DEPARTMENT OF MEDICAID SERVICES
DENTAL TECHNICAL ADVISORY COMMITTEE

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Friday, February 7, 2025
2:00 p.m.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

TAC Members:

Dr. Garth Bobrowski, Chair
Dr. Justin Kolasa
Dr. B.J. Millay
Dr. Joe Petrey
Dr. Carol Braun
Dr. Kaitlyn Patel

MS. SHEETS: Good afternoon. This is Kelli Sheets with the Department for Medicaid Services. I would like to welcome you to the Dental TAC this afternoon.

Dr. Bobrowski, I have 2 o'clock so if you would like to go ahead and get started, I will go ahead and turn it over to you.

DR. BOBROWSKI: All right. I was trying to go through the list of attendees and I was just trying to look and see if we've got a quorum here.

Do you want to do the roll call for us?

MS. SHEETS: I can do that for you. That's fine.

DR. BOBROWSKI: Okay. Go ahead.

MS. SHEETS: How about Dr. Justin Kolasa?

DR. KOLASA: I'm here.

MS. SHEETS: Dr. Kaitlyn Patel?

DR. PATEL: I'm here.

MS. SHEETS: Dr. BJ Millay?

(No response.)

Dr. Joe Petrey?

(No response.)

And Dr. Carol Braun?

Okay. I believe Dr. Braun did join. Maybe she is having some technical difficulties and got logged out.

DR. BRAUN: Sorry. I am here.

MS. SHEETS: Okay. Great. Thank you.

And Dr. Petrey, I think, is logging in right now.

Yes, Dr. Bobrowski that gives you a quorum.

DR. BOBROWSKI: Okay. Thank you.

Carol, I thought I saw your picture there a few minutes ago so I thought that you were here. I know that I have signed on these before and like, what happened?

Now I've got a new update on my Zoom here today, and I hope I don't push a wrong button, here.

Anyway, I want to welcome everyone to our Dental TAC this afternoon.

First, I want to introduce our new TAC members -- Dr. BJ Millay, who I thought was going to be on here, and he might just be running late, but he is a Medicaid general practitioner from the Somerset area.

And Justin Kolasa -- it's like my name Justin, I hope I got it right for you. He is an oral surgeon from the Danville area and we really appreciate their willingness to serve on this TAC.

And Justin is also on the Kentucky Board of Dentistry, so he offers another avenue of experience, you know, to this TAC.

And the first item on the agenda is to elect a new chair, so I just want to give a big thank you to everyone that I have known. I am going to kind of turn the reins over to another chair here, but I know that I want to thank you for putting up with me, number one.

Number two, thank you for your wisdom and your friendship and your kindness and your professionalism. I know

there are a lot of folks that have attended our TAC meetings that do a lot of work behind the scenes that sometimes we don't know about or recognize, but I just want to thank everybody at DMS, and the MCOs that I have gotten to know over the years, and the many TAC members who have come and gone -- and I know folks have to leave for health reasons and things like that.

I want to say thank you from the bottom of my heart for everyone who has helped on our TAC and, really, it is the betterment of delivering oral healthcare to the citizens of Kentucky. So I just want to thank everyone for that.

I will open the floor for nominations for a new chair, and even if we get a new chair today, I don't mind to finish today's TAC and you can start the next meeting, or if you want to jump in here today I will sit by the side and help in any way that I can, in any way going forward.

Actually, Dr. BJ Millay is going

to be taking my spot just on the TAC because I had talked to him a while back about that.

The floor is open for nominations for chair of the Dental TAC.

MS. SHEETS: Dr. Bobrowski, this is Kelli. I'm sorry to interrupt. I just need to remind the members that when they are voting, that in order to comply with open meeting laws in Kentucky, they have to have their cameras turned on. So thank you and apologies for the interruption.

DR. BOBROWSKI: Thank you. That is needed help. Thank you.

DR. PETREY: Doctor, as we have discussed, I don't think taking the role of chairman is in the cards for me at this time, but I certainly will assist in any way and will happily serve in a vice chairman's role.

I know Dr. Braun has also expressed it is not the best either, so that puts us with as new members -- he is in absentia, but I believe Dr. Millay has some interest, and I would nominate BJ

Millay to take over as the chair.

DR. BRAUN: I'll second that.

DR. BOBROWSKI: Okay. Good. Thank you, Carol.

If there are no other nominations, we will cast a vote or we can say, "aye" for BJ being the new chair.

And Joe, I guess we will put you down as vice chair, but I think technically in the Kentucky statutes and regulations, I believe there is supposed to be a chair and a vice chair, so we will put both of y'all names in there for those.

And then you guys who are doing these, at any time if you need my help or anything, you have all got my phone number so I will help in any way that I can.

I don't believe BJ is on here just yet so Joe, do you want to run this meeting or I will finish it up?

DR. PETREY: You have done such a good job to put this agenda together that I will let you keep rolling with that.

