

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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1 DR. BOBROWSKI: Let's call our
2 meeting to order. Will folks just call in on this
3 phone? Do we have to take that off the receiver?

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

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

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

17 We will go around the room and
18 introduce ourselves.

19 (INTRODUCTIONS)

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

24 We had a situation come up with
25 some dentists in Eastern Kentucky and I wanted to

1 thank him for coordinating a resolution to that
2 problem. And I don't know exactly. Dr. Caudill,
3 you all may have been involved - I don't know - but
4 it was a situation in Eastern Kentucky with some
5 dentists. It was nothing illegal but just getting a
6 new dentist in and getting him going and stuff like
7 that.

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

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

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

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

24 It says: Traditional Medicaid
25 pays providers 10% less than the MCOs. I believe

1 that was to mean that there were two MCOs that pays
2 providers 10% less than traditional Medicaid.

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

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

10 DR. JOHNSON: So moved.

11 DR. SCHULER: Second.

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

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

18 DR. SCHULER: The only question
19 I have, so, April 1st is coming along and I know
20 we're not dead positive that anything is going to
21 happen on or about April 1st but we're eternally
22 hopeful. With the portals that the MCOs are setting
23 up, do we have access to those portals currently the
24 way they're going to look on April 1st? What we see
25 now is the way it's going to be April 1st?

1 MS. ALLEN: With the exception
2 of a few new items that DMS is now giving us access
3 to, or I should say DMS and the MCOs are giving us
4 access to, for example, identifying if the member is
5 below the poverty level. That's a new indicator that
6 we currently don't reflect in our system. So, we are
7 updating our systems so that we can receive that
8 information and then share that information with you
9 on the portal.

10 But other than that, pretty
11 much that's it. The copays are there and that
12 information is there.

13 Dr. Bobrowski, may we say
14 something, if that's okay?

15 DR. BOBROWSKI: Yes.

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

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

25 So, if we can please state here

1 for the minutes that as a friendly reminder, please
2 do not submit claims for incarcerated members to
3 Medicaid.

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

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

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

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

25 DR. GRAY: That's actually when

1 we see them. So, how do we know? How do we know
2 this? How do we know how to bill it?

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

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

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

9 DR. GRAY: It would be while
10 they're in the hospital.

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

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

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

18 MS. BATES: If you are seeing a
19 patient that's incarcerated, my guess is that----

20 DR. GRAY: Well, they're not
21 incarcerated. They're in the hospital.

22 MS. BATES: Okay. If you don't
23 mind, let me finish. If someone is incarcerated and
24 they go to the hospital, they won't be alone. They
25 will be escorted in some way. So, that facility will

1 know if they are incarcerated. So, they should be
2 communicating that with you. Corrections isn't going
3 to let an incarcerated member just go to the hospital
4 by themselves.

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

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

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

25 So, somebody has to know that

1 it is fee-for-service as opposed to MCO, but where do
2 they get that information? If it's not on the
3 portal, what I'm saying is there's no way for us to
4 figure that out.

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

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

10 MS. BATES: No, it probably
11 won't say that.

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

20 And, then, we also did send out
21 a letter. DMS sent out a letter - I know this is too
22 far back - but it was August of 2016 that they sent
23 out a letter and we're in the process of drafting
24 another letter that we'll have to submit for
25 approval.

1 DR. GRAY: Somewhere the
2 twenty-four hours needs to be in there because that's
3 a caveat that if it's not twenty-four hours, it's not
4 covered. Is that right?

5 MS. BATES: But it's covered by
6 Corrections.

7 DR. GRAY: Whether that's
8 county Corrections?

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

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

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

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

22 MS. ALLEN: Number two is the
23 anesthesia notice.

24 DR. CAUDILL: A while back, DMS
25 added expanded coverage for intravenous sedation,

1 moderate sedation. It used to be only for children
2 and they expanded that to include adults so that oral
3 surgeons especially weren't forced to use a deep
4 sedation general anesthesia code when maybe they were
5 only doing moderate sedation.

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

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

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

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

1 used appropriately.

