COMMONWEALTH OF KENTUCKY

CABINET FOR HEALTH AND FAMILY SERVICES

FOR MEDICAID SERVICES

IN RE: DENTAL TAC

HELD VIA ZOOM

DATE:

MAY 10, 2024

2:00 P.M.

A T T E N D E E S:

Garth Bobrowski, DMD, Chairman

Joe Petrey, DMD

Carol Jean Braun, DMD

(and many more were on ZOOM)

May 10, 2024

2:00 p.m.

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DR. BOBROWSKI: Do we have a quorum?

MS. BICKERS: I saw yourself, Joe and Carol log in, so that should give you a quorum.

DR. BOBROWSKI: I saw we had Joe, okay. Well, hello. I want to thank you first and I want to welcome everyone to the Medicaid Dental TAC Meeting. I sent out the agenda the other day and I noticed a typo, but we will get to it later. It may not be any big significance on that. But we'll do the roll call.

Let's see. Dr. Petrey?

DR. PETREY: Here.

DR. BOBROWSKI: Dr. Braun?

DR. BRAUN: Here.

DR. BOBROWSKI: And this is Garth Bobrowski and I'm here.

Dr. Gray? I hadn't seen him in the picture docket yet.

MS. BICKERS: I haven't seen him come in yet.

DR. BOBROWSKI: Okay. Well, we've got a

quorum so we'll get started. And we will have the approval of the minutes from the last meeting from February the 9th, '24.

DR. PETREY: Make a motion to approve the minutes.

MS. BRAUN: Second.

DR. BOBROWSKI: All in favor say Aye.

(All Members vote "Aye".)

DR. BOBROWSKI: And those are approved. Thanks, Everyone.

And before we get into our official meeting here, I wanted to say congratulations to Nicole Allen. She has received a promotion and today is going to be her last day with our Kentucky TAC meeting, so we want to congratulate her. She's been working with us for nine years and we appreciate all that -- Nicole, all that you have done, you know, for the Medicaid population and for helping with our TAC.

And the other thing, I want to wish all the ladies and the moms a Happy Mother's Day this weekend. I can't think of a greater, more significant title than Mom.

So congratulations to all you moms out there. I hope you have a great and wonderful day.

We've got a pretty full agenda, so I'm going to move on to Old Business. I just wanted to bring up -- we talked a little bit about it before -- I guess it's a DMS rule on -- it's changed a little over the years from, you know, if somebody breaks off a front tooth, and you fix it and they might be a bruxer or -- and, see, in years past on the adults we could not -- Medicaid did not cover a bite guard, and they did not cover crowns. So, you know, sometimes these folks or bruxers would break these off again. Well, my question is does this become a non-covered service that the patient then would have to be paid for -- that they would pay for, or according to the wording of a 20140, it calls that we can do an anterior resin filling code to get paid for that service, but there's really no clear definition on that. And I didn't know if anybody from DMS had an answer to that one yet or -- and some of these -- there's going

to be a lot of questions today. We may not have time for answers, but we'll -- if we don't, we'll bring it up at the next meeting. But I didn't know if anybody had any ideas on how to cover that or what code to use. So anybody got any ideas?

MS. MADRAS: Hi, this is Ashley Madras with Kentucky Medicaid.

So when we went over the Dental TAC agenda, we weren't really sure which code was being talked about on that certain question. So what I will have to do is I'll have to take that back to management and ask them how to -- is the code that you are wanting to know about is that 20140? Is that the one that you are wanting to specifically know about?

DR. BOBROWSKI: Well, that's an option because the -- but the other qualifier is, is that on the filling codes it's got a wording in there that it will pay for a filling on the same tooth once a year. Well, and a lot of our folks have got -- they've got fillings on top of fillings. And, you know, we were just wondering how

can the dentist do this service. And it might be 11 months, it lacks one month being a year since that tooth was fixed, and well they, you know, had a sucker in their mouth and broke it off, bit on a piece of candy and broke it off or chipped it. I guess if we smoothed it for that time being, we would turn in a 911 because it was cutting their lip or their tongue. But I was just kind of wanting to see if we could get that one cleared up for our dental providers out there.

But, yeah, that will be fine if you want to bring some information back to the next meeting. That's fine.

MS. MADRAS: And any questions that you have today, just if you have any specific codes or examples or claims that you would like us to look at, they told me just to have you e-mail it to that division of healthcare policy e-mail. That way we can research it better for you guys.

DR. BOBROWSKI: Okay. Do you have that e-mail address?

MS. MADRAS: Yes. I can put it in the chat

for you.

DR. BOBROWSKI: Okay, thanks.

MS. MADRAS: You're welcome.

DR. BOBROWSKI: Another thing we were looking at was -- I was kind of going back on some questions that we had had in the past, is just like the utilization reports on adult root planning. And we've gotten some folks that, you know, they were denied, and I didn't -- and I apologize on my end of it. I didn't ask the dentist more details. Well, did they give you a reason why that was denied or -- because, you know, most usually, I mean, it's either they didn't have enough qualifying periodontal pocket numbers, or the X-rays were not adequate to show either bone loss or tarter. So I need -- when dentists call me about issues, or text me about it, I need to do a little bit more investigative work myself, so that it's more clear so that I can ask the appropriate question and get it to the appropriate department. But that was one of the codes that we were looking at was -- and I appreciate DMS and

Commissioner Lee for the work that they are doing on getting a few more of these periodontal disease codes in there. And I know once before I had mentioned to the Commissioner, said, well, let us treat the disease. Let us help people. And I think that's coming around.

Now, the tie-in question with that was -- and this is not aimed at any, you know, one person, group or MCO, but what can we as a TAC or as a group look at streamlining prior authorizations. They -- according to the paperwork and spreadsheet that's on the DMS website, like for dentures it doesn't call for a prior authorization on dentures or partial dentures, but it is required through the MCOs. So, you know, just that little bit of differences there and, you know, and I know -- and on some of those we are required to send in a Panorex; some of them we are not.

And the other one -- there was a new code that was added in, the D -- let me pull it up here -- 4346, and we appreciate that. That's one that can really help a lot of

people, the D4346. The only thing that I noticed on it, that it requires a prior authorization. Now, I'll give you an example. It doesn't happen real often, but periodically we'll have folks that come in, I mean, they are sick. They are running a fever. They can't hardly open their mouth. They can't eat. They can't drink. But they're in -- their gums are so infected -- and, again, because of lack of brushing, flossing, and dental cleanings typically -- and a lot of times we just got to start them with antibiotics and have them come back anyway. But now there's times when some of those folks, they just need to be numbed and scaled, cleaned, get that stuff out from under their gums. But then we've got -- according to this, I've got to reschedule them and get the prior authorization done and then have them come back. So that means it's two appointments that these folks have got to -- potentially have to take off work again. But, I mean, such is life, you know, even with the medical doctor sometimes we got to go see what the problem is and come

back and treat it. But I just wanted to give you that example of, you know, why -- why do we need to have a prior authorization.