DR. BOBROWSKI: All right. We need a motion to approve the minutes of our last meeting, it was August the 9th. We did not meet in November so we need a motion to approve the minutes from August, so the floor is open for that motion.

DR. BRAUN: So moved.

DR. PETREY: Second.

DR. BOBROWSKI: Okay. All those in favor say, "aye."

TAC MEMBERS: Aye.

DR. BOBROWSKI: I always like to put a time in here for Commissioner Lee if she is on here and with us today. I know she has like 1,001 meetings that she has to attend and see to, so I don't know if she is on here, or sometimes one of the other DMS staff will give a report for her.

So is Commissioner Lee on?

MS. SHEETS: No, commissioner Lee is not on.

I don't know -- is there anyone on in Medicaid that can give that report?

I can certainly take that back

and ask Commissioner Lee if she has an comments and if she does, I can send them out to you.

DR. BOBROWSKI: Okay. Thank you. We will move on.

At the time, I didn't have anything under old business and unless something has come up that we can put under the other section that I have forgotten about.

We will move on to new business, and as you can see on the agenda, a lot of these are under the Avesis portal we need to talk about.

And I did see where Jerry Caudill -- Dr. Caudill -- is on here, but these are listed and just comments that have been made to me and other TAC members, and I will get another one on there that I got just yesterday -- but this is from another oral surgeon office and they just said that it is just a nightmare working with it, so I hope that we can work with something with Avesis on their new portal. You can see

some of the comments there.

A lot of things that we are saying, it just makes it tougher on the providers to manage this portal. We have to know what is the purpose of the change to the portal. There has been a lack of communication, I have heard from several -- especially oral surgeons offices -- that they have tried to contact or they have left messages for folks with Avesis and have not gotten responses back -- very slow, everything is very different, they are having to -- and that was another thing yesterday. I heard again that they are having to process a lot of claims by hand and the payment is -- I think legally the MCOs have 30 days to make their payment, but I am hearing that some of them are coming in after 30 days, and they can't trust the remittances like they were before so they are having to go through each claim one by one when they get it back.

So any TAC member -- what are you hearing?

DR. KOLASA: I can speak to it a little bit. One of the things that we have noticed from the change is that the Avesis portal doesn't seem to populate active members appropriately. So one day it may be on there and one day it may not be on there.

So what we are having to do is do the legwork and then we go to the Kentucky Medicaid website and they are active, and then we have to make a phone call to provider relations, send an additional email to show that, and so you can imagine this over numerous times that is incredibly inefficient when you are trying to run a high volume Medicaid clinic. So that is the big thing there.

The second thing is the remittance or the EOPs. My office hasn't had a problem with delays in payment, but we can't appropriately run the EOP, or when we get the money, we don't know where it came from.

So I found the back door way. My girl who works on this tries to find

somebody on the EOP, it may take her once or it may take her ten tries, so she goes and finds that patient and then she clicks on the EOP from that guest and then matches it to what our remittance was -- or what our payment was. So there is not a way to go to the pay date and look at the EOP in that manner.

So those are the two biggest issues that the girl that handles all of these for me -- she has been doing it for 20 years in this office. So those are the two big things that we run into with the portal change in addition to the other comments, but we try to go with specific objective information to relay so hopefully we can improve that.

DR. PETREY: We have experienced both of those in our office and other offices that have contacted us asking what we are dealing with.

In addition to those, Justin, we are dealing with issues -- and I know that Dr. Caudill is aware of this -- that we have been dealing with since September and

that is our office is showing as provider not certified. And I know that I talked to another large group practice that also had that same situation which has been resolved.

So hopefully there are some resolutions coming, but provider not certified is also making everything to be hand claimed and really slowing the process of all of the portal itself.

DR. PATEL: Our big comment on that as well, the main thing that we have seen in our office is the same thing that Dr. Kolasa is saying. The patients that are active, we called to get a status and they say that they are active online, but when we are looking in the portal, they are not. We waited, telling us that it may be a little bit before everybody gets in there. We are waiting on a pre-auth, waiting on a pre-auth, and finally I was able to email provider relations and get that, but for each patient that is getting difficult.

DR. PETREY: Is there also a

WellCare issue as far as determining these patients as well? Because we are hearing that as well.

MS. APOSTOLIDIS: This is Melissa with Avesis, if I can jump in here, or are there more comments from other people that want to go first?

DR. BOBROWSKI: Go ahead, Melissa.

MS. APOSTOLIDIS: Well, thank you for having me this afternoon.

I did want to start by saying that the reason that we migrated to a new portal in October of 2024 was to move to a more modern platform away from the old unsupported technologies, so in case we needed to do future portal updates or enhancements, those could be made more quickly and efficiently.

The end state of what we have now is going to be better than the end state that we had before.

Of course, there were some initial challenges when we did our transition with claims submission and

eligibility benefit verification and some longer than usual wait times.

I know that our IT and provider relations teams have been working very diligently to resolve all of those identified issues. And a lot of those issues have been remediated at the present time.

