well, now it comes up that they don’t have any money accrued. Will they pay cash? Will they go to the emergency room and the hospital bites the bill?

So, that was my concern. Like I said, it was an unscientific personal study in our area that I was asking patients have you heard of My Rewards. No, they haven’t.

So, either they’re not reading their mail which that could be happening, but I just wondered what the State was doing on notifying patients of this change in eligibility.
MS. BATES: As far as the State, the State notice will be the Notice of Eligibility.

MS. HUGHES: And just to clarify, Stephanie. A while ago, you said that will go out in May. Did you mean to say March?

MS. BATES: Yes.

MS. HUGHES: There’s a lot of dates going around and I heard you say May and I was like, wait a minute.

DR. BOBROWSKI: You all can read the next one.

MS. BATES: Which one?

DR. BOBROWSKI: Pharmacy patients, they will swipe a card to get their medicines and to determine eligibility but that’s only on the State site, but, then, the patient—well, the pharmacy calls us back and it shows that they are eligible on the State site but they’re not eligible on the Avesis site.

So, the pharmacy is confused now. The office is confused and the patient is confused.

MS. BATES: The State site is the source of truth.
DR. BOBROWSKI: I’ve read that before but can I tell you something on that?

MS. BATES: Yes.

DR. BOBROWSKI: And I’ve had some Louisville dentists contact me about that, that if they still go ahead and see the patient because the State site says they’re eligible, then, they do the work. Their MCO denies the treatment because they weren’t eligible on their site.

So, then, a dentist has to go back and appeal and go through the appeals process and that takes more time that they just don’t see the patient.

MS. BATES: So, then, Avesis and DentaQuest need to answer to that because if they are showing as eligible on our end and the MCO gets a file every night, then, Avesis should also have that information. And, so, if you all want to speak to that, you can.

DR. BOBROWSKI: It’s a lot better than what it was six weeks ago but glitches are still happening.

MS. ALLEN: And is improving. With the changes for the new categories that members fit into and things of that sort, we are adjusting
I think I shared at the last Dental TAC meeting, we’ve basically moved the Medicaid patients into more of a commercial setup. So, we had to adjust our systems for that. Our systems are set up for Medicaid and a patient was a Medicaid recipient adult and they stayed in that one group and they stayed in that one group until they were no longer eligible for Medicaid.

But now with Kentucky HEALTH or the soon-to-be Kentucky HEALTH, members can switch between groups a lot which is very similar to commercial. So, we have updated our systems to accommodate that. We’ve worked with our MCO partners to ensure that we have the same information they have in their system. There are still a few glitches but we are working through them.

If the providers are receiving claims that are denying because the member is not eligible in our system but they’re eligible in DMS’ system, they’re eligible in the MCO system, please let us know. We have to work with that provider to get those claims adjusted. It does not require an appeal. So, you don’t have to go through that appeal process.
DR. BOBROWSKI: See, that’s what they were told.

MS. ALLEN: It doesn’t have to.

DR. BOBROWSKI: They had to go through the appeal process.

MS. ALLEN: And in those cases, if you could please encourage that provider to give us a call. As Dr. Caudill mentioned earlier, we can go back and educate that Customer Service representative that gave that information, but, no, that doesn’t have to go to appeal.

And also as a sidebar, if a member’s eligibility is listed incorrectly in our system and then we correct it, we do a look-back on the claims. So, if the claim processed incorrectly and denied as member not eligible on date of service and, then, we updated and it shows that they are eligible, we go back and we look at those claims and, then, we automatically adjust those to pay.

And as I say, it doesn’t require an appeal. As soon as we get that eligibility history fixed - the provider doesn’t have to do anything - we’ll go back and adjust those automatically.

DR. SCHULER: Do you all
require any documentation to show that the State site was looked at?

DR. CAUDILL: We just go to the State site and look and, yeah, it’s there and we fix it and auto pay it.

DR. BOBROWSKI: Any other New Business?

DR. GRAY: I would just like to air it for the record that CAQH is what most of the dentists are using for the central credentialing thing. So, if we can get input on that.

DR. CAUDILL: And that’s nationwide. It’s not just Kentucky.

DR. GRAY: That’s what we’re using. So, that would be helpful.

DR. BOBROWSKI: At this time, I would like to open the floor up to the Dental Health Director, Dr. Julie McKee.

DR. McKEE: I just wanted to bring up a couple of things, that it seems to be a snag not with Medicaid at this point but that the Health Departments bill their preventive dental services through the medical part.

And the medical part, two of the MCOs are going, no, we think you ought to do
Avesis. And Avesis is like, we pay dentists. We don’t pay Health Departments which that was the agreement.

