

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

IN RE: DENTAL TAC

HELD VIA ZOOM

DATE:

AUGUST 9, 2024

2:00 P.M.

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A T T E N D E E S :

Garth Bobrowski, DMD, Chairman

Joe Petrey, DMD

Kaitlyn Patel, DMD

(and many more were on ZOOM)

1 August 9, 2024

2 2:00 p.m.

3 * * * * *

4 DR. BOBROWSKI: We want to first welcome
5 our new TAC member, Dr. Kaitlyn Patel. We
6 are so glad to have you on with us today.
7 And just like I say during our meetings, we
8 do need you to have your video on. You can
9 take your audio on and off as you desire,
10 but we will need you to have your video on
11 the whole meeting.

12 And we do have a quorum, but now --
13 oh, I was going to tell folks, too,
14 Dr. Patel is from Harlan, Kentucky, so we've
15 got some young people on here now. That's
16 great.

17 But I was establishing a quorum. I'm
18 here, Dr. Petrey is here, and Dr. Patel is
19 on, so that gives us a quorum. And Dr. John
20 Gray may or may not be on. He said he might
21 be a few minutes late, but he may not be
22 able to be here at all.

23 And I want to -- I know Commissioner
24 Lee is on here, and we appreciate you being
25 with us today. And we have already had one

1 meeting with her this morning already, so we
2 want to again thank you for being here, and
3 I wanted to kind of give the floor to her
4 for a few minutes because she will not be
5 able to stay on for the whole meeting and I
6 wanted to let her go ahead and kind of go
7 first here. So Commissioner Lee, go ahead.

8 COMMISSIONER LEE: Thank you,
9 Dr. Bobrowski. I just wanted to attend the
10 meeting for a little bit today and, again,
11 thank you-all for everything you do for the
12 Medicaid program and the members we serve.
13 And a big welcome to Dr. Patel. Good to
14 have another Eastern Kentucky girl in this
15 arena here. I myself am from Hazard, so we
16 may have a little bit in common as far as
17 our roots are concerned and from being from
18 Eastern Kentucky. So just again wanted to
19 thank you-all for everything you are doing.

20 Don't really have many updates from
21 the Department. We have looked at the data
22 requests that you-all submitted. We have
23 some information that we are compiling and
24 should get that to you very soon so that you
25 can review it and maybe discuss at your next

1 Dental TAC meeting if you want.

2 We also have some updated reports that
3 we can share regarding the dental codes for
4 adults, since we have enhanced those dental
5 services for adults related to root canals
6 and that sort of stuff. So we will provide
7 those to you as well.

8 And, Dr. Bobrowski, I think under Old
9 Business on Item 1, if I can go ahead and
10 speak to that. We have looked at that
11 request. We have also passed it along to
12 our managed care members, because we want to
13 make sure that if we move down this path of
14 removing those prior authorizations, that
15 everybody operates the same way. And so we
16 do have -- our MCOs are looking at that.
17 It's under consideration and we should have
18 a response for you within -- definitely
19 before the next TAC meeting.

20 DR. BOBROWSKI: Thank you.

21 COMMISSIONER LEE: And I think that's all.
22 Again, thank you-all for everything you do.

23 DR. BOBROWSKI: Well, thank you for looking
24 at those codes and just seeing what we can
25 do to help streamline our dentists being

1 able to provide their services. And kind
2 of like I said, there's just so many times
3 we all have just walk-ins. And there's a
4 hospital right up the road from my office
5 here, and they have even got signs out
6 front that says walk-ins are welcome. So
7 we just don't know what we get to do until
8 we see the patient. And sometimes those
9 things we can take care of right away and
10 it helps the patients be seen in a timely
11 manner. So we appreciate you looking at
12 those.

13 Does any of the TAC Members have a
14 quick question for Commissioner Lee while
15 she's here? Okay. And we have been able to
16 ask some questions. Dr. Patel, I'm going to
17 put this one to you. We have been able, in
18 the past, to ask questions knowing that we
19 will not get an answer today, but they work
20 on it and, it's like Commissioner Lee says,
21 they will get back with us, you know,
22 within -- or by the next TAC meeting. So
23 that's just kind of the way it operates
24 here.

25 And so I want to go back up here to

1 approval of the minutes from the May 10th
2 meeting. And so I'll make a motion to
3 approve those minutes. We need a second.

4 DR. PETREY: I'll second the motion to
5 approve the May 10 meeting minutes.

6 DR. BOBROWSKI: All in favor say "aye."

7 (All members vote "aye.")

8 DR. BOBROWSKI: Thank you.

9 And then one thing I've got to ask --
10 and maybe Ms. Erin, if you're here -- I just
11 happened to be noticing in the minutes from
12 February, I think it was the 9th of this
13 year. I noticed a list -- that the first or
14 second page it listed the dentists that were
15 on the TAC and it listed a Dr. Kimberly
16 Hughes, DMD. I have no clue who that is,
17 and I didn't know if somebody from Medicaid
18 can help me on that, or is it just a typo
19 or -- but I noticed that I think she made
20 the motion or seconded the motion or
21 something there to approve the minutes. But
22 I'm just wondering and, in my mind, I
23 thought I heard Dr. Carol Braun. And I'm
24 just wondering if the names might have just
25 got mixed up somehow. But I don't know how

1 to research that or look at it, but we've
2 tried to look that up. I just found it last
3 night about 2:00 or 3:00 in the morning.
4 MS. BICKERS: I'm sorry. I can look into
5 that. I'll go back and review the minutes
6 and then also the recording on the YouTube
7 channel.
8 DR. BOBROWSKI: Okay.
9 MS. BICKERS: I do recall in a TAC
10 meeting -- and I apologize there are so
11 many of you -- we had a non-member vote on
12 minutes one day, and we had to go back and
13 revote. But I'll dig into that a little
14 bit and if I need to, I'll get those
15 minutes revised and out to the TAC just so
16 we have the most accurate information. So
17 I will put that on my followup to-do list.
18 DR. BOBROWSKI: Okay, thanks.
19 MS. BICKERS: I'll touch base with you next
20 week.
21 MS. HUGHES: Dr. Bobrowski.
22 DR. BOBROWSKI: Yes.
23 MS. HUGHES: This is Kimberly Hughes and I
24 work for Passport Molina. So I am not a
25 physician, but -- so I'm not sure how

1 exactly my name got on there, but I am
2 Kimberly Hughes. So I think it was just a
3 typo.
4 DR. BOBROWSKI: Okay. Thank you.
5 MS. BICKERS: Thank you, Kimberly.
6 DR. BOBROWSKI: Yes. Well, I was looking
7 at that and then I was telling somebody
8 early this morning, I said, I know I have
9 heard that name or seen you on the screen
10 that we have for our Zoom calls. I knew --
11 I knew somebody, but we looked on the
12 dental records and stuff and we could not
13 find a dentist named Kimberly Hughes. So
14 thank you for letting us know. Appreciate
15 that.
16 MS. HUGHES: You are very welcome.
17 DR. BOBROWSKI: All right. And we've got
18 No. 2 on Old Business. We've got
19 Dr. Kaitlyn Patel on here to replace
20 Dr. Schuler. And, again, I want to thank
21 you for taking on this role, and it is a
22 very important role and we want to make you
23 feel welcome. And any time you got
24 questions, ideas, you know, jump right in
25 there. And then Dr. Petrey and I are --

1 and Dr. John -- we have been on this
2 committee for a few years, so you could
3 even contact us after hours if you want to.