Now, does any TAC member or MCO have any comments on that?

DR. RICH: Yeah, Garth, this is Dr. Rich with United Healthcare. With UHC you can submit the prior authorization information with the claim, and if it qualifies we will pay the claim regardless of whether the prior authorization was done in advance or not.

DR. BOBROWSKI: Okay.

MS. MEDINA: Yeah, and this is Christina with DentaQuest. Pretty much the same, you know. For those type of cases we'll do the review as part of the claims payment, under prepayment review, so it doesn't necessarily -- you know, we don't want to be obstruction to care. There's no need to have to reschedule the member, have them come in. You know, some of those cases, they need to be addressed at that point, so there's allowances for that.

DR. BOBROWSKI: Okay.

DR. CAUDILL: Garth, this is Jerry. We're the same. We have always had the policy that if it's an urgent situation, emergent situation, and you feel you can't wait for a prior authorization, you can go ahead and do the treatment and send us a post-review, you know, with the same information required for the prior auth so we can adjudicate it.

DR. BOBROWSKI: Okay. Well, thank you-all. That's -- you know, when you just -- because this was a new code that was added in recently. I think this was updated on March 28th, I believe, of this year, and I noticed that prior authorization required, so, you know, that's a good point. I appreciate you-all working on that with the dentists and helping our patients just, you know, get some treatment. And you dentists know what ANUG is, acute necrotizing ulcerative gingivitis, and you just hope you never get that in your mouth.

And we just received today the -- and, Erin, thank you for you and your team to --

they got us these dental codes. And I'm sure probably the TAC members haven't had a chance to look at those fully yet. But we appreciate your all's work on getting that together. And we may comment on that after we have had time to review them. But does any TAC Member have any comments on that so far, or the prior authorizations, or anything like that?

Okay. Then I know I'm talking about rules and sometimes generalities, but if a full mouth X-ray series is done within a year we are not really going to get paid if we have to do another X-ray, you know, if they got a new trauma or new toothache. But it says we can get a PA when we use the D0140 code. Is that correct? Would we get paid for that PA even though the other rule says that once you get a full mouth X-ray series, we are not paying for any more X-rays for a year. So is anybody from DMS that can answer that one?

MS. MADRAS: This is Ashley again. I'm not sure on that. That one, again, I'll have to take back to management and we will have

to research that one as well.

DR. BOBROWSKI: Okay. That's fine, and thank you.

I tell you sometimes folks will come in, we'll do our exam, cleaning, they come in, they got a mouth full of old fillings, big fillings, and, you know, three months later they come in with a swelling, and, I mean, you just have to get an X-ray. But my point in all of this is, is that I think we get $7.25, so, I mean, it's not like that we are -- $10.00 for the first X-ray and 7.50 for the second.

But dentistry is -- and I'll explain this as we go through today. We're just getting hammered with the high costs. Our supplies have just gone out the roof. And I'll talk a little bit more about this after while, but a lot of folks are having staffing issues. And sometimes it just feels like that we are getting nickeled and dimed to death and Medicaid practices are really struggling, you know, to make ends meet.

Okay. Let's move -- is there any

other Old Business? Any TAC Members remember any Old Business that we need to bring up?

MS. ROEHRIG: Dr. Bobrowski, this is Rachael Roehrig with DMS. I put something in the chat, but I wasn't sure if you were able to see it. For the Old Business item on the follow-up questions, we had sent previously the top 15 used dental procedures and codes based on paid amounts and based on utilization. So we have those already, but we would be happy to do another data request to get that specific utilization report for the second one on the adult root planning. So we can take that back and get that information.

If you wouldn't mind to send Erin the exact codes that you want pulled, then that will just make it a lot easier, if possible.

DR. BOBROWSKI: I'm making a note right now. Yes, thank you. Yeah, that root planing and there's those other things. I'll try to get you -- I made myself a note to send those codes. Make a note here.

Okay. And we appreciate the research

that you-all do to help us figure out things. It kind of helps in planning or helps the TAC maybe make some suggestions and just helping providers give care.

Now, is there any other Old Business?

DR. CAUDILL: Garth?

DR. BOBROWSKI: Yes.

DR. CAUDILL: On your previous question about X-rays I put something in the chat that we go back from the KAR Regulations that shows that even if you've taken a full mouth series, if you need to take additional ones later on for a root canal or oral surgery, or you can show medical necessity like something got broke along the way, absolutely we can cover those.

DR. BOBROWSKI: Okay.

DR. CAUDILL: It's in the chat now.

DR. BOBROWSKI: Okay.

MS. MEDINA: And that is pretty much true, Dr. Bobrowski, I think for all codes, right, if there's a certain limitation or guide, that's usually the general rule of thumb, that, you know, if something is medically necessary, for the most part we

have to factor that in, and there's always exceptions, you know, going above limitations or outside of age ranges, and whatnot, to accommodate those type of situations.

DR. BOBROWSKI: Okay. Because that was kind of what -- I don't think I wrote it on the agenda, but I made a note to myself here that, you know, a lot of times we've got to show diagnostic -- the X-rays are for diagnostic purposes and for proof of medical necessity. And I believe that's what you-all are talking about is, like, well, yeah, sometimes you just got to get another picture and, you know, to help you make your diagnosis or to see if -- so many of these folks got such large fillings that, well, you don't know, well, is it this tooth or the one beside it, because sometimes the swollen bump is right in the middle of two of them. So that's why we do need X-rays. But, okay, thank you so much.

All right. We are going to move on to New Business.

DR. PETREY: Garth, I'm sorry, just clarify

one thing on X-rays.
DR. BOBROWSKI: Yes.
MR. MATTINGLY: And it's a horse that's been -- that's been beat to death years ago, but I continue to get questions about from an orthodontics perspective. I have -- we have worked under the understanding that we are -- the Panorex taken in the initial exam is inside of our records. Any Panorex taken after that, though, are -- we cannot and do not bill for those. Is that still the understanding? We -- obviously, we take radiographs throughout treatment of active canines, evaluating wisdom teeth, and more specifically evaluating root resorption. But the single initial exam X-ray is really the only one that -- until our final records that is -- whether they are taken or not, that is a covered service. Is that correct still?
DR. BOBROWSKI: That's the way I understand it, Joe, is that you take that initial X-ray, like that Panorex, and that's your one for two years. Now, I think even

though you may have a Panorex, the way I read the scripture is that within 12 months if you needed to take a PA, you know, like where you're moving the canine down, now they would still cover for the PA. Now, can any of the MCOs or DMS respond to that and how that's handled on your end?

