COMMONWEALTH OF KENTUCKY

CABINET FOR HEALTH AND FAMILY SERVICES

FOR MEDICAID SERVICES

IN RE: DENTAL TAC

HELD VIA ZOOM

DATE:

NOVEMBER 3, 2023

2:00 P.M.

A T T E N D E E S:

Garth Bobrowski, DMD, Chairman

Joe Petrey, DMD

John Gray, DMD

(and many more were on ZOOM)

1 MS. BICKERS: It looks like it's just now
2 2:00. Oh, I'm sorry, I'm echoing. So we
3 are clearing out the waiting room. We
4 still have several trying to log in. I
5 believe I saw three committee members log
6 in.
7 DR. BOBROWSKI: That's going to be correct
8 for today.
9 MS. BICKERS: Okay. Okay. Perfect.
10 DR. BOBROWSKI: Do you want to do roll call
11 in a minute?
12 MS. BICKERS: We sure can. Give me just a
13 second. We're about clear in the waiting
14 room. Okay. It looks like -- and I do
15 apologize, I'm getting some feedback. It
16 looks like I've got a Dr. Bobrowski on. I
17 have Dr. Gray and Dr. Petrey. Is there
18 anyone that I missed? Okay. You do have a
19 quorum.
20 DR. BOBROWSKI: Okay. Well, thank you.
21 And we want to go ahead and get started.
22 Want to welcome everyone to the Dental TAC
23 Meeting. And we do have quorum for our
24 meeting today. And Dr. Carol Braun will
25 not be able to be here today due to a

1 family issue that has come up. And I'm sad
2 to report that Dr. Phil Schuler is having
3 to resign from the TAC. And he apologizes,
4 but he's got some health issues. And he
5 said he's always enjoyed being on the TAC.
6 And if he gets his health straightened back
7 up, he'd like to return. But you-all,
8 let's all keep him in our thoughts and
9 prayers. He's going to need a lung
10 transplant. So he's got some serious
11 health issues going on.
12 And we will go ahead and approve the
13 minutes from our last meeting. If one of
14 our TAC members would make a motion and a
15 second, that would be great.
16 DR. GRAY: Motion made, John Gray.
17 DR. PETREY: Second, Joe Petrey.
18 MS. BICKERS: Guys, do you mind to turn
19 your camera on for me for the open records
20 law? Sorry.
21 MR. GRAY: Well, you have to tell me how to
22 do that.
23 MS. BICKERS: You should have a little
24 video-like icon next to your microphone.
25 DR. BOBROWSKI: John, mine comes up on the

1 lower left corner.
2 MR. GRAY: Is that working now?
3 MS. BICKERS: Yes, sir. Thank you.
4 DR. BOBROWSKI: And so that's a unanimous
5 vote. And I'll move on to old business.
6 There's a few things that DMS was
7 going to look up for us from our last
8 meeting, and I just got some of them listed.
9 Like I say, some of these things come up
10 right after I send in the -- it never fails,
11 every time I send in the agenda, I'll get
12 some pretty important stuff that we need to
13 talk about that comes up the week or two
14 before our meeting.
15 But I was just interested to find out
16 why a change was made -- it used to not be
17 any criteria on restorative limitations of a
18 timeframe to repair something, and then it
19 went to six months and then it went to 12
20 months. Is there a reason this was made?
21 MR. DEARINGER: Yes, sir. This is Justin
22 Dearinger with the Department for Medicaid
23 Services. Can you see me? My --
24 DR. BOBROWSKI: Yeah.
25 MR. DEARINGER: All right. Okay. So the

1 change from six months to 12 months, that
2 was originally on the fee schedule for 12
3 months. I think it's been in the system as
4 12 months. We never had it at six months.
5 So I think we had a fee schedule that had
6 came out -- we had a -- as you-all know,
7 multiple fee schedules this year in 2023.
8 And so in adding all the codes that we've
9 added, changing all the different codes and
10 limitations, the majority of that came from
11 provider feedback, a lot of it came from
12 this TAC's feedback that we were able to
13 make a lot of changes. And so several
14 typos were on some of the original -- or
15 some of the fee schedules that kind of
16 popped up on there.
17 So in the system it was always 12
18 months. I think we mistakenly had it listed
19 at six months at some point, but changed
20 that back to 12 months. And that's just
21 based on all of our research from
22 surrounding states. But since it came up
23 and since you had asked the question, we
24 started looking at that for 2024's fee
25 schedule. And that's something that we're

1 still kind of pending, but may be changed
2 when 2024's fee schedule comes out.
3 DR. BOBROWSKI: Okay. See, when you --
4 Justin, when you deal with us old gray
5 heads, you know, we go back a long way on
6 some of those old fee schedules and it
7 just -- I don't ever remember it being on
8 there in the past, but I would say as a
9 recommendation that -- I'll see what the
10 other TAC members think, too, but as a
11 recommendation it might need to be looked
12 at.
13 A lot of our patients are --
14 especially our adults, you know, they just
15 got fillings on top of fillings. And a lot
16 of times it can be a front tooth, it can be
17 a back tooth. And some of these folks are
18 bruxers, grinders, clinchers. They will
19 break off a front tooth and, boy, they got a
20 wedding to go to, but you just fixed it,
21 like, seven months ago. Now, does that
22 become a non-covered service and they will
23 just have to pay out of pocket for it? So
24 it puts us in the dilemma of, you know,
25 sometimes folks can't -- they can't pay for

1 it, but what are we to do? So and -- so I
2 don't know. Other comments from any TAC
3 members?
4 I've got several patients -- I've got
5 two groups of them myself that are traumatic
6 brain injury patients. Some have teeth,
7 some don't, but a lot of the ones that still
8 do are pretty heavy bruxers. And unless we
9 want to just go ahead and put caps on all of
10 them, that might be the next best thing to
11 do. But see, up until this year caps
12 weren't allowed to do. So we -- I think we
13 would need to maybe look at that for 2024.
14 And moving on to -- on our fee list,
15 it -- on the community health workers, it
16 uses CPT codes, but dentists can't use
17 those. We can use the CD codes. And I know
18 we've been talking about that off and on,
19 but, Justin, do you-all have a way to work
20 around that or -- and seemed like we had
21 something just about worked out and I forgot
22 what it -- what we had on it.
23 MR. DEARINGER: Yes, sir, that's okay. One
24 thing to remember, too, in the previous
25 topic, you know, previous fee schedules

1 didn't have any of the limitations, didn't
2 have a lot of the limitations. We had a --
3 we did a fee schedule project this year in
4 2023, because the fee schedules didn't
5 always match what billing actually paid.
6 The fee schedules didn't have a lot of the
7 limitations, the -- some of the different
8 things that you-all would like to see on
9 the fee schedule when you're actually
10 working on it.
11 And so during this fee schedule
12 project, we went through, we made sure that
13 all the fees were accurate as far as what
14 they were actually being paid in the system.
15 We made sure that everything matched up.
16 And we tried to include any limitations that
17 were listed in the system itself. So you'll
18 see a lot of things pop up that were not
19 previously there maybe. They were already
20 in the system, but they maybe were not on
21 the fee schedule.
22 As far as the CHW issue goes, we had
23 several options that we had put forward. We
24 sent those options in August, I think the
25 end of August, to some of the MCO dental

1 providers to get comment on. We've reached
2 out a couple of times in the month of
3 September and still haven't heard back from
4 those. So one of the things that I'd like
5 you-all to do as a TAC, we've got -- there
6 are some issues -- as you-all know, those D
7 codes came out this year and they are
8 completely different than the CPT codes that
9 we use. And one of the biggest issues --
10 the two big issues. One is when CMS audits,
11 they -- you know, we have to make sure that
12 the CPT code -- or the D code matches what
13 we're doing. And another big issue is that
14 on your-all's billing system, they don't use
15 modifiers. And so those modifiers would
16 have helped us a lot too to come up with
17 some solutions on the difference between the
18 CPT codes and the D codes.
19 But in the meantime, while we're still
20 working out a solution, one of our options
21 that we suggested was to do -- use one D
22 code for CHW services, and then you-all just
23 bill an amount for those as far as how many
24 times that's being billed. It would be one
25 flat fee. So you wouldn't be able to do a

