CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
DENTAL
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
November 14, 2025
Commencing at 2 p.m.

Tiffany Felts, CVR
Certified Verbatim Reporter

APPEARANCES

BOARD MEMBERS:

Dr. Justin Kolasa
Dr. Kaitlyn Patel
Dr. BJ Millay, TAC Chair
Dr. Joe Petrey
Dr. Jay Crews

MS. WASH: Hi, Justin and BJ. This is Barbara from Department of Medicaid Services. I have 1:58, and currently, I just have 3 out of the 5. Do you want to give it a few minutes till 2 o'clock?

DR. MILLAY: Yeah, we need to.

MS. WASH: Okay.

DR. MILLAY: I haven't heard anyone say they were going to not -- well, hang on. Dr. Crews just sent me a message asking how to get the link because he was having trouble finding it.

MS. WASH: Hm. It's on the website. And what is their email address? Hold on just a second, I'll see if I can forward it to him.

DR. MILLAY: J-C-R-E-W-S-D-M-D --

MS. WASH: Hold on just a second. Say that again.

DR. MILLAY: Hang on a second, I think I can forward it to him. I think I have it right here.

MS. WASH: Okay.

DR. MILLAY: Hang on a second, let me try to see if I can --

MS. WASH: It's pretty easy to forward it.

Okay. I'm still clearing the waiting room. So Joe Petrey and Carol Braun I don't see. Oh, here's Joe now, I see Joe right now.

DR. MILLAY: Dr. Braun was replaced with Dr. Crews.

MS. WASH: Okay, okay. All right, I'm sorry.

DR. MILLAY: Yeah, and I just sent him that link.

MS. WASH: Okay, thank you. If you would also send me any of his information, that would be great. I would appreciate it.

DR. MILLAY: Okay.

MS. WASH: Thank you. You have quorum.

DR. MILLAY: Okay. I'd like to welcome everybody to the Dental TAC meeting for 11/14/25. We'll jump into it, and it looks like quorum was established. At this point, we have myself, Dr. Millay; Dr. Petrey is -- looks like here --

MS. WASH: Yes.

DR. MILLAY: Dr. Kolasa is here, Dr. Patel is here, and I don't see Dr. Crews; however, I just sent him that information, so hopefully he will be joining us shortly.

MS. WASH: I'll let you know as soon as he's on.

DR. MILLAY: All right. Thank you so much.

MS. WASH: Mm-hmm.

DR. MILLAY: First order of business is to approve minutes from the 8/8/25 meeting. Do we have a motion to approve minutes?

DR. KOLASA: Motion.

DR. MILLAY: Motion.

DR. PETREY: Second.

DR. MILLAY: Second, okay. Motion to approve the minutes, all in favor from TAC members.

(Aye).

DR. MILLAY: So minutes have been -- I guess, any dissent to approving minutes?

(no response)

DR. MILLAY: Hearing none, minutes

are approved from the 8/8/25 meeting.

MS. WASH: And Dr. Crews is on.

DR. MILLAY: Okay. Okay. All right. Dr. Crews has joined us here.

So any -- I guess you would start with any options or opportunity for anyone to speak that is not a TAC member at this time. Any other representatives that need to address the TAC or has a question for the TAC?

(no response)

DR. MILLAY: Hearing no questions or seeing no hands raised at this point in time, I'll assume that is a no, so we will move on to old business.

The one thing we did have a question from old business was from the 5/9/25 meeting. There was a question regarding the medical loss ratio that was asked. And I know at the time, if I remember correctly, I believe it was one of the MCOs had got on and kind of briefly discussed it, but it was one of I guess you would say, the parent MCOs contracted the subcontractors. How do their contracts work with the MLR? Do we

have any subcontractors that can answer that? And when I mean subcontractors, that would be Avesis as managing for WellCare, or SKYGEN or whoever that may be. UHC is self-managed, so that one would be direct within their MCO. Do we have a representative from Avesis that could answer?

MS. GRAY: Hi, there. This is Kim Gray from Avesis. I'm just like -- I'm not quite understanding the question, and I may not be the subject matter expert that's able to answer that question for today. I apologize; I thought it may have been directed to the MCO.

DR. MILLAY: Well, as the MCO has certain standards issued from the state regarding their MLR and then they subcontract with the -- within Avesis or SKYGEN, whoever that may end up being, those contracts are not necessarily direct held with the state. They're held within the company to our understanding. So as those are held within the company, how does the medical loss ratio apply to those? And are

the same medical loss ratios being upheld by the subcontractors that the MCOs are responsible for with the state?

MS. GRAY: Well, it should be outlined in our contractual agreement between the MCO, so WellCare in our situation, and it should be aligned with what they are held responsible for in regard to their contract with the state.

DR. MILLAY: Okay. So that agreement can easily be accessed by state members then to see what that contract is?

MS. GRAY: I don't believe that our contract with WellCare is publicly accessible, if that's what you're asking.

DR. MILLAY: So then is that -- what you're saying is that that's not something that necessarily the state has access to manage --

MS. GRAY: It would be --

DR. MILLAY: -- or observe or look at.

MS. GRAY: They may, like if they perform an audit, yes, they would have access to that information.

DR. MILLAY: Okay.

MS. AGEE: Hi, good afternoon.

