DEPARTMENT OF MEDICAID SERVICES
DENTAL TECHNICAL ADVISORY COMMITTEE

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May 13, 2022
2:00 - 4:00 p.m.

Lisa Colston, FCRR, RPR
Federal Certified Realtime Reporter

A P P E A R A N C E S

TAC Committee Members:

Garth Bobrowski, DMD, Chair
John Gray, DMD
Joe Petrey, DMD

MS. BICKERS: It is officially 2 o'clock. And I believe, Dr. Bobrowski, you are the only member that I saw logged in. Did I miss anybody?

(No response)

MS. BICKERS: I will take that, I didn't miss anybody. Okay. Dr. Bobrowski, I will turn it over to you.

DR. BOBROWSKI: All righty. Well, I want to welcome everyone to the Dental TAC meeting. And I did send out reminders and agendas to all the TAC members. Now, Dr. Phil Schuler was the only one that I heard back from that was not going to be able to be on the call today. So that should have still left us with Dr. Gray and Dr. Petrey. So we don't have a quorum just yet. So, but, we will maybe give them a few more minutes to get on here.

DR. PETREY: I'm on. This is Joe Petrey. I'm on.

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

DR. PETREY: I was trying to get myself unmuted to talk, so sorry about that.

MS. BICKERS: Sorry, Joe, I missed you when you popped in there.

DR. PETREY: That's okay.

DR. BOBROWSKI: I was just making a note or two here. Let's see. Dr. Joe, had you heard from John or anything? I hadn't heard from him.

DR. PETREY: I haven't. I haven't heard anything from him. Well, it kicks me off video when I text him, but I can send him a text to see.

DR. BOBROWSKI: I mean, I can text him here real quick. I just texted him, so we will see what we have got here.

Ms. McKee, you were talking about the garden at your church.

(Discussion held off the record)

DR. BOBROWSKI: Okay. Is Dr. John logged in here officially now?

MS. BICKERS: If he is "Johnsipad," I believe that's him.

DR. BOBROWSKI: Yes. He said he was going to be working on getting logged in here. Dr. Gray, are you on?

MR. YOUNG: This is Jonathan Young

with Molina. It is probably my phone that is registering that you are referring to.

MS. BICKERS: Oh. I'm sorry.

DR. BOBROWSKI: We can go ahead and do -- part of the old business was to continue some of our MCO reports on the social determinants of health and their impacts on oral health and total healthcare. And I believe we were going to get a report from Molina-Passport, Aetna, and Humana. So, Molina, if you all want to go first if you are ready.

DR. BABBAGE: I am ready. I'm ready. This is Dr. Sherry Babbage Melisizwe with Molina-Passport. How are you?

DR. BOBROWSKI: Great.

DR. BABBAGE: I'm trying to push all of the buttons I need to push and get this presentation loaded up.

DR. BOBROWSKI: Just go ahead when you are ready.

DR. BABBAGE: All righty. Let's see what we can do. I will turn the camera off, but I wanted you all to see what I looked like. Here we go. Do you all see my

presentation?

DR. BOBROWSKI: Gotcha. Yep.

DR. BABBAGE: Okay. Perfect. I did it right for a change. Let me make sure my buttons are working.

All righty. Let's talk a little bit about the things of why we do what we do. So when we are talking about our social determinants of health, we are talking about -- I have got to move this off my screen. I'm so sorry, guys. I can't see my presentation. I see your-all's pictures. There we go.

So it is important that we take a look at all aspects of a person's health. So traditionally this includes physical health, of course, behavioral health, and dental health. In recent years, however, there has been a greater understanding of the importance of the social determinants of health as a significant influence on the overall quality of health and life and well-being. You know, I think we have -- all these years we have treated social determinants of health but now we actually

have the term that we can use, something we can go to, and I think it makes it easier for us to be able to put everything into a basket where we can make the patient better.

So what Passport has been doing, we have a health risk assessment that we provide annually to all of our new members to complete. And on that assessment are social determinants of health. So some of these responses that our patients, our clients, members give us trigger a referral to our case management team. And once it gets to our case management team, there are additional screenings and additional assessments that we can do to narrow down exactly what those needs are.

So we have this protocol, and we call it PRAPARE, which stands for Protocol for Responding to and Assessing Patients Assets Risks and Experiences. So this is a way that we can screen all our members and identify them for care management on their social determinants of health needs. This helps us better understand and address our member's health and the best way we -- we

want every one of our members as healthy as they can be. So by assessing their needs, we can help them achieve their goals.

So Passport employees, individuals that focus on the social determinants of health needs within our members. And some of these individuals are our community connectors or community health workers, housing specialists, and peer support specialists. So Passport will address the social determinants of health at the population health level in many ways, including we like to offer value-added benefits and we make donations to community serving organizations. So, for example, social determinants of health related value-added benefits include GED assistance, incentives, food kits, gas and bus cards to get to where you need to be, and dentures.

And then everybody knows when they have a member that is needing care management how to contact our care team. For example, our value-added dentures, Passport will pay 300 for a partial set or 700 for a first set of dentures. Our members, however, we give

them a little responsibility in the system to participate in care management. So they have to be a participant. You can't just say, oh, I want dentures and there it is. But we have things that we want you to do. We want you to be healthy all the way around. So this is a new benefit for our Medicaid members. It just went into effect in 2022.

I have a graph down here. And you can see that 178 members from 60 different counties have requested this benefit. The largest portion is from Jefferson County. And 28 of those members reside in the West Louisville, our poorest neighborhood, zip codes. So, and, it looks like most of the requests have come from Caucasian females. So, and, around the age of 50 to 59. And, so, we are doing stuff. And for this to have only been in place in 2022, it is moving right along. We are doing a really good job with this.

So what can the provider do? You know, we at Passport-Molina, we have a team of case managers. But how do the patients, you know, get to us? Sometimes they get to

us through the screening that we do with our new members, but we also have a way that our providers can also help us screen these patients. So we want our providers to know that when you use social determinants of health screening, it is a very effective way to assess the needs of your patients. So a social determinant of health screener, if there is not one already being utilized in the practice, there are several options that we can give you. There's the accountability health community-related social needs screening tool that we have on our website for our providers to use. We also have the PRAPARE experience that they can look at as well.

So it is very important that we let our providers know that they need to include the appropriate social determinants of health codes with their diagnosis and it will greatly impact how Passport-Molina will identify and assist the enrollees that have these social determinant needs.

You can also just directly as a provider make a referral to the case

management team. And most of our patients know that they have a case manager and who that case manager is, and they can share that with us and we can be the go-between sometimes or sometimes the patient will want to make that first contact with their case manager. And again, right there, simply make a referral to send a brief e-mail to CareManagementKentucky@PassportHealthPlans.com.

So here is a story, how it all comes together. Sarah, not her real name of course, a young woman. And a year and a half ago she had a pituitary adenoma. She was told that she only had a few months to live. And she's been through several treatments, chemo and things like that, to treat her tumors. But there is more to Sarah than her pituitary adenoma. We think Sarah, as a whole person, we want her dental and her vision issues taken care of as well and her mental health issues. So we have -- the remaining teeth that she has are pushing into her tumor, and a lot of pain with that. And the adenoma itself is already painful. So

this swelling has also caused her glasses to break when she tries to put them on her face. Sarah was also admitted as a behavioral health to a health facility for suicidal intentions. And she got treatment for that, for her depressions and her feelings of hopelessness.

But while she was an inpatient a referral was sent to our transition care team. And we had a 30 day program so that Sarah could stay home safely and be monitored at home. So Sarah and her transition care coach set goals together, which kept the depression symptoms stable. And other things that we wanted to do all over was improve Sarah's quality of life.