1 group of people all together because we --
2 that would be the issue of us trying to
3 figure out how to code that and you-all to
4 bill that, the groups of people together.
5 But so far what we've seen about 90 percent
6 of the billing for CHW services in 2023 has
7 been individual billings. And so I think we
8 could go ahead and resolve that for you-all
9 while we work out the issue of how to work
10 in the other fees for providing CHW services
11 to multiple people at one time. So
12 that's -- that's an option that we would
13 like to put forward. We've put that option
14 forward to some of the MCO providers, making
15 sure that would work in their systems. But
16 I think that's something that we would like
17 to move forward with. As long as it works
18 in the system, I think it should. I think
19 it will. And as we're waiting, we may go
20 ahead and just kind of implement that and
21 see if that works out. And then if it
22 doesn't, we can do something else.
23 But, you know, we've been waiting for
24 a few months now. I think it's time to kind
25 of move forward with that. So you will see

1 something within the next couple of weeks.
2 We will send out a provider letter talking
3 about the exact solution. And it won't
4 be -- again, it won't be exactly what other
5 providers have because your-all's system
6 doesn't use modifiers, but it will be at
7 least something to get you 90 percent of the
8 way there, if that makes sense.
9 DR. BOBROWSKI: Yeah, that makes sense,
10 yeah. As you're talking, it kind of came
11 back to that we were looking at one code, D
12 code, to come up with to handle that. All
13 right. Great.
14 There's -- and I'm not really on that
15 fee schedule project myself, but I've
16 noticed and sent in some suggestions, but
17 there's still some typos and things that
18 need cleaning up in there. One of them was
19 the cleanings. Just wondered the rationale
20 for it. It was changed to per provider, per
21 six months. And that was, you know, could
22 allow patients to go once a week and get a
23 cleaning done.
24 MR. DEARINGER: That was a -- that was a
25 typo that we've corrected. Of course,

1 we -- that won't -- you know, it takes a
2 while to actually make the change show up
3 on the -- online. But if you were to go
4 get one of those codes billed, say, at your
5 office and then that same individual went
6 to another office, that code would be
7 denied. So that's -- that's something
8 that's not in the system. It was a typo
9 and we're in the process of changing that.
10 DR. BOBROWSKI: Okay. Good deal.
11 DR. MCKEE: Justin, this is Julie McKee
12 Wasn't it added per member, per provider
13 and both of them applied?
14 MR. DEARINGER: Explain that again now.
15 What?
16 DR. MCKEE: That the prophy code was
17 services per member, per provider. So both
18 of those would be applied to the service so
19 that the provider could do them every week,
20 but the member couldn't get one every week.
21 MR. DEARINGER: That's -- that's correct.
22 Although, it's kind of incorrectly worded
23 on that fee schedule. I believe just per
24 member would suffice. So we're looking at
25 that and making that change.

1 DR. MCKEE: Okay.
2 DR. BOBROWSKI: Okay. And then another
3 one -- and we're getting some phone calls
4 from the pediatric dentists on the code,
5 the D2934, which are those famous steel
6 crowns, and, again, the same thing, it was
7 a typo was in there of per, per. And I
8 would say it was per member, per provider,
9 but I don't want to guess because this is
10 your-all's job.
11 But one of the other things was, it
12 listed it as for primary teeth. But in the
13 columns it also lists it as eligible for
14 Teeth 1 through 32, which are permanent
15 teeth. And then another problem is out
16 beside that, usually pediatric dentists and
17 general dentists that see children and put
18 those famous steel crowns on are -- it is
19 generally as a temporary crown to better
20 hold the tooth in position, because it helps
21 to create and leave space for the permanent
22 teeth as in -- instead of extracting the
23 tooth.
24 Now, the problem is, is it's down
25 there as one per five years. And that's

1 what the pediatric dentists are complaining
2 about, is that sometimes it's like around
3 Halloween or Easter when all these kids get
4 all these candies, they'll -- and it happens
5 during the year any time, but they get these
6 candies and they will pull a crown off.
7 Well, in pulling it off, they chew again and
8 again and it just mangles the crown, and so
9 the dentist or the pediatric dentist would
10 have to put another one on. But if -- and I
11 don't know if -- in doing the fee schedule
12 project, that if someone just saw the word
13 crown and put it down as one per five years
14 just like the permanent crowns are. So that
15 might be something to look at when -- to not
16 put that kind of a limitation on the
17 pediatric dentists and the GPs that are
18 doing a lot of those for the children. I
19 don't know -- I didn't know if you-all had
20 recognized that or not or...
21 MR. DEARINGER: We actually did. That's
22 one of the things that we're looking into
23 for 2024. It may be later in 2024, because
24 it requires a fiscal analysis, because
25 that's actually the way it's in the system.

1 So -- but we are looking at it and seeing,
2 you know, what kind of fiscal impact that
3 might have.
4 DR. BOBROWSKI: Okay. Let me see here.
5 I'm trying to make myself some notes on
6 some of this, so I don't have to ask again
7 on these. Well, and it was kind of the
8 same thing, Justin, with those codes at
9 D2930, 2932. Those are kind of the primary
10 teeth codes, but -- and then there's
11 another one D2951. It actually uses a
12 different tooth numbering system than I
13 think the rest of your fee schedules.
14 There's a Palmer numbering system, a FDI
15 system, a universal numbering system. And
16 as best as I could see, that one right
17 there picked out a different tooth
18 numbering system than anywhere else in the
19 fee schedule. So that's another one
20 you-all might want to look at.
21 MR. DEARINGER: I'm taking some notes too,
22 so we'll --
23 DR. BOBROWSKI: Okay.
24 MR. DEARINGER: I did want to let you know,
25 I saw No. 4, where we had -- we've had

1 multiple requests for increase of fees,
2 various fees, we have different D codes
3 that are listed on there. I think at this
4 time we have three different decision memos
5 that have been created and shared and those
6 memos go up, show different options for
7 increasing rates. We've already done
8 research in other states. When we do
9 research, we contact each state directly
10 and get their current rates that their
11 system is actually paying. We don't use
12 any kind of -- anything that's put out by
13 anybody else, so we contact those directly.
14 And we -- we compare and contrast those and
15 then we send those in and do a fiscal
16 analysis of where -- or what -- you know,
17 additional funds we would need and if that
18 funding is available. So those answers to
19 all of those should be sometime in 2024
20 with those -- with the budget and where we
21 are with those.
22 We did have one code, and that will be
23 kind of coming out a little bit later as
24 well, that kind of falls in that group. And
25 that was actually incorrect on the fee

1 schedule that was billed at a higher rate
2 than -- or it was showing a lower rate than
3 what it was actually being -- or supposed to
4 have been paid for. So that code -- and I
5 thought I had that written down. I can't
6 remember exactly the code. Kelly Kitchen's
7 on here. Kelly, do you remember what code
8 that was exactly?
9 MS. KITCHEN: Yes. It's the D1110, and
10 it's currently showing at 40- -- should be
11 60.13. And it is showing -- let me look.
12 DR. BOBROWSKI: 46.25? Yeah.
13 MS. KITCHEN: Yes, 46.25. It should be
14 $50.13, so we'll be updating that.
15 MR. DEARINGER: Yeah, D1110.
16 MS. KITCHEN: Yeah.
17 MR. DEARINGER: But the rest of them, like
18 I said, are in the decision memo process.
19 And we will have answers to those as -- as
20 we get the fiscal analysis back. Probably
21 be first part of 2024.
22 DR. BOBROWSKI: Okay. One of the things
23 I -- I just got a report -- you know, was
24 looking at these other states. And I just
25 got a report from Indiana and they were --