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

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

7 MS. ALLEN: And that's our two.

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

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

21 So, I applaud efforts to see
22 those people being seen through the Medicaid arena.
23 Our only choice in our area, there's a dentist about
24 sixty-five miles away that will do sedation but it's
25 fee-for-service. It's no Medicaid. Travel time is

1 hard. So, I applaud those efforts to make it
2 realistic but still be able to see patients like that
3 gentleman.

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

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

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

21 I won't bring this up again but
22 we mentioned it last time, but another patient
23 brought these in to me from an MCO. I've got four
24 letters to the same child in a family all on the same
25 day stating that it's time for checkups, not dental

1 but like their medical stuff. And the person that
2 brought it in, they know I'm on the TAC. A lot of
3 times, people see stuff like this and they say, well,
4 here's a good example of government waste and that's
5 what they tell me. So, I just wanted to make you
6 aware.

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

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

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

1 based on one, not four.

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

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

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

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

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

22 MS. BATES: Sure, and I agree,
23 but for purposes of the TAC meetings, I'm more
24 concerned that that person gets the care that they
25 need than whether the MCO sent out three extra things

1 because I know that we're not paying for the three
2 extras things. So, for purposes of this discussion
3 where we know where those dollars go, I just want to
4 put that out there.

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

9 DR. BOBROWSKI: That's just
10 good to know.

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

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

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

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

24 MS. BATES: I'm afraid I'm
25 going to be pulled, so, I just wanted to tackle this

1 now.

2 DR. BOBROWSKI: That's fine.
3 I've got that on there, that Commissioner Steckel had
4 formed an ad hoc committee for MAC members and TAC
5 Chairs to look at the TAC and MAC operations. Is
6 that a good term to use?

7 MS. BATES: Yes.

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

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

20 And, so, just in a nutshell,
21 just know that she is wanting to get away from the
22 one-off individual discussions; and by individual, I
23 mean down to a person out there and to bring those
24 back to you calling me or you calling the MCO or
25 whatever.

1 It got a lot of attention, but
2 at the end of the day, she wants you all to look at
3 the program and say we really have these situations
4 where individuals are terrified to get care. So, how
5 can you all add a service that will help that that
6 will result in more care for individuals like an IV
7 sedation or something.

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

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

22 Sometimes the dentist or the
23 patient - and I've got it in my notes here somewhere
24 - but they feel like they have tried all their
25 appeals or they've tried their mechanisms that they

1 know about, but you all know, when you get into MCO
2 and governmental language, it's like you might call
3 one person----

4 MS. BATES: It's intimidating
5 and you get the runaround.

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

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

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

25 MS. BATES: I know that Avesis

1 and DentaQuest, the folks here will help if there's
2 a phone call but there are Call Centers and things
3 like that. Just like at Medicaid, there are Call
4 Centers and there's miscommunication.

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

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

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

22 So, it might be a good idea for
23 the MCOs to set those up. You can't really meet as a
24 TAC without it being open, but as an Association, you
25 can. And, so, that might be another venue for you to

1 have regular meetings. A lot of the associations do
2 that. The CMHC's do it. KHA does it. The
3 optometric folks do it. And I don't think you all
4 have those separately but----

5 DR. BOBROWSKI: We don't.

6 MS. BATES: And I'm sure they
7 would be happy to do that.

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

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

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

25 Now, I will tell you that the

1 Commissioner is very adamant about once we've made a
2 policy decision, bringing it up at the next meeting
3 isn't going to work because we've made the decision,
4 whether it goes in the favor of whoever has asked for
5 it or not, but it is a higher level.

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

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

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

24 Sharley, you all jump in if you
25 want because Sharley is the leader and the organizer.

1 MS. HUGHES: One thing we are
2 putting together for TACs and I've got it to the
3 Commissioner and so forth for approval is we've asked
4 every MCO to provide us contact names, phone numbers
5 and emails.

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

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

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

21 DR. GRAY: With this idea of
22 higher-priority decision-making and higher-priority
23 program implementation, this is done at the higher
24 level without input from the TAC. That's what I'm
25 hearing. Is that correct?

