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

IN RE: DENTAL TAC

February 11, 2022
200 P.M.
(All Participants Appeared Via Zoom or Telephonically)

APPEARANCES

Garth Bobrowski
CHAIR

John Gray
Joe Petrey
Phil Schuler
TAC MEMBERS PRESENT

CAPITAL CITY COURT REPORTING
TERRI H. PELOSI, COURT REPORTER
900 CHESTNUT DRIVE
FRANKFORT, KENTUCKY 40601
(502) 223-1118

APPEARANCES
(Continued)

Leslie Hoffmann
Lee Guice
Judy Theriot
Angie Parker
Sharley Hughes
Erin Bickers
Jennifer Dudinskie
MEDICAID SERVICES

(Court Reporter's Note: At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances.)

AGENDA

1. Welcome and Roll Call

2. Review meeting dates: Fridays 2-11-22, 5-13-22, 8-12-22, 11-4-22 (2-4 P.M. Eastern) (all are Zoom)

3. Election of officers: Chair and Vice-Chair

4. New member needed to replace Dr. Brandon Taylor

5. Comments by Commissioner Lisa Lee

6. Approval of minutes from 11-22 meeting

7. Old Business
   a. Dr. Julie McKee - Dental Survey Report
   b. MCOs' report on Social Determinants of Health and their impacts on oral health and total health care

8. New Business
   a. Report on HB87(Senator Alvarado, Presenters: Mahak Kalra, Dr. Garth Bobrowski, Ronnie Coleman with Benevis)
   b. A new TAC has been formed called Persons Returning to Society from Incarceration (Steve Shannon-Chair)
   c. MCO reports (UHC, DQ, Avesis), FFS report
   d. On the DMS website, can a contact number be added for each TAC?
   e. Other

9. Motions for the MAC/DMS:
   a. For DMS - County-specific provider data on a quarterly basis showing activity levels for gross pay-outs beginning 1-1-22

10. See above for the next meeting

11. Public Comments

12. Dentist Comments

13. Adjournment

MS. HUGHES: Before you get started, I want to introduce you to Erin Bickers. Erin is going to be taking my place on working with the TACs and she is on here today. She is hosting the meeting today.

So, if you all have any questions after the meeting and so forth, you can address those to her. I will be sending out an email soon with her email address and so forth.

And now I will just turn it over to you, Dr. Bobrowski, to start the meeting.

DR. BOBROWSKI: Okay. Thank you, Ms. Sharley, for all that you've done for us. You've been such a reliable source of help with the protocol and meeting information and we want to thank you for all that you've done and wish you the best.

And, then, we want to welcome Ms. Erin to the club and thank you so much for your help, too.

And I apologize for my technical difficulties because I was just on a Zoom meeting this morning and it worked all fine but I don't know what I did. Maybe I just pushed a wrong button somewhere.

Anyway, we want to have a roll

call of our TAC members.

(INTRODUCTIONS)

DR. BOBROWSKI: I believe we've got a quorum here for today and we want to keep things moving since I delayed the meeting and, again, I apologize.

I put the upcoming dates of our meetings on our agenda sheet. So, you can look at those and review those. I think we voted last time to do them all via Zoom for this year until we got some kind of further notice but they're usually on a Friday afternoon and Sharley helped us get those set up at 2:00 Eastern Time.

We will next go to Election of Officers. Like I said, I'm the current Chair. I don't mind to do it again. And, then, Dr. Phil Schuler is our Vice-Chair. So, we'll need to have nominations for Chair and Vice-Chair.

DR. PETREY: I nominate, Garth, you back in the Chair position and, Phil, I would nominate you to the Vice-Chair as well, if you so still want it.

DR. SCHULER: That's fine. I appreciate it.

DR. BOBROWSKI: Are there any

other nominations? Hearing none, we'll just vote that as a slate of me and Dr. Phil for those two positions. All in favor, say aye. Any opposed? Okay. We thank you and we will try to keep going and do the best we can.

Some of today's TAC meeting is just some informational things that I wanted to pass on to TAC members and MCO members.

I have reached out to Rick Whitehouse at the KDA. We need to get a new TAC member to replace Dr. Brandon Taylor, and we're going to be sending out notices to the KDA, Dental Association members and try to see.

And I've asked several people already over the last few months and I don't get a yea response; but if any of you TAC members hear of anybody of interest or just go recruit them and just see if they would be interested. You can tell them we meet four times a year. Just watch out for that Chairman. He's a little late sometimes.

The other thing was the Zoom call this morning with Commissioner Lee. She said that she did not know for sure if she would be able to be on the call, but a couple of things that we talked about was some of our numbers.

And I brought up about, oh, three or four years ago, we brought up a paid claims' breakdown but I'm not sure that we ever got a breakdown on that. This is kind of by dollars earned.

I think we've talked about this at a couple of our last TAC meetings, too, just trying to find out how many people are actually doing dentistry with Medicaid.

What I had at our TAC meeting before was if you were doing paid claims of zero to $1,000, $1,000 to $5,000, $5,000 to $10,000, $10,000 to $20,000 and, then, over $20,000 worth of Medicaid business.

And we were hoping to see if we can also include the number of dentists that are in each range, and, then, also the age of the dentist in those ranges. We had less than 35, 36 to 45, 46 to 54, 55 to 64, and greater than 65. So, that was what we had a few years ago.

Now, the one thing I didn't have down there was a time frame. If any of you TAC members remember, was that per month or per year - do you all remember - or per quarter?

MS. NICOLE ALLEN: Dr.

Bobrowski, it was per quarter. This is Nicole.

DR. BOBROWSKI: Okay. Thank you, Ms. Nicole. That's kind of what I was thinking but I just didn't have it written down here handy. That was one of the things that we had talked about this morning.

And, then, another thing is we would like to find out from Medicaid what was the total dollar amount paid from Medicaid in 2013 and, then, each year after that up through 2021.

And, then, we would also need to maybe look at excluding the expansion population. That was just one of the things that Commissioner Lee had said maybe to exclude that part of the population.

Those were a couple of things that we talked about this morning, just trying to get some data to see who is doing the work, and maybe we can use this, too, as a recruitment tool to find out where our shortage areas are.

This is something we thought we could go to the Deans and say, look, we've got a dental office down here in Greensburg or over in Pikeville or wherever and just say we want to do a one-year or a two-year residency or that these

dentists are needing some help. So, this could be used as a recruiting tool to help fill in these areas of need where there's a higher Medicaid population.

Does any TAC member have any questions or comments about those two aspects so far?

DR. GRAY: Garth, this is John Gray. That was done in the late sixties, early seventies at UK with Dean Bohannon where the applicants from needy areas were looked at and UK was ranked in the top five dental schools in the country for some time after that and we still had a lot of practitioners go to under-served areas.

So, I think that's a wonderful idea.

DR. PETREY: To be frank with you, that's probably why we're in the places we're in. Dad did two years in Hindman and the setup actually paid for two years of his dental school, but you had people like Ray Mullins who went in public health dentistry that came out of programs like that.

So, understanding the data you have to have first to understand where the need is and the way to do it. So, I second what you say there, John.

Garth, one question. I can't

remember how we did it when we did it a few years ago, but were you breaking that down - and Nicole or Jerry or someone that was also part of that at that time from the other end of it might be helpful or from Medicaid, however.

Did we break it out by individual practices, by groups? How was it broken down as far as the providers?

DR. BOBROWSKI: And I know some offices or they're partnerships or they have associates, they just kind of bill under one tax identification number, that TIN number.

And I don't know if Nicole or Dr. Caudill or anybody with the Managed Care Organizations have any ideas on how to actually get those numbers because, like you said, some of them are reported. There may be two or three dentists in one office and it's all reported under one TIN number.