DR. MILLAY: Yes.

MS. AGEE: I just wanted to jump in really quickly here. My name is Chelsea Agee, and I'm the branch manager of the Contract Monitoring Branch with DMS --

DR. MILLAY: Yes.

MS. AGEE: -- and Health Plan Oversight. So I apologize I was a couple of minutes late to the meeting, but I kind of came in on the tail end of the discussion, and just wanted to clarify. So for MCO, you know, in their contract with DMS, it is a requirement that DMS has to review and approve all subcontractor --

DR. MILLAY: Yeah.

MS. AGEE: -- agreements prior to their implementation with the MCO and that vendor.

DR. MILLAY: Okay. So the state has looked at that to see then if that -- that's one thing that was not actually directly answered in that question from 5/9 when I know I had went back and looked and further

asking. So the subcontracted is actually reviewed by the state before those contracts can officially be issued to the new sub.

MS. AGEE: Yes, that is correct.

DR. MILLAY: Okay.

MS. AGEE: And if you're, you know, ever curious as to what the requirements that DMS has for the subcontractors, that is outlined in our contract that's on our CHFS website. I can put that link in the chat.

DR. MILLAY: Okay.

MS. AGEE: But there is a specific area that is relevant to subcontractor agreements, and it lists all of the regulatory requirements in that section.

DR. MILLAY: Okay. Thank you very much. That helps on that because, like I said, at the last -- I think there was a little confusion. We had seen that, but it does carry through to the sub, and the state does evaluate the subcontracts.

MS. AGEE: Yes.

DR. MILLAY: So, okay. Is there any other questions regarding old business or anything from the TAC that people would like

to request or have -- add?

(no response)

DR. MILLAY: I see that popped up at the bottom, Ms. Agee, and it vanished on my screen, so I'll have to go back to look at that. Will that be in the chat?

MS. AGEE: Yes. I just put it in the chat. I think I've sent it to the whole group. Yes.

DR. MILLAY: Okay, there it is.

MS. AGEE: So if you go to that link, if you go to the 2025/2026 midyear amendment, that is the most up-to-date contract, and you'll be able to see those subcontractor requirements there.

DR. MILLAY: Okay.

MS. WASH: I'll also add that to the follow-up notes.

DR. MILLAY: All right, thank you.

DR. KOLASA: Can I just ask a question about that link real quick?

MS. AGEE: Yeah.

DR. KOLASA: I don't see SKYGEN on there anywhere.

MS. AGEE: So Aetna, their -- are you

talking about the --

DR. TRAN: I'm sorry, this is Dr. Tran from SKYGEN. My director, Larry Paul, he was on Teams. I just forwarded him the link to Zoom. He should be joining any minute now.

DR. KOLASA: So you're saying that the subcontract through Aetna is what I should look toward for the SKYGEN management?

MS. AGEE: So we would not -- the link that I provided is the agreement between DMS and the MCOs. We don't post the subcontractor agreements or anything like that on the CHFS website.

DR. KOLASA: So I guess -- I guess the follow-up question is are they -- since those are not public, is the standard the same as the MCOs?

MS. AGEE: Yes. They are required to uphold the same federal regulation rules/laws that the MCO is.

DR. KOLASA: Okay.

DR. MILLAY: Any other questions or -- regarding the contracts and the MLR

aspect right now?

(no response)

DR. MILLAY: Seeing none, I guess we can -- any other old business that we would need to address?

(no response)

DR. MILLAY: At this time, I guess we move to new business. And on the agenda, first, we had talked, of course, with -- most people can, if they needed to switch an MCO or whatever for whatever reason, or if they were being assigned to a new MCO per a provider in their area, foster children don't have that option. And that's one thing that I know I have been faced with in our area is dealing with how do you get foster children treated because they are under only Aetna MCO? What options are out that can be done to give a better provider -- or open, I guess you would say, a provider network in areas where there may not be options for those individuals as that vulnerable population is needing care?

(no response)

DR. MILLAY: I see somebody did post

in the chat, "Foster children can opt out to go to another MCO." However, whenever I talk to any of the foster groups, that's not an option. I guess that would be -- would that be a question for DMS?

MS. WASH: I could take that back to DMS if you would like me to.

DR. MILLAY: Yes, because that's what at least case managers are saying, is that they have no choice to opt out if there was a need to be.

MS. WASH: Okay.

MR. DEARINGER: Barb, we may need to send that to somebody in eligibility after the call and get an answer back to the group from eligibility.

MS. WASH: I will do that, Justin. Thank you.

DR. PETREY: Just to follow up with a little bit of background on that. I think the TAC's primary concern is certainly with the most recent change with Aetna's management. We are fielding a significant amount of calls that providers are not sticking with and staying with and going to

be covering Aetna as they previously were. This is from general dentists to specialists to all aspects of dentistry. So our concern is that we have a very vulnerable population that will be required -- continue to be required to stay in one specific MCO's group mandated by the state or created by the state without an adequate provider network.