1 they were talking about the number one
2 reason dentists don't -- they did a study
3 up there -- that don't accept or stopped
4 seeing Medicaid patients was -- the number
5 one was reason because of the low
6 reimbursement rates. And I know at our
7 Medicaid forum, one of the things that we
8 had done was try to talk about moving
9 Kentucky from 49th in oral healthcare, move
10 them up -- move us up that ladder. And I
11 know, Dr. McKee, they did a study, and even
12 through the KDA -- it wasn't a scientific
13 study done through the KDA. But in talking
14 to most of our members, that the low rates
15 that have not been increased since 2002 was
16 the number one reason why some dentists
17 will totally drop out of Medicaid. Some
18 dentists will keep their Medicaid number,
19 but stop seeing patients.
20 And -- but -- and I notice that other
21 states around us are even involved with
22 their legislature on improving the dental
23 rates for people in other states. I know
24 Maryland is another state that just this
25 year started doing adults. And Maryland's,

1 on a lot of their rates, are much higher
2 than what Kentucky is getting.
3 But my goal is just to see that
4 patients get good dental treatment, get good
5 oral healthcare. But if there's a lot of
6 things out there that are hindering the
7 business process of it, well, we got to see
8 what we can do or else -- I've told some
9 other folks, if you can't pay for it all,
10 well, you know, you may have to drop some
11 items and pay a little better on what you
12 can do, but -- and, for instance, I got a --
13 let me turn my page here. I got a report
14 from a dental group. And I've got it kind
15 of in a chart form. But started in 2019,
16 their costs per day to run their offices
17 went up 3.5 percent in 2020. Went up
18 another 11.7 percent in '21, and for 2022
19 they went up another 22.4 percent. Our
20 costs to run our business and provide the
21 care is astronomically going up.
22 Wages, for example, a patient
23 coordinator was getting $43.58 per hour in
24 '21. Now it's gone up to 49.17, a
25 13 percent increase. Dental assistants have

1 gone up 12 percent in one year. Hygienists
2 have gone up 24 percent. I've got the --
3 more numbers with it here, but part of the
4 problems is, is inflation and our workforce
5 shortage over the last few years is really
6 taking a hurt on any kind of profit margin
7 we used to have. These are just some
8 reports that I've gotten from other dental
9 groups, so I just wanted to share those.
10 Any -- let's see. Any TAC member got
11 any other comments or questions on the fee
12 schedule? If you don't, we'll keep moving
13 along.
14 All right. Hearing none, I just
15 wanted to give a brief report on our
16 Medicaid forum that we had at the KDA annual
17 meeting. And we really had a good turnout
18 for the Medicaid forum. And, again, I
19 wanted to thank Avesis for providing the
20 lunch. I wanted to thank all the
21 participants that came. And I wanted to
22 especially thank Commissioner Lee for being
23 brave enough to show up. But I think she
24 was the highlight of the show, because she
25 was there to answer questions and I thought

1 she did an excellent job answering those
2 questions and, you know, fielding the
3 concerns that practitioners had. And I just
4 wanted to give a brief report that I thought
5 it turned out to be a very good forum.
6 Now, is there any other old business
7 that we need to talk about?
8 Okay. I'm going to move on to new
9 business.
10 DR. GRAY: Garth?
11 DR. BOBROWSKI: Yes.
12 DR. GRAY: John Gray. I would like to
13 second your comments about Commissioner
14 Lee. I think it was extremely helpful and
15 extremely well-received. I think if
16 there's any way to make that a yearly kind
17 of thing and get in touch with the dental
18 providers, I would encourage that because
19 it certainly was very helpful this year.
20 MS. LEE: Hi, Dr. Gray, Dr. Bobrowski.
21 I've been sitting back listening. Thank
22 you-all for your kind words. And I think,
23 you know, definitely as long as I'm here,
24 I'm always -- always up to come to the
25 conferences. I think that it's very

1 important to listen to our providers that
2 are treating our Medicaid members. And I
3 think, you know, regardless of who's in
4 this chair, continue to invite someone from
5 the Department to those meetings. I think
6 it was a really good conversation and I
7 appreciated learning some of the -- some of
8 the issues that the Medicaid providers are
9 wrestling with right now. And just, you
10 know, really look forward to future
11 conversations to make sure that we are
12 doing all we can to not only improve the
13 health status of our members, but to take
14 as many administrative burdens away as we
15 can from our providers so they have more
16 time to treat our members.
17 DR. BOBROWSKI: Well, we really appreciate
18 your willingness to talk with us and, you
19 know, try to work out some things that --
20 you know, like you said, to take some of
21 that administrative burden away. And I'd
22 really like to see all of us, even the
23 other TACs, work together to move the
24 healthcare in Kentucky up those ladders,
25 because Kentucky's not -- country folks

1 ain't doing so good. You know, where we
2 just need to -- we need to help people --
3 and I'm -- I got a little thing else there
4 in new business to talk about that just
5 briefly, to look at some things and ideas
6 and -- but I want to, again, thank you,
7 Commissioner Lee, for all your help and
8 support and giving out information and just
9 be willing to talk with us. That means a
10 lot.
11 I'll go on to new business. Of
12 course, I've already sent this to
13 Commissioner Lee, but there was -- and I'm
14 sure it was -- hopefully it was just a typo
15 on the oral pathology codes that had been
16 listed as for all ages. But then, I guess,
17 in one of the new revisions, it got shown as
18 only for patients under 21. So I put down,
19 is this a typo or has this been a major
20 change?
21 MR. DEARINGER: Commissioner, would you
22 like me to speak about that?
23 MS. LEE: Yeah.
24 MR. DEARINGER: Okay.
25 MS. LEE: You can go ahead, Justin.

1 MR. DEARINGER: Okay.
2 MS. LEE: And I'll chime in if I need to.
3 Thanks.
4 MR. DEARINGER: Sure. So like I said, when
5 we -- as you-all know, we updated this fee
6 schedule multiple times in 2023. This was
7 a typo that was listed on the fee schedule
8 briefly. That wasn't long on the fee
9 schedule. I think it may have been on
10 there for a couple weeks, two or three
11 weeks, that that was on there and we
12 corrected that. It's never paid in the
13 system that way. However, because of that,
14 it's been brought up that that may be
15 something that is needed, and I think we
16 are currently looking at that. And maybe
17 Commissioner Lee can talk a little bit more
18 about that.
19 MS. LEE: Yeah. So we have had some
20 conversations about the oral pathology
21 codes. There's just -- you know, there's a
22 small subset on the fee schedule. And it
23 really kind of doesn't make sense for us to
24 cover them under 21 and not over 21,
25 because I would assume that all -- most of

1 the biopsies that you-all do are for over
2 21. So we are going to pull together a
3 policy. We are just looking at a few other
4 things, but we'll pull up together a
5 policy. We are going to start covering
6 those for over 21, but we are just getting
7 a little -- a few more little bits of
8 information together. We are going to do
9 that policy, send it out to the MCOs. And,
10 of course, you know, circle back with the
11 dental community, keep them in the loop on
12 what we're doing and what that policy is
13 going to look like. So we will have
14 something out, you know, hopefully before
15 the holidays on that -- on that code and
16 what our policy is, but we will be -- we
17 will be covering those.
18 DR. BOBROWSKI: Okay. Thank you very much.
19 The oral surgeons and the universities were
20 starting to get nervous on that, because
21 the oral pathologists -- and I got some
22 letters from some of the oral surgeons
23 that, you know, they commented about how
24 valuable an oral pathologist is compared to
25 just a general pathologist. And it's a --