MS. ALLEN: Yes. And, Dr. Bobrowski, you're right. The reports that Avesis provided in the past, they were broken down by the tax ID number, so, by the TIN numbers and, therefore, you get the high-level view of the practice.

If the practice has five

providers but only two are rendering services, you're really only capturing the two but it's reported at the TIN number. So, it appears as though that all five providers are actively treating members.

So, there are benefits with running it by the actual treating provider instead of the billing provider or at the TIN level, but the way that we used to report it, it was reported at the TIN.

DR. BOBROWSKI: Okay. So, from your all's point of view, could it be done by provider?

MS. ALLEN: Dr. Caudill is suggesting no. So, I'll go with Dr. Caudill's answer.

DR. CAUDILL: I recall that we gave gross numbers but I don't think we could share individual doctors' information.

MS. JEAN O'BRIEN: Yes, I think that's right, Dr. Caudill.

DR. BOBROWSKI: We're not looking at individual names with the TIN. I was just wondering if by the method of reporting, if it was connected to gather the information, you would have to use the TIN. And maybe even the provider, that

part does not need to be reported to the TAC.

DR. CAUDILL: We can come up with the numbers by region or something like that. Even if you did it by county, if there's only one doctor in a county, that tells his numbers and that's not something that's proper.

DR. PETREY: I like the idea, Garth, of looking at it even by a county basis, and one of the reasons being looking at it from the other perspective that Phil might be able to speak more to, it's not solely if you have multiple clinicians at one location, but there are also many group practices that have multiple locations that may or may not be actively seeing patients every day, meaning that you have doctors that are not always in a location, but it's all billed under one tax ID.

And, so, it might be more appropriate to have it broken down in a way that actually shows the areas in which care is being delivered. Again, it might be difficult if it's billed in one location.

But don't you all bill - you bill by location, don't you, Jerry? So, you might be able to fix that there, but if it falls under one tax ID, a single entity that Phil might be able to speak

to would be multiple areas.

DR. SCHULER: The way we file claims is each individual location has its own tax ID number; but I think when we had this discussion prior, we were talking about regional data because even broken down by counties, some of these counties only have one or maybe two providers.

From a regional perspective, I think that would probably get it down to a level of detail that would be impactful.

DR. BOBROWSKI: I think that would be fine with me, too. Like I said, we're not interested in who is doing what per office. It's just if we could get a region in there of, well, who is doing - like, those categories I picked there a while ago. This is what I had down.

I think it was from a 2018 TAC report and I just don't remember us getting that data, but I just hear more and more of the legislators or other people saying, well, who is doing the work out there and I can't give them an answer.

So, if we could figure out a mechanism because I know the stats show that there is over 1,500 Medicaid providers.

Now, I've also had some oral surgeons and some general dentists tell me that they requested to be taken off the rolls because they're no longer a Medicaid provider or they've retired and their names and numbers are still being reported as being an active member of Medicaid.

One oral surgeon told me, well, I haven't done any Medicaid for twelve years. So, now he said my name is still showing up. I don't know how to fix that problem myself.

For the MCOs, are those categories of paid claims, are those a - do you feel like that's a sufficient category to look at?

MS. HUGHES: Dr. Bobrowski, this is Sharley. In order for us to be able to pull the data together for you, you all need to determine exactly what data fields you do want on the report so we know what you're asking for and you all vote on it. That way, we can look to see if we can get you the reports and the fields that you want.

DR. BOBROWSKI: If we did the categories of paid claims and if we did it per quarter and if we did it regionally, it would be awfully hard to figure out any kind of age group, which, the reason we had that on there before was,

well, you get into that 55- to 64-year-old age group and that's going to be more than likely your next age group to retire.

So, I think that was part of the reason we were looking at that was so that we could tell people or students to say, well, here's a dentist over here at such-and-such town. Even if the schools had - and the schools maybe have access to that information for recruiting dentists to Medicaid need areas.

I would just support a motion, then, to look at paid claims to be reported as, like I said a minute ago, from zero to $1,000 - and all these will be per quarter - $1,000 to $5,000, $5,000 to $10,000, $10,000 to $20,000, and greater than $20,000, and this is per-quarter data. That's the first part.

Now, the second part would be if we do it by regions, is there a mechanism for the reporting of that that makes it easier for the MCO or for the State, Sharley, is there a region mechanism?

MS. HUGHES: Lee, are you on here? Would we look at it from maybe the AD Districts?

MS. GUICE: Sharley, I was

listening to another meeting. Tell me again what the question was.

MS. HUGHES: For pulling data for the Dental TAC and trying not to give it to them on a county level for fear that they would be able to determine what doctors and how much they are getting or what dentists are getting, can we do it based upon the seven or eight regions that we used to have in the MCO districts or regions that I think were the old AD Districts?

MS. GUICE: How about if we just list the counties that you want to - if somebody can come up with whatever those lists of counties are, then, we can use that, yes. That's no problem. Now, it will take longer.

MS. PARKER: This is Angie. There are the eight MCO regions. So, 1 and 2 is Western Kentucky. Three is the Louisville area. Four is Northeast. Five is Fayette County and surrounding. Six is the Bowling Green area, I believe. I could be wrong on that. And 7 is North - I could get 6 and 7 confused but 8 is Eastern Kentucky. So, there are Medicaid Managed Care regions that we could pull from.

MS. HUGHES: So, we could do it

based upon those regions, Dr. Bobrowski, and provide you the data.

DR. BOBROWSKI: Okay. So, the first part of that will be the paid claims' categories and it will be paid by region using those eight MCO regions. So, we've got that.

Now, is there a mechanism to also include like the number of dentists in each of those categories?

MS. HUGHES: I think we could do it based upon - and I may be wrong - but dental groups, dental individuals and if they're orthodontists or the subcategories.

I hate that we didn't have a waiting room because I don't know who from DMS is on here.

MS. GUICE: Sharley, are you trying to figure out how we can separate out the groups from the individual dentists?

MS. HUGHES: Yes, and the subcategories that----

MS. GUICE: Like their specialties?

MS. HUGHES: There you go. That's the word I was looking for.

MS. GUICE: If we have them, we can try that.

MS. HUGHES: Okay. So, we can try to give you the number per specialty, number of dentists per specialty in that region.

MS. GUICE: We just need to get the request in writing and I think you already said that earlier.

MS. HUGHES: Yes.

MS. GUICE: Dr. Bobrowski, ask for what you want and we'll see what we can provide.

DR. BOBROWSKI: Okay. And I started it and now I think I'll be able to finish it. I need a motion from a TAC member, then, to have a report compiled that shows paid claims in the categories that I stated before, plus those specialties, subgroups, and the number of dentists in each paid-claim range per quarter and to use the eight MCO regions.

DR. SCHULER: Garth, can we also get a breakdown of ages based on five-year ranges, 25 to 30, 30 to 35, 35 to 40?

DR. BOBROWSKI: Yes. And if we need to, we could maybe just have that as a separate report. See, I don't know the mechanisms that they

compile the reports from and that's what I act a little hesitant because I just don't know the mechanism of how you all generate some of those reports.

But if that age group could be included in that report, well, then, we'll just add that to the motion.

MS. GUICE: What I tried to say before, Dr. Bobrowski, is ask for everything you want. We might not be able to put it in one single report but we will be able to tell you.

DR. BOBROWSKI: Okay. To add to that, then, we would like to know the ranges of ages, like I said, from less than 35, 36 to 45, 46 to 54, 55 to 64 and greater than 65.

So, we'll add that to the report if it's possible to get it. If not, we might have to break it out.

Any other questions from TAC members, comments?

MS. BICKERS: I believe Dr. Rich has his hand raised.