So she wanted to have her teeth removed so that they wouldn't press into the tumor anymore. And they didn't know where to begin. She didn't have reliable transportation. So her transition care coach, we were able to find a surgeon just a few miles from her home, where she could get a ride from family members. And after the consultation with the surgeon, she was able

to get that appointment and have her teeth removed. So Sarah graduated from the transition of care program and she continues to work with our case managers to achieve the rest of her personal goals.

The next step, dentures using the value-added benefit that Passport offers. Her care management team will help her walk through this process hopefully as easily as we helped her walk through the behavioral health issues and the extractions.

Her goals included in her individualized care plan are what we are working on now. So improvements in Sarah's quality of life and continued focus on her future oriented goals may help to add invaluable time to Sarah's life, actually, and give her and her elementary school-age daughter more time with her mom. And, again, hopefully we see the importance of interprofessional workings that we do with our case managers.

And I am very proud to be Dr. Sherry Babbage Melisizwe, Dental Director, Molina-Passport. Thank you.

DR. BOBROWSKI: Thank you very much for that report. I've got a question. Where I'm at, I'm about an hour and a half drive from the Louisville Airport, you know, probably a good hour, hour and a half, hour and thirty-five minutes or forty minutes into, you know, downtown Louisville. And I know you said that you all just started this in 2022.

But we see a fair amount of Passport patients in our area, but I had no knowledge of the denture being as part of a value-added benefit. Were you all going to send anything out to the providers or did I miss something in the mail?

DR. BABBAGE: I would have to let one of my -- that's not anything that I'm aware of. But as far as I know, every Passport provider should have gotten this information. And if anybody that is on my team has that answer, I would appreciate that. And if not, I will get that to you, the answer. And for our other providers as well.

MS. HUGHES: This is Kimberly for

Molina. I will double-check and see what communication went out. I can't answer that at this moment, but I will double-check and get back to you.

MS. MOWDER: Thank you, Kim.

DR. BOBROWSKI: Okay. Any other questions?

(No response)

DR. BABBAGE: Thank you.

DR. BOBROWSKI: Thank you so much. At this time, let's go with Aetna.

MS. MOERER: Hello. Good afternoon. Give me just a second and I will share my screen. Okay. Can everyone see the presentation?

MS. BICKERS: Yes, we can.

MS. MOERER: Okay. Perfect. Good afternoon. My name is Tristin Moerer. I'm the Director of the population health team for Aetna Better Health of Kentucky.

All right. So at Aetna, we take a total approach to healthcare. You know, our goal is to empower enrollees to achieve optimal healthcare outcomes and quality of life by addressing their social determinants

of health and giving them the skills and tools to navigate their healthcare. We understand that where our members live, work, learn, play affects these health outcomes.

So our innovative integrated system of care approach is based on the whole person view of the enrollee's physical health, behavioral health, oral health, health literacy, functional needs, and SDOH. We recognize that all of these aspects of these needs are woven together and often in unpredictable ways. The enrollee's complexity is driven by their unique physical and behavioral health conditions and social determinants of health factors.

So these next few slides, I won't spend a lot of time going over these, they are more just for you guys to take a look at. These come from a platform called Socially Determined, which is a social drivers of health risk stratification platform. It provides some features to look at community level risk stratification mapping and individual level risk stratification insights, including mapping and key community

asset overlays.

This slide in particular provides a visual representation of Kentucky's population and social risk at a community level. You can see the different categories here for residents at elevated risk. Economic climate is the highest among those categories at 48.6 percent. And here economic climate means the community's economic opportunity and resilience represented by average area incomes, household size, and neighboring housing costs.

So we will go, like I said, through these a little quicker. This is all from the same source here. This kind of just breaks down the top 12 counties by state intervention rank. So the top counties with elevated risk for financial strain, food insecurities, housing instability, transportation barriers, and health literacy. The state intervention rank is based on the number of people that are at an elevated risk for two or more of the five domains.

And then it breaks out each of

those risk areas. It gives you a visual representation, statewide, of these different risk areas. The darker areas are the counties at a higher risk for these disparities. So the first one here is for economic climate. You will see one for food landscape and housing environment, transportation and, lastly, health literacy.

So at Aetna Better Health we identify SDOH needs from a multi-source approach. So members are identified through our intake assessments, so like our HRA, contact assessments, healthcare equity assessments, and then internal and external referrals.

So just a few quick statistics here for 2021. Aetna made over 18,000 -- or completed 18,000 SDOH screenings. And this represents our general Medicaid and our Sky membership. We also identified over 14,000 SDOH needs and made over 4,000 referrals. So here you can see just kind of a breakdown of those SDOH referrals by category. And for the general Medicaid and Sky, food was among the highest, 30 percent for traditional

Medicaid and 16 percent for Sky, for those referrals.

So now I move on to kind of intervention. So after, you know, we screen these members, we are looking at the data and the needs of our population, you know, what are we doing about it? Aetna Better Health, we tailor our services and our programs to Kentucky's population health and social determinant needs, which to start is that internal social support team. So what does that look like?

Across our organization, from leadership to clinicians, to enrollee representatives, it is composed of individuals whose responsibilities and past experiences includes working on integrated teams and gaining an understanding of physical health as well as the behavioral health long-term care and other related social needs so that we can ensure enrollees are connected to the appropriate resources and services. So this supportive structure encourages coordination at every level, assuring a team approach centered on the

individual and their unique needs and leveraging needed resources to achieve those quality health outcomes. The teams that you see listed here are an integral part of that structure.

So member services. Staff are screening for those social needs related to enrollee status changes. Community health workers, part of our population health team, they are an integral part of the structure to meet the social needs of enrollees as they identify them through new member welcome calls, HRA, HRQ, healthcare equity, and direct referrals. Our CHW's engage the enrollees, caregivers, providers to provide those social needs support through in-office coordination or communications. And then, of course, care management takes on that member-centered approach and focuses on community relationships, integrating those physical health, behavioral health, and social economic status of the enrollees.

And then community development. Our community development team works to establish those partnerships and build

community relationships to help guide some of our initiatives aimed at improving the overall health of our enrollees and the communities in which they live.

So I won't spend a ton of time going over all of the different kinds of programs that we offer here at Aetna. But essentially our Aetna enrollee driven approach to value-added services and care management programs support our integrated care model. Through these programs we can outreach to address potential gaps in SDOH.

So as I had mentioned earlier, a top category for SDOH referrals in 2021 was related to food insecurities. So you will see here that we have a value-added benefit for home delivered meals. In 2021 we delivered 39,000 meals, which equated to about 223 unique members who received those meals. That is among several other programs here related to transportation, GED certification, and job skills training, remote patient monitoring, prenatal/post-partum support.

We have another program called

Momentum. This program is designed to empower the enrollee's self-care by providing them a menu of specific services and supplies. So qualifying members can have access to a pool of funds to use on certain items and benefits. Some examples of that could be funds to cover grocery delivery or other meal delivery programs, mobile technology to help manage certain conditions, utility payment assistance and/or dental services that may not be covered under their benefit.

So overall when we are looking at our value-added benefits, the projected number of utilization for 2021 was lower than the actual number of benefits utilized, prompting some discussion around expanding those key benefits to additional populations. As it stands now, many of the benefits have eligibility criteria that are inclusive of certain geographies or subsets of the population. So this would allow us to expand those benefits to allow access to a broader member base.

The next two slides here just kind

of breaks down our community resource referrals. The first slide is representative of our Sky members and the next of our general traditional Medicaid members. You will see in 2021 we had over 3,000 total community resource referrals documented in foster care events, equating to 1,154 unique members. So you will see the various categories there of the types of referrals that we are making. For our Sky population, dental made up the highest percentage at 22 percent, followed by behavioral health. And then SDOH was around 9 percent of those referrals.