1 like you said, it's almost a subset of the
2 pathology departments that are highly
3 specialized in our area. So thank you
4 again for working on that.
5 And the next item was -- and I know
6 we've talked about this before, but since
7 we've got some more expansion codes in
8 orthodontics or if a dentist starts a root
9 canal or starts a denture, starts a crown,
10 those dentists have incurred some material
11 bills, lab bills. But what happens if the
12 patient becomes ineligible right in the
13 middle of treatment?
14 MR. DEARINGER: That's a good question.
15 That's something that we have met multiple
16 times. I've met multiple times with CMS
17 trying to get that figured out and
18 evaluated. You know, that -- with all --
19 as with all provider types, if a member is
20 showing eligible on the date of service for
21 you-all, and then you get something later
22 saying that that member is ineligible at
23 that time, we always make sure that that is
24 paid and covered because that was something
25 that was out of your-all's control and out

1 of our hands. And it's really about
2 that -- then becomes about that date of
3 service.
4 If an individual -- so there's
5 multiple scenarios. But for an individual
6 to lose coverage -- now if it's a matter of
7 just switching MCOs or MCO to fee for
8 service, we have discussed that with the
9 MCOs, discussed that with our billing
10 providers to make sure those errors don't
11 occur. And if they do, we are encouraging
12 all providers just to reach out and we will
13 make that -- we will get that corrected so
14 that -- so that they are paid for that
15 regardless of timeframes or any other
16 issues.
17 But in the case of them specifically
18 losing coverage, you know, there are several
19 reasons why an individual loses coverage.
20 If they lose coverage because they simply
21 didn't turn something in or, you know, with
22 PHE ending and everybody having to do
23 redeterminations now, as long as they get
24 that information in, they will backdate that
25 coverage to when -- to make sure that

1 there's not a lapse in coverage due to that.
2 So that's not really an issue for
3 providers. Although, it may be an
4 inconvenience at the time, but they will
5 backdate that and we will make sure all
6 those claims get paid. If the individual
7 loses coverage because they have other
8 insurance or because they are no longer in
9 the acceptable income limits, unfortunately
10 right now there's nothing we can do about
11 that. CMS won't allow us to pay those. We
12 are looking at some other states that are
13 trying to come up with some ways to maybe do
14 some things, and we're continuously -- in
15 continuous conversations.
16 We have one actually scheduled, I
17 think, in the middle of January with CMS and
18 a couple of other states that have the same
19 question, trying to come up with unique
20 solutions. But as of right now, there's
21 nothing we can do about that scenario. So
22 that's kind of where we're at with that.
23 DR. BOBROWSKI: Making a note there. One
24 of the things when you're talking with CMS
25 that -- because I know like on a root canal

1 or a denture, a crown, we'll put it in our
2 system that we kind of got it started, but
3 as -- as the dental rules are, we can't
4 bill for it until the procedure is
5 complete. But something to think about
6 would be is if -- when talking with --
7 amongst yourselves and CMS, that if the
8 dentist can show in their records that the
9 procedure was started while they did have
10 coverage, that maybe you would -- even
11 though they have -- you know, maybe now
12 have other insurance or, you know, their --
13 even if their income will cover it now,
14 well, maybe it would cover, you know, at
15 least paying the bill for the dentist.
16 We are starting to get a few phone
17 calls about that setup and I know -- I guess
18 maybe where people are coming off the
19 emergency enrollment plans, they maybe are
20 halfway done a procedure and they now are no
21 longer on Medicaid. So we're starting to
22 get a few phone calls about that and...
23 DR. PETREY: And, Garth, I think it also
24 becomes to be a patient care situation that
25 becomes a challenge. I certainly feel it

1 for people in the midst of a root canal,
2 because an incomplete root canal obviously
3 in many ways will doom that tooth, and
4 start of that procedure will -- will lead
5 to have failure of that tooth. I can
6 speak -- I can speak from an orthodontic
7 perspective that if a patient loses
8 eligibility -- where we have the three-tier
9 payment system in orthodontics, if they
10 lose eligibility before the second or
11 third, but mainly specifically before the
12 second, we have a patient that has lost
13 eligibility. We did -- we did receive an
14 upfront payment, but we don't have a
15 payment sufficient to cover our costs in
16 the case and that leaves the patient in a
17 difficult position of what -- what they are
18 to do, because many of these people, even
19 though they are above the margin to stay --
20 to stay on Medicaid services, they are
21 not -- they don't have the ability to cover
22 their own -- their healthcare to the degree
23 of many things such as orthodontics, such
24 as finishing the root canal. And then it
25 puts the provider in a very difficult

1 position, because what we do in our
2 practice and what I think most of the
3 people that are involved -- certainly, the
4 TAC members that I know, you finish the
5 case, you finish what needs to be done for
6 the patient, but you do so at a loss.
7 That's a challenge when we're already at
8 a -- treating on the margins.
9 But you can't abandon the patient. I
10 mean, obviously, our Hippocratic Oath would
11 not allow us to do that and nor would we
12 want to do that. But to have no -- to start
13 a case and then not be able to finish it
14 financially, whether it's a root canal,
15 orthodontics, any of those aspects, that --
16 I understand why CMS is not wanting to
17 cover. We discussed this with patients that
18 turn 21 and that were a child service and
19 they age out, and we have to be mindful of
20 how we treat that. I'm not sure there's
21 clarity from CMS or from the MCOs how we
22 should treat that when patients come to us
23 asking for care and we know they are going
24 to age out of their eligibility and we know
25 they won't be able to have their full fee

1 covered, what -- what is required of us in
2 those cases.
3 But even beyond that, it's a good
4 number of patients that lose eligibility
5 that are -- that we have no way of knowing.
6 We have no -- it's not an age issue and
7 we're in essence left holding the bag. But
8 it's more than left holding the bag, because
9 we have a patient that we have a
10 responsibility to and we're left without any
11 means to financially help that patient
12 finish without out of our own pocket, which
13 is what we do.
14 MS. LEE: And thank you-all for bringing
15 up. I will reach out to other states to
16 see what -- how they deal with this. I'm
17 hoping that at our new -- you know, we have
18 continuous eligibility for children now for
19 12 months, so typically if a child was
20 enrolled in the Medicaid program and their
21 income changed or, you know, they had some
22 other change in circumstance in their house
23 that made them ineligible for Medicaid, we
24 would terminate them. But now regardless
25 of that change, we will have 12 months of

1 continuous eligibility for children. Maybe
2 that will help a small subset of children.
3 I'm not sure how -- as far as the
4 orthodontic piece goes.
5 But as far as root canals and that
6 sort of thing, let us reach out and see what
7 other states are doing about this and see
8 what we can come up with as a game plan.
9 DR. BOBROWSKI: Now, Commissioner Lee, you
10 always tell us to think outside the box.
11 MS. LEE: I am thinking outside the box.
12 DR. BOBROWSKI: Okay. All right. I'm just
13 making sure.
14 MS. LEE: And I think -- I think if we
15 could somehow quantify, you know, what
16 we're talking about, see how big of an
17 issue it is and see what we could do. I
18 don't know how we could get that -- it
19 might be easier in orthodontics to go back
20 and see how many kids age out or how many
21 kids lose benefits in the past that lost
22 benefits before their treatment was
23 completed. But for the root canals and
24 stuff, I'm not sure how we can quantify how
25 big of an issue that is so that we can look

1 to see, you know, what can we do and what
2 can we take maybe to CMS, or what could we
3 look at as a way to make sure that those
4 individuals complete their treatment.
5 Because as Dr. Petrey said, you can't just
6 abandon the patient, so you got to figure
7 out something that we can do.
8 DR. BOBROWSKI: See, and that's where
9 like -- like in my situation of a general
10 dentist, you know, doing more dentures for
11 folks. And making dentures are --
12 typically your better dentures are -- you
13 know, they are a multistep process to make
14 these. And you can easily run up an 8- or
15 900-dollar lab bill and then you're stuck
16 with their -- you know, the patient can't
17 get in to -- you know, to finish it up for
18 various reasons and that's a -- that's a
19 big chunk of money to, you know, not get
20 any reimbursement back on it.
21 But anyway, let's continue to work on
22 that one, and I made a note about that.
23 Okay.
24 The next one -- and I want to commend
25 the ADA that they did have a fee report out