DR. ADAM RICH: I do. Dr. Bobrowski, I just was curious. We're talking all about finances and dollars, but is there any value to

just looking at member visits per provider? Then you can narrow it down. I'm not sure that that information is quite as restrictive and it may be just about as productive.

For my information, I'm trying to figure out why the dollar amount is paramount.

DR. BOBROWSKI: Well, part of that reason was we've all heard of the dentists that see two patients a year and they would obviously fall in the zero to $1,000 category, but I guess you could also pick them up on a member-visit report also.

We would have to come up with a different category. I don't know. For years, Dr. Adam, this is what I've always heard was just to break it down by dollar amount off of paid claims.

So, that was kind of why I came back up with that again. I'm just going on history.

DR. SCHULER: Garth, if we were looking at it like Dr. Rich is talking about on just basically an encounter type of basis, then, you wouldn't have to bracket it. It would just be total number of patient visits or encounters per provider over a certain time frame.

DR. BOBROWSKI: Right. Yeah.

DR. PETREY: Other than the

arduous task of doing a larger report, is there anything negative to trying to achieve both goals and get both sets of information?

DR. BOBROWSKI: I'll have to refer to Sharley or I don't know if Ms. Angie Parker is on here or not or if there's someone else from Frankfort that could answer that question.

DR. PETREY: I think, Garth, my question is just why not get both? Why not try to get both sets of information?

DR. SCHULER: Ask for both.

DR. BOBROWSKI: Well, that's fine with me. We can just ask for both and, then, if they can't do it, they can just say they can't do it.

DR. SCHULER: That is true.

DR. BOBROWSKI: We can just add that to our motion but I will need somebody to actually make the motion and then second it.

DR. PETREY: If you re-read the motion, can we make the motion as stated as opposed to trying to restate what you're stating?

DR. BOBROWSKI: The motion would be to have a breakdown report of paid claims, and we've already listed the breakdown of that, the number of dentists in each category, the age of the

dentists per category that we previously listed, per quarter, and to use the eight MCO regions for our districts, and also to do an encounter or member-visit report also - I don't know how else to word that - but they can use the same parameters, per region and per quarter.

MS. PARKER: Is this just for one year or do you have a time frame?

DR. BOBROWSKI: Just to start it, as soon as we can and keep going for this year and see if the data, if that's accurate. Then, after that, we may be able to go to twice a year or maybe once a year to have that breakdown.

DR. SCHULER: Can we do a twelve-month kind of look-back, so, the four quarters prior to now, and, then, we can do this quarterly moving forward?

DR. PETREY: I think we would need at least a twelve-month look-back, especially with the aspect of the pandemic and the impact that it has had.

The preference would be epidemiologically to go back if we can. Otherwise, this is data that will be helpful but we won't be able to really look at and make determinants on until

more time has passed if we don't focus forward.

MS. HOFFMANN: This is Leslie. I was going to ask that question. Do you want pre-pandemic or do you want middle of pandemic? There may definitely be a difference between pre and post or in between. So, we need to decide which, you know, when you ask for that, make sure you say which four quarters you would like and, then, we can go from there.

DR. PETREY: We asked for this in '18. I don't see any reason why not to go back three years, if possible.

DR. SCHULER: That's what I was going to say as well because that would give you true pre-pandemic data compared to during pandemic. We haven't even hit post-pandemic yet but hopefully some day we'll have post-pandemic.

So, take it back to 2018 or at least make the request for 2018. And if that's the request, then, I would make the motion as stated.

DR. PETREY: Second.

DR. BOBROWSKI: Any other discussion? Hearing none, all in favor, say aye. Any opposed? Okay.

MS. HUGHES: Dr. Bobrowski,

could you send me that in an email form and, then, we can get that started?

DR. BOBROWSKI: Yes, I will do it. Let me make myself a note.

DR. SCHULER: You didn't get that full list, Sharley?

MS. HUGHES: No, I didn't.

DR. BOBROWSKI: We went around it three times and up the middle twice, didn't we?

MS. HUGHES: I know it and I still didn't get it.

DR. BOBROWSKI: I've got it written down. It was in the notes on the 2018 TAC agenda, but, like I said, I don't think it was this detailed. So, I believe we can hammer it down this time, Sharley.

MS. HUGHES: Okay. Thank you.

DR. BOBROWSKI: Thank you. We also need to go ahead and approve the minutes from the - and I made a typo there - from November of '21 instead of '22 TAC meeting. So, we need a motion to approve those and a second.

DR. GRAY: John Gray. So moved.

DR. SCHULER: I'll second it.

DR. BOBROWSKI: All in favor,

say aye. Any opposed? All right.

I know I had it on the calendar a thing from the last meeting to put it back on today, two things there - Dr. Julie McKee's dental survey report, and I didn't know if that was completed yet or not. And I can't see on the screen if Dr. Julie is on the call today or not either.

MS. HUGHES: It doesn't look like she's on here. Angie, were you working with Dr. McKee on that?

MS. PARKER: Yes, and I was glad to see this on the agenda because I haven't heard anything in a while on that. The last I heard, she was going to interview some of you all on the TAC and have you all take the survey to get feedback on it but I haven't heard anything since then.

We probably do need to make sure she's invited to the next one.

DR. BOBROWSKI: Okay. Let me make myself a note here. We'll add that to our next meeting also there.

The next thing - and, boy, I owe the MCOs a big apology because I know we talked about this at the last TAC meeting but, then, I was supposed to send out a reminder. And, then, I think

Christmas hit and the holidays hit and, then, I had a little health issue hit and I didn't remind everybody.

So, if you're not ready with a report on that yet today, we're not going to issue any fines or take any children away or anything like that. We can do it next time, but I do believe United Healthcare is ready with their report on the social determinants of health.

And, again, I apologize for not sending out a reminder. And, like I said, if you don't have yours ready today, it's no foul or penalty.

Dr. Rich, if you want to go ahead and do your presentation, that will be fine. We'll let you get started.

MS. HUGHES: And, Erin, I think you will need to make him a host because he has a presentation. And, Dr. Rich, when you finish, if you could put Erin back as the host.

DR. RICH: Okay. I'll try that. Whitney Allen is actually going to be doing our presentation today, but if you make me the host, I can share my screen if I can find the - right there. It says I can do it. Let's see if it happens.

MS. HUGHES: Erin, you may have to stop sharing your screen before he can share.

DR. RICH: It looks like it's going to work here. Can everybody see that? Maybe. Maybe not.

MS. HUGHES: Now try sharing it, Dr. Rich.

DR. RICH: There we go. I think you can see my screen now. Getting closer. Whitney, are you there?

MS. WHITNEY ALLEN: Yes, I'm here.

DR. RICH: Awesome. Well, I'll turn it over to Whitney for our SDoH presentation from United Healthcare, then.

MS. ALLEN: Thank you, Dr. Rich, and you can go on to the next slide, if you don't care.

Good afternoon, everybody. My name is Whitney Allen. I'm the Director of Enrollee Services and Advocacy for United Healthcare Community Plan of Kentucky and work closely with Dr. Rich.

I have been with United for about three years now and prior to that I was with the Kentucky Primary Care Association but I'm here

today to talk about social determinants of health and what our SDoH capabilities are and how we are addressing our members' barriers to health.

We know that social needs really drive health outcomes and beyond clinical care needs such as shelter, food, transportation and they really do impact those health outcomes.

I will apologize at the beginning to Angie and Lee. They did hear this spiel when we had our State ops meeting earlier this week; but for everyone else, our program approach is really to close the gaps so that everyone has an opportunity to be as healthy as possible.

So, we ask questions around basic needs through screening and, then, being able to connect members to community resources to meet those needs. And, then, ultimately the information that we're gathering through screening and referrals can help us make more informed decisions on investments in the community to expand capacity.