For our traditional general Medicaid, you will see a little bit less referrals noted here. So just over 1,000 total referrals documented, equating to the 529 unique members. SDOH did make up the majority of these referral types at 52 percent, followed by physical health at 21 percent, and then dental and behavioral health.

Our Sky model is very high touch with each member being assigned a care

manager with specific outreach timelines based on risk level. So in addition to a better re-treat, the assessments used in this population are more robust and for a lengthier list of needs as compared to our traditional Medicaid population, which is kind of why you see that lower number of referrals.

So our last few slides here are going to talk just about some of our collaborative partnerships. I have highlighted three here. So as I mentioned, you know, we talk about this whole person integrated care. Our collaborative partnership supports our organizational structure and culture to support that whole person integrated care. So the three that I have highlighted here are Unitas, Pyx Health and Avesis. Through our collaboration with Unitas we aim to improve inter-related access to community resources for their social needs. We recently partnered with Pyx Health to offer members companionship, connection, and power and wellness activities that target reducing loneliness and social isolation. So

members can get real-time help finding resources or chat with our compassionate care team. And then through our long-standing partnership with Avesis, we are continually assessing innovative ways to improve member health outcomes. In the middle of 2021 we worked with Avesis to implement SDOH screenings for members who call into the Avesis contact center. And we will get into some of those statistics over the next three slides here.

So this is Unitas. You will see, Unitas we had a total number of referrals of 615, with unique members referred to 234, and referral resolution of 46.8 percent. So members that participate in this integrated community-based -- or this integrated model with Unitas is a close-loop referral network, including all types of social service agencies. Enrollee referrals for integrated services for physical health, behavioral health, SDOH are triggered through multiple sources. There are no limitations on how enrollees' referrals are triggered. An example of that is our HRA assessment, which

we attempted to complete 100 percent of enrollees within 30 calendar days of eligibility. One reason you might see this lower resolution rate here could be duplicate referrals or being unable to reach members.

So as I mentioned, in collaboration with the Avesis we're getting those SDOH referrals for members. We didn't implement this until mid-2021. We have received 11 SDOH referrals in 2021 from Avesis and 408 in 2022, with the top category of needs being transportation, food security, and access to quality services, which typically means oral health needs not covered under their benefit.

And then just to give you some statistics around our Pyx Health partnership. This went live in January of this year, and we are very excited about it. All members 18 and over are eligible to enroll in the platform. However, we have some specific populations that we target, and that is recent EDM patient utilizers, high needs, as identified by our HRA or HRQ, and then pregnant or recently delivered members. In total we have 155 members who have onboarded.

Pyx also completes some different, various screenings. One of those is our depression screening, the PHQ4. We have had 14 members complete that to date and 124 members complete the UCLA3 screening, which is the loneliness screening, 28.6 percent of those of which have identified SDOH need.

And then the last slide here is just, again, kind of going back to from providers what we can do outside of, you know, the Z codes and, you know, screening their own patients. Anytime you identify needs for your members, those referrals can be sent over to our population health management team or one of our care management teams, depending on if it is a Sky member or traditional Medicaid member. And that's it. Any questions?

DR. PETREY: Thank you. Garth, I believe you are still muted.

DR. BOBROWSKI: Sorry about that. I got a tickle in my throat, so I muted myself.

So I was starting to make a note there about the referrals that were resolved,

and it was at 46.8 percent. And I was just looking at what steps that you all may be taking to increase that number. But I noticed one of the answers was that you all had a hard time reaching back with the members.

But do not all of the members get free phones anymore? Or do they just choose not to answer the phone if they see your number? Or do you know what is going on there? Do they just not call back or...

MS. MOERER: Yeah. It really could just be a combination of those things. You know, members just tend to be difficult to reach. I know that Unitas makes three attempts over an allotted time to make that outreach. And a lot of times, yeah, we are just not getting those either returned voicemails or being able to make contact, you know, maybe we are calling at a bad time. I know our CHW's are working to make some of those additional contacts out in the communities and sometimes, you know, they are more available at various hours and can kind of reconnect the member, you know, once we

circle back with them.

DR. BOBROWSKI: Any other questions?

(No response)

DR. BOBROWSKI: If you all notice, in your chat section at the bottom of your screen Ms. Erin has asked that everybody that gives a report, if you could e-mail or forward those on to Erin Bickers. And it is @ky.gov. But it is down on the chat, if you want to get the exact lettering for sending these reports in.

All right. Let's go with Humana.

MS. MOWDER: Hi. This is Kristan Mowder. I'm the Director of Population Health Strategy for Humana. I am going to be presenting, so let me share my screen.

Okay. Can you guys see my presentation?

DR. BOBROWSKI: Uh-huh. Yeah.

MS. MOWDER: All right. So is this in the presentation mode or is it in the -- can you see where it says "the slides"?

UNIDENTIFIED SPEAKER: We can see both slides at once, one big and one little.

MS. MOWDER: Okay. Let me see if I can fix that.

So the first thing I want to talk about is our population health programs. So in addition to our care management program we have a whole population health team. And, so, I was just going to kind of go through what the different aspects of that team is. So we have SDOH coordinators. And those coordinators work independently to work with the members and also support our case management team on addressing the social determinants of health and promote that prevention and health education. And while we are doing that, they address the dental needs of the member as well. They may help with finding a provider or working with case management, if it is more in-depth that they need more support on.

One of our next ones is our workforce development. So we have an employment coach that works with members who are having issues with finding stable employment. So they will work with them on, you know, coaching, resumé, all kinds of

different things.

The next program we have is our housing assistance. So we have a housing specialist that supports our members to find housing, to keep safe and stable housing, and assist them with eviction aversion services and things like that.

And then we also have our community health workers. So they do some of the same things that our SDOH coordinators do. But they also do have a hands-on approach. So they can go out in the community and meet with the members and help them navigate through the system and go to appointments with them and different things like that to help address their SDOH needs and things like that.

So some of those things that they do when they are working with the member is they also do the PRAPARE, that you heard about earlier in one of the previous presentations, that, you know, kind of assesses for the SDOH needs. And then on top of that we do a preventative screening. We do that with our adult and pediatric

populations. And in that preventative screening there are a couple of questions that do talk about the dental health. So the questions are: Have you seen your dentist in the last six months? And then what problems or concerns with your mouth, teeth, or ability to swallow have you had or did you have? So those are just kind of a couple of examples of some of the questions that they ask. In our case management program they also ask questions around dental health as well.

All right. So the next slide is to kind of talk about our comprehensive care support model. And so, as you can see, we have our care management and our enrollees in this, in the middle. And then you have your whole support of our case management, our community health workers, our medical directors, our housing specialists, our pharmacists. And then on the other side you have all of the community supports. And we work as a team, a peer model team, like it kind of says in the title, to try to pull all those pieces together and to support the

whole member for all of their needs.

And then the last thing is, we just wanted to give a success story around our population health team. So we had a referral for a 63-year-old member who was referred to our housing specialist by our case management team who was having some issues. The member was on a limited income and had some health concerns. So some of the barriers of not having sufficient income to pay for needed repairs to their house, to make it habitable, inability to pay for utility bills due to the fixed income. So the intervention, the housing specialist assisted the member for searching for different community resources that could assist the member to repair -- with their home repairs and financial assistance on the backpay of the utility bills. The member stated that he didn't want to lose his home, it was going to be the cold weather, was struggling, had high gas bills, all of those kinds of things. So the member was on a fixed income, like we talked about, in a dental rural area and was having problems finding that, these resources.

So the results. The housing specialist was able to work with the member, locate resources and obtain a $9,660 grant that helped with the home repairs. Due to the roof repairs being completed, the member was able to remain in their home. This process took about a year to complete. But ultimately some of the other repairs were not completed due to the COVID pandemic. But the member also received assistance in paying for those utility bills and got caught up with those.