4 But I'm going to move down here to
5 some other reports that I did receive back
6 from -- and I want to thank Commissioner Lee
7 for help on this, too. It's like a couple
8 of codes, the -- a lot of the filling codes,
9 we've got a notice from Ms. Erin Bickers
10 there that the limitations for once per
11 tooth per 12-month per member was removed.
12 So for us restorative dentists that really
13 helps, because we see a lot of folks that do
14 brux or grind their teeth, and up until last
15 year we could not, you know, make them a
16 bite guard to protect their front teeth.
17 And so many times they'd come in with a
18 front tooth broken, and you look back in
19 your record, well, man, we just filled that
20 eight months ago and now they broke it
21 again. And their front tooth and they are
22 wanting to go to work, you know. So we
23 appreciate you-all giving us the ability to
24 help people keep their smiles. And so that
25 one has been fixed.

1 And then let's see, the other one that
2 we got a report back on was -- one of the
3 questions at the last TAC meeting was -- the
4 question was asked if the MCOs were being
5 paid enough to cover them providing the
6 dental services for members. The response
7 is the MCO capitation payments are actuarial
8 sound and appropriate to cover all
9 healthcare services. The actuary took --
10 looked at the changes to the dental benefits
11 and rates, and they were all taken into
12 consideration for capitation rate
13 development. So we appreciate those answers
14 and responses there from our last meeting.

15 Now, is there -- is there any other
16 old business that I may have forgotten about
17 or left off?

18 Okay. I'm going to go to New
19 Business. One of the things that we were
20 looking at doing was -- and I don't know
21 exactly how to create this, but we were kind
22 of wanting to look at the comparison code
23 utilization, like a report from 2022 and
24 2023, just to see what is dentally being
25 done. And I know in '23 we added the

1 expansion codes, so I know that's going to
2 include, you know, dentures and partials and
3 crowns and stuff like that, so it won't
4 be -- we won't be able to do a comparison.
5 But after this year a comparison report
6 could be done just to, I guess, find if
7 there's any trends or -- and, Erin, and I
8 don't know exactly how to design that
9 report, unless one of the other TAC Members
10 have got a question on how to do that.
11 Maybe someone from DMS could help us design
12 that and get that to the MCOs for further
13 development.

14 MS. BICKERS: We can make that request. If
15 you don't mind, if there's certain codes
16 that you want compared, you guys are the
17 subject experts, so I just ask that you
18 follow it up in writing so I make sure to
19 pull the proper data and request the proper
20 codes and how you would like it broken
21 down, whether you just want it broken down
22 by code, by counties, age groups,
23 et cetera, just so we can make sure to pull
24 the data and provide it in the way the TAC
25 would like to see it.

1 DR. BOBROWSKI: Okay. I'm going to make
2 myself a note here.

3 Any TAC Member got any question,
4 suggestions at this point on that?

5 DR. PATEL: I think that would be very
6 helpful.

7 DR. BOBROWSKI: You know, it just helps the
8 practitioners see what's, you know, being
9 used. Helps us, gives us guidance in terms
10 of possibly developing policy on certain
11 codes. So we'll work on that and I'll try
12 to -- who should I send that to, to follow
13 up on writing that up?

14 MS. BICKERS: You can send that to me and I
15 can get it out to all the appropriate
16 parties.

17 DR. BOBROWSKI: Okay. Is that Erin?

18 MS. BICKERS: Yes. I'm sorry.

19 DR. BOBROWSKI: It just shows up Kentucky
20 Medicaid on your screen there, so...

21 Okay. Now, I've got a few other
22 questions here. Just bear with me on here.
23 Well, one of the things that I was looking
24 at, and Commissioner Lee already addressed
25 some of that this morning, or this

1 afternoon, was that they're working on the
2 prior authorizations. The -- I guess the --
3 and we mentioned this before. If the MCOs
4 could come up and just tell us what is the
5 primary reason for a denial, because maybe
6 that's something that the TAC, the Kentucky
7 Dental Association, sometimes we can -- you
8 know, or the MCOs can speak with their
9 provider dentist to, say, look here's what
10 you're doing or not doing to get your
11 treatment not authorized. So if we can be
12 of any help doing that. But if we can --
13 maybe the next meeting, if we could have the
14 MCOs just, you know, give us two or three
15 reasons, whatever, their top reasons that
16 things are getting denied, you know, with
17 the required prior authorizations, that may
18 be helpful for us. And let's see...

19 MS. BICKERS: This is Erin again. If you
20 want to add that to request, we can
21 ask that -- and I'll send a follow-up
22 e-mail after this to the MCOs and request
23 what maybe their top five denial reasons.
24 DR. BOBROWSKI: Yes, okay. That would be
25 great.

1 MS. BICKERS: And then we can give them
2 each a few minutes next meeting to kind of
3 present what they have and...

4 DR. BOBROWSKI: That sounds like a good
5 plan.

6 UNIDENTIFIED WOMAN: And, Dr. Bobrowski,
7 are you talking about just the top five
8 that are around the prior authorizations;
9 is that correct?

10 DR. BOBROWSKI: Yes.

11 UNIDENTIFIED WOMAN: I'm just trying to
12 write myself some notes, just trying to be
13 sure. Thank you. Just wanted to clarify.

14 DR. BOBROWSKI: Thank you.

15 The next one would be one of our
16 concerns, and we keep -- and I'm also --
17 some of you know I'm also on the MAC, the
18 Medical Advisory Committee, and, you know,
19 we hear from different provider groups, the
20 primary care physicians and others, that
21 where's the dental providers. They are
22 having harder and harder times of finding
23 dental providers in their communities. But
24 one other report, and I don't know that --
25 we have had this discussion before and --

1 because we talked about how many dental
2 providers are there truly in Medicaid. And
3 I know the Commissioner said one of those
4 questions they were working on still of the
5 providers. And we had it broken down by a
6 dollar amount that we were producing. Some
7 dentists may just see one family a year, you
8 know, some -- some dentists are seeing, you
9 know, 20 and 30 people a day. Some of the
10 oral surgeons are seeing more than that.
11 Some of the -- like Dr. Petrey, the
12 orthodontists, are seeing probably many more
13 than that per day. But if we could -- we'd
14 like to just find out, well, how many actual
15 dental providers are there, and then
16 Ms. Erin you-all may be already working on
17 that one.

18 And then I did get a call earlier this
19 week, and, Erin, I think you did help me
20 with that one, on -- had a call of wanting
21 to know what specialists and -- well, it was
22 oral surgeons in particular at that time.
23 But the other thing that sometimes we see is
24 now that they're covering root canals for
25 adults -- boy, to be honest, I don't know

1 anybody around my area that does adult root
2 canals. And if there's some way that we
3 could find a list, you know, from the MCOs,
4 if they've got somebody on their provider
5 list, that would be awfully helpful for us
6 making referrals, because some of these root
7 canals they've got roots on them that go
8 clear into the sinus and they're pigtailed
9 all the way up there. And I usually don't
10 do those kind of root canals, so -- and a
11 lot of general dentists will refer those
12 out. And I know I sure wouldn't want
13 Dr. Petrey doing a root canal on me. He
14 might straighten up those roots.

15 DR. PETREY: Yeah, Garth, I think it's a
16 very important point to gain a better
17 understanding of not just number of
18 providers, but what is being done
19 primarily, because -- I've said this before
20 in these meetings, but John and I, and all
21 the orthodontists, are in an interesting
22 position because we refer back to our
23 referring dentists. So we -- we see a good
24 number of dentists, dental providers, and
25 we refer back for restoration. We refer

1 back for those that aren't up to the
2 standard on oral health. And what we are
3 finding very clearly, and it's getting
4 markedly worse, is that many, if not most,
5 of our providers are not accepting new
6 patients or they are not accepting new
7 patients unless the family is already part
8 of their practice.