Dr. Rich, next slide. We actually have a Social Determinants of Health Advocate on staff. She lives in Kentucky and works closely with our clinical and behavioral health teams addressing members' unmet health-related social

needs.

So, we are constantly learning about our members and their health-related social needs, helping connect them with resources and working with community partners to ensure that those needs are met.

We leverage the insights that we gain about those members' social contexts to really tailor our clinical, our quality and our value-based programs to better care for our members and address any obstacles they have to have better health, if possible and, then, ultimately going beyond addressing the individual member needs to look at community level to address upstream social determinants of health that drive those individual social needs.

So, last year, in 2021, as a new health plan, we spent a lot of time laying groundwork for really understanding who our members are, building relationships with community partners that serve the Medicaid population really just to better learn what services are already available and where the gaps are.

And, then, we leverage our national community and state SDoH model in Kentucky

which embeds SDoH as part of the Population Health and Health Equity Framework.

So, we look at where we're screening, providing referrals, and, then, how we're closing the loop and where we are pulling that data from.

And, then, the next slide is a screen shot of a unique tool that we have. It's called an HRSN dashboard. That's the Health-Related Social Needs. It's a member-insight dashboard that captures SDoH data through a source identifying the HRA which is the Health Risk Assessment and, then, provider ICD-10 Z codes.

Last year we conducted over 24,000 screenings and roughly 10% of those screenings resulted in a need being identified. And the top needs of our members last year were housing, family support, employment and nutrition.

So, for example, you could click on nutrition and see where one of our top referrals is. For example, click Mom's Meals which is a home delivery meal service that we offer to our members. And, then, another top referral is through Community Action through their LIHEAP Utility Assistance Program.

Then, we also use the data to make funding decisions as well. So, with food insecurity being the top need, we provided community investment funding towards local community organizations like (inaudible) Markers Farm and Boxful (sic) to really help address food insecurities in the areas that we serve.

And, then, we also work with Dr. Rich to provide some funding in Eastern Kentucky for targeted outreach.

And, then, when members are in case management including behavioral health case management, they're also screened for health-related social needs.

And I do have a member's story I'd like to share on one of those case management interactions. That's on the next slide, Dr. Rich; but before I go to that, I do want to mention, in the second quarter, we're going to be launching what we call an RTO. It's a realtime offer for our inbound call center.

So, when a member calls in at the end of the day, they will be asked a couple of SDoH questions and the call center advocate can provide resources on the spot.

So, we hope this will really help increase our ability to screen members for health-related social needs outside of the Health Risk Assessment which is the HRA.

So, just real quick, a member's story. For those that are on the phone, I will kind of read through this slide. This is one of our members that were unemployed.

They had some SDoH needs with food assistance and utility assistance and didn't know how to apply for SNAP benefits or where food pantries were, and they had been unemployed since leaving a teaching position due to some mental health issues.

So, our BHA - that's our Behavioral Health Advocate - educated the member on how to apply for SNAP benefits and provided information on where to get food from local food pantries and, then, how to get utility assistance and discussed employment options with them and encouraged the member to apply for employment if they felt they were ready to.

So, the outcome - the member was able to complete the SNAP application, started getting those benefits to cover food expenses and get

resources from a local food pantry and, then, also utility assistance and, then, she had reached out to a local school system and had applied to be a teacher's aide.

So, lastly, I talked with the member. She reported that she was feeling like she was getting her life back on track and feels that she has made great progress towards accomplishing her goals.

So, we really feel that helping this member really put her back on track in getting some of her mental health issues underway because she wasn't as stressed about paying for her bills or for food. So, I wanted to share that member story with you.

I'm happy to answer any questions about our model and can continue to share updates in this forum as needed or if there's specific data points that you all are interested in, I'm happy to get those as well.

And, Dr. Rich, I'll turn it back over to you.

DR. RICH: Thank you, Whitney. I really appreciate that presentation. I don't have anything else either unless anyone has any questions

we can address.

DR. SCHULER: I have a question if you don't mind. How did you all conduct the survey portion of the presentation? How did you all do the survey? How did you survey your members?

MS. ALLEN: When we screen them for the health-related social needs?

DR. SCHULER: Yes.

MS. ALLEN: So, we are required by our Medicaid contract to do an HRA. It's a Health Risk Assessment. So, when we get a new member, we reach out to them by phone, through email, we do send correspondence in the mail to try to complete that initial HRA and it does ask SDoH screening questions. So, that's one way.

And, then, if a member is identified to be in case management or in behavioral health case management, they're also asked those SDoH screening questions as well.

I don't have the exact verbiage in front of me but it's just like three questions asking if they've had maybe trouble paying for utility bills or food or had trouble getting child-care assistance in the last year or if they have been homeless or had trouble paying utility bills or

consistent housing in the last year. Those are a couple of examples of the questions that we use.

And, then, also that data is coming from ICD-10 Z codes that providers can enter in as well.

DR. SCHULER: Thank you.

DR. BOBROWSKI: All right. Ms. Whitney and Dr. Rich, we thank you all so much for that report.

MS. O'BRIEN: Dr. Bobrowski, this is Jean from Anthem. I brought someone from our office. Her name is Gwen and she has her presentation that she would like to do.

DR. BOBROWSKI: Go right ahead.

MS. O'BRIEN: Gwen, are you hearing us?

DR. RICH: Ms. Sharley, do I need to do anything to relinquish----

MS. HUGHES: Yes. If you could, Dr. Rich, go ahead and make Erin back as being host. Jean, does she have a PowerPoint presentation to present?

MS. O'BRIEN: Yes, ma'am, she does. We can do it next time if you want us to just bring it the next time if we can't get it to work.

MS. HUGHES: No. If Dr. Rich can get Erin back to being the host.

MS. O'BRIEN: Gwen, we're trying to get your presentation.

MS. GWEN OCHOA: It still says it's disabled, so, I'm just waiting.

DR. RICH: Sorry. This thing is moving around on me like crazy. I can't get it to sit still. There we go. Erin, I think I've got you there.

MS. BICKERS: Okay, and I just made Gwen the host. So, she should be able to share her screen now.

MS. OCHOA: Yes. Thank you. All right. Well, welcome. I'm going to cover our Empowerment Team. They are our direct team that works with social determinants of health.

So, a brief description. It's made up of CENs and they work one on one with our members.

MS. O'BRIEN: Gwen, it's not presenting.

MS. OCHOA: On my end, it's showing that it is. I'm sorry. Is that better?

MS. HUGHES: There you go.

MS. OCHOA: Okay. Good. This is going to be an overview of the Empowerment Team. They deal with our social determinants of health.

So, the brief overview is it's made up of the Community Engagement Navigators. They assist one on one with our members' social determinants of Health. Each CEN is designated to a specific region and they are considered the experts of their area. We like for them to know their resources and what's out there.

They not only do phone work but they also do fieldwork. They go out and they meet with CBOs. They also try to meet the people in the field where they are. They can set up at a food pantry and help our members one on one if they are going to be at a food pantry that day.

So, they really do try to make connections in the field one on one with CBOs, faith-based organizations, food pantries, wherever they believe that it's going to best serve our members' needs.

The process is pretty simple. So, a member gets referred to the Empowerment Program through our email empowerment@anthem.com. They can self-refer. So, they can call the 1-800 number and

say, hey, I heard of this program. I got a flyer from a CBO, from a FRYSC, from whoever. It can be an MCC referral which is our Customer Service number. It can be an internal referral. If they're already in BH or BHBM, they can be referred.

And, then, once again, a CBO can actually refer on their behalf. So, if they go in to a CBO's office and a CBO knows of a need that they have that we can serve that's extra, that CBO can email us on that member's behalf.