We are asking for providers to reach out to us directly with any issues that they have identified and then we are actively working on them.

I know that our IT department are regularly pushing upgrades and enhancements to the system. Our lag in the portal and the timeouts have improved considerably since the last TAC meeting and we are continuing to see an increase in speed.

I know that eligibility has been an issue and our IT team has continued to do these large pushes to update eligibility on the portal.

If there are any discrepancies on what providers are seeing from the

member and on the portal, please call us and we can address those individually and we can address those pretty quickly.

I know it was a little tough in the beginning, but we are over the hump and rounding the corner here.

The good news is that we don't migrate to portals how often. So once we are done with this we will be good to go and we should be in a good spot and I do appreciate everyone's patience as we get through those issues.

DR. BOBROWSKI: Thank you, Melissa, for that report. Do you have a better number? I have had several people contact me that they either contacted the number that they had and left a message and nobody got back with them from Avesis. Do you have a better number that we can try to get out, or maybe you all could send a letter out to your providers with new contact information or something.

MS. APOSTOLIDIS: Of course. I can definitely send that. We have our provider relations representatives. We

have our call center and we also have email boxes that I can drop into the chat if needed.

Actually, our provider relations manager in Kentucky is on the call and she can address additional ways that providers can make outreach to us.

DR. BOBROWSKI: Okay.

DR. PETREY: Melissa, when do you anticipate resolving these issues? I know that we have had a number of practices -- speaking here today -- a number of practitioners and I've had a number contact me and I think that we all have.

All politics is local and we were one of the practices that were asked to start using the portal before the launch, so we are going back to September. So here we are in February, five months later, and the same issues we had in September with a provider not certified is still our issue.

All of that has been compounded with the issues with Avesis and the issue

with eligibility, but the original issue that we had five months ago is still there.

At what point do you think our practice and others who are still having these issues will see some resolution?

MS. APOSTOLIDIS: It is a great question. I don't have an end date as to when everything will be working perfectly. In a perfect world you have it rolled out and everything works just the way you planned, but unfortunately, that is not what happened this time around.

I know that we have made progress and there have been a lot of issues that have been remediated and when providers do reach out to us, we are able to address those issues and get them fixed.

So if that issue is still persistent, would you mind just reaching out to the provider relations representative to make sure that we can get that remediated for you? We have to enter tickets and those are triaged and

worked and remediated.

MS. RUSH: If I may, Michelle Rush with Avesis as well.

You can put your contact information in the chat, I would be more than happy to take that back and get you to the appropriate person to reach out to you and resolve that.

As Melissa was trying to say, some of these things have been fixed and then another fix will go in and another provider might have an issue and we are trying to deal with them situationally as well.

I would also like, if I have the opportunity, I would like to introduce Michael Scott who also joined the call today and he is Avesis COO. He has recently joined us as well, so he is on and listening to your concerns, as well, but if you give me your contact information, I will contact you to handle that.

DR. PETREY: I do appreciate that. I would say that I would wager that

our number of contacts has probably exceeded everyone else who has contacted you all.

We have had a great response, but it has been five months and I have contacted Tricia and Tory and everybody down the line -- Dr. Caudill -- some have been very responsive and some have not responded in any way. So I will certainly put my contact in. But it is not just our practice.

MS. RUSH: Understood.

DR. PETREY: Knowing that we are going on five months in ours and I don't know what everyone else is experiencing.

MR. SCOTT: I appreciate you raising that for us. The issue described is not the type of issue that should take that long so I will take that back and get that addressed. We do have issues like eligibility, those have been more challenging because it is an ongoing -- there are new issues that arise that are different from what we had early on so you may have -- you may end up with an

eligibility problem that looks the same, but we have a lot of issues solved and a lot have popped up, but we will continue to refine that.

I did want to comment on where we are with the payments, because I think that that is important.

One of the side effects that we had with this process is that we did have a pretty good number of providers that we had submitting their claims on paper where, historically, they submitted it through our portal.

I would say that our volume on that is we are probably getting half of the level through our portal than we did historically, so a lot of that really has to do with the issues that we had at the very beginning of the launch, and that behavior shifted and it hasn't been able to shift back yet.

So the impact of that is since we are getting so many paper claims now, those are more time-consuming to process, and we really started having a backlog of

paper claims. So if you are submitting through EDI or through the portal, those claims are processing in normal times for us, but we are struggling with the backlog and the paper claims, and I believe we have a work plan in place to get that backlog eliminated in the next 30 days.

So I think we will have probably another 30 days of slow pay on paper claims, but we will address that and we are also trying to have some broader education to get leadership back to EDI or the portal for the submission of claims because those are processing properly and appropriately.

This is going to be, obviously, an ongoing process where we will continue to take feedback in terms of where people don't think the portal is user-friendly, and where there is any functionality that used to be there that is not there now, then we will continue to drive through enhancements.

We do think that the biggest problem is behind us as it relates to our

government business, but we also acknowledge that there are enhancements that we need to do to continue to upgrade the portal.