DR. PETREY: I know Jerry was part of helping us figure this out years ago, because the number of orthodontists that had recoupments on X-rays that had been billed for. But I still continue to get the question of patients that are in retention, that are no longer in treatment that have radiographs by an orthodontist, we are under the understanding that we are -- that is a non-billable service or should not be billed by the orthodontist.

In our practice we don't do it anyway because we don't want to use the patient's benefit that might be needed in a general practice, but it is a -- it's a sticking question with a number of practices.

DR. CAUDILL: Joe, if I can kind of go back to those years ago when we were working on

this with Dr. Rich, who is the dental director at DMS. It was kind of like working linked radiographs on root canals. They said, well, that's part of doing the treatment, and they considered anything during the treatment to be I can inclusive. However, I don't personally remember saying that two years or three years later you couldn't take a Panorex.

DR. BOBROWSKI: That's kind of what I was looking at.

DR. PETREY: I'll pass that along -- I was just going to say, I'll pass that along. I just -- we still just take them and don't bill, and I think that's how we will continue to do so, but I -- I know that there are -- that's been a sticking point. So thank you for that clarification.

DR. CAUDILL: And if anybody has a problem, you know my phone number.

DR. BOBROWSKI: Okay. Thank you-all. We are going to move to New Business. And I just want to thank the folks that have -- the TAC and MAC. They have a member orientation packet that they have produced,

and I really don't know exactly who to thank for that, but I think that's a -- I don't know who worked on it, but that's a great idea to work on, and that way as we get new members, we are -- the KDA, Kentucky Dental Association, is working on a replacement for Dr. Phil Shuler. So hopefully when we get that person selected, we can get them one of these orientation packets and that will kind of help bring them up to speed.

But does anybody from DMS want to comment on those orientation packets?

MS. BICKERS: Dr. Bobrowski, this is Erin. That was all Kelli. I glanced at it, made a few recommendations, but she put a lot of work into that, and that was a recommendation, excuse me, from the Consumer Rights TAC.

DR. BOBROWSKI: Well, thank you, Kelly, for putting all that together. I think that will be a great addition to getting folks on board and up to speed.

MS. BICKERS: I will pass that along to her. She's on the beach this week.

DR. BOBROWSKI: Oh, that lucky little girl, I tell you what.

The second item under New Business is the dental codes were updated on March the 28th. And I just wanted to put a thank you in there that glad to see these additional codes to treat gum disease, and that way us general dentists and stuff, we are not accused of supervised neglect. But, you know, sometimes we tell patients, well, that's just not covered, you know, you will have to cover it yourself if you want it done, and I guess that's -- you know, what we've always told them. But now we are glad to see that some of these other codes are being added in.

Now, and I just listed the main five there that were added in. But I did have a couple questions on some of those. The D3120, it's called an indirect pulp cap. Now, again, it has a prior authorization required, and my question is why, because usually we don't know if it's going to really get close to the nerve or not. Yes, sometimes we can see our X-rays and we can

say, yeah, that's a big one, but sometimes it doesn't require an indirect pulp cap. But do you know why they added the words preauthorization required? And I guess I'll direct this to DMS.

MS. MADRAS: Hi, this is Ashley again. That was the directive given to me when we added the code to have a prior authorization, but that is something, again, that I can take back to management. And if you can send us, you know, just, again, a specific example of how that code would be used and, you know, reasons why we wouldn't need the prior authorization on it, that would probably help us as well.

DR. BOBROWSKI: Okay. So noted. Got it.

Now, another question on that same code is, like, why is there such a disparity in the fee ranges? Because, I mean, I'm glad to see the fee on there, because some of the things -- a lot of the things we do are so low that it's harder to recruit, you know, some of the younger dentists to accept Medicaid. But the -- kind of the cousin code to that is the D3100, is for a direct

pulp cap, which pays $17.00. And a direct pulp cap means if, you know, you are cleaning out a cavity and, boy, that cavity just barely nicks that nerve, that they may have not been in a lot of pain yet, but the cavity was that deep, and we can put some -- a medicated treatment on that and then put our filling in. But I was just wondering why there's such a fee disparity. So I'll add that into my notes, Ashley.

MS. MADRAS: Yeah. I will tell you some of those codes we had problems finding other states that paid for a lot of these codes, so we had to look at private insurance companies to get prices as well to get the average. So that could very well be affecting the price as well.

DR. BOBROWSKI: Okay. Well, and then see that was another thing, that since you have added the -- and I'll try to write all this up, but I may not get it done this weekend because I've got to mow my yard this weekend and let it dry up so I won't get mired up in the mud.

But anyway, the other one, question I

had on that was the D3100 is listed, and it's always been listed for children only. But since the indirect pulp cap was listed for children and adults, that maybe we could get that changed for -- to add the adults on the D3100 code, just to make it uniform across the board to just help us, you know, treat our patients.

The other code was the D4346, was the scaling in the presence of inflammation, and that's all I'll send -- I think the question on that one was -- we talked about that one a minute ago about the prior authorization. I'll make a note.

DR. CAUDILL: Hey, Garth.

DR. BOBROWSKI: Yes, sir.

DR. CAUDILL: Was your question that you wanted the 3110 -- 3110 covered for adults also?

DR. BOBROWSKI: For adults covered, yes.

DR. CAUDILL: Right, 3110. Okay.

DR. BOBROWSKI: Yes. Yeah. Those are things that -- I mean, they don't happen on every patient we treat, but it happens often enough that, boy, sometimes if you

could just treat it -- and I know I've told you-all before, I know I've got some -- at least two groups of patients in our area that are traumatic brain injury patients, and I know there's just no way they can come up with the cash to pay for some of these treatments, and I was just trying to get a more uniform across the board.

Now, the -- and then this is one that I think we had talked before about, the 6110 and 6111, the implant supported dentures. I think that's good to add that. The non IV conscious sedation, just having your anesthesia permit required. But I did have one other one, and I forgot to put that on our list, was the D0180, and which is a periodontal exam, and those do -- they take a lot of time to do them, I think, and do them correct, chart recession, gum pockets. But in the DMS website it does not show any criteria on how to properly bill for that. I know I personally have billed for it a couple of times and it did not get paid. So I was just wondering, well, what criteria do we use to get that done, so I'll -- Ashley,

I'll try to send that one in also. That way that can be looked at.