1 the last few years. And we've been telling
2 them and telling them, see, it's not right.
3 But they finally came out here in the last
4 couple months or something and admitted that
5 their Medicaid fee reimbursement report did
6 have errors in it. It wasn't as much as
7 what they originally said, but -- and
8 Commissioner Lee sent me a new report that
9 listed Kentucky as 40 -- I'm sorry -- as
10 19th for children and 26th for adults. The
11 only thing is, is even though they are 26th
12 in reimbursement, the -- it's reimbursed at
13 34.3 percent of the percentage of the charge
14 that was turned in.
15 So that's the -- so that's kind of
16 part of that problem, that in doing dentures
17 or some of the other products with the
18 expansion is, sometimes our lab bills really
19 jump up there. And that's -- that's another
20 thing, that those things haven't stayed
21 stationary, like back in 2017 or '18. Those
22 lab bills have really gone up. And to tie
23 in with this one, there's -- and I'm not
24 going to name any names on dental insurance
25 companies, but, you know, some of these have

1 not adjusted their fees and reimbursements,
2 the same thing, it's like Medicaid, for
3 years.
4 One company, a big company in this
5 state, hasn't done anything since 2019,
6 which it doesn't sound like it's that far
7 away -- ago, but it is. And like with
8 Kentucky at the adult rate of 34.3 percent,
9 this is what ties in to -- one of our dental
10 schools reported that they billed Medicaid
11 for, I think this fiscal year of '22 there,
12 over 12 million dollars in care, but they
13 only received right at 4 million. So
14 they're just saying that it's -- they've got
15 a budget, but they -- they are worried about
16 being able to sustain what they do. And
17 you-all know that our dental schools are
18 sometimes our last resort to send folks to.
19 But another study that I've seen is,
20 is that typically dental overhead in the
21 office would run anywhere between 65,
22 70 percent. The last report I saw is now at
23 85 to 92 percent. So it's just not leaving
24 us a lot of wiggle room to get ahead when
25 that 20,000-dollar suction machine goes

1 down, or your computers have got to be
2 updated. There's no cushion.
3 But on my -- under New Business Item
4 No. 3 -- and I need to maybe explain that a
5 little bit more, because I got this
6 information from two different sources, was
7 that Kentucky is 50th nationally in
8 insurance reimbursements. So even though
9 somebody has insurance, here again, Kentucky
10 is ranked 50th in reimbursement from the
11 insurance company. So if you're dealing --
12 and I know for a fact that some of our
13 specialists in our area have even stopped
14 accepting some insurance plans. So it's --
15 a lot of times it just gets down to a
16 business decision of, well, I can't keep
17 doing this procedure at a loss. And if
18 somebody wants it done, well, they can just
19 pay the fee and go on, is kind of the
20 business attitude, but they can't keep doing
21 it at a loss.
22 I'm going to move on to No. 4. And
23 this is just a thought that -- like
24 Commissioner wants us to think outside the
25 box on things, but was to develop maybe a

1 section in Kentucky on KMAP that helps
2 members in personal responsibility in the
3 care of their own bodies, in preventive
4 measures, in nutrition, in basic knowledge
5 of their body, keeping their appointments.
6 And they would also be in a commitment to
7 change to a healthier lifestyle, and give
8 rewards to members for this commitment.
9 Like if they lower their blood pressure,
10 they get a better A1C or blood glucose
11 reading, physical therapy improvements, a
12 decrease in the cavity rate, or at least
13 finish a basic dental treatment plan and
14 start having better oral health outcomes and
15 then get rewards. Not like it is now
16 where -- had a lady here two weeks ago, she
17 told me that she got a $100 gift card from
18 one of the MCOs just for filling out a
19 survey. In other words, reward good
20 behavior.
21 Another person brought up to me, said,
22 well, people are getting $50 gift cards to
23 get their exams done, but the dentist gets
24 between 26.50 and 32.50 for doing the exam.
25 Plus, out of that you got to pay staff and

1 supplies. So I'm just putting that out
2 there as an item of thinking outside the
3 box. Maybe we should tie some of these
4 rewards and awards to the Medicaid members
5 to get -- let them have a little more skin
6 in the game, that, well, we got to see some
7 improvements in what you're doing. Just an
8 idea. Any comments from any TAC members
9 or...
10 All right. The -- under new business,
11 under other, I guess all I can say is, just
12 to kind of -- we all need to work with our
13 legislatures. And if we want to have these
14 good programs -- and I've seen -- I have
15 seen so many times when people are just so
16 glad that they have had Medicaid to kind of
17 get them out of a tough situation, you know.
18 So I don't want to make this totally sound
19 like I'm always doom and gloom on this,
20 but -- and because we want to help our
21 patients in Kentucky have a -- have a much
22 better life, and sometimes we've got to work
23 through issues to get them there.
24 I do have a question on -- and I think
25 this was reported last year, but I've got --

1 let me pull that up. Give me one second
2 here. Let me close out this page. There we
3 go.
4 One of the questions that I've got is,
5 what is the -- I've got a few here that,
6 what is the value per MCO on the value-added
7 benefits per year? And these are some
8 things that -- if the other TAC members
9 agree, that we could maybe get some of this
10 in a report. Obviously not today, but by
11 our next meeting. What's the value per MCO
12 of the value-added benefits, you know, per
13 year? And maybe by January -- or, I mean,
14 our next February meeting, you know, maybe
15 we could have a report on what was done for
16 2022 and 2023.
17 MS. BICKERS: And Dr. --
18 MR. OWEN: Dr. Bobrowski.
19 MS. BICKERS: -- oh, I'm sorry, sir. Go
20 ahead.
21 MR. OWEN: Stuart Owen with WellCare. Are
22 you asking for like the total spend by MCO
23 on value-added benefits? I just want to
24 make sure I understand.
25 DR. BOBROWSKI: Yeah, spend on the

1 value-added benefits.
2 MR. OWEN: Okay. Thank you.
3 DR. BOBROWSKI: I know you got a range of
4 things that some of those monies are not --
5 I mean, I know you probably got a budget on
6 those things, but not everybody uses the
7 full budget.
8 MR. OWEN: So you would like to know, like,
9 how much actually was spent, used, spent
10 like of the budget --
11 DR. BOBROWSKI: Yes.
12 MR. OWEN: -- how much for the year?
13 DR. BOBROWSKI: Yeah.
14 MR. OWEN: Like for calendar year 2022?
15 MS. BICKERS: Thank you, sir. You asked my
16 same question. This is Erin with the
17 Department of Medicaid. And I just want to
18 make sure so when I send this out to the
19 MCOs. Do you want just a lump dollar
20 amount sum or do you want that broken out
21 per -- you know, what benefits were used?
22 You know, for example, like the gift card
23 reward like on the -- do you want that in
24 its own category how many dollars of that
25 versus say -- and, Stuart, help me. You

1 know your value added better than I do.
2 But do you want those broken out in
3 different categories or do you just want a
4 lump sum dollar for all the value adds for
5 those years?
6 MR. OWEN: And I was going to say, we have
7 a lot. It might be kind of a little bit of
8 a challenge to break it down by each
9 individual one, but...
10 DR. BOBROWSKI: My initial thought was to
11 just -- just a one total dollar amount.
12 And I know you-all probably do evaluate
13 those things to see if, you know, maybe one
14 value-added benefit is just not used at
15 all, that, well, maybe you can switch those
16 funds to something that is being used. But
17 I -- my initial thought was just a total
18 dollar amount. I know that would be awful
19 hard to go through each item that you-all
20 provide, but let's start with a total
21 dollar amount. That would probably be a
22 little easier to come up with.
23 MR. OWEN: Appreciate that. And we -- kind
24 of to your earlier point you talked about.
25 I mean, I know all the MCOs have rewards