1 My problem is, where I'm going
2 with this is you can we want this program. It's a
3 great program but we're not going to fund it at all,
4 zero funding, so, you really have no program.

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

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

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

23 You mentioned earlier you can't
24 imagine about the twenty-four hour deal. That's
25 because you're not an oral surgeon. That's not what

1 you deal with. That's what I deal with, so, that's
2 what I have to bring up.

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

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

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

21 So, it's hard to answer and
22 give a reason for everything, but every single one of
23 them down to why can't we see the My Rewards' dollars
24 in KYHEALTH.Net. So, we understand the reason for
25 asking for those things but some things we just can't

1 do because of reasons, because of HIPAA or whatever
2 they are, I don't know, and that's not a good
3 example, but we do take those into account.

4 But I hear you as far as things
5 like the incarcerated. And I'll tell you, that
6 particular issue is not new but it's newly arising in
7 Medicaid and being looked at all the way down to
8 connecting an incarcerated individual to care as soon
9 as they get out and are released which is important
10 which that hasn't been happening because of
11 eligibility things in the systems.

12 DR. GRAY: The problem is we
13 have to deal with the patient that drives two and a
14 half hours that doesn't even have the money to get
15 there. And when they get to our office and they're
16 already upset because they're hurting and they get
17 there and they don't have the money to have what they
18 thought they were going to have done and, then,
19 they're yelling and I mean literally yelling and
20 screaming at us. A doctor was shot in Eastern
21 Kentucky because he wouldn't give pain medicine.
22 It's real. It's real.

23 MS. BATES: I was yelled at for
24 thirteen years. I know. I've been on that side.

25 DR. GRAY: It's yelling at a

1 higher pitch than ever before. It's frightening to
2 people when we can't get that information. It's just
3 really important that we get it. That's just one
4 point that you brought up. We can't tell them before
5 they make that drive, we're not going to be able to
6 accomplish all this. It would be very helpful to do
7 that.

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

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

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

24 I'm really concerned about the
25 My Rewards Program, and I know what you all want, but

1 there's logistical things that are going on that are
2 going to really make it hard for a general dentist
3 office to absorb the additional cost of checking
4 these people in.

5 Right now, the patient, when
6 they come in, we are able--in Medicaid, if you're
7 doing fifty, sixty percent or more Medicaid,
8 sometimes it's not that you're trying to do illegal
9 treatment. The treatment that they need to have
10 done, it's right there.

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

18 MS. BATES: Right.

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

21 DR. McKEE: Well, on a higher
22 level, that's better patient management, too, not
23 just the extra \$71 or \$61. That's better patient
24 management.

25 MS. BATES: Well, because you

1 might not get them back, right? They might not come
2 back and there's that.

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

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

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

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

20 DR. SCHULER: Sure.

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

24 Yeah, I mean, those are totally
25 open for comment. Regulations are always open for

1 comment. A lot of our policies come out of things
2 that are changed in regulations and sessions like
3 this. So, if you all are interested in that kind of
4 thing, you really need to follow those types of
5 open--open whatever they are, regs or whatever.

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

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

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

22 And, so, if you come to us once
23 that policy is implemented and lobby for it to not be
24 and give us reasons why, which that particular
25 policy, I was on board with all the providers on

1 that, but, seriously, that's the kind of stuff. So,
2 it isn't that once a policy is implemented it can't
3 be changed, but the point is for purposes of the
4 Commissioner and I'm just warning you on this is that
5 if we said here is the answer to the question today
6 and, then, the next Dental TAC, the same question is
7 brought up like we don't like copays or something,
8 then, she's going to say we've already answered this.

9 And, so, that's the kind of
10 thing that I'm talking about. It's kind of from one
11 month to the next, the answer is not going to change
12 but it may when you get a new Commissioner or a new
13 administration or a new director over something or
14 whatever it is.

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

22 MS. BATES: I mean, and I'm
23 speaking for myself and Sharley can kick me, but any
24 advice that you have that is going to help the member
25 community, the providers because we wouldn't be here

1 without the members and the providers and I recognize
2 that very much so. So, anything that would help.