9 And I've had calls from providers that
10 have followed up with me saying I'm getting
11 these notices about making sure that I am
12 able to get patients in in a timely manner,
13 and yet the ones that are seeing the
14 majority of the patients, they can't do that
15 because they simply don't have enough open
16 spots and, thus, as these other providers
17 are restricting because they don't have
18 openings, restricting who they are
19 accepting, it's only making the system even
20 more burdened.

21 Statistically it doesn't look like it
22 is as bad of a situation as it is, but when
23 we -- our primary referral -- referrer in
24 Hazard is not accepting -- does not have an
25 opening appointment until March of 2025.

1 Now, they can -- there's a call list and you
2 can get in. But when you have patients that
3 we are referring with major dental needs
4 that can lead to the loss of a tooth, and we
5 are talking more than six months before you
6 are able to even have an evaluation, that's
7 a problem.

8 Now, these practices are shown as the
9 network being good because there are --
10 there are providers out there. But if they
11 are not accepting new patients or if they
12 are not accepting new patients that aren't
13 in that same family, we are not really
14 providing. And it's especially concerning,
15 and I think I brought this back up at the
16 last TAC meeting, it's especially concerning
17 because our pediatric dentists are so
18 overrun, they are more and more capping the
19 number of patients that they are able to
20 see. And to do that, the best way for them
21 is to -- is to age kids out. And so they
22 are aging kids out 12 and 14. Some go all
23 the way to 18. But there is a large gap of
24 patients that are aging out of the pediatric
25 dentist office that do not have a place that

1 they can go to that will accept them as a
2 new patient.

3 Now we are talking about patients that
4 have had good oral care that are now lost
5 because there is simply not a provider, or a
6 provider with openings that can take new
7 patients available. And so while our
8 statistics that are showing that there are X
9 number of dentists providing in an area are
10 helpful, understanding exactly whether new
11 patients are being accepted, whether true
12 care is being given, as you said, not the
13 provider that's on the register, but just
14 not seeing any patients, or seeing one
15 family a year, is critical to understand.

16 From our perspective, and we see the
17 statistics -- the statistics are scary as
18 they are. It's a lot worse out there than
19 what the statistics show, simply because we
20 have whole communities that we cannot refer
21 patients back for restorative or oral
22 surgery, and certainly for our pediatric
23 dentists.

24 DR. BOBROWSKI: And I'm glad you brought
25 that up, Dr. Petrey. Yesterday I was

1 helping a family that was here from another
2 county. They have a specialty needs child
3 that even -- even one of our local area
4 pediatric dentists, you know, can't handle,
5 but the other -- the rest of the kids in
6 the family have been coming to me. Well,
7 we were trying to get them lined up with
8 another pediatric office in another town,
9 oh, about 45 minutes from us here, but we
10 got online to check and already had the
11 referral form all filled out, and come
12 to -- the mother was helping look it up
13 real quick on the internet and, well, the
14 pediatric office no longer accepts Medicaid
15 patients, none at all.

16 DR. COLEMAN: Dr. Bobrowski?

17 DR. BOBROWSKI: Yes.

18 DR. COLEMAN: This is Ronnie Coleman. I
19 know that Ruby Dental generally has
20 openings. Obviously, this is a busy time
21 with school still being in session -- being
22 out. But I was wondering if maybe the MCOs
23 or the dental benefit administrators could
24 help to facilitate finding openings for
25 patients. Like if, say, you have a patient

1 in your community you can't find someone,
2 can they -- can they reach out to, say, a
3 Ruby or some other practice where we
4 already know we have the potential to see
5 them?

6 The other point that I would make to
7 add on with what Dr. Petrey was saying is
8 the other thing that's impacting access is
9 when we lose staff, whether it be a dental
10 assistant or a hygienist because we can't
11 pay them well since we are 80 percent
12 Medicaid, we have to see fewer patients.
13 And so we just can't be competitive in the
14 dental market place for staffing because
15 rates are so incredibly low in Kentucky and
16 that doesn't seem to be changing. But I can
17 tell you we have reduced our patient load
18 over the past -- well, since prior to the
19 pandemic, by like 35 to 40 percent and it's
20 not because the patients aren't there. It's
21 just we don't have the staff to be able to
22 address the needs.

23 DR. BOBROWSKI: Well, I know I'm in the
24 same boat. Sometimes you'll have a
25 hygienist and -- you know, and I've heard

1 this, too, that if you're a Medicaid
2 office, and even though you got to pay them
3 the going rates for the hygienist, well, so
4 many times what you pay the hygienist is
5 more than what you get for the service from
6 Medicaid. Now, we got that a little bit
7 improved, but still by the time you pay
8 your staff, pay your supplies, pay to clean
9 up the room and get it ready for somebody
10 else, you're in the hole again. So that's
11 an issue we are going to have to look at.
12 Let me see. Thank you, Dr. Ronnie.

13 MS. BICKERS: Dr. Bobrowski, this is Erin.
14 I believe I heard a question in there
15 whether members can contact the MCOs for
16 help and, yes, they can. They should be
17 able to contact their MCO, and the MCOs --
18 I handle constituent e-mails. The MCOs are
19 always very diligent about trying to help
20 the members find someone close, find
21 someone -- seeing someone soon. So you can
22 always encourage them to also reach out to
23 the phone number on the back of their card
24 if they are having some problems. And then
25 I will look into the request of active

1 providers seeking patients, and I'll see if
2 that's data I need to request from the MCO,
3 or if that's something DMS might be able to
4 pull. So you I will put that on my
5 follow-up list as well.

6 DR. BOBROWSKI: Okay. And see that may be
7 one of the ones, Erin, that Commissioner
8 Lee is already working on because I know --
9 I think it was two meetings ago we had
10 requested a breakdown of the number of
11 providers -- I think it was like who's
12 doing 0 to 3,000, you know, I think it was
13 per month, and then 3,001 to 10,000, or
14 something like that. And then 10,001 up to
15 15,000 per month. And we kind of had a
16 breakdown. And Commissioner Lee, they may
17 be working on that breakdown, so that way
18 you can really kind of tell who's doing the
19 work and -- but that's -- that's what me
20 and our staff tell patients if we are
21 needing someone, we tell them, look,
22 contact your MCO to find another dentist,
23 because -- it's just like yesterday. I
24 knew there was this pediatric office, but
25 they had not alerted me to the fact that

1 they were no longer seeing Medicaid
2 patients. And it's just -- it just helps
3 us to keep who's doing what.

4 Let's see, and then here's another
5 question. Well, talk about fees, was to
6 compare the current Medicaid fees, whether
7 it be the young -- young people under 21 and
8 the adult fees to the regional, usual and
9 customary rates, for example, on the ADA fee
10 schedule. If we can kind of look at that,
11 Erin, and I'll try to write this up and get
12 you a list on these. Yeah, we've talked
13 about the billing codes.

14 DR. COLEMAN: Dr. Bobrowski, I can supply a
15 pretty comprehensive comparison of the key
16 reimbursement rates for region, as well as
17 outside of the region. I think I've done
18 it before, but I'm happy to help if someone
19 from Medicaid would like to see what I
20 have.

21 DR. PETREY: Ronnie, I think the TAC
22 Members would also appreciate seeing that
23 direct if you could -- if you wouldn't mind
24 to send that on to us as well.