Now, it appears as though there's an adequate provider network because all providers with Aetna with the previous management have been just rolled over, but in actuality, if providers are not seeing patients or not accepting patients with Aetna post October 1, we have an inadequate network. And without the ability, from our understanding, for these children and these foster parents to switch to other networks, that's exacerbated by the fact that if you take simply the specialties, let's look at oral surgery. If you have someone in far East Kentucky, then there is no oral surgeon in East Kentucky accepting Aetna or Aetna patients at this time, then the only option is for the foster parent to take that child

to Lexington University. And that's, in many cases, not even an option for them.

So at the TAC we're concerned of the ability to receive care simply because of a decision to change who's managing for Aetna, but on top of that level, all foster children being required to be in the Aetna network.

MS. MADDEN: This is Shanna Madden. I'm with SKYGEN. It's nice to meet you all. I wanted to address that because access to care is of utmost importance to us. We understand that change is not easy and doing a network development completely new network for Aetna and Kentucky, I know that it can be a challenge. And sometimes with -- especially when you look at specialty providers, we see this across the board, but I know, particularly in Kentucky, oral surgery is a very difficult specialty to attract to a network. So if we have those situations, we will work with providers, perhaps in one-off situations for special case agreements. We want to make sure that that member, that patient gets the care that

they need. So we will work on that case depending on the situation, if they need to see a specialist, if there's not one contracted, we will do our very best to ensure that we get them to a provider as soon as possible so they can get the care that they need.

MR. DEARINGER: And this is Justin Dearinger, director for the Division of Health Care Policy, Department for Medicaid Services. I'll apologize for not having my camera on, I'm currently on vacation.

But I just want to let you all know Medicaid understands your concern, and we'll make sure to take your concerns and question back to eligibility division and get a response back to the group.

DR. PETREY: Thank you.

DR. MILLAY: Thank you. And so, well, now, Mr. Dearinger, is there a good email or time period I should follow up with you on that for the TAC?

MR. DEARINGER: You can -- I mean, we'll have -- we'll have something back to you next week, but if you -- you can always

send Ms. Wash an email, and she can put her email in the chat, or our general divisions email, either one. And I'll post that in the chat right now. So you can email either one of those if you haven't heard back or if you have further questions or can think of anything else.

DR. MILLAY: All right, thank you.

MR. DEARINGER: Yes, sir.

MS. WASH: I'd be happy to bring that back.

DR. MILLAY: Okay. And I apologize for writing -- I'm just writing it down so I can keep it on my radar.

And I know one another -- some other things that, of course, happened in going into down coding the procedures off fee schedules that are specifically on fee schedules. We've had that going on with some instances that have been reported. Dr. Kolasa, I think you had --

DR. KOLASA: Sure. Kind of in piggyback to what the SKYGEN representative said, you know, as a practice that tries to, you know, take all of the MCOs and try to,

you know, get as many people as possible, we did opt into SKYGEN and Anthem. And some things -- you know, part of this is growing pains, I understand that, but a couple things. I've had some other oral surgeons reach out. One of the things was that they were down coding panorexes, which is obviously, oral surgery that's pretty much standard, to PA series, and when questioned about it, they said it was more cost efficient for them. And I have a reference number on that. I think that's probably someone very new. I was little surprised that that was actually said, but we have appealed those. But, you know, that's a totally separate study. You know, there's a lot of gray stuff that insurance companies like the kind of push us on that are ethically questionable, but, you know, that's a totally separate study, so that doesn't really make a lot of sense.

And to piggyback on what we're going to talk about next on the agenda is, you know, with these new people, we don't have good appeals processes, we don't have a

director, and so it's very hard when these things go on when you're trying to serve these patients that you don't have someone to sort of get this stuff rectified quickly.

And so the other thing that was reported to me by a couple oral surgeons who also opted in was that specifically on full-mouth extraction cases, if the dentist bills for the denture ahead of the extractions. Dr. Wagoner, a good friend of mine, a good Medicaid provider out there in Western Kentucky, you know, he was not reimbursed for the extractions through Aetna because the dentist had billed for the denture ahead of time. That may be a problem with the system, but obviously, this is something that, you know, we don't have a contact with, and so it's very difficult to get these things fixed at this point.

MS. MADDEN: So this is Shanna Madden with SKYGEN again. I just turned on my camera. So yeah, with the down coding question, we are investigating that right now. We are working on an official response to Aetna on that, so we'll have more detail

as soon as we can get to the root of that.

So -- and also with the contacts for the SKYGEN team on the call here, we also have Dr. Larry Paul. He's our chief dental officer. Dr. Paul, would you mind, please, speaking a little bit about contacting us, and working with you and Dr. Tran?

DR. PAUL: Yeah, and I apologize, I had -- the Zoom link was just not working for me, so I was late, and I -- my apologies.

Yeah, I mean, we're in the initial stages of the transition to the program, and obviously, with any transition, we anticipate some hiccups. We want to be able to get to them as expeditiously as possible. So I would say on any sort of ad hoc scenario, I would recommend contacting Dr. Tran, who's really our lead consultant there now in Kentucky, and he'll be happy to be able to address those individual issues. You know, if there's anything that has to be escalated, certainly, I would get directly involved, but I think just in terms of being directly connected to a consultant, I think

Dr. Tran would probably serve the best role with that.

DR. KOLASA: Would you mind to put his contact in the chat so we have access to that, and I can share it with others who opted in?

DR. PAUL: Yeah, for sure. Yeah, for sure. Lu, if you could do that, that would be great.