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

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

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

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

20 Like Stephanie said, sometimes
21 those decisions are made a whole lot higher than my
22 level and even higher than her level. And once they
23 are made, then, at that point, it's like, okay, how
24 do we implement it, but the Commissioner did
25 challenge us of bringing, if we can possibly do it,

1 bringing to you all this is what we want to do. Tell
2 us, is it going to be a really bad idea or is it
3 going to be a great idea but it's going to be hard to
4 implement and that type of stuff.

5 DR. SCHULER: And that's really
6 what I was talking about.

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

10 DR. BOBROWSKI: And there's
11 some problems with some of that.

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

18 So, things that are wide open,
19 then, in my opinion, and the dental community should
20 have a very high interest in the telehealth
21 regulation, then, I would get your advice over and
22 your questions because even if it's not advice, if
23 it's a question that you have, it sparks in our mind,
24 oh, wait, that doesn't make sense, so, we do need to
25 change that. And we received questions very specific

1 to dental from non-dental providers and not
2 necessarily we haven't heard much from the dental
3 community. So, that's a perfect example of where,
4 even in this meeting but even outside of it, where we
5 welcome comments because this is the time. 7/1 is
6 game on and we are making those changes.

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

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

11 MR. OWEN: It's the end of this
12 month.

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

21 Well, the other people on the
22 committee had no clue. So, if you're not at the
23 table, you're on the menu. If you're not there to
24 make these things happen, then, you've got to try to
25 unwind it after it's already taken place and that's a

1 whole lot harder to do.

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

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

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

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

20 MR. OWEN: Five.

21 MS. BATES: Eighty-five.

22 MR. OWEN: I think it says to
23 allow providers time to acclimate and build the
24 technology and related infrastructure to do it more
25 efficiently. I think that's actually what the reg

1 actually says but that's the reason why.

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

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

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

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

23 MS. HUGHES: Yes. After we've
24 closed the TAC meeting.

25 MS. BATES: And that way, you

1 don't have to have a separate meeting and you can
2 kind of go over these one-offs.

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

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

17 DR. BOBROWSKI: And that's a
18 policy change through DMS that's been helpful to the
19 citizens out there.

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

1 Director.

2 DR. BOBROWSKI: Okay. Good
3 deal.

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

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

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

14 MS. BATES: What is that
15 question?

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

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

20 DR. BOBROWSKI: Yes.

21 MS. BATES: And you all got the
22 data.

23 DR. BOBROWSKI: And it wasn't
24 right.

25 MS. BATES: Wasn't right in

1 what way?

2 DR. BOBROWSKI: Well, we had
3 asked for an age breakdown of claims paid. We used
4 to get the geo maps where it showed where a dentist
5 was providing services, but we asked to get a little
6 bit more information on that of what age group of
7 dentist is providing "x" number of paid claims across
8 the state so that we could see who is providing
9 services.

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

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

16 DR. JOHNSON: You did?

17 MS. ALLEN: Yes.

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

20 DR. JOHNSON: I don't know how
21 to process it to send it to you so you can get the
22 data that you want. Basically what we're looking for
23 is paid claims on how much is, you know, a breakdown
24 of zero to \$1,000, \$1,000 to \$500, whatever per
25 provider and, then, we want to know age breakdowns of

1 how many providers are providing claims mainly so
2 that we can tell if 80% of the claims are done by
3 people who are 55 or 60 or older, what is going to
4 happen in ten years.

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

7 DR. JOHNSON: Of the provider.

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

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

14 DR. BOBROWSKI: I'll have to
15 look. I'm sorry. I didn't see it.

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

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

25 So, maybe if that's not

1 correct, they can speak to somebody that can tell
2 them, okay, this is what you need to request.

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

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

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

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

21 MS. BATES: Thank you.

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

24 MS. BATES: No, I didn't. I
25 said don't ask us to not implement copays because we

1 already said that we were.

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

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

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

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

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

23 DR. BOBROWSKI: Okay. And,
24 then, the same thing like here. Just kind of the way
25 things are worded, it just leaves it open for

1 ambiguity. And like I said, this one here, I got
2 this and they called the MCO and I've got a reference
3 number for it and the MCO said, yes, there is a copy
4 on the children.