25 DR. PATEL: Yes, that would be fantastic.

1 DR. COLEMAN: I'll get it to Dr. Bobrowski
2 and he can send it out to the entire list.

3 DR. BOBROWSKI: That will work. Let me
4 make my note here, another one.

5 I know a few years ago we really
6 talked about trying to look at efforts to
7 decrease the emergency room visits for
8 dental patients. And if there was a way to
9 compare that usage, you know, say going back
10 to '21 and '22 and '23, to look, are we
11 actually decreasing the emergency room
12 visits or since there's lack of providers
13 seeing Medicaid patients, is it the increase
14 in the emergency room visits going back up.
15 So I know we were trying to work hard to get
16 that down, but that's another report if we
17 can look at to use a comparison of, you
18 know, '21, '22, '23 to just kind of see if
19 we're gaining on that one.

20 DR. PETREY: Dr. Bobrowski, if I could
21 just -- I'm sorry to interject, but back on
22 fees --

23 DR. BOBROWSKI: Yes.

24 DR. PETREY: -- I just want to comment,
25 too, that it's critical to get this

1 information. And one of the main things
2 that makes it so critical is -- and I'm
3 obviously not in front of the computer or
4 at my desk for the day, but the data, and
5 it's the data that's been presented at the
6 TAC meeting before. The data comparing
7 Medicaid reimbursement rates for dentistry
8 in Kentucky compared to our region and
9 additional states around us showed that we
10 were being reimbursed at a higher rate, and
11 that has been -- through the ADA, and that
12 has been documented by the ADA and
13 understood that that was incorrectly
14 done --

15 DR. BOBROWSKI: Yes.

16 DR. PETREY: -- and incorrectly shown on
17 our state. So I still see responses
18 looking at our fees quoting and looking at
19 that report, which is incorrect. And so
20 the more that we can look at and
21 understand, as Ronnie pointed out, how
22 critically low the reimbursement is
23 relative to adjacent states, relative to
24 our region, the better -- the better we can
25 understand why we are having a lot of the

1 issues with providers dropping off and new
2 dentists not coming onto the system. So I
3 think -- I think Ruby's data and the MCO
4 data and DMS's data, and comparisons that
5 are legitimate are what we should be basing
6 policies and decisions off of. I would
7 leave to see more.

8 DR. BOBROWSKI: Well, if you-all
9 remember -- and Dr. McKee did a study a
10 while back, and the KDA had done kind of
11 a -- not a real scientific study, but just,
12 you know, a talking type of survey, but
13 they both agreed that I remember the top
14 three reasons that dentists were not taking
15 Medicaid or limiting their Medicaid was the
16 low fees, the high amount of paperwork, and
17 the failed appointments. And I just think
18 we just got to keep -- keep working on
19 these to -- otherwise, we are just going to
20 keep losing providers.

21 And I know at the last meeting
22 Commissioner Lee reported that there was 94,
23 and I think that was for the year 2023. She
24 reported that there was -- of the folks that
25 are reporting to Medicaid, there were

1 94,000 -- could have been 93 -- 94,000
2 failed appointments. Now, this is, you
3 know, across the medical fields. It wasn't
4 just dentistry, but you kind of -- it's just
5 a -- it just seems like it's just rampant or
6 that the patients just don't have a value
7 system for the services that they provide
8 and are provided to. And a lot of offices
9 you miss one or two or three appointments,
10 and you're just kind of locked out. You
11 find another place to go.

12 DR. PETREY: That's a very valid point.
13 You know how challenged I get when blame
14 gets primarily placed on the patient. We
15 need to have accountability. But we also
16 have to understand and factor in that
17 accessibility is the primary issue for
18 these. If there was providers that had
19 open appointments in a location close to
20 these patients, I think we would see less
21 no-shows. I think if we had better
22 access -- a lot of these folks don't have a
23 lot of transportation that is reliable that
24 can get them to these appointments. There
25 is no question that it is a higher no-show

1 rate than populations that are not on
2 assistance, but it is -- I think there's a
3 lot more to it than just a value question
4 in these patients. It's things that we
5 need factor in, not just the
6 transportation, but simply that there's not
7 a provider close to them.

8 I mean, we are seeing a significant
9 amount of patients driving to us in our
10 Somerset office from Bowling Green. It
11 doesn't take much of an understanding of a
12 map to know that that's not close and those
13 patients don't really have another option
14 but to come to us. And we love seeing them,
15 but I have no doubt we have a higher no-show
16 rate simply because that's quite -- that's
17 quite a distance and it's not as easy for
18 them to make their appointments. Used to,
19 it was always our Hazard office that we had
20 that we saw great distances that people
21 would drive to, but now as less and less
22 people are accepting Medicaid patients, we
23 are seeing even more distances from West
24 Kentucky heading our way.

25 So, again, we need more providers, we

1 need more open spots, and you named the
2 reasons why surveys show why we don't have a
3 sufficient system to cover the patients that
4 we have.

5 DR. BOBROWSKI: Well, you know, speaking of
6 the specialties, and lack of providers, I
7 had an oral surgeon contact me earlier in
8 the week here and he's down in, oh, the
9 central part of the state, and he said
10 we're just seeing more and more patients
11 coming from Northern Kentucky, you know,
12 the Medicaid patients from up there. So, I
13 mean, that's, what, two-hour drive from
14 Covington down into the Lexington area or
15 the surrounding counties and...

16 DR. PETREY: We have documented so few
17 people in East Kentucky that are working
18 their tails off trying to even keep up, but
19 there's just not an oral surgeon -- enough
20 oral surgeon coverage in East Kentucky, but
21 we are seeing even more -- I have two oral
22 surgeons in Somerset that accept cases, but
23 they have become very overrun, and we have
24 patients that drive to us from the Danville
25 area and other areas, and when we have

1 tried to refer back to Danville, the oral
2 surgeons in Danville are so overrun they
3 won't accept a patient from Pulaski County
4 with Medicaid because there is a provider
5 in Pulaski County, and they just don't
6 simply have a spot.

7 Well, unfortunately, if there's no
8 spot with a provider in Pulaski County, now
9 I have a patient that doesn't have -- that's
10 willing to drive that still can't get
11 coverage, can't get care. So it's -- we
12 need more providers and we, frankly, need
13 less paperwork, as you point out, but I
14 think fees are still the critical, the
15 critical reason why there's not -- why
16 Pikeville is the place that you have got to
17 go to, or Winchester with Dr. Gray, to see
18 an oral surgeon in East Kentucky, and that's
19 just not sufficient for the amount of
20 population that we have there.

21 Certainly, Dr. Patel can speak to the
22 challenges of getting care, especially in
23 our specialties.

24 DR. BOBROWSKI: Dr. Patel, how far away are
25 you having to go to to refer, like, for

1 endo or oral surgeon?

2 DR. PATEL: Right now endo and oral
3 surgery, basically I have to refer to UK.
4 And they are currently not even accepting
5 patients. They are just accepting names
6 for a waitlist to get a spot, you know, and
7 so we have ran into that problem lately. I
8 mean, UK right now is our only option for
9 endo referrals. We have gotten a couple of
10 kids in for oral surgery in Richmond, as
11 long as they are kids, but other than that
12 we are going to UK as well.

13 DR. BOBROWSKI: Okay. And one of my other
14 questions was on special needs patients
15 and, again, I have already told you that
16 story for this young little girl.