DR. BOBROWSKI: Do you go by Mike or Michael?

MR. SCOTT: Either one.

DR. BOBROWSKI: Well, thank you for joining us today, and Michelle and Melissa, thank you all for joining us today and giving us a report on that.

This is just one of those things that a lot of practitioners and Medicaid providers, sometimes they just -- they know you don't mean to cause problems, but it is just one of those things that comes up with technology, and I did read just the other day after I had already sent in the agenda, that I did read that one of the -- I put on there what is the purpose of the change to this portal, but I read somewhere that one of the reasons was to provide better security by using a portal.

So I know that that is a huge concern of mine and a lot of people with

our computer systems is just protecting our patients' information.

Any other comments from any TAC members on the portal? Or questions?

DR. PETREY: I would only say that I understand that backlog. That frustration there is when we are asked to pay for a claim because of the issues with the portal and then the backlog creates -- and certainly we are not the only ones in that situation. We are creating the backlog problem, but that is a portal issue on the front end, and certainly in our case that is a provider non-certified situation and then compounded by the remittance advice and the eligibility that we have talked about going from there.

Thank you very much for your assistance.

MR. SCOTT: Absolutely. Thank you.

DR. BOBROWSKI: The next item is the dental loss ratio, and I know some of the other meetings that I have been on, they have talked about this, and I guess I

put that on the agenda there, so that other states are looking at this and some may already be doing this.

It was awhile back -- a few years back -- that most of the MCOs, you know, cut the reimbursements to the providers by 10 percent, and that went on for years, and just recently did most of them take that off, which is highly appreciated, but we find out and we see things and the MCOs have cut us 10 percent, and every Medicaid recipient received 100 bucks just to go get their COVID shot -- their free COVID shot -- so they were getting paid to get a free service, yet the providers aren't being taken care of.

So we put on the agenda that they are getting more to get their exams than the provider was. And we have to pay for staff, supplies, so I hope you all keep these things in mind when you do your value-added benefits that -- just a word of advice to take care of your providers too.

Any TAC member want to bring up anything else on dental loss ratio?

Currently there is a medical loss ratio and that is what I put on some other states that are trying to add in the dental loss ratio with these contracts.

I am going down. The next one is a change that some of the MCOs are doing on their reporting of anesthesia times.

I don't use anesthesia in my office, but Dr. Justin, if you don't mind to maybe talk about that just a few minutes, you've got to the floor.

DR. KOLASA: Thank you, Doc.

That is one of the things at least Avesis worked into our contract that we didn't notice until a friendly interaction.

One of the things that oral surgeons do and dental providers do is we don't get facility fees, we don't get reimbursed. My wife is a general surgeon, so I get the good fortune to evaluate EOBs and how much money they pay for gauze and

supplies and all of that gets reimbursed. As dental providers, we eat that in the procedure.

One of things about Medicaid patients that I see a lot is sometimes they are a little bit more challenging for various reasons, whether that be medical comorbidities, history of drug use, things like that.

So you may use three or four IVs, new lines, new IV bags, it may take 15 or 20 minutes to get an IV sometimes, and I have an extremely competent staff and giving IVs better than our local hospital.

What is frustrating is, if I do a 22-minute procedure, then I get reimbursed for 15 minutes from Medicaid and then I pay for the other seven minutes.

So until I break into that eighth minute, there is no reimbursement for the anesthesia time. So I look at it like I am paying for it. I don't start anesthesia time until I start anesthesia,

so it may take 20 or 30 minutes. We already don't get reimbursed for diabetics sticks. If a diabetic patient comes in and I run a finger stick, that takes time. If they are on Coumadin and I have to run in the office INR, I don't get reimbursed for that, so I felt like nickeling and diming us for stuff that we already use for getting eight minutes into the procedure -- this is not just me, it's communicating with several oral surgeons -- is little frustrating.

I talked to some anesthesiologists at the hospital and their billing is much more complex based on the procedure, but they get billed based on rolling into that 15-minute interval, so I felt like it was a little bit of a disservice to your providers that you basically make the oral surgeon -- or whoever is providing anesthesia -- cover the first seven minutes of that, and that was kind of a new thing.

I didn't train that it had to be eight minutes in to bill for it, the ADA

doesn't make that specifically clear, but I think we all know the intent is if you start that second unit of anesthesia, that that should be covered.

So that is something that several oral surgeons have communicated with me and something that I personally found very frustrating with the amount of cost and time and difficulty that these are that that would be a change from, at least Avesis.

DR. BOBROWSKI: Thank you, Dr. Justin.

Any other TAC member got any comments or questions about the anesthesia?

DR. PETREY: I see Dr. Rich has his hand raised.

DR. RICH: Sorry. I had my hand raised, but then I had to get off of mute. My apologies.

A good afternoon, everybody. This is Dr. Rich with United Healthcare. I just wanted to follow up a little bit about the anesthesia thing and also on the

rates.