So, the bottom line is they have not been paid for a lot of their services since August and that’s a very big burden on Health Departments that are struggling anyway.

So, you may be getting some information through me or maybe through Stephanie from me on that because the MCOs have a contract with the Department for Public Health that says these codes are paid on medical. Even though they look “D”, they’re paid on medical and they should not go to Avesis.

And one of the MCOs said, oh, yeah, that. Okay. We’ll go ahead and re-run them, but in the future, we want Avesis to pay for it. And I’m like, no, that doesn’t work.

So, it’s difficult for these Health Departments to front a program like the Public Health Hygiene Program for seven months to do this, and I would hate for us to lose that valuable service that gets these kids into care at dentist offices because we can’t seem to remember what’s in the contract.
DR. CAUDILL: And I remember about five years ago, we looked at moving everything over to the MCOs, and I think Connie and you all----

DR. McKEE: Actually it was Dr. Mayfield.

DR. CAUDILL: Yeah, Dr. Mayfield looked at the contracts and said, no, it’s in the contract. Not this Dr. Mayfield.

DR. McKEE: Stephanie Mayfield.

DR. CAUDILL: Looked at the contract and said, no, this can’t be paid through the Administrator. It’s paid from the medical side and it’s in the contract because we were willing to take on that administration for our MCOs but it was determined five years ago, I think it was, that we couldn’t.

DR. McKEE: That it wasn’t. We can revisit it. We need to play by the rules that we’re given right now. And if we need to redo them, we can work on redoing them; but each MCO has a contract with the Department for Public Health and that contract not only has sealants but it also has immunizations and family planning and all that stuff.

Now, the Department for Public Health also has a Memorandum of Understanding with
the Department for Medicaid Services that lists
exactly what those codes are going to be. We can
never code a filling. Even though it’s a Medicaid-
covered service, we cannot do it because it’s not on
that agreement.

The agreement between Medicaid
and Public Health has not changed in those five
years. We want to try to change it soon hopefully
with SDF.

DR. CAUDILL: One of the
problems, though, is administrators normally do not
credential hygienists. We credential doctors.

DR. McKEE: Right.

DR. CAUDILL: And, so, that’s
another glitch in doing this.

DR. McKEE: You call it a
glitch. I call it a re-interpretation. And maybe
it’s just because I can justify anything, that the
credentialled entity in the medical part of the
contract with the MCO and the Department for Public
Health, the credentialled entity is the Health
Department. It’s not the nurse and it’s not the
nutritionist and it’s not the hygienist. It’s the
Health Department itself.

MS. O’BRIEN: Yes, you’re
correct. Provider Type 20.

MS. ALLEN: The credentialing is done at the provider level.

DR. McKEE: Exactly. And, so, that’s why it’s difficult for Avesis to say, oh, come on. No, can’t do it. So, that’s why.

And like I said, of course I care what the rules are but I want to play by the rules as they’re set forth now. And, then, if they need to change, we’ll work on changing them and then implement.

So, just a heads up. You may be getting information directly from me or information from me through Stephanie’s office to see if we can do this better. They’re paying the varnishes because they pay nursing varnishes but they’re not paying the other stuff. Done.

DR. BOBROWSKI: Thank you. I put down public health on our agenda more or less to make folks aware of what’s going on like on Ms. Stephanie’s arena more.

We sat through a two-and-a-half hour video conference the other night on KALBOH which is the big organization of health departments, and one of their issues, again, like a lot of
governmental issues is the pensions – I’m not going to talk about that – but they had other public health issues.

And I put on here community fluoridation. There is a bill being presented this Session, not that they’re against fluoridation, per se, but they want local options. So, if a community doesn’t want fluoridated water in their city or county system, that local place can vote it out.

Now, when you look at it from a public health standpoint, the studies have shown that without fluoridated water, it could cost an estimated $54 million extra per year because there’s going to be 40% more cavities.

The other thing I put on there was just even from the CDC and prevention, community water fluoridation is one of the top ten most important public health initiatives of the 20th Century.

So, it has been proven even through the CDC that this is a good deal. As a practicing dentist in a rural area, when I first started, you could tell the kids that lived out in the county. Their cavities were bigger. Their cavities were probably half as many again; but the
kids that lived on the city water system, I mean, they had some cavities but historically they were smaller and less in number. So, it’s anecdotal but I see what I see.

So, there is legislation out there in this Session to go for a local option on it and I just wanted to bring that to your attention if you need to contact a legislator.

MS. BATES: We opposed it already with money attached to it for the reasons that you stated. It ultimately will cost us more.

DR. BOBROWSKI: Thank you. It will. It will.

DR. CAUDILL: But based on your observations, is there any way that the KDA could cooperate more with the pediatric people or the pediatric dentist community to go back to more supplementation for these people on well water or that drink bottled water all the time and they’re losing out on the benefits of fluoridation?