DR. TRAN: Of course. Hello. Thank you, gentlemen, for having us. So right now, I understand your concern. Dr. Kolasa. I've seen that immediate dentures were denied, I think, because teeth were extracted? It's weird. It's supposed to be approved.

DR. KOLASA: Well, no, the extractions were denied because the dentist billed for the denture.

DR. TRAN: That's right.

DR. KOLASA: Yeah. I just want to make sure --

DR. TRAN: I saw that.

DR. KOLASA: Yeah.

DR. TRAN: I did that appeal. I

don't know who did the first line, but I appealed -- I saw the appeal and I approved it, of course. But I will, during this transition, give you my cell phone. Any of your providers have any concerns, they can reach out to me directly and I will immediately address it or answer within 24 hours. They're not going to be waiting for a long time for an answer.

DR. KOLASA: Perfect.

DR. TRAN: Does that help alleviate some of the concern?

DR. KOLASA: Absolutely. I think that's -- you know, that part of this with so many different MCOs and the shifts is like, you know, making sure we have a contact. You know, a lot of these people are old hat here in the state with providing Medicaid, and it's, like, you know, having to redo this every time and find the director --

DR. TRAN: That -- and --

DR. KOLASA: -- and who to appeal to. Just want to make sure that that's transparent for the providers.

DR. TRAN: Of course. It's growing pains. We have a director, a local Kentuckian, he is onboard -- doing onboarding processes right now, but I have 33 years of clinical experience, military service, seen it all, done it all, and I understand what the providers are trying to achieve. And this is a population that is underserved, and if they don't do it, who's going to do it, right? So I understand that, and it's important that we serve the public. Because at some of these other meetings in the past, dentists, like, you know, "let's make it, we don't want it." Okay, then do you want it? No, you don't. So, you know, let's not -- let's not judge these providers who are providing care under difficult situations. And we're doing our best to get, you know, things approved. Even if the written narrative's not there, I can see the x-ray that they need that procedure. So I think outside the box, so they don't have to worry about that.

DR. PAUL: We'll make it as easy as we can for everybody. Listen, we -- I'm a

dentist by training. I don't work in people's mouths anymore. I have the ultimate respect for the dentists that are serving the Medicaid population. There are inherent challenges to that, so just in terms of this administrative transition, 100 percent we are committed to making it as easy and as pain-free as we possibly can for everybody.

DR. KOLASA: Thank you.

DR. MILLAY: I was going to say, that contact information, Dr. Tran, how would be the best way to get that? Or can you post it in the chat?

DR. TRAN: I can do that.

DR. MILLAY: Thank you.

DR. TRAN: I mean, it's my cell phone. They can call, leave messages. Obviously, I will return it. Now, I'm new to tech, so in the chat, just type in my number?

DR. PAUL: Yeah, we -- and Shanna can help out with that, Lu. We can make sure --

DR. TRAN: I'll take it.

DR. PAUL: Yeah, we can make

sure that --

DR. KOLASA: Or your email. Yeah, your email's fine, too.

DR. MILLAY: Email's fine as well.

DR. PAUL: Yeah, we'll get that over to you.

DR. TRAN: You will have all my contacts. Okay, Shanna, you're going to make that happen.

MS. MADDEN: Working on it now.

DR. PAUL: And Shanna, you can send my --

DR. TRAN: I'm a dentist. I'm a dentist, I don't know --

DR. PAUL: Send mine as well. Let's make sure we have --

MS. MADDEN: Yep, got it.

DR. TRAN: -- I do claims --

DR. PAUL: Yeah.

MS. MADDEN: You got it.

DR. TRAN: -- and appeals. I'm not on social media for a reason.

DR. MILLAY: Okay --

DR. TRAN: Perfect.

DR. MILLAY: -- and that kind of

enters and feeds into the next topic as we're discussing lack of dental directors, lack of appeals process/claim reviewers. And it sounds like, of course, with SKYGEN being new, that is starting to go through, I guess being rectified, getting people involved in those positions.

DR. PAUL: Yeah, I mean, we should have a full contingent and certainly an adequate enough contingent of dental reviewers, of dental consultants. You know, in terms of the dental director, we will have an outstanding local dentist, whom many of you probably know already. Just there's an onboarding process that takes place. We're moving as quickly as we can with that, but I think everybody will be -- at the end of the day, be really happy when that person is on board.

DR. PETREY: That's great. That's great. I think we -- a lot of our concerns, you gentlemen have begun to alleviate by just giving us one contact and a name and a face --

DR. PAUL: Yeah.

DR. PETREY: -- to be able to even speak to or to tell those that contact us how to get there. Obviously, as well, we realize that it is a challenge to start anew, but the difficulty from providers is we are not starting anew. And October 1, our expectation would have been to have all of these things in place. I realize that's a challenge, and I realize that there were delays that held things, but it's been a major issue in the dental community having a lack of understanding of who to even contact or who the direct contacts are.

I don't like being reactionary, especially in these meetings, and oftentimes, meetings like this can be, but I do think it important for you all to be aware of some of the situations going on with the -- with right now, with the transition. And again, you all are new to the meeting, so please don't feel that we are gaining up necessarily on SKYGEN. It is just the current concerns in some of these things. And so as I move forward with what I'm about to say, I know that we've had

conversations with every aspect from MCOs to administrators to even discussions amongst dentists about making the network better and helping providers to be able to provide for the patients, and at the end of the day, to provide care for the patients.