So that is just, kind of like, an overview of our population health program. I will open it up if anyone has any questions.

(No response)

MS. MOWDER: All right. Well, thank you.

DR. BOBROWSKI: Thank you all. And I want to thank everyone that made a presentation today and at our last TAC meeting. I know it takes a lot of time and effort to put these things together. And, again, I want to say thank you for a job well

done. It kind of helps give us TAC members, you know, some other broader scope of what you do and, you know, the factors that are social determinants; that all plays together.

Dr. John Gray, did you finally get on? He said he did. But...

DR. PETREY: He was on. He was driving, Garth, but he was on. I don't see him now.

DR. BOBROWSKI: Okay. Let's see. I'm getting a buzz on my phone. Let me see here. He just put the letter Y on there. Let me...

Okay. He just texted me. He said he is on.

MS. BICKERS: Can you ask him to turn on his camera, please.

DR. BOBROWSKI: Okay. He said it is not working. Okay. I am just going to see if he can get on here in a minute.

And I have not heard -- I know I did talk with Dr. Julie McKee, and she was not going to be able to be on our meeting today. And the report that she was working on is not quite ready, you know, for

distribution yet. But she was not able to be on here to give us any kind of brief summary.

Is there any other old business that we need to bring up?

(No response)

DR. BOBROWSKI: I've got one item that -- and, boy, I hate to have to admit that I think I made a mistake, or I failed to finish up on something. I had a note to send a -- some of this -- it was a long motion that we made the last time. And I don't know if I ever -- I was asked to send this to Ms. Sharley. And I don't know if I did or not. I would have to look that back up. But I'm thinking I did not send that to her.

But do I send that to Ms. Erin now or who do I send this to?

MS. BICKERS: Yes.

DR. BOBROWSKI: It was a motion.

MS. BICKERS: You would send stuff to me.

DR. BOBROWSKI: Okay.

MS. BICKERS: Are you talking about MAC recommendations or just questions in general?

DR. BOBROWSKI: The one we had was for DMS, some reports. And I think I messed up; I hate to admit that, but I did.

Anyway, I can send that to you, Ms. Erin, if that will be okay.

MS. BICKERS: Yes, sir. Send it to me and I will follow-up.

DR. BOBROWSKI: All right. I got the note there. I even put a sticky note on it to flag that rascal.

Well, let's go on to new business. I will just -- and I know a couple of things that are -- I wanted to just talk briefly about, you know, Medicaid fees and reimbursements. And I've gotten several -- some data.

This is talking about the general fund receipts from April are generally up from last year. But my main first question is, is -- and this might be -- go to Angie. I am not sure who to direct this to.

But, just, does the Cabinet for Health and Family Services, do they go to the Legislature or do they go to the Administration and ask for any additional

funding or how does that work?

MS. PARKER: Lee, do you want to take this one on?

MS. GUICE: Sure. Hello. It is Lee Guice from Policy & Operations in Medicaid. Just give me a second. I will put my face on camera so you can see. Oh. There we go. And I have to turn the camera on versus the mute button.

So the process is, each individual department within the Cabinet works with the Cabinet's budget office, and they put together a budget request from the Cabinet that includes all the departments. So, like, the Office of Inspector General and the Department for Health and the Department for Behavioral Health, et cetera, Medicaid is included in that. Then we have -- that information goes to the Governor's office. And our budget is part of the Governor's budget request because we are part of the Executive Branch. The Governor's budget request then is worked on. And every Cabinet submits their budget request, and I'm sure everybody else does.

So then the Governor's office works on their budget bill, what they are going to request from the Legislature. Then the Legislature -- the Governor submits that budget to the Legislature. And then I think that you saw recently the Legislature has to go through several steps. And then they pass the budget.

Does that answer your question, sir?

DR. BOBROWSKI: Yes. That helped a lot. I just didn't know the mechanism and that even if you all were allowed to have input into that budget making process. So thank you very much. I appreciate that.

MS. GUICE: You are welcome.

DR. BOBROWSKI: What I have got here, this is from May the 10th, on General Funds Report. It said there was an 80 percent increase of revenue since -- over last April. And it was mostly from individual income tax. And this is a -- I am not an economist or an accountant. But it just -- I don't know how all of this -- I'm just going to read some of this. But...

The 16.4 percent year-to-date growth rate exceeds the 7.2 percent budgeted growth rate for the current fiscal year. Sales and use tax, even though they fell for the month, they are still -- for April they were still recording the third highest month ever. Corporate income, limited liability entity tax, LLET, some of you all will know what that is, and it continued to be strong and increasing at 29.7 percent. Individual income tax collections grew by 80.7 percent. Let's see here. The motor vehicle use tax collections fell 18 percent but are still on pace to be one of the second best fiscal years ever.

So, you know, we just -- and sometimes when we talk to legislators about, you know, the funding for Medicaid, well, they -- I just keep hearing, well, we don't have any money. We don't have any money. Well, these reports that I am getting tell us different. And I don't know if, you know, we are not pushing the right buttons or not getting the right help. But I know, you know, dentistry hasn't had a fee update

except for a few months ago on eight codes, you know, for 2002. That's 20 years ago. And a lot of dental offices are just -- I mean, I'm getting a lot of phone calls and text messages of how they are struggling. And I know the reports show that you may be getting some more members to get on-line. But then I hear a lot of members are limiting their access to care. And I guess this is the thing I worry about, is access to care.

Here's a report from the State of Virginia. The State of Virginia used to be one of the top Medicaid. I mean, that was the go-to place to look for Medicaid, how to do it, how to get reimbursements. And now they are 48th out of 50 in their Medicaid status. Here, this is a good one. The issue in this, they were 16 years without an increase in reimbursement rates. Virginia's Medicaid Smiles For Children program has gone from a national leader to one of the programs with the lowest participation rate in the country with reimbursements and participation well below neighboring states. And they even mentioned Kentucky, that, well, they are even

-- you know, now they are even below Kentucky and West Virginia, Delaware, and Washington, DC. I mentioned they were 48th out of 50.

But I'm just -- what I was looking at was, what kind of incentives are out there for a Medicaid -- for a dentist to want to become a provider? And another question is, and whoever from the State can help me answer this or give me some guidance, and I don't know if some of you all were at one of our meetings six years ago or seven years ago, I asked the same question: What carrots are out there for the dentist to continue?

And John just texted me, Dr. Gray, that they have lost two front office staff in two weeks. A dentist up in Campbellsville texted me yesterday, said, "Do you know of any assistants out there that can help us? My hygienist is off for shoulder repair. And we have put -- two or three weeks ago we have put ads out there, have not gotten the first bite of somebody to come in and help us." So staffing is becoming a real issue.

And I know I'm supposed to be

talking about Medicaid fee and reimbursements, but I was talking with somebody this morning about the -- earlier about the perfect storm of problems. But let me find the ADA booklet here.

DR. PETREY: Garth, while you are looking at that, I think it is also -- I mean, we consistently talk about in 2002 -- the only change since 2002 being a reduction in fees, let alone an increase. And during the pandemic, obviously we had the added costs for PPE and those issues. We understand that that is out of the control of everyone because it is a global pandemic. And that's been exacerbated by not only inflation but also targeted inflation. I'm sure in your office, we have seen it in ours and in the dentists that we discuss it with, a box of gloves going from $4.29 to $19 and change for a single box of gloves. When you are looking at a 300, 400, in some cases 500 percent increase in material costs and, yet, we have practitioners out there that are treating this population but they are doing so on the margin. As we see that, we see

practices, and John's is one of them, that it is becoming budget negative to try to continue to treat with the current fees.