So to start with the anesthesia, and Dr. Kolasa, I understand your concern. We spoke about that earlier in the week.

We are paying what the provider bills, and as long as the anesthesia corresponds to the treatment that is delivered and is reasonable, and unless it is an outlier, it is not on our radar.

We are trying to pay the provider for the services they are doing and we respect that. We appreciate any providers that are working with this and caring for this population. So I thank you for doing that.

And I want to note that -- just the other thing we discussed was the ADA recommendation for billing is when you enter the next 15 minutes, that you report that as the next anesthesia segment.

Billing is what it is and that is your contract with the MCO and we are following that guideline with the ADA at this point. As long as it aligns with the treatment that is done and the time, that

is the critical thing.

So then back to the pay, Dr. Bobrowski, and compensation, we have always paid at or above the state rate and we continue to do so, and we will continue to try to do what we can to meet the needs of the providers and the members.

If you have any questions regarding UHC, or SKYGEN is our billing service, I would be happy to follow up with that, too, or if there is another question or concern.

DR. BOBROWSKI: Thank you, Dr. Rich, for that information.

Dr. Petrey, thank you for noticing. I can see when people have a hand raised, but I don't have the control button to change it, so Joe, help me watch for those hands. Okay?

Moving on, I just wanted to bring this up. I put on there, implants are allowed to be placed by Medicaid now. Doing some research there, and the American Association of Oral and Maxillofacial Surgeons have developed a

position paper. The method of choice to develop diagnostic information to evaluate the implant site is the use of a CBCT-type of x-ray.

The current fee structure does not allow for this, so I feel that that is another item that the surgeons are having to eat, but I do know through the ADA, there is a code specific for that but it can also be used by general practitioners in the diagnosis of root fractures. Is it worth even trying to do a root canal? There is a root fracture you probably don't need to try a root canal, especially for children who have airway problems, even children snoring.

I remember when one of my boys with little, and boy, you could hear him upstairs. These are airway problems that can be evaluated, but I would like to open the floor for discussion on that for the TAC members, and just see if the TAC would recommend the addition of this code to DMS.

Any TAC member have any further

discussion on the CBCTs?

Hearing none, is that something that -- I know Dr. Kolasa on your all's business -- and I had it in here -- I think there is another item down the list where maybe by the next meeting we maybe could find out how many implants -- we may have that information today -- but how many implants were actually completed in the state or paid for by the MCOs for 2023 and may have the data for 2024 now.

MS. SHEETS: Dr. Bobrowski, I do have that data completed. I can send that file and email it this afternoon.

DR. BOBROWSKI: Okay. Thank you.

That's what I mean. I know there are a lot of folks doing stuff in the background in helping us and using that data and that information to guide implementation of care.

The next item -- I will make one a note here for myself.

The question is: How is the state and the MCOs verifying an adequate

provider network? If so, is there a place in the contract that specifically allows for this? How is the state and the MCOs verifying adequate provider network?

MS. PARKER: Hello, Dr. Bobrowski. This is Angie Parker with Medicaid.

First, I want to say that you will be missed and we want to thank you for your service on this TAC. You are a breath of fresh air every time, so I know that you will be missed leading this TAC.

DR. BOBROWSKI: Thank you.

MS. PARKER: To answer your question, how do we verify an adequate provider network, that is a challenge. We do get monthly reports from the MCOs on what their network looks like and they are to maintain -- I don't have all the numbers here as far as a percentage -- but there is a certain percentage that they are to make sure that is in place.

We do know that there are challenges to this for each MCO in knowing that whether or not there are enough

dentists in a certain area and sometimes they have to ask for exceptions.

If there are holes in their network, they are to work with the network to try to get them to a place where they can be seen.

If there is language in the MCO network regarding network adequacy and we are currently working on a report to find out whether a provider has not billed within the last year and to identify what type of providers they are, and if they are not, are they being counted on the network adequacy roles, and if they are, should they be.

So there is a lot of oversight with this, but we also recognize that sometimes there are holes in the network that are challenging to fill.

DR. BOBROWSKI: Thank you. I know that a couple years ago I reported about this and I know that there was a dentist over in another county that he told me, he said, Dr. Garth, they still have me listed as a provider for Medicaid

and I quit 20 years ago.

I think you kind of answered my question on that.

If you all are asking the MCOs and folks within the last year who has billed, then that is a good idea to find out are they still participating. I know that there are several providers that have cut back on their Medicaid patients and they are seeing certain families that they know need extreme help or they are reliable to show up for their appointments and they just need help, but thank you for that information. I appreciate it.

MS. PARKER: You're welcome. Again, we will miss you.

DR. BOBROWSKI: Thank you.

Do we need -- on the implants, did you all get any information on that or do you want to wait for the next meeting?

MS. SHEETS: Dr. Bobrowski, that data was completed and the spreadsheet was sent to me and I will send that out to you guys in the follow-up email.

DR. BOBROWSKI: I will make a

note of that, so thank you for that research.