5 MS. BATES: No. I'd have to
6 see the example.

7 DR. BOBROWSKI: That's where
8 we're getting mixed messages.

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

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

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

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

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

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

25 DR. BOBROWSKI: It's just like

1 on here, copay is not deductible when maximum cost
2 share levels are met and, then, it's got 5% out there
3 at the end of that sentence. Are you all trying to
4 throw me off? What is that 5% on there for?

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

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

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

25 DR. GRAY: When you say can't

1 deny services, what does that mean?

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

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

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

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

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

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

22 MS. BATES: Now, My Rewards is
23 a totally different story. We're getting into some
24 weeds but I'm talking about in today's world of
25 copays outside of the waiver, you can't deny them

1 services if they can't pay. My Rewards and Kentucky
2 HEALTH are totally different.

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

5 MS. HUGHES: Yes.

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

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

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

23 DR. BOBROWSKI: I know that
24 David Gray came to the KDA and I was there and it was
25 a good introductory meeting.

1 MS. BATES: Well, he's not
2 going to know all the policies and that's fine. His
3 role is to say, all right, so, I met with them and
4 they don't know anything, so, you all need to meet
5 with them. I mean, that's basically what it comes
6 down to and we're happy to do that to get in the
7 weeds, but, again, I don't know that we need to do
8 that here.

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

16 MS. BATES: Right. Right.

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

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

23 DR. BOBROWSKI: Thank you.

24 MS. BATES: We're all human
25 beings, right?

1 DR. BOBROWSKI: You take an
2 office that's got a new receptionist and----

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

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

16 DR. BOBROWSKI: Well, my staff
17 says call Dr. Caudill. Don't call Phoenix.

18 DR. CAUDILL: And that's why I
19 give my cell phone to everybody.

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

1 Now, this is two days of webinar information.
2 My question is, why could the
3 State not have--a lot of dentists are already signed
4 up with a national clearinghouse, ProView
5 Administrators, CAQH. Why could the State not have
6 used that because all of our information is already
7 on there and the dentists can click buttons? Do you
8 want to allow all insurance companies that are
9 requesting data from you to get this data or you can
10 select which insurance company or entity like that to
11 use your data.

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

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

19 MS. BATES: No, no, no. It's
20 the provider portal.

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

23 MS. BATES: So, the provider
24 portal is enrollment and credentialing is separate.
25 So, those are two separate things, and House Bill 69

1 has told us that we have to do one credentialing
2 verification organization, that we have to have one
3 of those. And, so, right now, we're in a procurement
4 status where we are procuring for that one entity
5 which will be combined with the provider portal to
6 try to--it's basically an automated process for
7 enrollment and credentialing but where you as a
8 provider will only have to do it one time.

9 So, back to the provider
10 portal, everything that Medicaid does is tied back to
11 some sort of permission and funding from the feds.
12 And, so, if we start something and say we're going to
13 do "x", whatever it is, a provider portal, then, we
14 have to follow through that in order to still receive
15 the federal funding for that. And, so, that's part
16 of the reason.

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

23 As far as the amount of
24 information, if we didn't give that amount of
25 information, then, we didn't give enough. If we gave

1 more, we gave too much. So, we're kind of in a
2 win/lose situation with those types of things, but
3 there is a current development right on the edge of a
4 procurement for this uniform, centralized
5 credentialing verification organization which will
6 kind of integrate with the enrollment process to make
7 it easier for you as a provider so you don't have to
8 enroll with us, go to Avesis, go to DentaQuest, blah,
9 blah, blah.

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

23 So, if you guys can make that
24 happen, we would support that a lot. If there's one
25 that's for pharmacy and one that's for medicine and

1 one for dental, I don't know that any one meets all
2 the needs and it would be nice to look at that.

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

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

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

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

24 DR. BOBROWSKI: See, even on
25 the back of this cover page here, another thing, it

1 just says Tips for Success. Stay in Touch with your
2 Kentucky Department of Medicaid Services, your
3 Technical Advisory Committee, the TACs, licensing
4 boards or professional associations for updates and
5 information.