1 programs where we're trying to incentivize,
2 you know, good behavior, which is healthy
3 behavior. They are tied to, you know,
4 preventive visits, getting visits like
5 that, you know, actually tieing it to a
6 member improving in a given area. I mean,
7 I don't think we do that. That can become
8 a challenge. But anyway, it's always --
9 it's good to think about, for certain. But
10 I know we all have rewards programs try to
11 incentivize members, you know, including
12 like quit smoking, a lot of different
13 things; controlling, you know, diabetes and
14 blood pressure and various things. But
15 anyway, I appreciate the dollar amount
16 would be total...
17 DR. BOBROWSKI: Okay. I just --
18 MR. OWEN: Thank you.
19 DR. BOBROWSKI: I just saw another saying
20 from Albert Einstein this morning. It's
21 like, if you keep doing the same old, same
22 old, well, you're -- I forgot the full
23 thing, but you're not gaining anything.
24 MR. OWEN: You get the same results.
25 DR. BOBROWSKI: You get the same result,

1 you know.
2 MR. OWEN: Right. Exactly.
3 DR. BOBROWSKI: So -- but anyway, that's
4 what I was looking at is, are there things
5 that we can look at and maybe even have a
6 section of Medicaid that these patients
7 would agree to -- well, getting either an
8 additional reward if they complete a dental
9 treatment plan, get all their cavities
10 done, get their cleanings done, you know,
11 just the basic stuff. Or if their blood
12 pressure improves, those are things that
13 have better health outcomes.
14 And I did get a report from Medicaid.
15 It was the number of Medicaid dentists per
16 county. But I am so sorry that I can't find
17 it. Like you-all, when you get about 70 to
18 100 e-mails a day, it -- or sometimes they
19 get lost. And I'm not saying that my little
20 chubby fingers might accidentally hit the --
21 the delete button on some of those that I'm
22 getting rid of, but --
23 MS. BICKERS: Dr. Bobrowski, we have a
24 couple of hands raised.
25 DR. BOBROWSKI: Yes.

1 MS. BICKERS: Danita, I believe you were
2 first, and then Dr. Theriot. You're on
3 mute, Sweetie.
4 MS. COULTER: Hi, Dr. Bobrowski. This is
5 Danita. I'm with Quality Population
6 Health. I'm Equity and Determinates of
7 Health. We thank you for up-lifting your
8 concerns about the value-added benefits.
9 And we just want the TAC to be aware that
10 our team is also interested in connecting
11 the value-added benefits with the health
12 outcomes and figuring out how we can best
13 get our enrollees to utilize those and to
14 connect those with health outcome and tie
15 those to the population health reports. So
16 that is something that is on our radar. We
17 are working on that, so I just wanted to
18 acknowledge that to the TAC.
19 DR. BOBROWSKI: Great. Thank you so much.
20 DR. THERIOT: And hi, Dr. Bobrowski. I
21 actually have been thinking about this a
22 lot, because when you get the information
23 from the MCOs, you are going to be
24 surprised about how few members take
25 advantage of those value-added incentives.

1 And I've always wondered that. Like if you
2 can get $100 for going to a visit, why --
3 you know, that's a free $100. Why don't
4 you just do it? And I think it actually
5 goes back to that Maslow's Hierarchy of
6 Needs that we all learned sometime in
7 college, that -- you know, that baseline
8 level is you need to have shelter and food
9 and safety before you can look higher up.
10 And you don't get to that personal
11 responsibility until the very tiptop of
12 that pyramid. And so if you're a family or
13 a member that is struggling with food or
14 housing instability, you're -- you know,
15 you're just not going to be on -- it's just
16 not going to be anywhere on your radar --
17 DR. BOBROWSKI: Right.
18 DR. THERIOT: -- to control your blood
19 pressure or go to the dentist or anything
20 like that. And so I think that's where the
21 social determinants comes in and population
22 health is to actually -- you got to help
23 try to address some of these problems that
24 are at the bottom of the pyramid before you
25 can even think to make any movement on the

1 top.
2 So I do agree it's personal
3 responsibility, but in the same time, people
4 just can't get to that level without
5 climbing up from those other levels and --
6 and so that's where the problem is, I think.
7 DR. BOBROWSKI: I agree. It's just -- and
8 that was kind of why when I made that
9 comment, was maybe develop a section of
10 KMAP members. You know, it's hard to make
11 a blanket of policies that you'll get 100
12 good responses from. We just know dealing
13 with humans, or puppy dogs, that won't
14 work, you know. But it -- I just hear --
15 well, and it's not even with just Medicaid
16 patients. It's with everybody. You know,
17 you've got all kinds of people that just
18 have even got regular insurance that the
19 doctors, the physicians, have trouble with
20 compliance on like diabetes, diabetics.
21 They're just -- they're just not eating
22 what they are supposed to do to help their
23 diabetes and it just creates other health
24 problems. But I don't know, I'm just
25 trying to think outside the box on trying

1 to get something going. And I hope that we
2 can all put our heads together and just
3 help with health outcomes. But thank you.
4 Let's see. There was a report that we
5 asked for a while back. I don't remember
6 receiving it, but it was on a report on --
7 from the MCOs on paid claims, and it was
8 what was paid at different levels per
9 quarter. We never did get that report that
10 I can recall. We used to get it a few years
11 ago, but we've stopped getting that. But
12 maybe if somebody from DMS can help me --
13 because we've already sent in to you-all. I
14 think we sent it back in maybe April or May.
15 MS. BICKERS: Dr. Bobrowski, this is Erin.
16 I'll search my records for the data
17 requests.
18 DR. BOBROWSKI: Okay.
19 MS. BICKERS: And I apologize. I do see --
20 I'm scrolling really quick. I sent a
21 supplemental report in August. Is that the
22 same report or is this something different?
23 DR. BOBROWSKI: I'd have to look and see
24 what that supplemental is, because I was
25 looking all week and again last night. I

1 was pulling up your name to see if I could
2 find it under your name or Kelly's or
3 Commissioner Lee's and I just couldn't find
4 that one that we requested, because we had
5 requested that -- well, we actually had it
6 a few years ago. It was kind of like a
7 paid claims of how many dentists were
8 getting paid like $1,000 a month from
9 Medicaid or from the MCO, how many were
10 getting 1,001 up to $5,000, or something
11 like that, and then 5,001 up to $10,000.
12 So it was -- we kind of had it broken out.
13 MS. BICKERS: Okay. I'll go back through
14 my records. I do see a couple of things
15 that I've sent that I'll get when we get
16 off here. I can go through and actually
17 pay attention and try to pull anything.
18 DR. BOBROWSKI: Okay.
19 MS. BICKERS: And if we have not sent you
20 anything, I will follow up. And I do
21 apologize for the delay in that request.
22 DR. BOBROWSKI: Well, we'll forgive you.
23 But it might be me, too. I might have just
24 not found it in my stuff, but I've searched
25 numerous times for it and I couldn't find

1 it.

2 Then I've got another request. What
3 number of procedures require a prior
4 authorization through the fee-for-service
5 group or the MCOs and the number of denials,
6 number of approvals, but what are you-all
7 seeing as the reason for the denial? I
8 mean, is it that we got to educate our
9 dentists better for -- their front office
10 staff not sending in the X-rays with the
11 requests or did it not meet the criteria?
12 What are some of those reasons for denials?

13 And then I had another request of what
14 is the number of general practitioners that
15 are Medicaid providers per region? That may
16 be able to be tied in with that report on
17 the -- well, I don't know. I'm not a
18 statistician, so if somebody is, you can
19 help me on that. But tying that back in
20 with the paid claims report.