Once they do that, the case is then assigned to a CEN. The case is opened. We make contact with the member. If we don't reach them the first time, we try again. If we don't reach them the second time, we do send a letter after two phone call attempts.

And the case remains open with this member until goals are met, and what that means is they stay with us. We've had members that we've been helping for a year or two that are applying for disability because those processes are really long.

So, we want to make sure that we stay with the member as long as we are needed. We don't just want to say, hey, a thirty-day process, quick in and out; or, of course, if the member leaves

Anthem or if the member chooses to close. If they have gotten their needs met and they think, hey, I'm good, they can say I would like for my case to be closed and it is and they can reopen at anytime.

This is just a few of the things that we can do. We do assist with food insecurities, housing, clothing. We can work with Goodwill for clothing vouchers.

We connect members, of course, with community resources. We help them with employment searches, and we also use a website called findhelp.org. It has a lot of CBOs listed.

We can do a search via what type of assistance they need. If it's child care, if it's transportation, if it's low-income housing, we can search by ZIP Code, and we can send referrals to that CBO for that member on their behalf if they would like or they're given the information and they can contact the CBO on their own behalf. It's just whichever way works best for the member, quite honestly.

So, how do we assist? I already mentioned findhelp.org. We also have what's called a Flex Fund. It's almost unrestricted. It's for those members who are experiencing homelessness

or are in imminent risk, just complete immediate risk of either eviction or something is about to happen to make them homeless.

It can help pay for rent, rental arrears, security deposits, utilities, utility arrears. It even helps pay for move-in items. So, when I say move-in items, I don't mean like a mirror or anything like that. I mean like pots and pans, shower curtains, towels, utensils. It even pays for bedtime mattresses, dressers. A couple of times, a member didn't have anything to sit on. So, we were able to get a couch. So, we do serve our members with our Flex Fund.

We have our transportation value-added benefit. It is $200 annually if you use a gas card, so, that is $50 per quarter, or you can get a 30-day bus pass per quarter.

And as you can see, the other ways we also help is, like I said, we've helped them find income-based housing. We connect them with LIHEAP. We help them fill out job applications, the Medicaid and SNAP applications.

So, we are there specifically to assist members however they best need their needs met.

Does anyone have any questions? I know I went through that kind of fast.

MS. O'BRIEN: Gwen, thank you so much and I appreciate you showing up today and doing the presentation for us.

MS. OCHOA: Not a problem. If anyone does come up with any questions later, feel free to reach out to Jean or myself and I'm happy to answer any questions that you do have, and thank you, guys, very much and I hope everyone has a good day.

DR. BOBROWSKI: Thank you.

MS. HUGHES: We need to make Erin back as the host. And, Gwendolyn, can you please send me your presentation also?

MS. OCHOA: Sure, absolutely. You are now host.

MS. HUGHES: Thank you. Now, Garth, did you have anybody else?

DR. BOBROWSKI: I wanted to thank Ms. Gwen. Jean, would you mind to re-send me your contact information? I just want to make sure I've got all the mechanisms down here to get a hold of you.

Now, we'll go on to Avesis. Nicole or Dr. Caudill, do you have anybody ready with

theirs?

MS. CATHY STEPHENS: We will be doing our presentation at the next meeting, if that works.

DR. BOBROWSKI: That will be fine.

MR. OWEN: Dr. Bobrowski, this is Stuart Owen with WellCare. I don't have a Powerpoint but I've got a lot of information to share if you don't mind listening to me.

DR. BOBROWSKI: That's fine.

MR. OWEN: So, to give you an overview, how do we identify individuals who have social determinants of health needs?

And as has been mentioned before, Gwendolyn was talking about - and the prior - I've already forgotten your name - the first presenter and I apologize - there are ICD-10 Z codes. There are nine that providers can report on a claim.

So, that's one of the things. We've got Provider Relations representatives that are statewide that work with their providers. And, so, they actively encourage them to report those. Then, when it comes in on the claim, it identifies the need.

And, then, we've got ways that providers can also contact. We have a Community Relations Team, like I mentioned, statewide.

Also, we have quite a few community agencies that we actually give grants to. As part of the condition of getting the grant money is we ask them to identify individuals with social determinants of health needs. We ask them to look if it's something they can address, is it a barrier that they can address? If not, then, we turn it over to our Community Relations Team.

And the Community Relations Team, they're involved, they're actively involved in their communities. They're on participating community councils, adjoining community coalitions. As you can imagine, I mean, they work evenings. They're very, very active players in their community.

And one of the things that we did that's been really helpful, in 2014, we launched a help line, a help hotline, Community Connections' hotline and this has been mentioned by a couple of others.

This helps with housing, helping individuals if they're in an unsafe situation, domestic violence, some kind of dangerous

situation at home, food, transportation, financial assistance, utilities, rent, child care.

We help with affordable child care and a lot of job- and education-related assistance, and I'll get into that in a little bit more detail.

So, I wanted to just give you an idea. We're always looking at the impact and getting an assessment on the numbers. In a typical year, we have about 40,000 referrals of individuals that we do through the Community Connections and we refer them to whatever needs.

And our top five for Medicaid in order is food, number one; and number two is medical transportation; three, general transportation; four, help with utilities; and, then, five, clothing.

And, then, we also refer individuals - we do this through Medicare as well - but one of the things, as I mentioned, we're always looking at the impact, we've discovered that 68% of people that have an unmet social need are more likely to be re-admitted to a hospital. If they've been hospitalized for surgery or whatever episode, 68% more likely to be re-admitted within a month if they

had an unmet social need.

And, so, I thought I could give you just some examples. This is certainly not comprehensive but some examples in communities, some of our partners.

And, so, one of them is a nonprofit called Rural Transit Enterprise which is in Southeast Kentucky and they provide transportation not just to medical appointments but also for schools, for job placement and food.

And we've learned just looking at the data with those that those individuals, the beneficiaries that receive transportation through that have on average four-and-a-half chronic diseases, four-and-a-half chronic diseases. Hypertension was number one. Asthma, 48% have asthma.

But we looked at the impact of that initiative and it has shown over time to result in a 21% reduction in ER visits which obviously is a big positive, and a 57% reduction in non-emergency visits in general, basically, the individuals just becoming more stable health-wise, and also a 62% reduction in hospitalizations related to asthma.

Another one we have is we're a

founding partner with an organization called Hotel, Inc which launched in 2016 and we remain a partner with them. And, so, they're basically helping individuals who are experiencing homelessness and just basically get them the essential resources, whatever they need to get back on their feet, obviously housing, food, education, employment assistance, access to medical care and transportation both for medical and non-medical.

And we've shown with them - and, again, this is since 2016 - that the members, the beneficiaries who have accessed or used Hotel, Inc have a 10% ER visit reduction.

And just to give you a specific example, I guess a case there, there was a mother who was living in the car, struggling with opioid addiction. She had kids but the kids had been taken away from her and were living with relatives.

And, so, we got her into Hotel, Inc and, then, she started receiving treatment as a result of that and, then, was ultimately reunited with her kids. And, then, a year after that, they had their own home. She's with her kids and still continuing treatment.

Another one is called Welcome

House which is also a nonprofit. It's in Northern Kentucky and, again, it helps individuals primarily in homeless situations.

And for that, we discovered that 48% of the people who participated in that program, that benefit increased the primary care visit, going to the primary care doc, a 48% increase.

Another one that we've done, and we launched this when KyHealth you remember under the prior Administration was kind of redesigning the Medicaid Program to have a community engagement work requirement if you're able-bodied to get Medicaid.

And, so, we launched it then and it really targets helping individuals to get employed. We help them with resume' prep, job training, coaching, GED prep, paying for the GED, coaching them on interviewing and just basically everything on trying to help them get employed and I have an example there.