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

9 DR. SCHULER: I'm not up to par
10 on it.

11 DR. BOBROWSKI: You're not up
12 to par?

13 DR. SCHULER: No, I'm not.

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

18 MS. BATES: We're full of
19 information.

20 DR. BOBROWSKI: Any other
21 questions?

22 DR. SCHULER: So, back to the
23 copays and the portal changes that you all are
24 talking about, do you have any idea when that will be
25 done or will we be notified when that is done? Will

1 the providers be notified if there's like a change in
2 how that looks?

3 MS. BATES: So, yes, and I'll
4 tell you one change that's definitely getting ready
5 to come up in March is currently providers can't see
6 the medically frail status anymore because medically
7 frail is not an active status right now because we're
8 not on with the waiver; but in anticipation of our
9 4/1 go live, we're going to start making that visible
10 like the first week of March, but everything aligns
11 with big, huge system uploads. They take days, days
12 at a time for these changes to take place.

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

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

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

25 MS. BATES: It should be.

1 That's what we've asked.

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

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

9 So, I understand if you're
10 changing words and it's the same concept, yes, I
11 totally understand.

12 DR. SCHULER: Thank you.

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

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

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

23 MS. BATES: So, medically frail
24 is determined in a few different ways. One is there
25 was a medically frail tool that was developed by

1 actuaries that uses already the MCO claims data
2 that's out there. So, it looks at services and
3 diagnosis codes. And, so, that spits out a bunch of
4 people that are medically frail. That's a simple way
5 of saying it. So, it spits out that list.

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

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

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

25 DR. GRAY: I've never seen a

1 list that says if you're on Suboxone, you're
2 medically frail.

3 MS. BATES: There's not going
4 to be.

5 DR. GRAY: So, there's not
6 going to be a list.

7 MS. BATES: No.

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

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

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

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

20 So, if you have that in front
21 of you and you can attest to what you see, that
22 doesn't mean that their diabetes doctor has to sign
23 off on it. You can sign off on that because you have
24 the proof right there, right? And you don't have to
25 send that in. That's not required to send in to the

1 MCO but you are signing off with your name. So, if
2 it ever came back to you, you could say, well, here
3 it is. We had it in the medical record. Does that
4 make sense?

5 DR. CAUDILL: Yes. Thank you.

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

8 MS. BATES: No. We're talking
9 about the attestation. The algorithm is the
10 automatic.

11 MS. PARKER: Okay.

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

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

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

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

25 There's still a handful of

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

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

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

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

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

23 MS. BATES: That's separate.
24 Why are you trying to confuse them?

25 DR. CAUDILL: Because I think

1 it goes to saying that if there's no copay, it's
2 going to be assumed they've made a premium payment
3 even if they didn't, right, and I think maybe that's
4 where he's getting that information.

5 MS. BATES: But if you're
6 assessed a premium, then, you don't have to pay a
7 copay.

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

19 DR. BOBROWSKI: Right. I read
20 that, yes. There's the part about the pregnant
21 women.

22 I'll just have to get with you
23 on some of these other questions.

24 MS. BATES: That's fine. You
25 can come in and we'll knock them all out.

1 DR. BOBROWSKI: Okay. Still
2 back on Old Business, I know that Jessica was going
3 to look into a couple of things. One was they were
4 going to look into DMS developing U-Tube
5 instructionals, and the other thing was like on
6 prescription filling policies.

7 MS. HUGHES: What prescription
8 filling policy? She didn't----

9 DR. BOBROWSKI: She didn't pass
10 on anything?

11 MS. HUGHES: No.

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

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

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

21 Hearing none, New Business. I
22 put some of these questions on here. How are persons
23 notified that they are not active? How are patients
24 notified that they are being moved into the My
25 Rewards Program? How are patients from another state

1 receiving Kentucky Medicaid? I know sometimes there
2 are certain situations on the borders.