I would like -- and I wanted to do it a better way, but I would like to read a response from my coordinator, insurance coordinator, from her experience this week that I think is important for you to be aware of and in hopes that these issues can be addressed. I can tell you our practice has been a part of the program since its inception, and we've accepted every MCO since the MCO inception, but we -- we've had our issues, and this onboarding has had its own issues. I apologize for reading someone else's words, but I will read this in Threesa's verbiage, and she states: "Information available to providers is lacking. We have no provider office reference manual, ORM. We are only provided a two-page desk reference guide." She showed a screenshot there of it. "Providers

have to just guess what is required to submit with claims using their prior knowledge of Medicaid. Understanding all the plans are supposed to follow the Kentucky statute, but we know from past experience there are often different forms and codes each plan ends up adopting, especially in orthodontics. There's been a lack of communication from SKYGEN and Aetna Better Health. When you call with questions, you are told to call the other and vice versa. I have been told to call Aetna Better Health directly, and then Aetna has apologized and told me that they do not know why SKYGEN is telling providers to call with dental questions as they do not administer the dental benefits. Also, the provider service numbers on the office desk reference manual from SKYGEN is actually for Aetna Better Health, who tells you then to call SKYGEN."

She states she "spent 45 minutes trying to find out how we were going to be paid and called 4 phone numbers just to be referred back to the first number, and then

miraculously they found the answer that they could not find on the first call." That's her words. "E payment center has had a hard time setting up EFTs. When called to get everything set up, they set us up with Aetna. Upon completion of this process, I noticed no past or future payments were showing. Then after some research, I discovered we were set up for EFT on Aetna Senior Supplemental, obviously not what we were looking for in dentistry or in orthodontics. I had to call again and ask if this was correct. They had a hard time figuring out if this was correct. They told me to call Aetna Better Health and to see who was supposed to do the ETF for that plan. I explained to them that their phone number is on the SKYGEN desk reference manual and tells you to call them," and I have that number here if you're interested, "to set up the ETF. Finally, they think they found the plan and said they think it is not called Aetna Better Health. It is in their system, rather, as Optum SKYGEN IHP payments. We hope this is right, but that's

what we're set up with now.

We had a provider training with them that was vague and ended by letting us know that they would not be answering any questions. That's a challenge. We were still not provider -- were not provided a provider relations person for Kentucky. I was told during recruitment that we would get a phone call from provider relations and be provided their contact info. I was told that the person would have our office reference manual info. Still no phone call, still no reference manual. All other plans have provided provider relations personnel and their contact info in case you have issues that are above general provider inquiries. Being that SKYGEN is unable to answer plan-specific questions, not having a contact is a challenge."

Now, that again, is an employee of mine who I have a lot of respect for, but I think new network, new challenges, but October 1st, we started seeing patients under this plan. Since October 1st, we have had no contact, no ability to even have a

contact and the contact numbers we have bounces back and forth without answers. That is a major challenge in my practice. I have been doing this my entire career. Our practice has been doing it since its inception. There are many, many doctors that do not have the experience or the staff experience that my office does. I have a great concern if this staff has this much issue, what new practices are experiencing and what they are even able to attempt to put together with the network.

DR. PAUL: Yeah, that's a lot, and I -- it's -- it dismays me to hear this, and I feel your frustration, I really do.

MS. MADDEN: Yes.

DR. PAUL: Yeah.

MS. MADDEN: I'm sorry that that was your team's first experience with us. I -- it's true, we had some trips right out of the gate where there were a couple of fumbles, and I think that while we've fixed those items, it's still -- it was your and your team's first impression of us, right? And that's regrettable and I do apologize

for that.

I will give you my personal email. I am responsible for the relationship between SKYGEN and Aetna. So contracting, making sure that we're doing everything that we're supposed to be doing from not only a regulatory standpoint, but also from a contract standpoint, that is my responsibility. So I would be happy to provide my contact information to you so that you and your team never have to go through that again. I realize that there is a larger systemic concern here. It's not just you, right? So I will get with our provider relations team right away to ensure that not only do the providers in the network have all the appropriate contact information, but to ensure that we're addressing any lingering concerns or issues as soon as possible.

DR. PETREY: Thank you. And I appreciate your all's response. And I want you to understand that it is -- we all know that this is new, and we stumbled, too. We went so far as to signing up with Senior

Supplemental with Aetna thinking we were signing up for the EFT, and that was our mistake. But we made that mistake because there's a lack of information, and there's a lack of information because it's new. But again, we're six weeks in and patients are being treated, and I have a great concern for all of the practices that have the same questions/concerns that we do.

MS. MADDEN: Absolutely. I share your concerns, and I greatly appreciate the feedback. We're not going to get better unless we get honest and open feedback, and that's what's going to make us better. We're going to be better tomorrow than we are today, and I commit to you that we will get on top of this right away and ensure that we're closing those gaps.

DR. PETREY: It's all we can ask. Thank you very much.

MS. MADDEN: Sure.

DR. MILLAY: Any other concerns or questions over lack of directors, appeals process, claims reviewers for MCOs? That topic section?