I have mentioned this before, and I checked it the other day and it is still on the fee schedule. As a general dentist, I wish you all would look at removing the prior authorization for a code 3120, that is an indirect cap and I think the commissioner said that they were looking at that, but it has -- so many times folks will walk in and they have a broken tooth.

Well, you get your x-ray, evaluate the tooth, and it has a deep old cavity under the broken area, and you tell them up front that this looks awfully close to the nerve, but we will clean it out and see because there are times that you can clean out the cavity, but -- and it doesn't get into the nerve, but it is so close that you do your indirect cap and I don't have a prior authorization done.

So it does put another layer for the time and the patient, because you get your x-ray and, technically, if you don't

have a prior authorization, you can't begin treatment, and I have time today to do that filling, but now we have to reschedule the patient because I don't have a prior authorization.

So I don't know if any of you all have any comments on that, or if you do, please tell us now.

MR. DEARINGER: Dr. Bobrowski, thank you. This is Justin Dearinger with Healthcare Policy.

We had gotten that recommendation from you previously and we did some research on it. We found through that research that there were multiple codes that had potential issues that they were structured on the fee schedule that opened up in to a much larger fee structure review.

We had some codes that we pay that most people don't pay and we have some codes that are being overpaid and some that are being underpaid, so that kind of opened up a much larger dental fee schedule review as a whole.

We conducted the research and analyzed it, and we still kind of put it in a readable format and create some narrative around it and submit that to cabinet-level leadership to see what, if any, changes need to occur.

That is not going to be removed any time soon. That is part of a much bigger process.

We initially started just by looking at that one request or moving that prior authorization and that led to an overall in-depth review of our dental fee schedule.

So sometime within this calendar year, we will have an answer for that. I don't know exactly what that is going to entail or look like, but we will work with you all and keep you all apprised of everything we have come up with, any questions that we might have, or anything like that moving forward, but as of right now, that is going to remain there.

And then, just an update on our fee schedules, we are still waiting for

feedback from those fee schedules and that, hopefully, will be completed very soon, as well, and when we get that back, we will make sure to send notice to all of the TAC members on that.

DR. BOBROWSKI: Justin, we really appreciate all the work that you and your crew does on evaluating these things and doing the research that it takes, because I know there have been some times and some nights that I can't sleep.

I get on and look at the fee schedule -- and it is odd for a guy to do that at two in the morning, but sometimes the house is quiet and the phone is not ringing, it's a good time to get some work done.

I know a while back I had got a meeting request from your all's office and I sent in some available times, but I never did hear back from you. I figured that maybe you all got it worked out or something, I don't know, but I did get an email the other day from -- I notice she is on the call today, I will bring it up

now but Ashley, I may mess up your last name, Madras?

MS. MADRAS: Yes, sir, that is correct.

DR. BOBROWSKI: All right. Yes. One of the codes was -- I think I did send in a response on that. It was kind of like the word, "crown" was on the fee schedule, and it had one per five years like the adult crowns, but the question was on the children's stainless steel crowns, or the aesthetic coded primary teeth crowns, and I've got the exact wording here, but you know what I am talking about.

Carol, this might be a good one for you to help respond on this one. What I have seen -- and I feel like I was the pediatric dentist in our area in rural southern Kentucky for quite awhile until we got Dr. Heather Wise in the next town over.

She is a pediatric dentist so that took a lot of load and worry off of my mind, because she was able to come in

and help, but Carol, I think this is where you can fit in on this, that in terms of stainless steel crowns, I didn't have too many that came off, but a lot of times when they did come off, they were cracked, split, not usable again, but the tooth was still able to have another crown put on.

But with that five-year rule, it's like the child is here, what do I do, just pull it? You don't know exactly what is happening until you look at it, so that was a question to you, Ashley.

But Carol, do you want to talk first about that, or do you see it happen very much?

DR. BRAUN: I do see it happen, and this language was put in probably two or three years ago when they started covering more crowns on adult teeth, and the construction and the placement of these is not at all like what you would see on a permanent tooth.

While you want it to last as long as you can, if you put a crown on a child until they are four, and the

expectation is it is supposed to come out at ten years of age, the abuse that goes to those crowns is much different than the abuse that goes to permanent teeth, and the technique is not the same, so to consider the life and the replacement life, the same is absolutely apples and oranges.

If you get a child who bruxes, if you get a child who eats a lot of Tootsie Rolls, and you want to try to teach keep that tooth in there so you don't have to apply a space maintainer. All of those things. Applying the crown five years to the stainless steel, or the 2930 or 2940, is really inappropriate, and once again, that language is introduced very recently.

DR. BOBROWSKI: Ashley and Justin, my recommendation that I sent in was to just take off any limitation on it because, as you all know, it is -- these kids for some reason, they like Tootsie Rolls or gummy bears. It happens.

And a lot of times when those

crowns come off they are mangled up so much that you just can't straighten them back out appropriately and you have to do a new one.