Beyond that, to ask any new providers to join is not -- is quite a challenge to do. But as the whirlwind of not only added costs with pandemic issues but now the inflationary costs and all of dental -- and, frankly, all of medical spending makes it even more challenging for all of the practitioners to be able to continue at this pace and to continue with the cases. We are overwhelmed with patients. But we are under whelmed with the ability to cover those patients with the reimbursement that we have.

DR. BOBROWSKI: Thank you, Dr. Joe. This is another sheet that I have got here, just that the Governor's budget fully funds the Medicaid program, including the Medicaid expansion. But then here's another one that says, well, they, Medicaid, has extended the reimbursement rates for nursing homes. And I'm the Chairman of our local Health Department. And we did get -- it says, "Substantial funding of $17.7 million for

fiscal year 2023 and 19.1 million for fiscal year 2024 is in the -- intended for the public health transformation."

And I'm on our local Health Board. And, you know, it is like everybody needs some money to keep functioning. And it is, like Dr. Joe said, it is like, what carrots are out there for any dentist to want to be a Medicaid provider knowing that, the costs of what we have got. And I see a lot of these, the reports that were given. There's all kinds of benefits for being on Medicaid, and I don't begrudge anybody for that, you know, and I know the MCO's are making their money, but the dentists are flat going in the hole trying to see the Medicaid population.

Now, here's another issue. I've got a memo from an oral surgeon. And he has actually gone on public media to ask people to quit sending him Facebook messages and Messenger contacts to be bumped up in his list of, you know, trying to get people in earlier. One of the Virginia -- there's a Virginia dental clinic that had a waiting list of over 200. This one oral surgeon said

he has a waiting list of over 400. And he said, "I just" -- he is just asking the public, please quit messaging me on Facebook and Messenger because there's people ahead of you and, you know, he can only -- he is just one man. And he says, "I'm the only oral surgeon in over 100 mile radius. And I can" -- he said, "I can only do so much in a day's time."

So I guess what I was looking at, to summarize this, was access to care and reimbursement rates is the number one complaint that I get from dentists and their dental offices on just making ends meet. And I wish we could work together with, you know, the Administration and the folks at the Cabinet, you know, on seeing what we can do to get some better reimbursements. And I just heard that Indiana just got a fee update. Virginia is looking at that. I've got some papers here on Georgia.

MR. COLEMAN: Dr. Bobrowski?

DR. BOBROWSKI: Yes.

MR. COLEMAN: Dr. Bobrowski, let me chime in. This is Ronnie Coleman from

Benevis. We support Ruby Dental.

So you may recall that during the last legislative session we tried to work with Senator Alvarado to encourage a policy change that would have allowed Medicaid to draw down more money so that they could increase Medicaid dental rates. Unfortunately, the bill passed out of the Senate Health Committee but stalled in the Appropriations Committee. Allegedly it was only going to cost, like, $5 to $7 million. And he said it would be, like, a 70 to 80 percent match. And, unfortunately, the Legislature didn't see fit to do that.

But from what I understand, and I heard this from people within the Legislature and elsewhere, that that is literally something that can be done by the Cabinet. You don't have to pass legislation for that. So that's one thing we tried to do to try to be proactive to see if you could increase rates.

But to build on what Dr. Bobrowski was saying, I'm responsible for a bunch of states. I was literally -- I just got back

from Maryland about three or four hours ago. I was in a similar meeting to this one yesterday where we had a lot of Medicaid interest, the providers, advocacy community and so on, for a good reason, because we are trying to figure out how we are going to spend $20 million that the Governor, Governor Hogan, put in his budget to increase rates. They have not increased rates there significantly for, I don't know, it has been 10 years. But this year they were able to pass the creation of an adult Medicaid dental benefit, which you already have. And separately they put $20 million in the budget, which is mainly due to the efforts of myself and a few others, to increase rates. And, so, what we are looking at there is, do we focus on some key rates or do we do it across the board? But they are making an effort.

Indiana has not. Indiana is in a position where they are probably going to have to significantly increase dental rates next year. Because when they created their adult program, they reimbursed for adult

dentistry 30 percent more than for kids. They do that for physician services, too. I don't remember what they did to get providers to participate years ago. I don't know how CMS approved that, but now CMS says they are out of compliance. And to fix it, what I'm hearing from people in the know, is that ultimately this year the state is going to have to submit a plan that is likely going to raise, significantly raise reimbursement rates for the kids program. They are going to have to. I mean, the Legislature is going to have to pass it next year. So there is going to be something there.

Virginia, as Dr. Bobrowski mentioned, is way behind. They have not seen a rate increase since 2005. And we had a lot of support there from the Department and one of the Chambers for a 30 percent increase. But, unfortunately, the new house majority and the new governor, they decided to squash the 30 percent increase recommendation, drop it to 5. But it doesn't even matter because their Legislature still hasn't decided on a budget. They adjourned a month and a half,

two months ago and they are still squabbling about what their budget is going to look like. So we don't know what is going to happen.

But I will say, in Georgia, another sort of conservative state, this year we were able to get 15 codes increased by 7 percent and 2 extraction codes by 10. And what is special about Georgia is, they are set up a lot like yours, where the MCO's run everything and they contract with their dental benefit administrators. And they, the dental benefit -- or I should say the MCO's take money off of that fee-for-service reimbursement, just like in Kentucky. Well, the positive is, every year the Legislature considers some kind of rate increase from the dentists. It can be anywhere from 1 percent on, like, 10 codes to 3 percent, like last year, on about 15 codes, this year 7 percent. And that money, when it is passed, flows through. So they are doing something every year to try to help their dental providers.

And I'm just amazed that Kentucky has done literally -- well, I am not going to

say that. Obviously, I'm very thankful for what Avesis did in terms of their advocacy with their MCO's to increase rates on those eight codes last year. So thank you very much. But as Dr. Joe was just saying, I mean, the costs that our practices are incurring are staggering. I mean, I looked at some of the numbers. The workforce costs are up, supply costs are up, rent and leasing is up, everything is up. Patient show rates, still the same. But we are busy, but we are losing staff. I think our staffing is down 50 percent or more in our four offices in Kentucky because we cannot afford to compete for talent with people who are not, you know, completely -- who are commercial-oriented dentists. We are mostly Medicaid.

And, so, I'm I guess asking, and I'm sure this is what Dr. Bobrowski is doing, what is Medicaid thinking about? What are you going to do to try to support your Medicaid dental providers? I understand not wanting to, you know, increase rates every two or three years. But it has been literally, what, 20 years.

DR. BOBROWSKI: Twenty years.

MR. COLEMAN: Twenty years. Not counting, of course, the thing that Avesis was able to put through last year, which was helpful. But in the whole scheme of things, you know, it is just not enough. And, so, do you have any answers, folks from Medicaid?

MS. GUICE: I'm afraid I don't have any answers for you. Right now, certainly not. Make a recommendation, you know, and talk about some of your ideas about what you would like to see and we can take it to leadership and to the MAC and see what we can come up with.

I hear you. I hear you. And I think everybody at Medicaid does hear you. I would, Mr. Coleman, I would ask some of those people who are telling you that the Legislature doesn't have to pass anything for us to have a larger draw, to ask what they mean. What is the authority for that? Because that was my understanding. Now, I am not a budget person and I don't know all of the in's and out's. But my understanding was that it is the Legislature that holds that

key for us, about how much we can draw down; the appropriations amount I think is the right wording for that. So perhaps you can ask for that. You know, what do they mean we can draw down more money without even asking for legislative authority? It is our understanding that the Legislature is the appropriations branch of government, and they are the ones who make the appropriations. So we have certain limitations that we have to deal with.