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

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

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

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

22 MS. HUGHES: For Kentucky
23 Medicaid?

24 DR. BOBROWSKI: Yes.

25 MS. BATES: Well, so, but you

1 have to--and, again, we don't want to get into
2 specifics here. So, if you send me some of these,
3 but a lot of times, so, Vanderbilt is a big Medicaid
4 provider. And, so, sometimes the address might
5 because of the care that they're getting there
6 because we don't have it here, that might be why the
7 address change.

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

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

20 Well, they're not eligible.
21 They're driving two or three hours to get to this
22 oral surgery appointment or this dental appointment
23 or they're driving an hour.

24 I've gotten calls from dentists
25 in Louisville that are Medicaid providers that are

1 seeing patients from Western Kentucky because there's
2 not very many Medicaid providers in Western Kentucky.
3 So, people are driving to Louisville.

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

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

13 DR. McKEE: They haven't gotten
14 it.

15 DR. BOBROWSKI: They haven't.
16 Now, I saw a thing that said something like the State
17 was advertising - not advertising but announcing that
18 there had already been \$70 million accrued in My
19 Rewards, but people in my area don't even know what
20 My Rewards is and this is supposed to go live on
21 April 1st.

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

25 DR. McKEE: Isn't this what the

1 Foundation is supposed to be doing?

2 MS. BATES: What?

3 DR. McKEE: Informing potential
4 My Rewards' recipients on how to work the system.

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

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

22 So, their Notice of Eligibility
23 will tell them where they are, like what plan they're
24 in, if they have to access My Rewards or if they
25 don't and that won't go out until May because we

1 won't know the eligibility file. It's all very
2 technical but the eligibility file that we use to run
3 to know exactly who is going to have that on 4/1
4 doesn't even happen until March. And, so, we don't
5 want to notify you. That's mistakenly notifying you.

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

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

19 And I understand that Medicaid
20 recipients, they don't understand. A lot of them do
21 actually understand and there's a lot of questions
22 out there, but I think that as of right now, the
23 folks that make those decisions have decided to be
24 very sensitive to making a mass notification once,
25 twice, now we're on number three. And, so, we've

1 just got to be really careful about how we implement
2 this going forward.

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

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

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

22 So, either they're not reading
23 their mail which that could be happening, but I just
24 wondered what the State was doing on notifying
25 patients of this change in eligibility.

1 MS. BATES: As far as the
2 State, the State notice will be the Notice of
3 Eligibility.

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

7 MS. BATES: Yes.

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

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

13 MS. BATES: Which one?

14 DR. BOBROWSKI: Pharmacy
15 patients, they will swipe a card to get their
16 medicines and to determine eligibility but that's
17 only on the State site, but, then, the patient--well,
18 the pharmacy calls us back and it shows that they are
19 eligible on the State site but they're not eligible
20 on the Avesis site.

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

24 MS. BATES: The State site is
25 the source of truth.

1 DR. BOBROWSKI: I've read that
2 before but can I tell you something on that?

3 MS. BATES: Yes.

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

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

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

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

23 MS. ALLEN: And is improving.
24 With the changes for the new categories that members
25 fit into and things of that sort, we are adjusting

1 our system.

2 I think I shared at the last
3 Dental TAC meeting, we've basically moved the
4 Medicaid patients into more of a commercial setup.
5 So, we had to adjust our systems for that. Our
6 systems are set up for Medicaid and a patient was a
7 Medicaid recipient adult and they stayed in that one
8 group and they stayed in that one group until they
9 were no longer eligible for Medicaid.

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

18 If the providers are receiving
19 claims that are denying because the member is not
20 eligible in our system but they're eligible in DMS'
21 system, they're eligible in the MCO system, please
22 let us know. We have to work with that provider to
23 get those claims adjusted. It does not require an
24 appeal. So, you don't have to go through that appeal
25 process.

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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

1 require any documentation to show that the State site
2 was looked at?