(no response)

DR. MILLAY: And I did have in the same -- and somebody else may have an answer to this. This is one -- I think the appeals process for just the state, I know the last email I had, and I actually called the representatives in the provider relations line, and the email they gave me was incorrect and kicked back. So I didn't know if anybody else had one for just regular fee-for-service DMS Medicaid, a contact for the appeals process.

MR. DEARINGER: Yes, sir, this is Justin Dearinger. We do have a contact for that. I will send you that right after this meeting.

DR. MILLAY: Okay. Yeah, because --

MR. DEARINGER: And I'll make sure that Barb sends that out to the whole committee.

DR. MILLAY: Okay, thank you. The -- yeah, the email that the customer service -- or sorry, I say customer service -- provider relations had given me, I tried a couple of variations of it after it got kicked back

the first time thinking maybe I wrote it down wrong, and it still was getting kicked back. So any other TAC members, Dr. Crews, Dr. Patel, Dr. Kolasa, any issues or things to add regarding the MCOs, the appeals process claims you've run into?

DR. KOLASA: I think Joe summarized it pretty well. I think -- you know, I think the point is we just want this to not be so complex, just a contact and then a response. You know, all the people in here are pretty old hat with this stuff and so we're used to it, but, you know, if I'm trying to encourage new providers and say, "Hey, this is -- you know, we want to care for our Medicaid patients. You know, it's not too bad to sign up, it's easy." You know, what I'm not going to do is be a liar. And so I guess that's my goal with this is if as a specialist, if I want to try to convince these people to stay in network or to give it a shot, you know, I want to be able to -- you know, I don't want a call back saying "I'm not sending you anything ever again after this."

And so I guess that's the goal with everything is, you know, just communication, transparency, and then, you know, feeling confident that I can recommend this for other providers is -- you know, as we try to expand the network as best we can. So I think Dr. Petrey summarized it better than I ever could.

DR. CREWS: Could I add something? We are, as an office, having a little concern with our third party, which we use Vyne through Eaglesoft, and being able to submit claims. I'm not sure if anybody else is running into that issue, but as of right now, we have not submitted a claim to Aetna for any patient we've seen since October 1st.

DR. MILLAY: And we use Vyne as well. Now, we haven't submitted with Aetna. Now, we -- and I know this is dealing with Medicaid; however, I do think -- I believe SKYGEN -- is it the same SKYGEN that houses claims processing for in the portal system, I guess you would say, of submission that does, like, some of the private insurances?

I don't know if that's the same kind of web portal access or not. Does anybody from SKYGEN know?

MS. MADDEN: I'm sorry, I'm not following the concern or the question.

DR. MILLAY: Well, my question is, and I think Dr. Crews' question I think his claim processing software is not linking to SKYGEN.

MS. MADDEN: Hm, okay.

DR. MILLAY: And if I'm incorrect, Dr. Crews, please correct me, but I know --

DR. CREWS: That's correct, BJ.

DR. MILLAY: Okay. I know we use the same processing system, and I do know that there are some private insurances that use Optum SKYGEN parent company, and I did not know if that's the same portal system that would be operating through the Medicaid system for SKYGEN.

MS. MADDEN: I'm not familiar with that. I put my email in the chat. I believe you said it was Dr. Crews, if you wouldn't mind, you can shoot me an email, and I'd be happy to get you pointed in the

right direction. I unfortunately don't have the answer to that right now.

DR. CREWS: Okay, thanks.

MS. MADDEN: Thank you.

DR. MILLAY: Okay. And this -- moving into the next topic, and that's kind of what a lot of it is the parent MCOs, I guess you would say, your WellCares, Humanas, Molinas jumping at any time without a lot of notice it seems like to providers, which creates strain on provider networks, patient care, continued care. Who at -- is there a, I guess that -- is there a process for state evaluation of these and a time frame that has to be given to providers? It often seems like it's very abrupt. Now, it may be sent out in certain time periods or something, but who's really, I guess you'd say, overseeing a lot of these changes to make sure providers are aware?

DR. PATEL: Yeah, I would just like to add in on that as well. That was something we faced in my office as well, BJ, is just not, you know, knowing exactly when these changes were going to happen. It was

like the month before we found out that, you know, patients were switching MCOs and we weren't prepared to get everything billed through that new MCO. Or that they were losing it, and we had to contact patients and say, "Hey, we're not a member of this MCO," you know, and all that stuff to make sure. So I was also wondering that same thing. You know, is there a certain time frame that has to be notified, you know, and also, is there something that is reported to the state for that as well, just so we know how long -- you know, when those contracts come up?

MS. WASH: So this is Barbara with the Department of Medicaid Services. Chelsea, do you have any input there?

MS. AGEE: Hey, good afternoon. Sorry about that. I was just trying to quickly pull the contract up and get the exact time frame, but there is a requirement in the contract that there has to be a provider notice. I was thinking it was 30 days, but I want to double check, it might be 60. So let me take that back so I can

get the exact date -- dates for you. But yes, I mean, we do require any type of large changes such as this that affects networks in this capacity, there is a requirement that they have to notify the network prior to that implementation. I just need to get that exact time frame for you.