MR. COLEMAN: That is a good point. And what I will say with this, the people that I spoke with, what they said was, it didn't have to be initiated by the Legislature. It could have been something initiated by the Governor's office, by the Department. And, so, typically -- and I don't necessarily know how well the Administration gets along with the Legislature there. But I do know that oftentimes when things start in the Governor's budget they have a better chance of passing through. I know that's not -- again, that is not always the case. But I

think that is what they were talking about, was that it didn't have to be led by the Legislature. It could have been led by the Administration. So that, hopefully, will answer your question.

As far as suggestions going forward, I mean, I'm sure Dr. Bobrowski and his team can come together on some ideas for codes that need significant attention, whatever. I'm sure if he takes it to the MAC they will agree, yeah, something needs to happen. But then what happens from there? Where does it go after that?

MS. GUICE: The Department -- okay. So let's just say that the Dental TAC makes a recommendation to the MAC to give a 10 percent rate increase over all dental codes beginning, and pick some date, okay? We will do a fiscal impact on that and see if there is any money in the budget and see where that can -- whether -- you know, we would come back to the MAC and say, okay, that will cost, you know, whatever it would cost. And there would be a discussion about it. If there is no money in the budget to do

it, then we would talk to the MAC about that. The Commissioner would speak to the MAC about that, about how to, you know, make those requests.

They can't -- when I talked earlier about how we make our budget requests, we don't go to the Governor and say, "We have to have this." We send our budget request to the Secretary. The Secretary works with all of the Cabinet's budget. And they send all the budget requests over to the Governor's office along with all of the other Cabinets and their budget requests. The Governor comes up with a budget and submits that to the Legislature. The Legislature is the one who makes the decision about what is passed in the budget.

Our Governor is a Democrat. Both legislative houses are Republicans. They managed to override most of the vetoes that the Governor issued this year. So I think, you know, those are just facts. And that's all I can tell you about the facts. And very little -- I know that I can talk about budgeting all day long, but I don't really

know very much more than what I have just said to you. So if you have specific questions that you want to talk about, we can try to make sure that someone from our budget office comes to the meeting. If you can put some questions in writing that you would like to know, they can be prepared to come and talk to you about something.

I'm sorry that I can't offer you anything else, than that. And that is my dog moaning, not me.

DR. BOBROWSKI: Well, thank you so much, Lee. Sometimes, you know, we -- even though we have been on the TAC or around this for a few years, sometimes we still don't understand the full, you know, flow of things.

And, but, I just want to -- you know, I keep bringing up this access to care. Yesterday I had a lady call our office, you know, from Bowling Green. And depending on what part of Bowling Green she lives in, I'm probably a good hour, hour and a half drive. And she said, "I can't get in. I'm hurting. I can't get in anywhere," said,

"I could get in July the 16th." Now, would you want to have a toothache until July the 16th? So we told her, I said, "Well, load up and come on." And then I got a text from another MD late yesterday afternoon. "One of his nurses from another county texted me. Would you be able to see somebody tomorrow?" Well, technically I'm off today because I've scheduled these meetings, several meetings and had this TAC meeting scheduled this afternoon. I said, "Well, get down here, you know, 7:30 or just as soon as you can this morning and we will see what we can do for you." Like I said, I didn't really have assistants or anybody here, but the office was open, but my other -- my son, who is a dentist, but they had their staff and their patients already booked up. But, anyway, I went ahead and saw her. But she said, "I can't get in anywhere in two counties," around where she was from. And, you know, this -- she's a nurse that works at this other MD office. And the MD, you know, texted me. So I said, "Well, just come on." So we got her in this morning. But I'm just

telling you, there is an access to care problem across the state. And I don't know. We will just have to keep plugging at this.

And maybe the TAC can come up with some ideas and have some -- you know, again, it will be, you know, three months or so before we can make an official vote on anything. But we will just see what we can bring to the TAC, the TAC can bring to the -- make the recommendations and vote on that and then it will go to the MAC. But we are just kind of looking for some advice and some help.

But, you know, the access to care is getting very problematic with general dentists and oral surgeons. And just a lot of offices are having the added problem of staffing. So it is just a report out there.

So I'm going to move on to other new business.

DR. PETREY: Garth, before you do, can I piggyback on that?

DR. BOBROWSKI: Yes.

DR. PETREY: And just to say that one of our top referrers in our Somerset

office is in Bowling Green as well. And they drive an hour past you to come to me.

DR. BOBROWSKI: Yeah.

DR. PETREY: So they have got an over two hour drive to come to me because no one is accepting them with Medicaid. And as you know, orthodontics is one of the most highly controlled aspects of the Medicaid plan. We only see the worst of the worst conditions. And these folks are driving from Bowling Green to see us. So that access to care is -- you know, my heart is in Eastern Kentucky because that is where I'm from, that's where two or our three offices are. But it is spread from East to West with an access to care issue.

On top of that, though, John is on the call here. Do we have a quorum with the three of us?

DR. BOBROWSKI: I think, Ms. Lee or Angie correct me, if he's not on video --

DR. PETREY: He is on video, Garth.

DR. BOBROWSKI: Is he on?

DR. PETREY: Yeah.

DR. BOBROWSKI: Okay. All right.

DR. PETREY: But the question that I have is, Ms. Guice, that, you know, I have been on this TAC and I have been attending TAC meetings, I can't tell you how many years now before I was actually on the committee itself, and I have obviously an inability to keep my mouth shut and I apologize to everybody for that, but what was said I think is one of the most important things that has been said by you today in what this TAC can do and, that is, if we have a quorum I would suggest we make a motion to request a 10 percent increase in dental fees across the board to the MAC from DMS. And if we have a quorum, I would like to see if we can get that motion passed. Because as we all know, these governmental motions are slower than steering the Titanic, with good reason. But if we wait, then we are waiting more. So I would make that motion now.

DR. BOBROWSKI: Do I need to go back and establish a quorum or can I just say that, well, since Dr. John Gray is on here now we do have a quorum?

MS. BICKERS: He is not showing in

the populated sixth screen. Mr. Coleman, can you turn your camera off.

DR. PETREY: He is "Johnsipad."

MS. BICKERS: Yes, sir. But I can't --

DR. PETREY: He is wearing a blue shirt and sunglasses. If you can scroll to the right, you can see him.

MS. BICKERS: I do see him. However, I do have to have all three of you on camera at the same time in the screen. So let me see if I can hide, because I removed mine. Let's see here.

(Technology administered to)

DR. GRAY: Can you hear me now?

MS. BICKERS: Yes. We can see all three of you. Thank you.

DR. BOBROWSKI: Thank you, John. Dr. Petrey made a motion that -- we do have a -- we do have a quorum. So we have got that established.

But Dr. Joe Petrey has made a motion to increase all dental fees across the board 10 percent. Now --

DR. GRAY: Discussion?

DR. BOBROWSKI: -- I will second the motion. And now we have got discussion.

DR. GRAY: If we had a 100 percent increase across the board, just, we would be at less than 50 percent reimbursement rate. And 10 percent, you know, for our practice I don't know that that's even a stopgap amount. Maybe it is all what you get. Maybe it would help someone somewhere. But we're losing money every time we see a patient for one, two, three extractions. Every single time we are paying to treat the patients. And we can't -- everyone wants $15, $17 an hour when they walk in the door for -- we just -- we cannot continue with a 10 percent increase, 20 percent increase. We are so far behind this that it is going to end up there is going to be absolutely no care. You talked about driving two hours. I've had patients this week from the West Virginia border, Ohio border, Tennessee border, and Illinois/Missouri border from Paducah, Kentucky because nobody else will see them.

Ten percent, we would be glad to have 10 percent, better than nothing. But it

is a joke to even suggest anything less than 100 percent. That's all I have to say.