17 Let's see -- well, another question I
18 had here was on pregnant moms. And I don't
19 know who the MCOs or -- through
20 fee-for-service, is there a way to find out
21 if the pregnant moms are receiving or
22 seeking care especially -- well, you know,
23 especially oral hygiene care with pregnancy,
24 gingivitis, or even just, you know, fillings
25 or a needed extraction periodically. Is

1 there -- can somebody help me answer that?
2 Is there a way to document the pregnancies
3 and if they are seeking care for oral
4 healthcare?
5 DR. RICH: Dr. Bobrowski, this is
6 Dr. Rich --
7 DR. BOBROWSKI: Yes.
8 DR. RICH: -- with United Healthcare.
9 So for pregnant members we have care
10 providers and our care coordinators that we
11 try to identify pregnant members as soon as
12 possible so that we can make sure that their
13 care is coordinated across all aspects and
14 make sure that they are getting their
15 prenatal visits, but not just their prenatal
16 visits, their dental visits or any other
17 visits that are critical to the health of
18 that baby. And we know that helping a mom
19 with healthy teeth is going to have a better
20 chance of having a child with -- a healthy
21 delivery and a healthy baby. So the care
22 coordinators are going to find a provider
23 for those members that are identified every
24 time.
25 And, you know, it's something I wanted

1 to point out earlier, and it keeps
2 coming up. We work really hard and I've
3 been very impressed with how my care
4 coordinators and my provider advocates work
5 together to make sure that we find -- I know
6 the state said this earlier, too, that we
7 are finding providers for members whatever
8 it takes, whether it's in network or an
9 out-of-network provider. If we have a
10 member with a need, we find a provider for
11 them.

12 It's not -- to your point it's not
13 easy. It's very challenging and it doesn't
14 always -- and I wish that there were less
15 obstacles, but your three obstacles are our
16 three obstacles. We understand that fees
17 are important, but, you know, I think it's
18 really provider shortage is our struggle,
19 because there's been multiple times that --
20 and continue to be that the fees are not as
21 -- I know they are critical, but regardless
22 of what fee is offered a provider, that does
23 not mean they are going to accept Medicaid
24 or have the bandwidth to do it. So I just
25 wanted to throw that out there, too. But

1 I'm always welcome and open to talk to
2 providers any way that -- however we can
3 make ends meet for you, we will -- we will
4 look under every rock and try any
5 opportunity to try to make a work with a
6 provider and UHC, but we are always
7 committed to finding our members care.
8 Thank you.

9 DR. BOBROWSKI: Thank you, Dr. Rich. And
10 while you were talking I was kind of
11 watching. We got some responses in the
12 chat room from, you know, some of the other
13 MCOs, that the MCOs are trying to find and
14 help their patients find practitioners to
15 seek oral healthcare. So that's good.

16 This morning I saw a report from, I
17 think it was Becker's Hospital Review, and
18 they were talking about the dental shortage
19 across the nation. And I'm not a
20 statistician, so I can't even say the word,
21 but if you could -- somebody can help me on
22 that. They said, well, there's a shortage
23 of dentists across the nation, and they
24 listed 68- -- approximately 6800 dentists
25 would be needed. Well, but then on the next

1 sentence or two down they say, but to fix
2 that shortage, we are going to need 9600.
3 I'm not a statistician, but it seems like
4 somehow their numbers are off, but I don't
5 know.

6 DR. PETREY: I think I read that as well,
7 Garth. I think they are factoring in the
8 attrition rate of retirement --

9 DR. BOBROWSKI: Okay.

10 DR. PETREY: -- and the number of new
11 dentists versus the lump of dentists that
12 are going to be leaving the profession over
13 the next few years.

14 DR. BOBROWSKI: So see right there, folks,
15 you can see what us dentists do in the wee
16 hours of the morning, is we read the
17 hospital reports, so just trying to keep
18 one stuff.

19 MS. BICKERS: Dr. Caudill has his hand
20 raised.

21 DR. BOBROWSKI: Yes, Dr. Caudill.

22 DR. CAUDILL: Yeah, I was just going to
23 refer back to your finding access to care.
24 At Avesis we also have scattered across the
25 states certain offices that are serving as

1 oral surgery access points. It's not an
2 oral surgeon, but it's a doctor who has
3 taken advanced training in oral surgery and
4 they are licensed in moderate sedation to
5 put people under in the office. And so we
6 have numerous of those. So if you just
7 look strictly for an oral surgeon, yeah,
8 they are far between, but we also have, in
9 areas in between those, filling in offices
10 that do have this extra training.

11 Now they wouldn't, you know, reset
12 your jaw like an oral surgeon is trained to
13 do for orthognathic surgery, but they
14 certainly receive this advanced training for
15 extractions and alveoloplasties and things
16 of those, that kind of nature. So providers
17 should always feel free to reach out to us.
18 Our provider relations department is aware
19 of all these extra access points, and can
20 make those calls, and quite often I'll pick
21 up the phone myself. So we are always here
22 to help.

23 DR. BOBROWSKI: Okay, good. Thank you.

24 I know we've got one or two around
25 here, and there's another dentist down in

1 Bowling Green that does sedation. They are
2 a general practitioners, but they don't
3 accept Medicaid. So that's where we may
4 have to -- you know, maybe if the MCOs could
5 look at their providers and maybe help us
6 establish a referral base, that might help
7 the other dentists in the area have that
8 information, Dr. Caudill. It might be
9 something that we can look into there.

10 DR. PETREY: Certainly something that we
11 would like to have a better, clearer
12 picture of. That being said, that can be
13 challenging at times because when -- as an
14 orthodontist, when I'm referring back for
15 oral surgery needs to a general dentist,
16 even with extra training, but I'm referring
17 a patient from a different general dental
18 practice, that can get a little tricky.
19 But just getting the care will be -- would
20 be fantastic, especially third molars,
21 canine exposures, and severe tooth decay
22 extractions.

23 DR. BOBROWSKI: You know, I think,
24 Dr. Patel, you had mentioned that UK had a
25 situation there now that they are in is

1 that they are just putting people on a
2 waiting list. And I know last summer I had
3 the same situation over here sending people
4 up to U of L. They just -- they said don't
5 send any more; we can't handle them. But,
6 you know, they just kind of say give us
7 their name and we'll -- name and number and
8 we'll contact them. So even our
9 universities are getting slammed, you know,
10 with requests for care.

11 And I know at one of our executive
12 board meetings with the Kentucky Dental
13 Association, Dr. Okeson at UK, the Dean
14 there, was commenting about, again, going
15 back to the fees of it's just even for them,
16 as a university, harder and harder for them
17 to make their budget needs with the fees.

18 Of course, some of the oral surgery
19 fees we were able to get adjusted there last
20 Christmas or the Christmas before, in that
21 time period. So we are working on things,
22 but it still -- we just got to put our heads
23 and thoughts together on what can we do to
24 keep making things get any better.

25 Now, TAC Members, do you have any

1 other questions that we need to maybe look
2 at or get some research done on?

3 MR. PETREY: The only other comment that I
4 would make is that I wholeheartedly agree
5 with Dr. Rich that it is a -- it is a
6 provider issue and we certainly do not have
7 a sufficient amount of providers covering
8 the network. But I do feel that the
9 primary reason for that is a fee issue, and
10 especially when we are looking at dentists
11 coming out of school with the amount of
12 debt that they have and looking at starting
13 new practices in areas that are underserved
14 is quite a challenge. And the fees
15 themselves I believe are the primary issue
16 how that can be resolved to help grow the
17 network, but as we are -- as we have
18 folks -- as our agenda shows, when you have
19 great practitioners like Dr. Gray who are
20 on their -- on their last days of the
21 profession, when we don't have someone to
22 step in, that only exacerbates the problem.
23 And so growing the network is critical, but
24 I think you grow that network by making it
25 more attractive to the new dentists to do

1 it from a fee schedule, and also by getting
2 people that are no longer accepting it to
3 get back on board by it being a reasonable
4 fee again.