21 MS. ROEHRIG: Dr. Bobrowski?

22 DR. BOBROWSKI: Yes.

23 MS. ROEHRIG: Sorry. This is Rachael
24 Roehrig, research and analytics with DMS.
25 And just to clarify, the supplemental

1 report that was sent in August, what is
2 listed on there are the top ten dental
3 provider counts, the bottom ten dental
4 providers counts, the top ten paid fee-for-
5 service dental procedures, top ten paid
6 dental procedures by MCOs, denied reasons.
7 So if you need us to resend that to you, we
8 are more than happy to do that, but it
9 definitely has lots of things I think that
10 you're looking for on there.
11 DR. BOBROWSKI: Okay. Okay. Please resend
12 that to me and I'll be looking for it here
13 today or the next few days or next week
14 and -- I don't expect you to do it on a
15 Friday afternoon, but --
16 MS. BICKERS: I've already sent it to you,
17 Dr. B. I've sent it to the whole TAC.
18 DR. BOBROWSKI: Okay. You're special.
19 MS. ROEHRIG: Thank you, Erin.
20 DR. BOBROWSKI: Thank you.
21 Let's see. Let's see. Let me look at
22 my little list of questions here. What is
23 the Medicaid fee-for-service dental budget
24 and the MCO dental budget? And how much of
25 that is actually spent on true patient care?

1 We're not interested in -- and that would go
2 back again on those patient -- on those paid
3 claims, but we're not interested in -- go
4 ahead and then --
5 MS. BICKERS: I think someone actually
6 unmuted.
7 DR. BOBROWSKI: Okay. And then what I was
8 looking at, well, if what was actually
9 spent, does that come under budget or over
10 budget? If it comes in under budget,
11 what's done with that additional left over
12 money? Or if it's over budget, where are
13 you getting the money to pay for it?
14 But -- let's see.
15 And then I've got another question
16 on -- and I can send you this list if
17 somebody will give me a -- who to send it
18 to, an e-mail address. But wondering, well,
19 what is the dental ER usage rate? And maybe
20 look at a yearly comparison, because I know
21 what was one of the things we have talked
22 about for years, was decreasing the
23 emergency room visits and it would just be
24 good to track that to see if we are making
25 some inroad. And my thinking is that the

1 more dentists that we can get to be a
2 Medicaid provider, that emergency use of the
3 ER should go down. But if we could look at
4 that kind of as a yearly comparison to see
5 what's been spent at the emergency room.
6 DR. MCKEE: Dr. Bobrowski?
7 DR. BOBROWSKI: Yes.
8 MS. MCKEE: It's Julie McKee. That
9 particular question is something that I'm
10 going to be developing a request with the
11 DADD people for that for a completely
12 different reason, but to find out
13 specifically non-traumatic dental
14 presentations in emergency departments, but
15 I will share that when I get it.
16 DR. BOBROWSKI: Thank you. All right. And
17 then I know we've had reports on the failed
18 appointments and the reason for these
19 failed appointments. And it seems like the
20 last several reports we've gotten on that,
21 the majority of the failed appointments had
22 no reason or there was no reason given.
23 Now, yes, sometimes there could be a
24 transportation problem or a child may get
25 sick and not be able to come to their

1 appointment, but the majority of those was
2 no reason was actually given, but would
3 like to kind of follow up with that one and
4 see if there's any change, just to -- to
5 watch that and look for changes.
6 Is there a way to quantify treatment
7 for special needs groups of patients? Or
8 what health outcomes are we -- are we
9 actually helping special needs patients?
10 And then another one -- and I know
11 when I was looking at the value-added
12 benefits, I know there was some things to
13 help ladies in pregnancy. But I was just
14 wondering if there was a way to quantify
15 oral health outcomes for our pregnant moms
16 in our communities, and especially our new
17 moms that this is their first child. What
18 kind of health information are they getting?
19 What kind of oral health information are
20 they getting for our new parents? And I
21 guess this kind of ties into what is being
22 done for oral health education and treatment
23 recommendations from the MCOs. And I know,
24 I did see a few things on the value-added
25 benefits, but I didn't know if anybody from

1 the MCO wanted to briefly talk about that.
2 The floor can be open. Just got a couple
3 more questions here.
4 MS. BICKERS: I believe Justin Dearinger
5 has his hand raised.
6 DR. BOBROWSKI: Okay. See, I don't -- I
7 don't get to see those hands being raised,
8 so you got to help me on that part.
9 MS. BICKERS: I gotcha.
10 DR. BOBROWSKI: Okay.
11 MS. BICKERS: And, also, if you would like
12 to e-mail me a list of all of those
13 questions, I can make sure they get to
14 their appropriate person to get you some
15 answers.
16 DR. BOBROWSKI: All right. I'll mail them
17 in just a few minutes. Justin?
18 MR. DEARINGER: Yes, sir. I did want to
19 let you know that we have a new system --
20 or, I'm sorry, a new report, an MMIS, which
21 is the billing system for providers. So
22 when you go into that system, there is a
23 report that is a no-show report and -- or a
24 missed appointments report and you can
25 actually run that yourself at any time. It

1 shows you how many missed appointments
2 there were. You can break it down by
3 provider type and reason. And you are
4 correct, the number one reason is still
5 unknown. And that's one of the reasons why
6 we wanted to put that report out there,
7 make it public, make it instant, so that
8 you have access to that 24/7 in order to
9 try to get providers to understand how
10 important it is to reach out to individuals
11 to try to get a reason why they missed that
12 appointment. You know, the majority of
13 those missed appointments may still be
14 something that we can't control, but if we
15 have a large percentage of those
16 appointments missed due to transportation,
17 childcare, other issues, we can really
18 focus on getting those taken care of and
19 try and cut away at that percentage. So I
20 just wanted you to know that that report is
21 out there, it's available to all providers,
22 and it's in the MMIS system.
23 DR. BOBROWSKI: Okay. I wrote that down.
24 Thank you, Justin. Now, is there a way to
25 get a -- like a yearly report on comparing

1 the total Medicaid reimbursements to a
2 regional usual and customary rate of --
3 like, for instance, on the ADA fee
4 schedule? I know there's been talk about
5 comparing us to other states. And it
6 really -- when I looked at some of these
7 things, it really is hard to compare apples
8 to apples because of certain states have
9 limitations -- and I think even some of the
10 ADA, I think that -- the report that
11 Commissioner Lee sent me a while back was,
12 they got Kentucky with the adult level as
13 listed as limited. But this has all
14 changed since the beginning of this year.
15 Some states are extensive and some states
16 only do emergencies for adults. And, of
17 course, it lists as Maryland as one of the
18 states that had no Medicaid coverage for
19 adults, but I believe that's one of the
20 ones that changed for adults January of
21 this year or thereabouts.
22 And then the next question I got will
23 be covered by that report that you're going
24 to send me.
25 And then does Medicaid update their

1 records on providers who show that there's
2 been no treatment activity from that
3 provider for years? I know of one dentist
4 that he said, I haven't seen a Medicaid
5 patient for 25 years, but he says, but my
6 name is still on the roles. Does Medicaid
7 reach out to those providers to see if they
8 want to keep their name on there or -- I
9 know at our church, you know, it's kind of
10 one of those things you hate to have to do
11 on membership, but, you know, we do have a
12 membership committee and, you know, some
13 people have deceased, some moved away, or
14 they have gone down there to that Baptist
15 church, you know. I'm teasing, but just --
16 that's another question I had. And I'll
17 send this to you-all.
18 But then another -- one last question:
19 What is the MLR for the dental MCOs only?
20 Now, TAC Members, is there any other
21 question that -- I've tried to cover some
22 bases here and just try to get us looking at
23 our whole package here, so that was the
24 reason for such a lengthy list of questions.
25 DR. GRAY: Garth, John Gray.