DR. BOBROWSKI: Well, John, if you wanted to amend the motion or Dr. Joe could allow a friendly amendment to your motion of a different percentage.

DR. PETREY: Well, continuing in discussion I would -- I would -- I absolutely wholeheartedly agree with you, Dr. Gray. But I do think that any motion that is at 100 percent or more is going to fall on deaf ears. And I feel like we need to consider what is reasonable and realistic. I don't know that 10 percent will even be heard. But I am -- certainly would be willing to increase the requested amount. Part of my goal is to see what can come back from DMS from a study evaluating what change that would make.

But continuing discussion, what would you all be acceptable with, more than 10, less than 100, to take to the MAC as a request?

DR. GRAY: I think that's a question for Medicaid and the social

services. We are expanding. The Governor has expanded Medicaid services by providing more services, but the ones we're having are inadequately funded. So...

DR. BOBROWSKI: Yeah.

DR. GRAY: I think you are right, there is no way they will do 100 percent. I'm open to anything.

DR. BOBROWSKI: Well, why don't we just put in the motion, then, of I would say 30 or 35 percent. And even at that, that's, like I say, a lot -- I've just gotten letters from all of our dental suppliers. They would not even put it in their letters how much they are going to increase their costs to us. I got a letter from our laboratories for dentures and stuff that, you know, the fees from the laboratories are going up, and some of those were in the 15 to 25 percent range.

And just to go back on the Passport-Molina, I know you all had the service of making the dentures and it was $350 -- or $700 for a full set. One of our lab people told us, he says, "I will not even make one of those dentures." He said, "They

are of such poor quality, such cheap teeth that they won't even hold up." He says, "I won't even make them. If a doctor asks me to make them, I won't even make them." So, you know, you get what you pay for.

But I would entertain at least to go up to 30 percent, John.

DR. GRAY: Thirty percent, Garth, on a $40 procedure is $1.20. You know, I will go for 30. And I'm sure I won't be asked to unmute again.

DR. BOBROWSKI: Dr. Joe?

DR. PETREY: I'm with you, John. And I'm fine if we want to go to 100 percent and let DMS' calculations show what is and what is not acceptable. I would love Ms. Guice's input on that as well. Because if our feeling is, if you shoot for the moon and you -- or shoot for the stars and end up on the moon, you are a heck of a lot better than where you are. But my only worry is, if you shoot for the stars, you never leave the launch pad, that is the worry that I have with going at such a high rate.

Dr. Guice, would you have a comment

on that?

MS. GUICE: It is just Lee, okay? I don't -- you make the recommendation at the level you feel is appropriate. And our budget and our financial folks will do an estimate based on what your request is. It is not that -- the amount at this point in time. It was my understanding that what we needed to do for every provider group, because believe me it is not just the dentists or the orthodontists who are asking for more money, and it is incumbent upon us to let you know that we get a dollar and we spend that whole dollar and we try to spend it, you know, with good stewardship to provide the best care for everybody that we can. And, so, that's why talking about going to the Legislature and asking them to appropriate more money or to appropriate money specifically for dentists would be another way to go.

Because if the Legislature tells us to do something and they fund it, then we will do it. So I don't think that we would ignore you if you asked for a 500 percent

increase. But there might be some eyebrows raised at that point in time, simply because. Otherwise, you ask for what you think that you need and we will do a fiscal impact on it. If you want to see what the cost might be, you can always go ask for a couple of different, I wouldn't, you know, go 10, 20, 30, 40, all the way up to 100. But you might ask for what the fiscal impact would be for a couple of different percentages and include 100, if that's Dr. -- is it Dr. Gray? Yeah.

DR. GRAY: It is Dr. Gray, Lee.

MS. GUICE: Yeah.

DR. GRAY: And one more quick question. Has there been any other group, hospital, pharmacy, nursing homes, any others, social work, any other thing that is under DMS that has not had a raise since 2002? Are we the only ones?

MS. GUICE: No, sir. Physicians. The physicians fee schedule has not been updated since 1996.

DR. BOBROWSKI: And that physician that called me or texted me yesterday, they told me the same thing. "Our fees are so low

we can't hardly keep, you know, doing this." But it is like you used the reference to the -- that you get a dollar and you have a good steward and you spend it wisely. Our problem is, is that our costs have gone up so high that we may get a dollar but it costs us $2 or $3 to provide the service.

MS. GUICE: Yes, sir. I understand about the costs rising. Because I, too, live in the world. And, so...

DR. BOBROWSKI: Okay. Good.

MS. GUICE: Yes. So I'm with you there.

DR. BOBROWSKI: Okay.

MS. GUICE: And I hear you. It is just that it is not possible for me to say, "Well, yes, we would be happy to and we will be able to increase your fees." I'm just trying to give you some ideas and some thoughts about ways to go about finding out what it would cost, how much it would cost, and what you can ask for and how you can ask for it. And certainly I want the MCO representatives to hear that.

MR. COLEMAN: Lee, I have a quick

question. Do you know if the physicians get the full fee-for-service schedule reimbursement, like what you have printed on your schedule, or do the MCO's take from them as well?

MS. GUICE: I am not privy to what anybody is paid by the MCO's. Sorry.

MS. PARKER: The contract -- this is Angie with Medicaid. The contracts with the MCO's are negotiated separately. We do not get involved in contract negotiations between the provider and the MCO.

DR. PETREY: John, as a point, you may want to look at what oral surgery alone has been. Because the 2002 date is an important one. But I do not believe the orthodontics has been changed since 1984. And I am not sure that oral surgery got much change in 2002.

DR. GRAY: Whatever you want to put in, let's put it in. And I'm fine with, you know, maybe starting at 50. Let's start at 50 and make a recommendation and see if we get any traction. I am not sure of the differences in orthodontics and dentistry as

opposed to physicians, because they don't have to buy supplies. And probably 50 percent of our overhead is supplies that we have to buy, increases, and we have to use. So we are in a highly competitive area in terms of supplies on one end, which are going up astronomically, and controlled rate on the other, which is quite different than a lot of other things, hospitals. We are all suffering. Everybody is underpaid with what is going on with this massive inflation.

So I would say, let's ask for 50 percent, if that works for you, and see where we go.

DR. PETREY: Dr. Bobrowski?

DR. BOBROWSKI: Yes.

DR. PETREY: I would agree to amend the motion to a 50 percent increase.

DR. BOBROWSKI: Okay. Any other discussion on that?

(No response)

DR. BOBROWSKI: All in favor say "Aye."

(Aye)

DR. BOBROWSKI: And no opposed. It

will be unanimous. So we will pass that on to the MAC. And then we can see what the MCO's can come up with and the State. And we will just try to keep this going. Like I said, it is just getting to the point of access to care and being able to, you know, financially stay open because of staff turnover.

I guess, let's see, Monday night I got a text of a dental office in Elizabethtown just had to shut the whole office down, can't get staff. So it is a real problem out here just to stay alive out here. But, okay, anything else on fees and reimbursements?

DR. PETREY: No. I would just add that I hope -- I know the people on this call understand it. But I don't know beyond the folks on this call how much they understand that this system is on the verge. When we have some of the best practices in the state, one of them in Somerset, that takes a tremendous amount of care in their patients, is now telling patients they cannot schedule them, they can call in the morning to see if

there is an opening because they cannot schedule because they are overrun, it is -- we are on the verge of collapse with this. And I know it is everywhere. But I think that -- I appreciate everyone taking the time every three months to have a discussion that seems to be a lot of the same discussion over and over, but I'm very pleased that we are putting forward this to the MAC because I think it is probably the best thing in the last decade that I have seen come out of what we have tried to do.

DR. BOBROWSKI: Thank you, Dr. Petrey.