5 DR. RICH: Dr. Bobrowski, let me just add
6 that in Missouri, where most of you heard
7 they have done a really good job on rates,
8 they are reimbursing at the average of
9 usual and customary, and so their rates are
10 very high. And I have spoken with people
11 from the Missouri Oral Health Coalition and
12 they tell me that provider participation
13 has gone up dramatically since they started
14 making those changes. Half of it was taken
15 care of a couple years ago, and then just
16 this session they, I think, added like the
17 oral surgery fees and some other things.
18 But they were saying that the rates are
19 higher for Medicaid there than many
20 commercial dental plans, and so there are
21 plenty of dentists that are seeing more
22 Medicaid rather than commercial, even
23 though they still have the challenges with
24 show rate, obviously.

25 The other one that I keep hearing

1 about -- I don't know as much about -- is
2 Colorado. I understand they did something
3 pretty significant there. It would be
4 interesting to hear what provider
5 participation looks like since they made
6 their changes, or maybe it's a little too
7 soon.

8 The other state that made a
9 significant increase of late is Louisiana.
10 They increased rates by about 38 or
11 39 percent towards the end of last year, so
12 it might be too early to find out from their
13 dental association what Medicaid dental
14 participation looks like, but I can imagine
15 it's probably gone up.

16 And this is the point I generally have
17 to make to legislators, is they will ask,
18 well, how much do rates need to go up to
19 make a difference. It's just hard to say
20 because we are so far behind. They might
21 think, wow, a 50 percent increase, that
22 sounds like a lot. Well, we are so far
23 behind the eight ball, that a 50 percent
24 increase is not a lot. So nobody really
25 knows the full threshold that it needs to be

1 at in order to see dramatic improvement and
2 provider participation. But, you know, a
3 10, 20 -- 15, 20, 30, percent increase in
4 Kentucky may not even move the needle. I
5 hate to say it. I've had to say that before
6 to be honest with legislators, but it's
7 true. I mean, if you -- if you're getting
8 reimbursed, like, 80 percent lower than your
9 usual and customary and you only increase
10 rates 20 percent, it's just not worth it to
11 go through the hassle associated with
12 Medicaid, and, you know, the issue with show
13 rate and all of that. So anyway, I just
14 thought I'd add that.

15 DR. BOBROWSKI: Yes, thank you. Thank you,
16 Ronnie. I had heard about Colorado this
17 morning and some of the things that they
18 are doing to get more providers, so -- and
19 the other thing you mentioned, the
20 insurance, a lot of these insurance PPOs,
21 they are just driving their rates, their
22 pay rates down, down, down, yet they charge
23 more to the customer in terms of premium
24 increases. It's like, come on guys, what's
25 going on here now. You are charging your

1 patients more for services, but you're
2 paying your providers even less. And I've
3 brought that up at other meetings. It's
4 like some of their payments are below
5 Medicaid, even before we got an increase
6 here this last year. And I've seen even
7 some of our folks that we refer to
8 specialists, they are starting to drop even
9 the insurance plans, you know. So it's not
10 only affecting, you know, Medicaid, but
11 it's affecting the insurance on the
12 patients being able to find somebody that
13 takes their regular insurance. Maybe not
14 quite as bad as Medicaid, but it's getting
15 there. So, you know, and it's not --
16 people see professionals a lot of times as,
17 well, those greedy doctors. I'm sorry,
18 it's not that way. Not around where I
19 live.

20 I've had a dentist tell me that he
21 personally cut his salary in half, which he
22 told me -- and a lot of times this is
23 information that's not -- people don't
24 really like to talk about, your personal
25 income. But they -- he offered this and

1 said, in order to keep his practice viable
2 and to keep some staff, like a hygienist
3 and, you know, some assistants, he had to
4 cut his salary in half, and he says I don't
5 even make the state average with my regular
6 salary and -- but that's just what you do to
7 keep your business running.

8 And a lot of times -- I am not going
9 to blame a lot of the dentists. A lot of
10 them that are Medicaid providers, they are
11 trying to hang in there, but a lot of them
12 are having to make adjustments to try to
13 keep their business a viable place.

14 Okay. Any other discussion, questions
15 from TAC Members? All right. And I don't
16 know, did Dr. Gray ever -- was he ever able
17 to get on?

18 MS. BICKERS: I don't believe so.

19 DR. BOBROWSKI: Okay. Well, he said if he
20 wasn't able to get on, he wanted me to tell
21 everyone that he had really appreciated
22 working on the TAC, enjoyed meeting and
23 getting to know everybody, but with his
24 upcoming retirement from his oral surgery
25 practice, he was going to have to -- he was

1 also going to retire from the TAC. So we
2 are -- I have made that information
3 available to the KDA executive director,
4 and we would like to try to find another
5 oral surgeon, you know, that will fill in
6 in that position, but we are still in the
7 looking and asking stage. So hopefully
8 before our next TAC meeting we'll be able
9 to find another person to help fill in that
10 position.

11 Now, on our questions, is there
12 anything that we need to maybe --
13 (Interruption by unmuted Zoom participant.)
14 DR. BOBROWSKI: Well, those folks work all
15 the time. I like it.

16 Let's see. One thing I did want to
17 bring up under Other -- and, again, it made
18 me think of it again this morning, I got a
19 little brief notice on just waste, fraud,
20 and abuse. And I know through CDC, I know
21 through the MCO status that each medical
22 office, dental office are supposed to do
23 training for our staff members, even people
24 that we might use as contract labor, like if
25 some of the hygienists that move from one

1 office to another just to help fill in at
2 different places.

3 But one of the things -- and I saw a
4 young man, I guess in his 40s, last week,
5 just -- it just disturbed me that he's got
6 his own private business, he comes in with
7 his Medicaid needs to be done, but he gets
8 to talking about trading vehicles. So,
9 well, you kind of start, well, what are you
10 trading for. You know, you get to doing a
11 little small talk. Well, you know, he
12 drives in in a relatively nice-looking Audi,
13 and he says, well, I'm going to trade, I'm
14 going to trade into a Mercedes.

15 Now, I don't understand. Like I said,
16 he runs his own business, but if you can
17 afford a Mercedes in the newer range, I'm
18 talking either brand new or one or two years
19 old, how can somebody that can afford that
20 still have a medical card? And my question
21 is, is does the state or the MCOs do any
22 checking for wage fraud or abuse on their
23 patients? And I'd just like to throw that
24 out there for a minute or two to see if any
25 of the MCOs have any mechanisms to look at

1 that, or somebody from the state, because
2 there's -- I know it's awful easy to look
3 for abuse because of the electronics that we
4 now have for providers, because you can see
5 if there's an outlier awful easy off the
6 computer screens, and then there's service
7 codes that they are doing.

8 But does any MCO or someone from the
9 state have any ideas or suggestions, talk
10 about or information on what -- what are
11 they doing to verify patient qualifications
12 to be a Medicare member or Medicaid member.