Dental TAC Members, are there any other questions or comments on any of those new codes? Hearing none -- and, again, this will go -- this question will go to the -- to DMS and to the MCOs.

Of course, most everybody is aware of the Change Health computer hack, and now correct me if I'm wrong, but I had heard that they got hacked a second time and that I think they wound up paying right around 22 million dollars to get their stuff back or access back to their records, and my question was how has this affected the fee for service and MCO payments and EOBs. And I made a note that if each MCO wants to give a response back to us, because this is really affecting the dental offices. If want to start with DentaQuest, if you want to comment, or if you don't, that's okay. But if you don't want to say anything right now, just say pass, and we will go on to another one.

MS. MEDINA: So on -- I think from our

perspective we haven't really seen any type of delays, you know. We -- particularly -- now that's not to say the providers aren't impacted. They go through different clearinghouses before they come to us. So I think the delay is happening before it reaches kind of our organization. So we have been able to kind of process everything timely and within our normal cadence.

Now, understanding that, you know, there was a lot of kind of, you know, challenges put forth for, you know, across the country. We did put out some education materials on some resources possibly, you know, for providers to be able to submit directly through us, you know, as an end-term solution until some of those things got cleared up.

DR. BOBROWSKI: Okay. And Passport?

MS. MARCUM: Hello, this is Becky with Passport. Just a high overview. Molina responded swiftly to CHC incident to limit the impact to the provider community. The clearinghouse options -- providers

utilizing CHC can submit claims to Molina prior to the outage may now do so alternate establish connections with the SSI Claimsnet LLC Clearinghouse or another clearinghouse of their choice. The provider portal, which is Availity Assistance Provider Portal Solution was not impacted by this outage and remains available as another option for the claim submissions. The provider payments -- Molina has established a direct connection with ECHO, a CHC partner, to resume provider payments for processing. ECHO has not been impacted by this outage. Payments have resumed and will be processed in the order it was received.

DR. BOBROWSKI: Okay. Thank you-all.

United Healthcare?

DR. RICH: Dr. Bobrowski, I show alternative methods of payments either using the portal or other exchange systems were used in the meantime by many providers. It didn't affect our system directly. Obviously, it depends on which exchange the provider was using at the

time. But everything is back online. I don't know the exact amount of money that was spent on resolving the problem, but the information that you presented earlier, I'm fairly certain was not correct being the -- about the 22 million. But I will tell you that United Healthcare spent over a billion dollars reestablishing the system and putting it back together, and then also put out more than three billion in loans to providers to help them stand between the -- while the service was down.

DR. BOBROWSKI: Okay. Thank you.

WellCare?

DR. OWEN: Good afternoon, Dr. Bobrowski. This is Stuart Owen. So, first of all, paper payments and virtual credit card not affected at all. Certainly to what others have said, we tried to help providers use other clearinghouses and platforms. A key one that we connected folks with was Availity. And so we had assistance to expedite providers to be able to enroll with Availity to use that platform. That's what we tried to steer people to.

DR. BOBROWSKI: Okay. Thank you, Stuart.
MR. OWEN: Sure.
DR. BOBROWSKI: Humana?
MS. GRAY: Hi, this is Kim Gray with Avesis. I can speak on behalf of Humana and Aetna. So Avesis did act swiftly to the CHC incidents that occurred at the end of February. We are accepting claims via paper, as well as through various clearinghouses including DentalXchange or Vyne for electronic claims submission, and we also accept claims through -- directly through our portal. We are currently making payment via paper and EFT, and EOBs are available for download on our portal. Notification did go out to the provider community at the end of February, around the February 26 time period.
DR. BOBROWSKI: Okay. I want to thank you.
Any TAC Members have questions or comments?
I know some of those -- let me make one more note. So a lot of those we can go to the portals. I've had some dentists say, well, they were afraid to, you know, get

some treatments started on, you know, root canals or dentures or something, because they just -- we were having so much trouble getting -- either getting paid, or if they did get a check, it's like, well, which accounts do these go on, or did they deny payment. That would probably be the worst scenario, if did go ahead and do treatment and for some reason it didn't get covered. So thank you-all for those comments. It looks like everybody is on top of that.

And I've got another question, and I guess this will -- well, this will be for DMS or for the MCOs. Now, this one happened to me. I had a lady, you know, come in for new dentures, and I think she had had some immediates several years ago or something and now has Medicaid, but she understands that, you know, the Medicaid dentures are not the -- you know, I guess you'd call it the premium dentures. But anyway, she asked me about it. She said, I would like to get a premium style denture and she offered to pay the difference between, you know, what Medicaid pays and what the premium denture

is. Now, since it involves a payment, I know Medicaid has a form that for anything that is not covered by Medicaid or like this difference here, they sign it that they agree to this price, and we -- we just go. We do it.

Now, I told her, well, I don't know really what Medicaid will do on this. The first time we have ever really had anybody ask. But I'll tell you, I know one of the labs we use, they told me, said, now, Dr. Garth, we are not going to -- some of these cheap dentures -- even the lab said we are not going to do those because they don't want their name on it. And it's the same thing. I mean, it's just the -- on some items of the expansion codes that the payment is -- is quite a bit less than what a -- like a premium denture would be. I'll use that as an example again. But our lab said -- or one of the ones we use, he said I'm just not going to go there with that style denture.

So then sometimes you're trying to do these treatments and it gets to really

sometimes your labs are limited on -- you got to go hunting a lab that will do these 4A -- or I guess sometimes we just say, well, you've got to go to one of those places that's a denture mill and you go in at 8:00 in the morning and you come out at 4:00 and you get your dentures. And then those denture patients come to me and they say now what can we do, because they are just so cheaply made that they are just not holding up.

But can anybody from MCO standpoint or from DMS standpoint, can you help give us some guidance on that?

MS. BICKERS: Dr. Bobrowski, I'll take that back to the policy department.

DR. BOBROWSKI: Okay.

MR. OWEN: I was going to say -- this is Stuart with WellCare. I mean, generally if something's not covered by Medicaid, then the member basically has to give written consent to the provider that they agree to pay for it if it's not covered. This is a little bit of a gray area.

DR. BOBROWSKI: Right.

MR. OWEN: The denture is covered, but she wants a better one.

DR. BOBROWSKI: Right.

DR. CAUDILL: It's usually an aesthetics thing. They want the more natural-looking teeth. So it's more aesthetics is what it is.