We had a 54-year-old male who was working in a factory job and had a knee injury and he couldn't stand anymore. In his job, he had to stand eight hours a day and he couldn't do that anymore.

So, we got him enrolled with

the Kentucky Community and Technical College system and he ended up getting financial aid for that and now he's working on a medical coding degree, working towards that.

Some of the other things we do, we do address this through value-added benefits as well, and most of these, the vast majority of these they just have to ask for. They don't have to do anything.

But one of the things we discovered under COVID obviously is children are working remotely, I mean, in school remotely. They weren't in class. And, so, that was a key issue.

So, what we've offered is an Internet hotspot. It's for a full calendar year, for twelve months. It's for kids eight to eighteen. We also offer tutoring, twelve one-hour tutoring sessions also for kids eight to eighteen.

Another key thing, of course, is people lost jobs and, so, they needed assistance paying the bills, paying utilities, paying housing. And, so, we have a $250-a-year benefit to assist with that and it's done on a quarterly basis - $62.50 a quarter.

We have college scholarships.

We award fifty $1,000 college scholarships each year. They've got to be at least eighteen and been accepted to a college or a university.

As I mentioned before, the GED preparation, we pay for that if they're at least sixteen. We pay for the preparation and tools to get ready for the test and we pay them to take it up to four times to actually take the test.

We also have meals for individuals who have been discharged from an inpatient hospital or a rehab facility or a behavioral health residential facility. It's ten meals. They're authorized to get up to ten meals upon discharge and that's within fourteen days getting discharged.

Criminal record expungement, obviously that's key to a barrier to getting a job. We'll pay for that. We'll pay $40 towards what that costs.

We also do sports physicals kids six to eighteen. We obviously want them to be fit and active and that helps with their health. So, we pay for that.

We have quite a few other things but I'll just stop there.

DR. BOBROWSKI: A question. You were talking about 4.5 of the people have chronic diseases and it was one of the first ones you mentioned about decreasing ER visits. I know you had two or three that you mentioned but what was that first one that decreased? Do you remember?

MR. OWEN: That was with Rural Transit Enterprises which is in Southeast Kentucky paying for transportation, and not just for medical but also for education, job placement, food.

That's the one that we found out that the individuals who were in that program had four-and-a-half chronic diseases on average and, so, if you're needing transportation and you've got a chronic disease, and that had a 21% ER visit reduction.

DR. BOBROWSKI: Okay. Yeah.

MR. OWEN: Over time, that's what that has shown.

DR. BOBROWSKI: All right. Great.

DR. SCHULER: Stuart, that was a very insightful report. We're all working towards examining these social determinants of health; and, really, at the end of the day, what it's about is

getting people healthier by helping them overcome some of these non-medical challenges that they have.

Garth, I'm assuming that all the data and statistics and everything that Stuart was presenting will be captured in the minutes. Is that accurate?

MR. OWEN: I can send it out.

DR. SCHULER: I'd love to have that. We're actually involved with a couple of different groups on starting patient survey type activities and stuff like that, but it's nice to know what could be the outcome from some of the efforts that we're starting on.

MR. OWEN: I'll send that out. I'll make a little package. I'll make it pretty and put a bow on it.

DR. SCHULER: You don't have to make it too pretty for me. The numbers speak for themselves but, indeed, I mean, when you're talking about trying to get people healthy, you can't just look at their physical health. There are so many things that go into it from a lifestyle perspective, from housing and food availability and just all the things.

It would be interesting to see

over time - and you could say there's also the drive to lower overall cost of taking care of these folks - and, yeah, sometimes you do good by doing good. I mean, that's okay, but, really, over time, so, the people that are involved in some of these program have four--and-a-half chronic diseases.

If you could help them with transportation and food and housing and some of these other things, over time, does that drop to three and a half or three? Are you really making changes, long-term changes in people's lives by helping them overcome some of these social challenges that they have? So, it's good work. Good job.

MR. OWEN: Thank you.

MS. HUGHES: Stuart, can you send that to me, please?

MR. OWEN: Sure. Yes. Certainly, Sharley, we'll do. And, by the way, best wishes to you, Sharley.

MS. HUGHES: Thank you very much, Stuart. I appreciate it.

DR. BOBROWSKI: Again, Stuart, that was a good report. And it's really interesting because our church is talking about some of these same things of how can we as a church help people in

our community.

And really it's good to know some of these other programs and work with our Social Services' people in our communities on how we can get our churches involved. We're not a big church but we do try to help where we can, and I just think this is just very interesting. So, thank you, Stuart.

MR. OWEN: You're welcome.

DR. SCHULER: Garth, I was wondering, from the first two presenters, Gwen and whoever Dr. Rich had presenting - I'm sorry, I don't remember her name either - I'm so sorry.

DR. BOBROWSKI: Whitney.

DR. SCHULER: Whitney. Thank you. But if now or in the future, if you guys have some data kind of like Stuart has of some of the results of what you're seeing or where you started and kind of where you've gotten to over six months or a year or two years, it would be interesting to see that data kind of across the board because the wider swath of this you see, you kind of get more of a feel for the actual impact of it. So, good job from everybody.

MS. O'BRIEN: Dr. Schuler, we do have additional information very similar to what

Stuart had presented. It's all part of a PIP that we do in all the health plans. So, I'm sure we all can give you some data that you are looking for overall.

MS. PARKER: If I may, Dr. Bobrowski - this is Angie Parker from Medicaid - Medicaid also did a focus study through our external review organization on social determinants of health and I would be more than happy to share this. I'll send it to Sharley and there's some data in there, too, that's very eye-opening.

DR. BOBROWSKI: Yes. Thank you. If you all could send a copy out to each TAC member, I think that would be great to look at it and review it and just to have it in our files here. Let me make a note.

MS. PARKER: It is on our website, but like sometimes trying to find things on our website is like finding a needle in a haystack. So, there is a link to that.

DR. BOBROWSKI: Okay. All right.

MS. PARKER: I will also send that to Sharley.

DR. BOBROWSKI: I'll make a note of that.

DR. SCHULER: It would be easier for us if you would just send the needle, wouldn't it?

MS. PARKER: And I will do that.

DR. SCHULER: Thank you.

MS. ALLEN: Dr. Bobrowski, this is Nicole. I just wanted to share with you, as Cathy stated, Humana, Aetna and Molina will present at the next meeting.

DR. BOBROWSKI: And I've got it noted.

MS. ALLEN: Okay. Great. Thank you.

DR. SCHULER: Nicole, if they could bring any of the data kind of like Stuart presented, like, what are you guys seeing and what are some of the results you're seeing over the time that you've been doing this, that would be great.

MS. ALLEN: Okay. We'll definitely talk about that.

DR. BOBROWSKI: And I'll add that to our agenda for next time. Sometimes I start preparing - and I owe you all another apology. Sometimes I truly do start the agenda like almost immediately or the night or the next day after our

TAC meeting, and, like I said, this last week or so, I just haven't done it.

So, I failed my duties and responsibilities and I promise Santa Claus that I will do better. So, I'll get a good report to him.

Anyway, is there any other Old Business that we need to bring up? I know our time is starting to run short but I think we can make it.

Okay. Going down to New Business, I want to give you all a brief report through Frankfort on the House Bill 87 - I'm sorry. It's a Senate Bill from Senator Alvarado.

Basically, it did come out of the Health and Welfare committee but it was basically to raise the floor so that the MCOs could not go below the fee-for-service fee schedule.

What else do I have written down about that? It did come out of the Health and Welfare Committee and now it has been sent to the Appropriations and Revenue Committee.

Let me go to this other page. It was brought up by a pretty large Medicaid clinic in Lexington, Kentucky. They're just really having a hard time. They're just really struggling as a dental clinic that was just struggling to make ends

meet at the current reimbursement rates. So, that was the impetus for bringing that up. So, that's that report there.