13 MR. WILLIAMS: Hi, Dr. Bobrowski. This is
14 Justin Dearing with Department for
15 Medicaid Services. I'm not sure if we have
16 anybody from the Department for
17 Community-Based Service or the Office of
18 the Inspector General on the call; however,
19 these organizations within the Cabinet for
20 Health and Family Services, that starting
21 with the Department for Community-Based
22 Services who does eligibility and
23 enrollment. And so the Department for
24 Community-Based Services looks at -- looks
25 at a lot of different things. They look at

1 tax income statements. They use any income
2 verifications from employers and
3 employment. They track down and look at
4 child support payments, all kinds of
5 different employment records. So anything
6 that we have access to, like I said, again,
7 including tax return statements and IRS
8 records as far as who qualifies for
9 services. And, again, the Cabinet
10 utilizes, and the Department for Medicaid
11 Services contracts with the Department for
12 Community-Based Services to do those
13 initial eligibility, you know, enrollments.

14 And then we also use the Office of the
15 Inspector General, who has staff that goes
16 in and reviews and looks at any instance of
17 individuals that may be abusing that system.
18 So they will do from desk audits, where they
19 look at, again, IRS statements and income
20 statements, any type of banking information,
21 all kinds of different things to verify
22 income to verify resource allocation. So
23 it's not always just income. They look at
24 how much money is in their bank accounts,
25 whether they have stock options, housing,

1 all those different type of assets that --
2 business assets, all those types of things
3 are taken into consideration as well. And
4 then they are always looking from those type
5 of audits all the way to going out in the
6 field and doing actual in-person
7 investigations. So the Office of the
8 Inspector General has personnel that kind of
9 run the gamut. Again, I'm not an expert in
10 those things, but having worked in the
11 Cabinet for 26 years or so now, I've been
12 with each of those departments at one time
13 or another or worked with them at one time
14 or another, so I can tell you it's a pretty
15 extensive fraud and abuse detection system
16 that they have set up. Of course, there are
17 always outliers that may not get found.

18 DR. McKEE: Justin, it's Julie McKee. In
19 the Inspector General's office would
20 Dr. Bobrowski be able to make a complaint?

21 MR. DEARINGER: Absolutely. So Department
22 for Medicaid Services, as well as
23 Department for Community-Based Services and
24 the Office of the Inspector General have
25 multiple ways where they detect fraud. One

1 of the main ways they detect fraud and
2 abuse is through the electronic desk audits
3 that they do. But another way that may be
4 just as equal in the amount that they
5 receive is by individuals contacting and
6 making -- you know, letting us know what's
7 going on. So we get calls all the time
8 about providers, about members, about
9 different fraud and abuse allegations, and
10 we send all those to our -- if it's DMS
11 specifically, we send those to -- to our
12 Division of Program Integrity. But there's
13 also -- you know, they all kind of get
14 funneled to the same place through the
15 Office of the Inspector General or DCBS.
16 And thank you, Ms. Parker, for putting some
17 of that -- those links in the chat.

18 But, absolutely, we would encourage
19 that, and that's always very helpful.

20 DR. McKEE: Thank you.

21 DR. BOBROWSKI: Thank you, Dr. McKee, for
22 that question, because it seems like the
23 ones that I see in my practice, it's
24 typically people that have their own
25 business. And I guess through their

1 business they are able to hide that a lot
2 of their income, you know -- and then we
3 don't -- you know, we just want to fix
4 their toothache, we just want to fix their
5 broken tooth, you know, but it's like then
6 we'll see some -- you know, somebody that's
7 60 or 61 or 2 that's in really bad health,
8 and they get 800 or \$1,200 a month, you
9 know, off their Medicare disability. And
10 just all their life they just scrape to get
11 by, and, boy, you think, boy, these folks
12 need some help.

13 This young buck over here, he's got
14 his own business, he's got business trucks
15 running, and -- well, you know, you-all know
16 how it is. But I just was wondering if
17 anything was -- anything more was being done
18 to watch the waste, fraud and abuse of the
19 system.

20 Are there any -- for the TAC are there
21 any recommendations that we need to make to
22 the MAC coming up here in the next month? I
23 think a lot of those questions that we have
24 asked, we will just need to kind of get it
25 typed up and get it to Erin there to follow

1 up on those. And I know she knows that --
2 she and other staff members do a really good
3 job on getting us information back, but I
4 didn't know if there's anything in
5 particular.

6 Now, Ms. Angie Parker has put a phone
7 number on here. It's 800-372-2970, to
8 report, you know, like Medicaid -- you know,
9 kind of welfare fraud.

10 MS. PARKER: It's a phone number if you
11 suspect it, that you can call them and they
12 will investigate.

13 DR. BOBROWSKI: Thank you for that
14 information.

15 If there's no other recommendations
16 that we need to make, that's fine.

17 I got a couple more announcements
18 coming up. The KDA is going to have another
19 Medicaid forum and luncheon. And this year
20 Avesis is going to provide the luncheon.
21 Just to give you a brief format -- I was
22 just talking with Commissioner Lee this
23 morning and she is going to be flying back
24 from a meeting. She was going to be at this
25 like she did last year, but that same

1 morning she's flying back from another
2 meeting now, so she's not going to be able
3 to be there. But she talked like maybe she
4 may be able to have some other folks to come
5 and be there to give us information at the
6 forum. And then after we have that forum
7 and discussion from the -- I just like to
8 have a time where dentists can have an
9 opportunity to talk to the MCOs and just try
10 to get issues resolved. And I really
11 appreciate the MCOs having a good show at
12 the last few of these meetings, and I think
13 they have been really productive. I had
14 people come up to me later and said this was
15 good. So that's encouraging.

16 And then after that -- oh, it's going
17 to probably be about an hour-long session,
18 and Avesis is sponsoring it and going to
19 provide lunch that day. And then after
20 that, Dr. Caudill is going to be providing
21 approximately an hour CE course on handling
22 special needs patients. So I think that's
23 going to be enlightening, too.

24 Oh, I left out one thing. Back up on
25 Other. And this is another thing we were

1 talking about this morning, was
2 credentialing. Somehow we've got to look at
3 streamlining that process. We've got an
4 office up here in Central Kentucky that's
5 trying to -- a large group is kind of trying
6 to come in and buy some other ones, and they
7 are reporting that they are still waiting
8 on -- the bank won't let them have a full
9 loan to get their practice going until they
10 are fully credentialed, and they have been
11 working on this between three and six
12 months, you know. So we need to get our
13 MCOs looking at that mechanism, or is there
14 one source that we can use? I know for just
15 regular insurance we can use the CAQH
16 mechanism where it's all in one spot. And
17 that's one thing I would like to maybe put
18 on the agenda for next month is -- next
19 quarter, is to look at that, ideas from the
20 MCOs on credentialing and what can we do to
21 make this easier, simpler, decrease the
22 paperwork for our providers.

23 So I know with -- I've got my office
24 on that CAQH. Now, you do have to do an
25 update every three months, which is kind of

1 a hassle, but usually you just got to get on
2 there and say, well, no change because there
3 hasn't been any change. But, you know,
4 usually at the end of the year, or sometime
5 during the year, they want the updated proof
6 of insurance, and then every two years you
7 got to give them a new license, a copy of
8 your license, but, I mean, that's been kind
9 of a nice thing that you don't have to fill
10 out 14 pages of -- I'm joking, but it seems
11 like 14 pages or 40 pages of stuff. So I
12 just wanted to bring that one up on maybe we
13 can work on credentialing.

14 DR. McKEE: Dr. Bobrowski --

15 DR. BOBROWSKI: Yes.

16 DR. McKEE: -- it's Julie McKee again. I
17 agree credentialing is difficult. It's so
18 difficult. It's very, very time consuming.
19 But a practice in Western Kentucky pulled
20 that same thing saying we can't get our
21 bank loan until we get credentialed in
22 Medicaid. They actually called the bank
23 that they were going to be dealing with,
24 and they are going we don't -- we don't
25 require that. No, we don't require that.