1 DR. BOBROWSKI: Yes, sir.
2 MR. GRAY: I'd like to go back to No. 4.
3 If there's any interest in having dental
4 input into the rewards program, I would be
5 happy to meet with whoever is heading up
6 that rewards area as to some possibilities
7 for dental input. I think you outlined it
8 pretty well. So if anyone is interested,
9 I'm -- I would be glad to make myself
10 available one-on-one or however we need to
11 do that.
12 DR. BOBROWSKI: Thank you, Dr. Gray.
13 Appreciate that.
14 MS. ROEHRIG: Dr. Bobrowski?
15 DR. BOBROWSKI: Yes.
16 MS. ROEHRIG: Hi, there. This is Rachael
17 Roehrig again with research and analytics
18 at DMS. And just wanted to let you and the
19 TAC know that we are currently working on
20 developing a report that will look at
21 different providers, such as dental
22 providers, and see if there has not been a
23 date of service, there haven't been any
24 claims billed within a certain amount of
25 time. So that way we can make sure that

1 the listing of providers are actually
2 seeing the Medicaid members and are
3 servicing them and that they shouldn't be
4 removed or they should based on our
5 findings. So that is something that we are
6 developing currently to look at just that.
7 DR. BOBROWSKI: Okay, great. Thank you.
8 MR. OWEN: Dr. Bobrowski?
9 DR. BOBROWSKI: Yes.
10 MR. OWEN: Stuart again with WellCare.
11 Just back to when you were talking about
12 ER, I do recall early this year DMS talking
13 about, I believe last year $9 million was
14 spent on dental care in the ER. And that's
15 one of their key lobbying points with the
16 expansion of dental benefits for adults.
17 So I would definitely think that that would
18 have a -- would influence the ER, that it
19 would reduce the ER, but I do remember them
20 reporting that earlier this year. I know
21 they are working on a report. But anyway,
22 I do recall hearing that 9 million last
23 year.
24 DR. BOBROWSKI: That's what -- seemed like
25 I can remember it was a pretty good chunk

1 of change there that -- because now -- and
2 I'm sure it's different in different
3 localities, but I've heard that, you know,
4 it's a minimum charge of over $600 for a --
5 say, a patient to walk in and just to have
6 something looked at at the emergency room.
7 And I would say it's probably a lot more
8 than that in some of the more urban areas
9 of our state.
10 MR. OWEN: And it's --
11 DR. BOBROWSKI: Go ahead.
12 MR. OWEN: I was going to say, and a lot of
13 times, I think it's just dental pain for
14 something that's probably not real
15 expensive to treat.
16 DR. BOBROWSKI: Right.
17 MR. OWEN: But it's very costly because
18 they end up in the ER because they're in
19 pain.
20 DR. BOBROWSKI: Well, I'm hoping that with
21 the increase in oral surgery fees, that
22 more oral surgeons will come on board and
23 more general dentists will come on board
24 and treat folks.
25 Now, this is just a general notice,

1 that we are seeing a lot of dentists that
2 have just almost quit taking teeth out. You
3 know, they will -- if you need one out, they
4 will refer it to the oral surgeon, and maybe
5 that's why there's such a backlog getting a
6 patient into the oral surgeon's office.
7 Now, that's -- that's an observation. I
8 have no scientific data on that, but it just
9 seems like the oral surgeons have commented
10 to me about, you know, well, dentists, you
11 were trained to take out some teeth, but
12 they are just not doing them a lot. Okay.
13 I think that's got that.
14 Is there any other discussion points
15 from any of the TAC Members? Any other MAC
16 recommendations? I would -- I would maybe
17 just suggest that some of these questions --
18 I know it's something that the MAC wouldn't
19 have to vote on, but just to send them a
20 list of some of these questions that we are
21 asking DMS or the MCOs to research more for
22 us and I just -- my opinion would be an
23 appropriate thing to, you know, make a
24 motion on. But if the other TAC Members
25 don't think we should, well, then, we don't

1 have to. But John or Joe, you got any ideas
2 on that?
3 DR. PETREY: I would honestly say, Garth,
4 we need to -- some of those, you know, I
5 mean, John and I both are hearing for the
6 first time. So I think we need to -- I
7 would recommend that we clarify those a
8 little bit better before we make
9 recommendations to the MAC.
10 DR. BOBROWSKI: Okay. All right. Now, we
11 need to look at setting our meeting dates
12 for next year. And, again, it just seemed
13 like that Friday afternoons was a better
14 time for all of us to get together, and so
15 I put down some dates similar to what we
16 had this year.
17 MS. BICKERS: And, Dr. Bobrowski, this
18 afternoon --
19 DR. BOBROWSKI: Yes.
20 MS. BICKERS: -- I had sent out an e-mail.
21 And the dates you have listed are the same
22 dates that I had recommended for your same
23 schedule.
24 DR. BOBROWSKI: Okay.
25 MS. BICKERS: I do know at one point you

1 mentioned not liking to meet until 4:00 on
2 a Friday. I didn't know if the TAC wanted
3 to move it up an hour and go 1:00 to 3:00
4 or keep it at the 2:00 to 4:00 moving
5 through next year.
6 DR. BOBROWSKI: One reason, if I remember
7 right -- Dr. Joe, you correct me. I think
8 with his schedule, the 2:00 Eastern Time
9 was about as early as he could get on the
10 call.
11 DR. PETREY: That's correct. That's
12 correct.
13 DR. BOBROWSKI: Okay. And I don't mind to
14 leave it at that at all. And so I like --
15 I like you being on the call here, Dr. Joe.
16 MS. BICKERS: Well, since these are the
17 same dates I have in the e-mail, I will
18 just mark them as approved by the TAC, if
19 you guys are okay with the dates listed
20 down here. And I'll start working on
21 getting the calendar invites out. We are
22 currently on an uploading freeze with our
23 website because we are trying to revamp it
24 to make it a little more user friendly. So
25 your meeting minutes from today won't get

1 uploaded for about week. And then so your
2 meeting dates next year won't be added on
3 there until about a week, until I've been
4 lifted off of my freeze and I can edit the
5 website.
6 So I just wanted to let you know, just
7 in case anybody goes out to look for
8 anything from today's meeting, the website
9 won't be updated until next week. I've just
10 been trying to let some of the TACs know,
11 because I know a lot of you like to go out
12 and pull some of the information, or if
13 there's presentations and things of that
14 nature. So I've just been trying to give
15 everybody a heads up.
16 DR. BOBROWSKI: Good deal. Thank you.
17 And one quick question. I know you
18 gave your name, but I didn't get a chance to
19 write it down. There's a -- from research
20 and analytics?
21 MS. BICKERS: That was Rachael.
22 DR. BOBROWSKI: Yes. Okay, got it. Okay.
23 Well, TAC Members, is there any other
24 business that we need to discuss?
25 Well, we will -- please keep

1 Dr. Schuler in your thoughts and prayers.
2 And we are already in the process of looking
3 for another TAC Member. I really feel
4 honored to have -- you know, the TAC Members
5 that we've got, I think we've got a good
6 cross section of what's going on in the
7 state. And I really value these guys and
8 gals for being on the TAC and taking the
9 time to do these and I really appreciate it.
10 But if there's no other business to
11 come before the TAC, I'll acknowledge a
12 motion to adjourn.
13 MR. GRAY: Motion to adjourn, John Gray.
14 DR. PETREY: Second, Joe Petrey.
15 DR. BOBROWSKI: Thank you. All in favor
16 say, "Aye."
17 DR. GRAY: Aye.
18 DR. PETREY: Aye.
19 DR. BOBROWSKI: Thank you-all. You-all
20 have a great weekend and have some fun.
21 * * * * * * *
22 THEREUPON, the TAC Meeting was concluded.
23 * * * * * * *
24
25

STATE OF KENTUCKY)
COUNTY OF FAYETTE)

I, JOLINDA S. TODD, Registered Professional Reporter and Notary Public in and for the State of Kentucky at Large, certify that this transcript is a true and accurate record of the Dental Technical Advisory Committee meeting.

My commission expires: August 24, 2027.

IN TESTIMONY WHEREOF, I have hereunto set my hand and seal of office on this the 2nd day of January 2024.

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

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