DR. PETREY: Is there any vetting of these administrators, or is that simply through if you meet the contractual with the greater -- with the WellCare, Molina, etc.? And would this be something that would fall under the purview of a dental director if we had one?

MS. AGEE: I'm unsure about your second question, but regarding the vetting, so yes, we have subject matter experts within DMS that will review the subcontractors depending on the business area, so, you know, for specifically for dental, or if it was, you know, behavioral health, say. So we do have subject matter experts that look at those contracts, make sure that they meet the minimum requirements that are outlined in our MCO contract, and

then as well as, you know, mitigate if there is, you know, risk. You know, we also have collaborative discussions with our MCOs. If you have questions about any type of vendor changes, so, you know, we work pretty closely with the MCOs through that process, and, of course, you know, do our own checks on the DMS side, you know, to determine if they're meeting, you know, that criteria.

DR. PETREY: I think as we've -- as we stated --

MS. HENSEL: Hey, no.

DR. PETREY: -- go ahead.

MS. HENSEL: Sorry, it's Krista Hensel with United Healthcare. And Chelsea, I would just add on to your comments that the MCO contract that you pointed this group to earlier in the conversation also outlines that as an MCO, you have to have a dedicated dental director to this Kentucky work. So your comment around having a dental director, that is in fact a contractual requirement that DMS has for each and every MCO.

DR. PETREY: Thank you --

MS. HENSEL: And most of you I think know -- you know probably Dr. Rich, who is our dental director for United Healthcare. If you guys ever need anything, he's an amazing resource.

DR. PETREY: Absolutely. I think -- not to belabor the point, but I think some of our concerns for the foster children and -- could also stem from some of this change. And it's new with SKYGEN, but we've weathered storms with Kentucky Spirit and other -- and others that have made challenges and have made it difficult for us to have an adequate network. Again, if we look at the network, because providers were rolled over, because they're Aetna and they're still Aetna, it seems as though there's an adequate network. And it seems on paper that we don't have an adequate network in general. We know that. The CMO of WellCare testified to that at the MOAB on Wednesday. You guys know that. But on top of that, the smoke and mirror of a network is that right now we have one with Aetna, and yet, as a provider who is referring

patients for all aspects of dentistry, except for orthodontics, they stay with me for that, but from oral surgery to general dentistry to periodontics, all kinds of treatment that we refer to, we have a vacuum of providers for Aetna because -- since October 1.

Now, some of that simply may be because of the issues in the transition and being able to understand, but much of it does seem to be from previous experience, and especially our oral surgeons are not wanting to be in network. Now, I will say that on this TAC meeting are providers that are working diligently to maintain Aetna patients, to treat Aetna patients, and to work with SKYGEN in doing so. But our concern is this change was made, somebody vetted it, but the vetting did not include what is actually happening with the network, and whether people will be -- will seek care. We currently have patients that are being told in the vernacular of the dentists, "we no longer accept that insurance. You'll need to find another

provider."

Now, if it is a provider that is readily accessible, you're still three to six months to get a patient in. If it is in Aetna provider, I -- at this moment, I don't know where to send parents, patients, foster parents. I don't know where to send people. If we're waiting six months to get into UK because they're the only people that from far East Kentucky we can send patients, these are patients in pain to be frank. And I should've said it at the MOAB, but if I'm sending someone for pathology, let's conceptualize what can happen in a cancer of the jaw in six months because we just don't have an adequate network. We started this October 1. We're six weeks in and we're still -- we still have these serious concerns. I'm not sure the fix, but I do know that whatever a vet was and whatever our decision to vet and go forward should have made a better look to see if there was going to be an adequate network, one; but, two, should require that the onboarding, and I don't know if this is through the MCO or

if this is through DMS, but whoever is managing it has things in place to run a system, which quite frankly, as has been admitted and discussed here, is not yet in place.

I appreciate the effort to bring it on forth and the difficulty of it, but we have patients that are in dire need that cannot be seen because of this change, and a 30 to 60-day notice.

MS. PARKER: Hi, Dr. Petrey, this is Angie Parker. I'm the director of Quality and Population Health. I just want you to know that we do hear you, and we do want to make sure that there are access, and we are -- we hear your concerns with this transition. It sounds like SKYGEN is very much willing to help you with that. Unfortunately, we can't go back now and we can only move forward to make sure that your patients, our Medicaid enrollees are getting the care that they need. And whatever we can do, Chelsea's group with the Contract Monitoring Branch as oversight, if there are particular complaints or issues that you are

having with any of the members in trying to find assistance with, we are more than happy to help with that.

And you can have my email address as well. I can -- I'm more -- because we -- as you said, we do know that there is an inadequate access for our -- for dentists in the state of Kentucky, and we are working to identify those dental deserts and how we can improve in those areas and help each other in making sure that our Medicaid enrollees do receive the dental care that they need timely.

DR. PETREY: Thank you. And we certainly appreciate that, and we appreciate DMS's work. We appreciate the MCOs' work, and we appreciate the administrators' work. And SKYGEN, it is a challenge, and I know you guys are -- have a lot on your plate. My concern, though, is that the network that is apparently there is really not there. It's -- when you -- nuts and bolts --

MS. PARKER: And we are evaluating --

DR. PETREY: Okay.