DR. BOBROWSKI: Well, and then the other thing is it's like the quality of the actual teeth that go in the denture, the cheap ones they just -- it's just like buying a 29.95 tire versus a $99.00 tire. The $99.00 ones typically last longer. So by using a better quality teeth, those patients are going to get a little -- hopefully going to get a little longer-lasting denture, because they wear down, they get so flat they are just mashing their food, not chewing their food. So that was kind of another, I guess, a point of information on those that just the quality of the dentures -- but I'll send that to DMS there and...

DR. RICH: Hey, Garth, this is Dr. Rich. I think the problem that we are running into

here is the fee is not -- you know, the fee is what it is, right. And the code is what it is. There is only one denture code. There's an upper denture code and a lower denture code. There's not a premium denture code and a mid-level denture code and a low denture code. There's one denture code and there's one fee associated with it. If it's a commercial insurance, they pay one fee. You can't -- you don't get to change your fee depending on what kind of denture the patient wants. Your fee is the same. And I totally understand and appreciate what you're saying. You know, it's like, hey, we want to make better dentures for these people, but we can't afford to. They would like to pay for a better denture. You can't afford to. You can't make the procedure dependent on the patient paying partial, part of the -- that's not the way Medicaid works, you know. And that's the place we are stuck in here. And so I totally appreciate and I know you are trying to do the best for the patient and everything else, but I think we

ought to come up with a way to resolve -- the initial problem is how do we address the fee itself and what do we want -- what does Medicaid want to provide for the patient. If this is the denture that we are seeing everybody in the state gets, that's the one you get and I don't think there's another choice, you know. It's like that's what the state said they are going to cover. That's what they cover. If you want something else, that's on you. This is what -- I don't know. You know, there's a lot -- there's a lot of, you know, opinions and thoughts on this, but really in the end it's one code, it's one fee, and if you get down to the black and white, you know, you can't charge -- you know, just because you want to shine the amalgam more, you can't say, hey, I'm going to make this one extra shiny if you'd like it, but it's going to cost you another 20 bucks. You can't do that. So it's the same thing with -- you know, you got to have the same rules, everything, or it doesn't work out.

So, you know, like I said, I totally appreciate it, but until we -- we got to fix it universally. We can't do this piecemeal thing together. And I think we are all going to stumble until we figure out a way to come up with a universal fix. And partial payments, or making one procedure that's not covered required for a patient to have a procedure that is covered, that doesn't work either. You know, that's not the way Medicaid is designed to work. So, I don't know, I'm with you on this, and you -- we want a solution that works for the patient. It's not just a service that's there that's not functional or really doesn't benefit the patient, because we are spinning our wheels. So, you know, but I think we need to address the fact that there's just one denture code, and no matter how you do it, you know, if you work with an insurance company or if you work with Medicaid or if you work with Medicare, one fee is assigned to that code and you can't balance bill. That's just always been, I know -- unless CMS changes the rules, you

are not going to be able to balance bill. Enough of me rambling, but thank you.

DR. BOBROWSKI: But, see, that's what I mean, that's a good point, you know, because there is one fee and typically that fee that Medicaid covers is really not a fee for, you know, IPM teeth and, you know, the best teeth out there. You know, some of those IPM teeth are, you know, a little bit less than what the whole thing that Medicaid covers on those. But that's a good point, too. So, anyway, we'll send it back to the policy department.

But I told that lady, really, that's probably about the first time I've had that asked to me, but it was one of my patients, and I said, well, I'll just ask at our next meeting and see what they say on it. So I'll get this sent to you-all quickly here.

Now, here's where my typo was on that -- the previous agenda I sent out. It's the PIP Program, or Performance Improvement Project, for children's dental visits, topical fluoride, sealants. And I wanted to put that on the agenda today

because it's so new for us the TAC Members, that all this is just -- is just brand new for us, and I wanted to make sure that the TAC Members knew what was going on with this.

Let me see. I've got some information, but -- and we probably don't have to spend a lot of time on this, but just wanted to -- it's a state I-Prof Focus Study on children's oral health, and it's called the Performance Improvement Project, PIP, and it's going to be for the years '24 and '25, so it's a two-year project. It comes through the Quality of Care Department that reaches out and works with the MCOs, kind of looking at increasing the rates of topical fluoride application for children ages one to four, using the dental code D1206, or the physicians code, and an oral evaluation, dental services for under age 21, and for sealants for the age group of six to nine, dental sealants for the age group of 10 to 14.

But I believe, and somebody correct me if I'm wrong. I can look it up here, too.

But I was believing that as long as they are 20 and under, we could still apply sealants to the children or teenagers' teeth. Now, there's another section of this, is that there's a dental provider access on focus counties from the focus study, and it listed, oh, about four or five counties in Kentucky that just had limited provider access, and that there may be other counties out there that have a disparity in provider access. And some of this was related to a provider within 50 miles of the member's county. And they are going to use this to educate primary care physicians and their staff on how to apply fluoride varnish in the medical setting, but I wanted to bring that up so that other TAC Members -- TAC Members, I'm just kind of getting information on this just recently, and I know we haven't had a chance to talk about it, but I wanted to start letting you-all know about it, that the MCOs are working on this. And, again, part of this is just to, you know, try to move the needle into better oral health for our Kentucky patients.

Now, any TAC Member got any questions so far?

DR. PETREY: I just want to say thank for sending the link there. That's helpful. Thank you.

DR. McKEE: Dr. Bobrowski, it's Julie McKee.

DR. BOBROWSKI: Yes, Dr. Julie.

DR. McKEE: I just have a couple of comments here. I've been working with these people on trying to get these projects off the ground and I appreciate their inclusion for me. The sealants -- the targeted sealants six to nine and 10 to 14, those are actually national standards that we can benchmark ourselves with. Yes, you can put sealants on any kid at any time until they age out of Medicaid as a pediatric patient. But we really try to work with providers to get those sealants on when the teeth are erupting at those ages, so that's why they are kind of divided up.

DR. BOBROWSKI: Okay.

DR. McKEE: Now, we are not doing a real

good job of it, thus the Performance Project, because according to more recent Medicaid data for Kentucky, that these children at the optimum ages of six to nine, 10 to 14, only between 11 and 13 percent of any eligible patient is getting one sealant, and it could -- it should be more than that and that's what they are trying to do. Also, I really commend them trying to reach out to the primary care medical community for oral assessments or screenings and varnish application. They can -- I've offered to train their physicians, and I've got a presentation; I can do that at any time. But they can also provide to their providers an online course called Smiles For Life. And what that does is that teaches non-dental health professionals how to do an oral assessment, why to do it, how to do varnishes effectively, and why to do them. And that should train them enough to apply the varnish for billing. So it's pretty good. And the thing is, is the provider can do that at their own leisure,

the training.