DR. SCHULER: What fee schedule are they talking about raising it up to? I mean, I read the Senate bill. I couldn't really tell. I mean, are they talking about raising it up to usual and customary fees which they can look at on the claims or are they talking about raising it up to Kentucky State Medicaid fees? What are they talking about?

DR. BOBROWSKI: From whatever year it is, it's like the State fee-for-service Medicaid fees, that the MCOs can't go below that.

DR. SCHULER: Okay.

DR. BOBROWSKI: Now, the thing is, it's like - and Senator Alvarado did have - any kind of bill that they present like that, I mean, if you don't have a way figured out to pay for whatever you're promoting, your bill is pretty much dead in the water.

So, it did have a component in the bill, I believe, to look at a payment method and it did mention about an 80/20 match from the federal CMS or CMS would cover 80%. The State would have to

cover 20%, but, like I said, it's in the Appropriations and Revenue Committee at this point.

So, it's like any bill. They've got a long way to go on bringing things forward. I hope I answered your question.

Just some information. A new TAC has been formed. It's called the Persons Returning to Society from Incarceration and Steve Shannon, I believe, is the Chair of that new TAC.

Are there any other maybe brief reports that the MCOs want to report on? I didn't have anything specific that I wanted you to report on or the TAC wanted you to report on, but if there's anything else you would like to let us know about, I'll turn the floor over to you all.

I'll just start with Avesis. Sometimes I go by alphabetical order but we did that earlier, so, we'll start back up with the "A's" again here.

MS. ALLEN: Sounds good. Thank you for the opportunity. We do have a request. This is actually for DMS regarding the 2022 procedure codes. We are asking if DMS can please load the codes into DMS' operating system.

We're not asking that DMS

identify if the codes are covered or that DMS identify a reimbursement rate. We just need the codes loaded into DMS' operating system so that our claims will pass through.

If we bill a procedure code that DMS does not have in their operating system, then, the Avesis encounter will deny as an invalid procedure code and, then, we incur encounter penalties.

So, I'll be submitting a formal request to the MCOs to submit the question to DMS but I thought since we have the open forum today, I would share the request with this team also.

MS. GUICE: Noted. Thank you.

MS. ALLEN: Thank you.

DR. BOBROWSKI: Anything else, Ms. Nicole?

MS. ALLEN: No. Thank you.

DR. BOBROWSKI: Okay. Ms. Jean, have you got anything from your side?

MS. O'BRIEN: Christina, are you on? Did you have anything from DentaQuest?

MS. MEDINA: We are on, and, no, we don't have anything. CPT codes was one of those things on our items but Nicole already mentioned

that. So, we're good. Thank you all so much.

MS. O'BRIEN: Thank you.

DR. BOBROWSKI: Thank you. Dr. Rich.

DR. RICH: Dr. Bobrowski, thanks. I just wanted to say again, I wanted to recognize you and thank you for your testimony to the Senate Health and Welfare Committee on Wednesday to increase the reimbursement rates. You guys did a great job there and I think it was really well-received.

And I want to point out that while we're talking about rates that United Healthcare does reimburse at 100% of the State fee schedule. So, we're already in that game and we intend to stay there. That's all I have, though. Thank you.

DR. BOBROWSKI: Thank you for those kind comments. I appreciate it.

Sharley, this is for you. On the DMS website, can a contact number be added for each of the TACs or at least the Dental TAC or we can start it, whatever. Is there like a phone number or an email or something like that? And you may not have an answer today.

MS. HUGHES: I do, Dr. Bobrowski. In the past, the TACs have not wanted any of their contact information nor the MAC's contact information out on the website.

DR. BOBROWSKI: Do you all have anybody on your all's staff? The reason I'm asking that, I've had a couple of people here this last quarter to ask me about how do we get information, and I didn't know if there was a mechanism through the website that could be easier. If I just say, well, go to the website, well, sometimes they say, well, I can't find anything.

MS. HUGHES: If it's somebody that's needing something, they can always contact me until the 28th and Erin starting March 1st, or they should actually start with Erin now and we'll be more than happy to assist with getting people in contact with whomever they need.

DR. BOBROWSKI: Okay.

MS. HUGHES: I have asked before about putting contact information and they're like, no, I don't - and I kind of understand a little bit, Dr. Bobrowski, if I can just take a few seconds here.

People, when they go to a website and they find an email address or a phone

number, they seem to just think I'm going to call that person and, then, you all would start getting calls that you don't need to be receiving at all because they would find your phone number and just say, oh, they work for Medicaid, I'm going to call them.

That's one of the reasons why we've kind of refrained from even putting contact information for our committee members out there.

DR. BOBROWSKI: That's fine. As long as we've got a place that we can, like, get a hold of Ms. Erin or you for a few more days, that's fine, or even if we get a question sometimes, then, I can contact you or Erin and that gives us a place to say, well, listen, I'll look that up and get back with you. So, that's fine. That's great.

Is there any other New Business?

DR. PETREY: Garth, in the interest of time, I think I'll follow up with Dr. Caudill, but I still want to - I'm sorry about the wind here - I still would like to have some follow-up concerning the billing change D8670 and D8080 and the impact that it had on underpayment for orthodontic services.

In our practice, that's 150 cases. I don't have a number of how many patients statewide were affected by that; but, Jerry, if maybe you and I can have a conversation about that and also some of the other issues that I emailed you about last week relative to Passport as well as WellCare issues related to appeals and also some Provider Relations' issues that I'd like to follow up with you on.

DR. CAUDILL: I did escalate that to Provider Relations, though. So, I did push it up the line.

DR. PETREY: Great. Thank you. I don't know if it would be easier. I don't know if the WellCare and Passport concerns should be addressed through you or through them direct. The Passport appeals haven't been looked at in a year.

DR. CAUDILL: I did push those up, too. So, they're working on it right now is what I understand.

DR. PETREY: Thank you. Should I expect something back from you or from someone in-----

DR. CAUDILL: I pushed it on up to the supervisor. So, let's see what she comes back

with.

DR. PETREY: Okay. Thank you very much.

DR. CAUDILL: And we are working on the D86 issue, too, by the way.

DR. PETREY: Right. It's not a problem for new cases, but those that were in the window when the fee structure changed from when the payment was made or obviously underpaid. And as I said, in our practice, it's a healthy number at over 150. Statewide I don't - I mean, that could be fairly significant.

DR. CAUDILL: As soon as I get all the approvals, I'll let you know how it's going forward; but so far, it's looking very positive.

DR. BOBROWSKI: All right. Any other New Business?

Motions or recommendations for the MAC or DMS. I know it's probably two or three years ago, I did get a report and it was county-specific provider data - I did get that - showing activity levels for the gross pay-outs.

And we talked about this at the last couple of TAC meetings, I believe at least the last one, but I believe since we have figured out

this motion for today on getting that provider information on how much work people are doing, I believe that will be sufficient, but I had it on the agenda.

So, I believe what we worked out before should cover that unless a TAC member has got another idea. Okay. I believe we're good there. Let me make a mote there.

I had a note there from another meeting that maybe the Dental TAC could have a recommendation for other TACs - I think there's nineteen or twenty of them - to look at the social determinants of health just kind of going forward.

I know each TAC has got their deal, but I just had that note written down on a piece of paper and I just thought, well, I'll follow up with the TAC members here just to see if we want to make any kind of recommendation to the MAC or we've done our part.

DR. SCHULER: Garth, we talked about that. I remember talking about it and obviously we're doing our part. We're getting our information and stuff.