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

6 DR. BOBROWSKI: Any other New
7 Business?

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

12 DR. CAUDILL: And that's
13 nationwide. It's not just Kentucky.

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

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

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

24 And the medical part, two of
25 the MCOs are going, no, we think you ought to do

1 Avesis. And Avesis is like, we pay dentists. We
2 don't pay Health Departments which that was the
3 agreement.

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

8 So, you may be getting some
9 information through me or maybe through Stephanie
10 from me on that because the MCOs have a contract with
11 the Department for Public Health that says these
12 codes are paid on medical. Even though they look
13 "D", they're paid on medical and they should not go
14 to Avesis.

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

19 So, it's difficult for these
20 Health Departments to front a program like the Public
21 Health Hygiene Program for seven months to do this,
22 and I would hate for us to lose that valuable service
23 that gets these kids into care at dentist offices
24 because we can't seem to remember what's in the
25 contract.

1 DR. CAUDILL: And I remember
2 about five years ago, we looked at moving everything
3 over to the MCOs, and I think Connie and you all----

4 DR. McKEE: Actually it was Dr.
5 Mayfield.

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

9 DR. McKEE: Stephanie Mayfield.

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

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

24 Now, the Department for Public
25 Health also has a Memorandum of Understanding with

1 the Department for Medicaid Services that lists
2 exactly what those codes are going to be. We can
3 never code a filling. Even though it's a Medicaid-
4 covered service, we cannot do it because it's not on
5 that agreement.

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

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

13 DR. McKEE: Right.

14 DR. CAUDILL: And, so, that's
15 another glitch in doing this.

16 DR. McKEE: You call it a
17 glitch. I call it a re-interpretation. And maybe
18 it's just because I can justify anything, that the
19 credentialed entity in the medical part of the
20 contract with the MCO and the Department for Public
21 Health, the credentialed entity is the Health
22 Department. It's not the nurse and it's not the
23 nutritionist and it's not the hygienist. It's the
24 Health Department itself.

25 MS. O'BRIEN: Yes, you're

1 correct. Provider Type 20.

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

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

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

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

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

22 We sat through a two-and-a-half
23 hour video conference the other night on KALBOH which
24 is the big organization of health departments, and
25 one of their issues, again, like a lot of

1 governmental issues is the pensions - I'm not going
2 to talk about that - but they had other public health
3 issues.

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

10 Now, when you look at it from a
11 public health standpoint, the studies have shown that
12 without fluoridated water, it could cost an estimated
13 \$54 million extra per year because there's going to
14 be 40% more cavities.

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

20 So, it has been proven even
21 through the CDC that this is a good deal. As a
22 practicing dentist in a rural area, when I first
23 started, you could tell the kids that lived out in
24 the county. Their cavities were bigger. Their
25 cavities were probably half as many again; but the

1 kids that lived on the city water system, I mean,
2 they had some cavities but historically they were
3 smaller and less in number. So, it's anecdotal but I
4 see what I see.

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

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

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

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

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

1 therefore, to the family for supplements.

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

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

8 That's something that my office
9 could do through a public information campaign to
10 providers and maybe to the public to do that to let
11 hem know.

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

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

22 So, we've got a huge number.
23 It's like maybe, believe it or not, between 92 and
24 95% of all Kentuckians live on municipal water, but
25 it's the ones that choose not to drink the water - in

1 Martin County, I'm not sure I would - and those that
2 choose not to drink the water for other reasons that
3 don't get fluoridated water. That's what we see, but
4 we still see those communities and we've got them
5 mapped out - we know where they are - where they have
6 a much higher rate of well water just because they're
7 never going to have municipal water because the
8 terrain is just ridiculous to make it worth their
9 while.

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

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

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

25 We as Public Health do not go

1 out and collect the water. The parent does and they
2 write down the names of the children and what their
3 ages are because it's a different supplementation for
4 age.

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

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

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

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

19 DR. BOBROWSKI: The average
20 well water has got like .3 parts per million of
21 fluoride naturally in the water, but the optimal
22 level is up around .7 parts per million and that's
23 where you actually see a decrease in the rate of
24 cavities is when you get up to that more optimal
25 level.

1 But you're right. I have sent
2 in some water samples from our county and a lot of
3 them come back as .3.

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

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

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

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

24 The next meeting will be May
25 15th. We've got a lot of work to do.

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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