DR. BOBROWSKI: I'm making a couple notes there. Well, yes, and thank you, Dr. McKee, on that.

I got a couple of things, and TAC Members please chime in with some ideas or if you think of something, you know, later on or over the weekend or next week, just either get them to me and I'll forward them on to DMS, or you can send them yourself.

But, Dr. McKee, have the focus groups reached out to maybe -- I know it said the primary care physicians' offices and their staff, but what about also the public health departments?

DR. McKEE: The public health departments -- excuse me. I think I must have been talking all week because it's Friday afternoon and my voice is finally wearing down.

The public health departments do tens of thousands of varnishes a year with their clinical patients. Now, they have decreased over the years for a couple of reasons, and one of them is because of the swing of the

pendulum, and that's a whole another hour lecture. But our public health departments are doing less and less hands-on clinical procedures for patients in a clinic. It's become more population based, so we are not seeing even the opportunity to do the varnish, so it is decreasing. But I train nurses all the time and it still happens, but it is decreasing. Once -- and I say a pendulum, because one day soon, not in my professional lifetime, it will swing back where health departments will see patients for clinical care such as well-child examinations, immunizations, family planning, things like that, the hands-on clinicals that they can do. We tried to incorporate varnish into the WIC visit and the HANDS visit, and their curriculums are so tight right now they don't allow that. But we are going to try again soon for that.

Health departments are doing what they are interested in doing. For a varnish just one more hour-long lecture is not considered a core function in health departments. It's optional. Now, is it optional to Julie

McKee? Blankety-blank, no. It should be mandatory. But it's an optional thing. A lot of health departments coming out of Covid have rethought and they have paired down to what they either have to do according to the law and what they get paid enough to do, and they don't get paid enough to do the varnish.

DR. BOBROWSKI: Okay, yeah. Because I know -- I'm on our local health board, and I know, you know, year by year -- I mean, financially, you know, we are okay, but, boy, sometimes you hope the refrigerator or the air conditioner doesn't go out, you know. Sometimes it just runs pretty close. And I told one of the ladies, one of the nurses over at our health department, I said, well, listen, whenever you want to get that one room painted, I said, call me and I will come over and help you move the furniture and help you get that room painted, because for some reason it was painted years ago -- it was painted some kind of brown, and just didn't look very good in a health department. So anyway, I

told her to call me, we'll get this thing painted and done for you.

But, you know, one of the things that we do at our office is -- well, two things for the -- usually for the one to four or five-year-old group, we just call them a fun visit. And we'll tell the parents to bring them in, let us, you know -- you know, just have some fun with the kids. I know one of our daycares here in our county, usually once a year they will bring 30 or 40 kids over. You know, nothing gets billed. We just bring them in and have fun. We just ride them up and down in the chair. Sometimes we will get five or six in one chair. We will -- we kind of squirt water on their hands and then get the little Mr. Slurpy, you know, and let it suck the water out of their hands, so that they start to get used to the noises and the equipment, and let them know that this is not totally dangerous stuff. But we just call ital fun visit.

And then another thing we do is we tell the parents, well, go home and just,

you know, like kids like to play doctor or they like -- I said, well, play dentist. I say get the flashlight out and get a spoon. Kids are used to putting a spoon in their mouth. You know, just let the spoon be your mirror, and just tell the kids, well, we are going to play dentist and the dentist is going to count your teeth, and you help me count them. We are going to look at them and shine a flashlight in there, because that's the term we use when they come in. So I don't know -- those are -- each office has got their way own way of handling little ones, but I think you got to try to make those first visits, you know, fun and enjoyable and educational. And, of course, from those days all the kids, they get to go get in the prize box, you know, and pick out a prize.

But any TAC Members got any questions so far on the Performance Improvement Project?

Okay. Let's see, let me get my other page here. I wanted to get a couple of things just out for DMS and the MCOs. This

comes from the USA Today, Becker's Dental Health Review and the New York Times and the AGD News. These are just some tidbits. Wal-Mart is closing health centers in 51 locations in five states along with their telehealth program, and the reason why is just escalating operational costs and challenging reimbursement environment, is the terms that they used. They are not closing the pharmacies or the vision centers.

Now, some states we are doing kind of a hybrid of, you know, telehealth and hybrid care. And one other tidbit was they were talking about, like, for folks with total hip arthroplasty -- this was a large ten-year study on hip replacements, that they were suggesting to wait one-year postop before they have any invasive dental treatment. And they also say to be sure to take your preventive antibiotics or premeds. But this is a thing that maybe as a TAC, and maybe we could bring this up at the MAC, that, you know, due to these recent studies, that people that are anticipating, you know,

hip, knee replacements, things like that, they may want to get a dental visit in and just make sure that if they got any bad teeth, either get them out or do a root canal, or, you know, be aware of them. It's just, you know, so that they don't have complications while they're recuperating from like a hip replacement.

And then another tidbit was the -- some of the independent pharmacies are really struggling. Now, when they passed the bill through the Kentucky legislature that limited it to one PBM, they commented that, well, this has helped them, but, again, their low reimbursements are making their life challenging. And that just kind of ties in with some of the things that dentists are doing.

And I'll just give you an example out of my office. Two years ago we had to replace the whole suction system, and that was listed at close to $21,000. I had -- about a month and a half ago I had one X-ray unit go down. That's going to be another 5,000 to fix that. About two weeks ago my

air compressor that runs the whole office is going down. And when you live out in the country, you know, you try to buy stuff that's got two or three motors on it, and the pressure that I had was -- did have three motors on it. But these are air compressors that you shouldn't go down to Lowes or the hardware store and just buy a regular air compressor. They usually don't work as good and as well, and to provide quality dental care. But these are specialized air compressors where dental offices -- but they -- I just got my quote in this week and it's another $20,000. So I just want to let you -- it's expensive to run a dental office and, yeah, there's money that comes in, but when you got these kind of expenses -- and these are pieces of equipment that are, you know, 10, 12 years old, and they are already having to be replaced.

Now, let me see. Now, here's another situation that a lot of offices are having, and I'm going to put this down in our Other New Business or our tidbit section, is

that -- this is coming from the ADA's Health Policy Institute and McKinsey & Company, and it just says the numbers are scary. The 34 percent of dental assistants are expected to retire by 2028; 31 percent of dental hygienists are expected to retire by 2028. That's just four years away, folks. And 36,000 is the number of dental workers that United States could be short by 2031. And we definitely need to look at working on things that we can do to help keep our Medicaid, you know, doctors going.