I'm going to move on to Other New Business. And I had a note from the last meeting that Ms. Parker was going to present a focused study done through DMS, the external review organization, on social determinants.

And, Ms. Angie, I know I had that in my notes and I did not ask you for a report or even if you had one ready earlier. And I will just ask you now. Do you want to do that at the next meeting?

MS. PARKER: Well, I think, I will have to go back and check, but I believe I sent that to Erin the last meeting, but I will double-check that to share. If not, then yes, please, I will go through it the next meeting.

DR. BOBROWSKI: Okay.

MS. BICKERS: And I will double-check my records that that was sent out. And I will re-send it, just to make sure you got it.

DR. BOBROWSKI: Okay.

MS. PARKER: And, Erin, make sure I sent it to you.

MS. BICKERS: Yes, ma'am.

MS. PARKER: Thank you.

DR. BOBROWSKI: Under new business, again are you all prepared yet to give us any information on the new program that we got some e-mails about this week? It is the basic health program and how it concerns dental. And I did send in a list of questions, and I printed off what we got on the e-mail the other day. But I still had a few other questions. But is there anybody

that is able to talk about that program at this point? Because it is due to launch in November and the effective date will be January the 1st of next year.

MS. GUICE: Yes, sir.

MS. PARKER: Yes, sir.

MS. GUICE: Go ahead, Angie.

MS. PARKER: I can speak, too, on a very high level. And pretty much what you received is what it is all about. It is kind of a bridge between Medicaid and what you would call a qualified health plan, the marketplace. And for those people who will not be eligible for Medicaid but fall into that 138 FPL to 200 percent would be eligible to apply for the basic health plan.

And we are looking, meeting with issuers, which are also called MCO's, to see who will be offering this at that time. Yes, we are working fast and furious and ensuring that we can get this program up and running for personnel to get enrolled. That's it on a very high level.

I do have some -- I did receive your questions. The questions that you sent

in the e-mail box does go to me.

DR. BOBROWSKI: Okay.

MS. PARKER: And I will be sending those questions back to you once we finalize the answers.

DR. BOBROWSKI: Okay. That's fine. I just thought, well, since we have got our TAC members here it might be good to, you know, give them an overview. I'm sure they got the same letter I did. But just I didn't know if you had anything new that was not on the sheet just yet. So...

MS. PARKER: Not really.

DR. BOBROWSKI: Okay.

MS. PARKER: Now, if you have any other questions that -- while I'm here. I may not be able to answer them, but I can certainly get them to you.

DR. BOBROWSKI: One of the questions was: Do you at all know that -- does this have to go through the Department of Insurance for Kentucky or is it just totally DMS, CMS, or?

MS. PARKER: That's a very good question. The Department of Insurance,

because it is -- would be -- have some involvement with the oversight of the managed care portion of this. This is not what you would call a -- it is kind of a hybrid between a Medicaid and a qualified health plan. It follows more rules from a qualified health plan than it would Medicaid.

DR. BOBROWSKI: Okay.

MS. PARKER: So there won't be a fee schedule, like there is with Medicaid. You would be contracting specifically with the MCO, also known as an issuer, which you will probably see that word, "issuer," a lot more than "MCO."

DR. BOBROWSKI: Do you know, will they be offering some type of knowledge on what their reimbursement will be before they sign up a contract or?

MS. PARKER: Well, that will be between you and the issuer on what you agreed to contractually.

DR. BOBROWSKI: Can you answer this? If you can't, just say no.

MS. PARKER: I will.

DR. BOBROWSKI: Just, do you know

which MCO's or are there other new MCO's that are going to be involved or?

MS. PARKER: Well, at this point it has not been finalized which ones. There have been a couple that have said that they will not at this point. But it doesn't go through the RFP process like it does for Medicaid MCO's.

DR. BOBROWSKI: Okay. Are there any other questions on the basic health program?

(No response)

DR. BOBROWSKI: All right. Is there any other new business to come before the TAC today?

(No response)

DR. BOBROWSKI: Hearing none --

MS. BICKERS: Dr. Bobrowski?

DR. BOBROWSKI: Yes, yes.

MS. BICKERS: Since you have your quorum, did you approve your February minutes yet?

DR. BOBROWSKI: Oh. Yes, we need to have a motion and a second, then, to approve the minutes from the February 11th

meeting.

DR. PETREY: I can make a motion to approve the minutes from the February 11th meeting.

DR. BOBROWSKI: Okay. Thank you.

DR. GRAY: I second the motion.

DR. BOBROWSKI: All in favor say "Aye."

(Aye)

DR. BOBROWSKI: Thank you. All right. That passes there, so we've got that done.

And I want to thank our TAC members for -- I know sometimes it is difficult with all of the other stuff going on in our offices and our lives, that I appreciate you all taking the time to get on our TAC meeting today.

The MAC -- well, the next two things. At the next MAC meeting, I've already made arrangements and plans to attend this. It is May the 26th at 10 a.m. Eastern Time. So I'm planning on attending that. The MAC recommendation, we voted on that a few minutes ago, so I will be bringing that

before the MAC on May the 26th.

Any other questions or comments about the MAC?

(No response)

DR. BOBROWSKI: Hearing none, our next meeting will be August the 12th. Again it is a Friday afternoon. And I will bet you it will be 92 degrees and sunny and we will all want to be kayaking down the river.

But is there any other business or anything we need else to bring up at this meeting?

MS. ALLEN: Dr. Bobrowski, this is Nicole. If I could just ask one quick question, please.

DR. BOBROWSKI: Yes.

MS. ALLEN: In regards to future meetings, do you anticipate that any will be in-person, just in an attempt to try to prepare for travel arrangements if necessary?

DR. BOBROWSKI: At the last meeting we voted to carry on this year's meeting as a Zoom.

MS. ALLEN: Perfect.

DR. BOBROWSKI: And then,

hopefully, then we will have a meeting there in November. And then we can, I guess, take a vote at that time to, you know, see what we are going to do starting in February or at the next meeting. So we will have three months of time between the November and the February meeting to help with time for those travel arrangements.

MS. ALLEN: Perfect.

DR. BOBROWSKI: So if that is okay.

DR. PETREY: Can I make a motion that we travel to wherever Nicole's background is, because that's where we need to have this next meeting.

MS. ALLEN: I wish I was there.

DR. BOBROWSKI: Yeah, I saw that a while ago. All right.

MS. ALLEN: Thank you.

DR. BOBROWSKI: You're welcome. Thank you.

And, again, I want to thank everybody for being on the Zoom call today and appreciate your attendance and comments. And anytime somebody needs to speak up, we will just -- try to let me know.

And there's one more little button showing on the chat thing here. Okay. I will e-mail the recommendations prior to the MAC meeting. I will get that done. So we will do that. So, all right.

MS. ALLEN: I'm sorry, Dr. Bobrowski, I did have one other thing. There was a question at the beginning of the call regarding the provider relations representatives. I do have a list of all of the representatives with Avesis. We are staffed, so I will forward that over to Erin so she can get that over to everyone.

DR. BOBROWSKI: Okay. Thank you.

DR. PETREY: Nicole, thank you. I found out today that we have been contacted in our office.

MS. ALLEN: Great.

DR. PETREY: And I really appreciate having an actual contact. So it is great to have somebody in that position. So thank you.

MS. ALLEN: You're welcome.

DR. BOBROWSKI: All right. We will adjourn this meeting at this time. Thanks,

everybody, for coming.

(Proceedings concluded at 4 p.m.)

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C E R T I F I C A T E

I, LISA COLSTON, Federal Certified Realtime Reporter and Registered Professional Reporter, hereby certify that the foregoing record represents the original record of the Dental 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 16th day of May, 2022.

/s/ Lisa Colston

Lisa Colston, FCRR, RPR