DR. McKEE: Well, that program is free, absolutely free. When a dentist, a physician or a Health Department samples water and we find deficiencies, we have a standing order to provide supplements free of charge to the dentist,
therefore, to the family for supplements.

        DR. CAUDILL: It seems to have
fallen off over time.

        DR. McKEE: It has. We have a
few pediatric practices and pediatric dental
practices that are bestest customers and they are
really routine.

        That’s something that my office
could do through a public information campaign to
providers and maybe to the public to do that to let
them know.

        DR. CAUDILL: It just seems
over the years, dentists have gotten away from
looking for that and acting on it.

        DR. McKEE: And, actually,
there’s a pretty good reason that they’ve gotten away
from it is because municipal lines have really, no
pun intended, have really saturated Kentucky. It
started in the Patton Administration but it still
continues today with a lot of federal grants coming
in to supply that.

        So, we’ve got a huge number.
It’s like maybe, believe it or not, between 92 and
95% of all Kentuckians live on municipal water, but
it’s the ones that choose not to drink the water – in
Martin County, I’m not sure I would – and those that choose not to drink the water for other reasons that don’t get fluoridated water. That’s what we see, but we still see those communities and we’ve got them mapped out – we know where they are – where they have a much higher rate of well water just because they’re never going to have municipal water because the terrain is just ridiculous to make it worth their while.

We can do more of that, but there’s a reason and the reason is the saturation of municipal lines through Kentucky even over the past twenty years.

MS. BATES: So, you’re saying that if there’s a question as to the amount of fluoride in the water, that someone could send that to Public Health and it’s tested?

DR. McKEE: Yes. All Health Departments have them because I make them have them, but interested dentists and interested physicians have – excuse me but they’re call coffins for a reason – but they are a Styrofoam mailing package that has a little tube inside it and the directions on how to collect the water.

We as Public Health do not go
out and collect the water. The parent does and they write down the names of the children and what their ages are because it’s a different supplementation for age.

So, they send it to the State Lab. The State Lab does it in our budget to do it and, then, they send the requesting provider, the family and us results from that. That way we can say, oh, you’re this much too low.

Now, we do have occasions where we’re this much too high and we work with them and counsel them on how to get past that, too.

DR. CAUDILL: But one of the results of our modern society is a lot of bottled water doesn’t have fluoride in it and so many people, that’s what they live on is bottled water.

DR. McKEE: Or lower than optimal is usually what it is.

DR. BOBROWSKI: The average well water has got like .3 parts per million of fluoride naturally in the water, but the optimal level is up around .7 parts per million and that’s where you actually see a decrease in the rate of cavities is when you get up to that more optimal level.
But you’re right. I have sent in some water samples from our county and a lot of them come back as .3.

DR. McKEE: We can do another outreach for that just to let people know. I think the point was well made is even if you had municipal water, if you choose not to do it, you may need supplementation. Now, we don’t need to spend the State money sampling Nestle’s purified water because we can go on a website and find that out what that is, but we can supplement it according to that.

DR. BOBROWSKI: So, I brought those things up because those are some public health issues, kind of like what you were talking about, issues that we can bring up that maybe we can all work on and make improvements in these children’s lives because the more cavities they’ve got, the more dental fear we’re bringing into their little lives.

DR. McKEE: And the more need for SDF in public health settings.

DR. BOBROWSKI: Are there any other public, dental, any hygiene comments or questions?

The next meeting will be May 15th. We’ve got a lot of work to do.
And, Dr. McKee, even through the KDA or however you want to work it, we would be able to put out any information you want to because I know they’re doing tidbits for a newsletter and, then, they’re also doing a newsletter from the President monthly.

So, those are things that could be included in those to help get the word out on public health issues or other Medicaid issues or stuff like that. So, if you want to work with us on that, we’ll help get the word out on that.

DR. McKEE: Be glad to. Let me know what I can do.

DR. BOBROWSKI: Okay. Thank you. Any other questions?

DR. GRAY: I would move for the next meeting that after the official meeting, that we do have time to meet with the MCOs and address any specific issues that don’t involve the State with the MCOs and the TAC members.

MS. ALLEN: Can I piggyback on that? If you could please give us the information that you would like to discuss prior to the meeting so we can come prepared to have a discussion.

DR. CAUDILL: And have answers

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for you if we can or even resolution before the meeting.

MS. ALLEN: That’s what I’m trying to say.

MS. HUGHES: And I will check to make sure that the meeting room is available for a longer period of time so you can have this same room.

DR. BOBROWSKI: All right. Thanks, everybody. It was a productive meeting. We stand adjourned.

MEETING ADJOURNED