This is just stuff I found out this last two weeks, was that in Kentucky there's a -- one of the pediatric offices that I know about is no longer accepting any new patients. Another one is stopping to see their older teens. Let's see. And I guess that's my point of bringing some of this up, is that, you know, we need to keep working on things that we can keep our doctors in our Medicaid house, and even recruit new doctors.

You know, in my county here -- I know I don't look like it, but I'm going to be 71

this summer. I know I look like 41. But anyway, the other dentists in our county that takes Medicaid, I believe he is 68. And the young ones that are in our county do not accept Medicaid and can't get them to. Part of that, you know, they say is low reimbursements, the paperwork, the prior authorizations, you know, cost of equipment, cost of staff, and the staffing shortages. The debt they got when they get out of school, you know. So those are all things that -- you know, they play it into the factor. So as a Medicaid provider for 44 years, we have just got to keep looking at things that we can do to help providers stay an active provider in their counties.

But any TAC Members have any Other New Business?

DR. BRAUN: This is Carol Braun. I just have one question in particular. About a week ago we received something from Passport regarding prepayment review of some procedures which would be instituted as of June the 1st, and then they underlined that this is not a prior

authorization, but it really sounds like the steps are the same. So has anyone else looked over that or have any concerns about that?

DR. BOBROWSKI: Anyone from Passport or DMS talk about this?

MS. BICKERS: I don't see Jennifer from Program Integrity on, so I can take that back to her and get you guys some clarification.

MS. BRAUN: It's just concerning because it sounds like, okay, prepayment review, it's like you could submit it, they are not going to pay you 'til they review it, which to me is the same as prior authorization. And as a pediatric dentist, the code for stainless crown, D2930, is something that we use really quite frequently. And the other for everyone is on extractions. Well, of course, you are going to have an X-ray. Depending on the child, you may or may not have an X-ray, but it is -- to me I don't get the difference, so that was my concern.

MS. BICKERS: I'll take that back. I was

typing it up. Sorry for the delayed response.

DR. BRAUN: No. Thank you.

DR. BOBROWSKI: Erin, is that you?

MS. BICKERS: Yes, sir.

DR. BOBROWSKI: Okay. Sometimes I'm trying to take notes so that I don't forget something. But, Erin, I hope you are taking notes, too, just to keep up. And I do apologize, sometimes I'm so busy taking my notes own notes again on this, sometimes I don't get the things out of the chat. I'll see it sitting there with the numbers on there. I just haven't had time to write on that.

That was another question. Is there a way that these websites, some of them have got a name on them two miles long. But is there a way that I can get somebody from DMS to just e-mail me those -- that information out of the chat box?

MS. BICKERS: Yes, sir. We always add -- everything that I send, that meeting information e-mail I send you after every meeting, that always has all the chat

information included.
DR. BOBROWSKI: Great, great.
MS. BICKERS: Yeah. I always try to grab all of that. That's why I'm also delayed in responding sometimes, because I'm grabbing chat information or --
DR. BOBROWSKI: Yes.
MS. BICKERS: -- constructing the DMS follow-up e-mail that I also send.
DR. BOBROWSKI: All right. Dr. Braun, did you have anything else?
MS. BRAUN: No. That's all. Thanks.
DR. BOBROWSKI: Or Joe? Okay, thank you.
DR. PETREY: Garth, I would comment on your last statement about simply number of providers. One situation that we are beginning to see really in all of our locations is pediatric dentists being overrun and lowering the age at which they will -- they will continue to treat --
DR. BOBROWSKI: Yes.
DR. PETREY: -- which I completely understand. The issue is that in two of the three areas we don't have providers to take these what become new patients. In

essence, it's a patient who has had care, but then can't find care because they simply aged out of the pediatric dentist. And as we are seeing them through this time period while they are under orthodontic care, or retention, we are having a major struggle with dealing with patients with active decay and simply just not being able to even have a prophy because they have aged out of the pediatric dentist. And our pediatric dentists are working with us, but they have limits to what age that they are able to do to continue to even function, and we have this almost gap of patients that are getting lost because they are not -- older patients that have already been in an active adult practice, or they are -- they are new to the system because they've essentially been dropped from the provider that they had and don't have anybody accepting new patients. It's very challenging.

DR. BOBROWSKI: Yes, and thank you for bringing that up, because that's exactly right. And I know of another pediatric

office that they have done just that. They have lowered their age down to, you know, nine to 12-year-olds and under. So you got that teenage group that's like where do we go. And a lot of offices are not accepting any new Medicaid patients. But it's like -- and, Dr. Joe, it's like on these fillings, like, they -- and I think DMS needs to look at this seriously, is the fee that we are getting paid for a filling. Like a one-surface filling, I noticed that was one on that list was one of the top 15 or top 30 codes that's used. And if we can get those in and get them fixed, that one surface filling will prevent a tooth loss or an abscess or several hundred dollar root canals, several hundred dollar crown, so -- but DMS, I'm just encouraging you to really look at the fee. I mean, you get $38 for an amalgam and $44 for a white filling. I mean, for a lot of offices, you can't -- by the time you pay for your front office staff, one person, you pay for an assistant, $34, you're already in the hole, and that's what we are hearing a lot of

dentists complain about, well, I can't keep working and we want to help people, but I can't go in a hole, or else you don't have any dentists at all.

DR. PETREY: I think, too, it's also -- there's an economic consideration to have there as well, especially these patients that are, in essence being dropped or lose their dental home because they are aging out. There's no doubt in my mind from an economic perspective from what limited funds and limited resources the state has, when that patient is dropped that needs a one-surface restoration and we -- we work to get them into a new dental home, and sometimes that can take six, nine months, that may now turn into a root canal, which we are talking about a root canal, a multi-surface restoration, we are talking about a crown. So the economics of it is that that patient not only has not gotten the care they deserved, but also from the state's perspective, the cost to treat has gone up significantly on that individual because we were not able to get them into

care when they had a minimal treatment, the single surface restoration.

I know that seems -- that seems like, gosh, that happened on Thursday and that's the only time. We are consistently seeing that. And it's a -- and it is especially in this age group of kids that are aging out of the pediatric dentist and there just is not anybody taking them. And the practices that are taking them are so overrun, we are not able to get them into the new dentist for nine months, and that is -- and when they do go they get a cleaning and then back another three, six months to get the restoration. By that time we have a major problem.