1 I'm not saying it doesn't happen. It did
2 not happen with that.

3 And to be real salty on a Friday
4 afternoon that it would be difficult for me
5 to understand that a bank had to wait for
6 credentialing information for a plan that
7 people claim to lose money on?

8 DR. BOBROWSKI: I don't know. This is -- I
9 don't know the bank. I was just -- I just
10 found that out this morning.

11 DR. McKEE: I'm just giving you my
12 experience in Western Kentucky. I worked
13 the same claim.

14 DR. BOBROWSKI: Yeah. Well, I also
15 heard -- I'm also a director at our bank.
16 It's based out of Lexington, and they have
17 got about 31 other banks in other towns.
18 But I know that, again, with the debt load
19 that young people are coming out of school
20 with, the banks are looking more serious at
21 the young practitioners coming out of
22 school with such -- I think the average
23 indebtedness across the nation is -- the
24 last I heard was \$306,000, and they haven't
25 seen their first patient yet. Pretty good

1 chunk of change. And I know that the banks
2 are getting more serious at that.

3 I know when I came to our little town
4 and I went to the banker, they just said,
5 well, how much do you need, you know, and I
6 thought, yes, we're -- we found the right
7 town. And it's a matter of just working
8 with the banks. But I don't know, this,
9 Dr. McKee, this is a new one up here. Oh,
10 was it the Bardstown, Danville area? But
11 they have been waiting and waiting. So
12 let's see what we can do to help our
13 providers out and get them to work.

14 DR. McKEE: Oh, I don't disagree with that.
15 The credentialing -- I wish we could all
16 work together to get it more streamlined
17 and not have the credentialing that it
18 takes for a level four neurosurgeon.

19 DR. BOBROWSKI: Yeah, yeah.

20 And I've got one more. To me it's a
21 sad announcement that -- speaking of
22 credentialing, I think my credentialing was
23 up August the 11th, which is Sunday, but I
24 will -- I personally will no longer be a
25 Medicaid provider. So I'll have to check

1 with the powers that be on whether I can
2 stay on the TAC or not. But anyway we will
3 probably need to have, you know, some new
4 elections at the upcoming TAC meeting. And
5 the next TAC meeting will be November the
6 8th of this year at 2:00 Eastern time, and I
7 can be sure to help in any way I can. Have
8 to just see what this status is going to do.

9 But are there any other questions or
10 comments for the TAC today?

11 DR. PETREY: The only other thing that I
12 would like to add -- I already used my one
13 last thing to add, but the only other thing
14 that I'd like to add is appreciation for
15 the MCOs working through and the new
16 portals that are being worked on and active
17 and trying to enter response to the data
18 breach that we previously had to update, to
19 make it more secure on the providers in,
20 more secure for the patients, and more
21 secure on the MCOs. And I will say that I
22 hear a lot, and I know the MCOs do as well,
23 about the issues with the portals coming
24 live. We are having significant issues in
25 our own practice with that and even being

1 able to use the new portal. But it's -- on
2 the whole from a provider perspective, we
3 appreciate the effort. None of us are
4 patient, especially as it relates to being
5 able to upload things to the portal and to,
6 frankly, be paid for services rendered.
7 But we understand that the difficulty of
8 uploading this massive change in new
9 portals and thank you-all for making the
10 effort to do so, and know that you are
11 working hard. Just deal with some squeaky
12 wheels from providers who are struggling
13 with the new portals. Thank you.

14 DR. BOBROWSKI: I'll echo that. That's
15 good work.

16 Well, hearing nothing else, we will
17 need a motion to adjourn the meeting for
18 today.

19 DR. PATEL: I'll make a motion.

20 DR. BOBROWSKI: Thank you. And I'll second
21 it.

22 DR. PETREY: Second.

23 DR. BOBROWSKI: Okay, thank you. And it's
24 a unanimous vote, so we are adjourned. And
25 I want to thank everyone and our TAC

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Members and our new TAC Members for being
here, and appreciate your input. And just
please don't be afraid to jump right in.
Thank you-all and you-all have a great
weekend.

DR. PATEL: Thank you.

DR. PETREY: Thank you, Garth.

* * * * *

THEREUPON, the TAC Meeting was concluded.

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STATE OF KENTUCKY)
COUNTY OF FAYETTE)

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

My commission expires: August 24, 2027.

IN TESTIMONY WHEREOF, I have hereunto set
my hand and seal of office on this the 27th day of
October 2024.

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

	2:00 [3] 1/17 3/2 8/3 2:00 Eastern [1] 60/6	active [2] 23/25 60/16 actual [2] 16/14 51/6 actually [2] 26/11 57/22 actuarial [1] 11/7 actuary [1] 11/9 ADA [3] 25/9 27/11 27/12 add [7] 14/20 22/7 42/5 44/14 60/12 60/13 60/14 added [2] 11/25 42/16 additional [1] 27/9 address [1] 22/22 addressed [1] 13/24 adjacent [1] 27/23 adjourn [1] 61/17 adjourned [1] 61/24 adjusted [1] 40/19 adjustments [1] 46/12 administrators [1] 21/23 adult [2] 17/1 25/8 adults [3] 5/4 5/5 16/25 advanced [2] 38/3 38/14 Advisory [2] 15/18 63/10 advocates [1] 35/4 affecting [2] 45/10 45/11 afford [2] 48/17 48/19 afraid [1] 62/3 after [6] 10/3 12/5 14/22 55/6 55/16 55/19 afternoon [2] 14/1 58/4 again [20] 4/2 4/10 4/18 5/22 9/20 10/21 14/19 23/10 30/25 33/15 40/14 42/4 47/17 47/18 50/6 50/9 50/19 51/9 57/16 58/18 age [2] 12/22 19/21 agenda [2] 41/18 56/18 aging [2] 19/22 19/24 ago [4] 10/20 24/9 26/5 42/15 agree [2] 41/4 57/17 agreed [1] 28/13 ahead [3] 4/6 4/7 5/9 alerted [1] 24/25 all [41] 3/22 4/11 4/19 4/22 5/21 5/22 6/3 7/6 7/7 9/17 10/23 11/8 11/11 13/15 16/16 17/9 17/20 19/22 21/11 21/15 28/8 34/13 38/19 44/13 46/15 47/14 50/4 50/21 51/1 51/2 51/5 52/7 52/10 52/13 53/10 53/15 56/16 59/15 61/9 62/4 62/4 allegations [1] 52/9 allocation [1] 50/22 along [1] 5/11 already [10] 3/25 4/1 13/24 16/16 18/7 21/10 22/4 24/8 33/15 60/12 also [16] 5/2 5/11 8/6 15/16 15/17 23/22 25/22 29/15 37/24 38/8 42/1 47/1 50/14 52/13 58/14 58/15 alveoloplasties [1] 38/15 always [12] 23/19 23/22 30/19 35/14 36/1 36/6 38/17 38/21 50/23 51/4 51/17 52/19 am [5] 4/15 8/24 9/1 18/11 46/8 amount [7] 16/6 28/16 30/9 32/19 41/7 41/11 52/4 And, [1] 15/6 And, Dr [1] 15/6 Angie [1] 54/6 announcement [1] 59/21 announcements [1] 54/17 another [21] 4/14 21/1 21/8 21/8 24/22 25/4 26/4 26/16 29/11 30/13 33/17 38/25 47/4 47/9 48/1 51/13 51/14 52/3 54/18 55/1 55/25
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