So I hope you all can look at that, and Justin and Ashley, if you want to have the floor for a minute and talk about that, the floor is open to you and then Dr. Rich has his hand up here in a minute.

MR. DEARINGER: Yes, sir. We received that and have kind of rolled that into the overall part of the project on gathering more data and information so we can make a better informed decision.

That is still separate from that project I was talking about, but we are gathering more data on that right now. So by the next meeting we should have an answer on that issue as well.

DR. BOBROWSKI: Thank you, all. I appreciate you all reaching out to me on that and Justin, actually too, on some of those things, I know sometimes you go by what other states are doing and really, I

think that Kentucky has been way ahead of a lot of other states in a lot of avenues with their care for patients, but I would just recommend that on some of these things to continue, look at your Technical Advisory Committee for ideas or suggestions, because, I guess, over the last few years, I have tried to get a good broad section of representation of Medicaid providers, and we have oral surgery covered, and orthodontics covered, we have general practitioners covered, so that is kind of the bulk of that. So please keep the TAC in mind for some of your research. Those are the folks who are out here doing this work every single day, and again, I appreciate the research that you all are doing.

The next thing that I had a question on is are any of the MCOs doing any subleasing.

MR. DEARINGER: Dr. Bobrowski, did you want to let Dr. Rich and Dr. Caudill talk about that previous issue?

DR. BOBROWSKI: Oh, yes, yes. Thank you, Justin.

Dr. Rich had his hand up first.

DR. RICH: Thanks, Dr. Bobrowski.

I really wanted to go all the way back to the prior authorization thing that we were talking about just a little bit ago.

Just to say that for anything that is an emergency or needs to be done or can be done the day of, it is fine even if it requires a prior auth, submit the information that you need with the prior auth with the claim and it will be reviewed in the same way that it would with the prior auth.

So if it justifies a necessary treatment like a root canal or anything, if you've got the member there, and it needs to be done, please do the service, send in the same information that you would send in if you were going to have a prior auth and we will review it and pay it at the same time.

The only thing I wouldn't recommend doing that for is dentures orthodontics. I think orthodontics is self-explanatory.

Dentures, the reason for that one, if you don't know if the member just went down the road and had a denture made by somebody else and didn't like it, and said, "I want a denture," and they said, "you qualify," but they don't but they didn't tell you, they just had one made that they didn't like.

So for anything else, treat the patient the way that they need to be treated, and if you have any information or any concern, reach out to me and say, "how do we deal with this," and I will make it work for you.

DR. BOBROWSKI: Thank you, Dr. Rich.

Dr. Caudill?

DR. CAUDILL: Along that same line, Avesis has always had the philosophy that if it is emergency treatment and you need to go ahead and do it, then you go

ahead and do it, and then just file a normal claim and put in a narrative requesting the post review due to an emergency and that tells us that you couldn't wait the 48 hours for prior authorization and all that, you need to go ahead and treat the patient right there.

So we do that exactly the same way.

Also, talking about the stainless steel crowns, we agree with you on that that, you know. I assume that when it was being set up, they saw the word, "crown" and lumped it in.

Nonetheless, for those, you can request that coverage under DPSTD for under 21, and certainly, if you make the case that it is medically necessary, then we can certainly cover it on DPSDT.

DR. BOBROWSKI: Okay. Great. Thank you for those comments, guys. Appreciate that.

Let's go back to that question about the MCOs subleasing.

MR. OWEN: Dr. Bobrowski?

DR. BOBROWSKI: Yes.

MR. OWEN: Stuart Owen with WellCare. I'll touch on that briefly.

You will be greatly missed and I have been sitting here trying to think that I don't think I can adequately commend you. No matter -- obviously over the years there have been -- not necessarily controversial topics, but you have always 100 percent, no matter if there is a disagreement, never disagreeable, never uncivil, never unpleasant, it has always been human-to-human conversation and you would be a role model for our elected leaders and politicians. You really should. You would be the perfect role model for that and I really can't commend you enough. You absolutely will be missed.

DR. BOBROWSKI: Thank you. Thank you, Stuart. I appreciate that.

MR. OWEN: Regarding the subleasing, WellCare did clothes because of remote work -- closed a couple of offices and have subleased those. Is that

what you are asking about?

DR. BOBROWSKI: Kind of, yes. So those were a couple of offices that were closed. That term, "sublease," does that just mean that you all found another office to take care of those patients?

MR. OWEN: Okay. Personally, offices that we have for staff, we didn't need them as much due to remote work and we were leasing to a company so we sublease from somebody else. I didn't know if you're talking about that or something else.

DR. BOBROWSKI: That's fine. Yes. That was more for remote work. Gotcha.

MR. OWEN: Can ask you, since you are stepping down from this, are you going to maybe run for office? Senate, maybe?

DR. BOBROWSKI: I appreciate your confidence. I'm like you. It's gotten to the point where I don't like to listen to the news on any channel.