DR. BOBROWSKI: Yeah, yeah. And speaking of the two things, the dental homes and the mobile dental units, they do provide some good service, but the problem that we see, and another dentists across the state says the same thing, it's just like, well, we call the mobile unit that went to the school system, and I understand that really helps the parents get the kids checkups and a cleaning. They will send a sheet home

that, well, your child has three cavities, you need to go see your local dentist. Well, then we try to get ahold of them to -- well, which three teeth is it? So, well, parents don't know. They weren't told that. So then you say we've got to have you in and do an exam. Well, that's another fee. But I always thought that the mobile units, if they find cavities and have the opportunity to provide that service, they are supposed to fix that stuff. Well, then we call them -- they don't do that, then we call them and say, well, can we get the X-rays you took. No, we can't get the X-rays. So that means we got to take new X-rays. So that's a situation that needs to be looked at too.

And the other thing, Dr. Joe, you brought up about the dental homes, and this is just an idea. You know, we -- we have people every day just flat not show up for their dental appointments. And the one guy yesterday, I looked back in his chart and he's missed six appointments. Now, how nice am I supposed to be, you know, to let this

continue? And usually when folks miss -- and it doesn't matter if it's a Medicaid or not Medicaid, but we try to ask them, well, what happened, and we hope nothing bad happened. And, you know, yesterday this guy, the one that missed six appointments, it's like, well, the last one he missed is -- we actually made a note in there. We got ahold of him and said, well, he just didn't want to come that day. I mean, that's just not acceptable behavior for them not to even call or have the respect for that dental office or their dental home. And this was one of the -- this is an idea that I had yesterday. I said, well, when these homes are -- these dental homes are being established, if there would be a way or a form they could sign emphasizing these failed appointments, or not to fail appointments call the dental office, call the clinic to let them know that you can't come. That gives them a day or two of time to get somebody else in.

But, you know, these dental homes just when they are being set up for these

patients, say, look, this is the only dentist we've got in 50 miles. If you don't keep your appointments, you are going to have to go 50 miles or more to get your dental work done. I'm just -- and I know some offices, you miss one, maybe two appointments, they just dismiss you. But anyway, I think this failed appointments stuff has got to be addressed. That's another big reason that Medicaid is losing providers. But I'll not say any more about that.

Now, one other question I had, and I guess this is for DMS to look into, are the MCOs being paid enough on their capitation plans, I think is what you call it, to cover their expansion codes on the adult dentures, crowns, et cetera. I have no idea, but I just want to be try to be fair to everybody to make sure that, you know, we're viable financially to do the things that we're doing. And maybe that's a topic we can bring up at the next meeting, but I just wanted to put that out there just being fair to everybody that works with Medicaid.

And, Dr. Joe, you talked about the people not accepting patients. Yesterday I had a 73-year-old lady, mentally retarded, but she's cooperative, but she is hard for me to get X-rays due to her movement. But her dentist that she had been doing to for years, I guess, had said, well, she took -- she quit taking this lady's Medicaid. But I can understand why in a way. It took us 90 minutes for the hygienist, you know, just to polish her teeth and, you know, get her, you know, kind of up to par. Could not do a lot of scaling, but we did -- we were able to get some bite wings that show the tarter. We got a periodontal exam done. And it also took another assistant 30 minutes of time just to go in there and help the hygienist with her, you know, and we get paid $60 or $61 and change.

So you can see there's just another example, yeah, we want to help these people because her other dentist, you know, quit seeing her. And she's a non-verbal, you know, patient other than grunts and noises like that. But these -- these folks need

help, and I just wish we could do more, you know, for them. But at the same time we've got a small business to run, and like Joe said a minute ago, that some of the offices that do take the Medicaid, we just get swamped. But anyway, we just got to keep working on all this. We got to get some new people helping with the Medicaid program in terms of being providers.

That's all the New Business I got. Any TAC Member got any other New Business? Do the TAC Members feel like there's any motions that we need to present to the MAC? It sounds like a lot of these dealing with these codes, I believe we can get a lot of those questions to Erin and she'll be able to spread the love and get some of these -- get some of these codes looked at. But any other ideas from the TAC Members?

DR. PETREY: Not at this time.

DR. BOBROWSKI: Okay. Well, thank you-all. And I wanted to remind everybody that there is going to be another Medicaid forum this fall in August, the 24th, at the Galt House 11:30 to 1:30 Eastern time. You know, last

year I thought we had a really good turnout. We had a lot of good conversations with providers. Commissioner Lee was there, and we were glad that she was able to be there and talk. And, you know, we had representatives there from the MCOs. And I just thought it was a really good turnout. And we wanted to thank Avesis for providing the luncheon, and I believe they are going to do that again for this year, and we do appreciate that and -- excuse me.

But our next meeting is going to be August the 9th at 2:00 p.m. Eastern time.

Is there any other business to come before the TAC meeting today?

MS. O'BRIEN: Dr. Bobrowski, this is Jean from Anthem. I just want to ask a quick question. For the KDA meeting, is it going to be just a form? No presentations or anything are needed for that; is that correct?

DR. BOBROWSKI: Right. There's no presentations from the MCOs. We do like to have a representative from each one if we

can --

MS. O'BRIEN: Yes.

DR. BOBROWSKI: -- to answer questions. And then I believe we are also going to have a course presented by Dr. Caudill this time on -- well, kind of on these handling our special needs children, I believe is maybe not the exact title, but -- and then we are going to be including other MCOs as we go. But we are going to -- we'll give everybody ample time to have something prepared, you know, when we do those going in the future. But, yeah, you don't have to have anything specifically prepared other than bring your knowledge cap with you, and I --

MS. O'BRIEN: Okay.

DR. BOBROWSKI: -- know you got plenty of knowledge, Ms. Jean.

MS. O'BRIEN: You are so sweet.

No. I just I wanted to be sure. I just wanted to ask so that we were prepared.

DR. BOBROWSKI: Yes.

MS. O'BRIEN: Thank you.

DR. BOBROWSKI: Yes. Thank you.

Well, I believe that's got everything on my list. And I want to thank everybody for hanging in there with us today. A lot of -- a lot of stuff to look at and keep working on, but we'll just keep working together.

Anybody from DMS want to say anything while we got a minute?

All right. Well, I will make a motion we adjourn.

MS. BRAUN: I second that.

DR. BOBROWSKI: All right. Thank you. Thank you-all. You-all have a great weekend, and I hope you-all have a great Mother's Day.

MS. BRAUN: Thank you so much.

DR. BOBROWSKI: Thank you. Bye, bye.

* * * * * * *

THEREUPON, the Meeting was concluded.

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STATE OF KENTUCKY)

COUNTY OF FAYETTE)

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

My commission expires: August 24, 2027.

IN TESTIMONY WHEREOF, I have hereunto set my hand and seal of office on this the 8th day of July 2024.

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