It seems like Sharley or somebody had made the comment or was giving some

guidance on it's not necessarily each individual TAC's responsibility to communicate to the other TACs kind of what they should be focusing on but that we could as a TAC roll it up to the MAC that we're focusing on it and we feel it's impactful and something that is improving the lives of our patients and we just wanted to make that known to all the other TACs that that's a focus of ours as opposed to something along the lines of we're focusing on this and we think maybe you guys should be, too. Does that make sense?

DR. BOBROWSKI: Yes. I got you. What I could do is just at the next MAC meeting, I'll just make a note and report that our TAC has looked at that and recognize the benefits of all of that and that the MCOs are seriously looking at that and doing what they can.

DR. SCHULER: I think having some of the data that has been shared - Stuart certainly shared quite a bit - I'm sure the other MCOs will share more as we go along - to kind of package that up nicely and present that to the MAC just so that everybody hears that because between all the different TACs that report to the MAC - it sounds like a TAC MAC attack, doesn't it - that we should be

able to make a really positive impact on a lot of people's lives, but everybody has got their role to play in it, whether it's mental health services or behavioral health or DMS or just whichever TAC there is. So, a lot to do.

DR. BOBROWSKI: I'll just make a record, like you said, that our focus was to look at that. I know when we give our reports to the MAC, we do have limited time but they give us time to make our report.

But those that have reported today and going forward, the ones that are going to report next time, if you have all have data that you want to just send to me, I'll include that in my report, or if you've got one or two or three one-liners of benefits, that will be great and I will include that in my report to the MAC.

It is good to see the good things that the MCOs are doing and I think it's good to report that to the MAC that good things are happening out here. People are getting help. So, I think that's good.

Any other motions that we need to bring up for the MAC or to DMS at this point?

Then, our next meeting is going

to be May 13, 2022 at 2:00 Eastern Time. We'll probably be doing a Zoom again. And, again, I apologize for whatever happened to my computer. I don't know but it went fine this morning for another Zoom meeting.

Are there any other public comments or dentists' comments that you want to briefly bring up today? Hearing none, we will consider this meeting adjourned.

MEETING ADJOURNED

KENTUCKY DENTAL TAC MEETING MINUTES
Cabinet for Health & Family Services
February 11, 2022
2:00 p.m. EST.

The TAC members in attendance via Zoom: Dr. Garth Bobrowski, Dr. John Gray, Dr. Joe Petrey and Dr. Phil Schuler.

Medicaid staff in attendance via Zoom or telephonically: Leslie Hoffmann, Lee Guice, Judy Theriot, Angie Parker, Sharley Hughes, Erin Bickers and Jennifer Dudinskie.

The Managed Care Organization (MCO) representatives in attendance: At the request of DMS, MCO participants appearing via Zoom or telephonically will not be listed under Appearances.

Also in attendance: At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances.

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1. WELCOME AND ROLL CALL: Dr. Bobrowski called the meeting to order. Introductions were made and a quorum was present. Sharley Hughes introduced Erin Bickers as the new DMS liaison for the TAC and she will provide Ms. Bickers' email address to the TAC members.

2. REVIEW MEETING DATES: The future meeting dates are May 13th, August 12th and November 4th, 2022 at 2:00 p.m., Eastern Standard Time and will be held via Zoom.

3. ELECTION OF OFFICERS: Nominations were made and approved to name Dr. Garth Bobrowski as Chair of the TAC and Dr. Phil Schuler as Co-Chair of the TAC.

4. NEW MEMBER NEEDED TO REPLACE DR. BRANDON TAYLOR: Dr. Bobrowski noted that he reached out to Rick Whitehouse at the Kentucky Dental Association asking for nominations to replace Dr. Brandon Taylor.

5. COMMENTS BY COMMISSIONER LEE: Dr. Bobrowski noted that Commissioner Lee was not sure she would be able to attend the TAC meeting but he spoke about items that they discussed. One item included receiving data on how many dentists are actually practicing in the state and getting a paid claims' breakdown according to certain categories. Another item discussed was receiving data on the total dollars paid from Medicaid in 2013 and, then, each year after that up through 2021, excluding the Expansion population. Dr Bobrowski noted that this information would be a useful recruitment tool to find where the dental shortages are.

   After a lengthy discussion amongst TAC members and others in attendance, a motion was made concerning the TAC receiving county-specific provider data on a quarterly basis showing activity levels for gross pay-outs. This motion can be found below under Motions for MAC/DMS.

6. APPROVAL OF MINUTES FROM 11/22 MEETING: The meeting minutes of November 12, 2021 were approved.

7. OLD BUSINESS:
   a. Dr. Julie McKee – Dental Survey Report: Dr. McKee was not in attendance and, therefore, this item will be included on the next TAC agenda, and Dr. Bobrowski will reach out to Dr. McKee to invite her to the next meeting.
   b. MCOs' report on Social Determinants of Health and their impacts on oral health and total health care: United Healthcare, Anthem and WellCare made reports on the social determinants of health and their impacts on oral health and total health care, and these PowerPoint presentations can be found on the Dental TAC website. Humana, Aetna and Molina will present reports at the next

meeting. Angie Parker will also provide the TAC with a focus study done through DMS' external review organization on social determinants of health, as well as the website ink where this information can be found.

There was no other Old Business discussed.

8. NEW BUSINESS:
   a. Report on Senate Bill 87: Dr. Bobrowski stated that this bill would raise the floor so that the MCOs could not go below the state fee-for-service fee schedule. The bill came out of the Health & Welfare Committee and has been sent to the Appropriations & Revenue Committee.
   b. A new TAC has been formed called Persons Returning to Society from Incarceration: Dr. Bobrowski announced that this new TAC has been formed and Steve Shannon chairs the TAC.
   c. MCO reports (UHC, DQ, Avesis) FFS report: Nicole Allen with Avesis requested DMS to load the 2022 procedure codes into DMS' operating system. If Avesis bills a procedure code that DMS does not have in their operating system, then, the Avesis encounter will deny as an invalid procedure code and it incurs encounter penalties. Ms. Allen will submit a formal request to the MCOs to submit the question to DMS. There were no other MCO reports given.
   d. On the DMS website, can a contact number be added for each TAC: Ms. Hughes noted that DMS will not post contact information for TAC and MAC members and any and all questions may be directed to Erin Bickers with DMS.
   e. Other: Dr. Petrey will follow up with Dr. Jerry Caudill concerning the billing change to D8670 and D8080 and the impact that it had on underpayments for orthodontic services. He also will follow up with Dr. Caudill on other concerns with Passport and WellCare related to appeals and Provider Relations' issues. Dr. Caudill did note that these issues have been pushed up the line.

9. MOTIONS FOR MAC/DMS:
   a. For DMS – County-specific provider data on a quarterly basis showing activity levels for gross pay-outs beginning January 1, 2022: A motion was made, seconded and unanimously approved to ask DMS for reports going back to 2018 and going forward that show paid claims' data paid by region, using the eight MCO regions, reported per quarter, the number of dentists listed by specialties, of Medicaid business of zero to $1,000, $1,000 to $5,000, $5,000 to $10,000, $10,000 to $20,000 and over $20,000, and a breakdown of dentists by age ranges of less than 35 years of age, 36 to 45, 46 to 54, 55 to 64, and greater than 65. The motion also included asking for a report that reflects the total number of patient visits or encounters per provider, using the same parameters. Ms. Hughes asked Dr. Bobrowski to send her this motion via email.

10. SEE ABOVE FOR NEXT MEETING: The next TAC meeting will be held on May 13, 2022.

11. PUBLIC COMMENTS: There was no public comment.

12. DENTIST COMMENTS: There were no dentist comments.

13. ADJOURNMENT: The meeting was adjourned.

(Minutes were recorded and transcribed by Terri Pelosi, Court Reporter, this the 24th day of February, 2022.)