I had one of my assistants --

her husband is retired from working, I think, 30-some years at Fruit of the Loom. He drove from here to Bowling Green every day for almost 30 years and that is about an hour and 15- or 20-minute drive every day back and forth. And his wife said, boy he came home and all he did was sit around and watch the news, and I said, "We can't do this."

He was getting so depressed and mean and I think he got another job. She said, "I think he's doing janitor work in one the high schools here, locally." So he went from an administrative job at Fruit of the Loom to being the janitor so, hey, I'm thinking that might be what I need to do too.

MR. OWEN: You really are an example, though. We discussed topics and there are issues and problems, but you have always done it in such a pleasant way. We can disagree and not be disagreeable, and you really are the perfect example of how to handle that.

DR. BOBROWSKI: Well, thank you.

And I know that some of these problems that come up are out of all of our control, but we have to do the best we can to work together and, I guess that my ultimate goal is we have to work this out to tell the patients that need care.

Get them out of pain, number one.

Number two, what can we do as dentists to improve someone's smile? And that has been one of my goals.

I know when I started here in this small town that I am in, 45 years ago -- my goodness, all we were doing -- here, I thought I was this big hotshot out of school and I thought, "Wait a minute. All I am doing is pulling teeth."

And, I mean, it needed to be done, but I told my staff, we've got to start an education program in our little town here that you don't have to have all of these teeth pulled.

So I guess, bless their hearts, I had a lady here this week that came from another office and she said -- she lives

in another county and she said, "I just heard good things about your office and wanted to check you out." But she does, she's got periodontal disease and every one of them come out and there are factors that are involved and this was her factor, that she was scared to death to come and see about it.

She said, "Some of my teeth had already fallen out on their own." It was that bad. And people are just afraid, and I guess, one of our goals was to try to make going to the dentist -- for some, it is not pleasant, but what can we do to make it pleasant for patients to get in?

And I guess I have to complement my staff that it is not uncommon to hear laughter in the dental office. They cut up. They laugh. They tease each other. The patients are cutting up with the staff. It's not like that every day, but you hear laughter at the dental office and that is unusual.

Anyway, I have to give my staff credit for making the office a pleasant

and -- relatively pleasant -- place to be, but again, I do appreciate your comments.

I think if we look at those goals -- I tell you I am really proud of this TAC coming forward, and proud of our recent TACs.

I think, in their hearts they've got the same goal and I have been so proud that they have agreed to be on this TAC to guide our Medicaid followers here in the state.

MR. OWEN: We have a common mission. The MCOs as well. We want to help our members. Like I said, we address social determinants of health, we have care managers, we want to see our members improve, the exact same mission.

DR. BOBROWSKI: Yes, yes.

And I think the main thing is to keep these lines of communication open between the providers and the practitioners because that was one of the things, Stuart, that I got several calls about.

The dentist would say, "Well, I

have called I have called here and I've called here and nobody calls me back. I have texted and nobody calls me back."

It's just one of those frustrations, and some of these were coming from oral surgery offices, and we have to keep our oral surgeons, because there are some teeth out there that I don't need to be pulling.

It's like Dr. Justin said a while ago. The health problems that we are seeing with patients, it has gotten a lot worse from when I first started.

These folks come in and they've got one or two sheets of medicine that they are taking. And these are high risk patients and I am so glad that we have folks like Dr. Justin and Dr. John Gray and all of our TAC members that are on here, that they truly do care, and down deep in my heart I have always appreciated these folks that we have out in our state that really care, and I am just so glad they are willing to be on this TAC. So I appreciate that, Stuart.

Is there any other new business?

Hearing none, are there any motions that we need to take to the MAC for the new folks? I am also on this committee, but I may have to look at that one too. That is the Medicaid Advisory Council.

They are looking at a federal change that is going to be called the MAC/BAC, which is going to add more consumers and consumer input into the treatment, so that is going to be changing here this year and next year, but you can get more information on that by following the website at DMS there. So that will be a place to look at for that.

I don't hear that there are any motions for the MAC.

Is there any other business that we need to bring up or anything from any of the TAC members that we may need to add for the agenda for the next meeting? It will be May the 9th and I think that Kelli will have those on the website, if I'm correct.

Kelli, you have those on there? I think I saw them the other day.

MS. SHEETS: That is correct, sir.

DR. BOBROWSKI: Thank you very much. Friday afternoon, same time same channel.

And I didn't hear any other questions or comments, so I would say I need a motion to adjourn the meeting.

DR. BRAUN: I will move.

DR. BOBROWSKI: Thank you.

DR. PETREY: Second.

DR. BOBROWSKI: We've got a second. All in favor say, "Aye."

TAC MEMBERS: "Aye."

DR. BOBROWSKI: All right. Goodbye, everybody, and thank you all so much.

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C E R T I F I C A T E

I, STEFANIE SWEET, Certified Verbatim Reporter and Registered CART Provider - Master, hereby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 12th day of February, 2024.

/s/ Stefanie L. Sweet

Stefanie L. Sweet, CVR, RCP-M