MS. PARKER: -- just as an FYI,

Dr. Petrey, I didn't mean to interrupt, but we are looking at the dental network as a whole, not just SKYGEN. So this is -- but all MCOs drilling down on that, and obviously, we want to make sure, regardless of the dental subcontractor with any of the MCOs, that our members are able to obtain timely dental care, and we know that that's a challenge.

I can apologize regarding the issues that you had with this transition with Aetna, and it is typically 30 days when those changes do occur that they are to notify the members and the providers of any significant changes. It is 30 days, and I know that really may not seem like a lot of time, I can understand that. So if there are any particular issues that you would like to bring to our attention that need assistance right now, we can certainly get with Aetna/SKYGEN and see, drill down on how we can help facilitate any movement that you may need.

DR. PETREY: Thank you. And again, and I want to reiterate, no apologies

needed. We are all here to try to make this better. Our concern is just that we want to make it clear that, as a TAC, we are getting -- fielding a wave of questions about network adequacy across the board, but it's been exasperated since October 1. And then the foster children aspect of that certainly is a concern of ours, but --

MS. PARKER: And I understand.

DR. PETREY: -- we appreciate everyone.

MS. PARKER: We have around 25,000 children in foster care I believe or that are within the Aetna network, and yes, they are the only MCO for foster children. There are -- and I don't have it in front of me. I tried to find it, and I know it's addressed in the Aetna contract, too, as well on how -- if foster children are able to move from another MCO. There are -- there is language specific to that, but I don't have it at my fingertips today, but thank you, Dr. Petrey.

DR. KOLASA: If I --

DR. PETREY: Thank you. And to be

frank, we don't want them to move, we just want the network to be there, right?

MS. PARKER: Right, exactly.

DR. PETREY: But if it's not, then they --

MS. PARKER: I get it.

DR. PETREY: Yeah.

MS. PARKER: Yes, absolutely. I understand.

DR. KOLASA: I don't want to beat the dead horse, but maybe in the future, you know, the difference between, like, medical and dental is a lot of these are small businesses, so there's a lot of slop that a hospital can handle. You know, 30 days may be adequate for that side, but, you know, as someone who manages this myself, and, you know, pays my employees, etc., like maybe a 60 to 90-day lead time as opposed to 30, you know, and then, you know, maybe a little bit of onus on the state to make sure these things that they're contractually obligated to do as in having a dental director already in place before allowing them to start. And I guess that would be what we could improve

on going forward is more lead time in the contract. I mean, I'd like -- you know, what's the harm in 90 days to allow this transition and probably get more people to transition with that? And then secondly, you know, to make sure that they're fulfilling their obligation in the contract. As Krista mentioned that on the link, you know, if they're contractually obligated to have one and they're not meeting the contractual obligation, then that's a problem.

MS. PARKER: Yes. Yes.

DR. KOLASA: And we're held to those standards. You know, if I don't do something right, if I don't code this right or just right, they're sure as heck going to take money away. So, you know, I would expect those to be held to the same standard that we are.

So that's just for the future. You know, what can we do different, and, you know, not beat this, belabor this any longer, but next time, if there is a next time this comes around, those are things

that I would suggest would be helpful.

MS. PARKER: Well, we appreciate your candor and your input.

DR. MILLAY: Piggybacking on some of that as well, I mean, I know in the past you've always had to sign two recredentialing agreements and recredential with multiple groups with the sub and the parent company. So, you know, during that process, if you never credentialed with SKYGEN, or -- and I know this does seem like it's picking on SKYGEN, that's just because of the transition at this time -- you know, 30 days is not a lot of time to go, "Oh, I need to recredential with this company" and get your credentialing packet in.

MS. PARKER: Yeah, I -- and don't quote me, but I believe there is a little bit longer period for the credentialing process. But I think I'm pretty sure it's longer than 30 days, but don't quote me on that.

DR. MILLAY: Because, yeah, for providers to credential, it takes some time.

So -- and that does bring me to a

point going -- does the -- if the MCOs have a dental director, does the state not have a dental director that helps manage these aspects?

MS. PARKER: We currently do not.

MR. DEARINGER: That's correct, and this is -- again, this is Justin Dearinger with the Division of Health Care Policy. So on that issue, a state dental director would not be involved in this issue. This issue is a -- we have our contracts directly through with each MCO. We do review the subcontracts to make sure they meet the requirements that are laid out, but that MCO are the ones that are responsible for ensuring network adequacy. They are responsible for ensuring that they have everything in place, that they have what they need, and then DMS holds our contractors responsible through our contract if there are any issues and errors. So a state dental director wouldn't look at those contracts because this really wouldn't be in their purview.

DR. PETREY: Network adequacy,

though, is determined by the MCO's own review of their network adequacy; is that what you're saying, Justin?

MR. DEARINGER: That's correct. The managed care organization, through their contract with the state, with the Department for Medicaid Services, has to ensure network adequacy to their members that are enrolled with that group. It has to be for every aspect of care they cover whether it's orthopedics or dental, and so if they don't, then there are certain things that happen with -- through the contractual process as far as penalties go.

DR. PETREY: Can the TAC --

DMS: Agreed. And just to be clear, the state, while the MCO is monitoring the network and the network contracts and ensuring that the downstream contract obligations are fulfilled, DMS is certainly doing the same thing with the MCOs, whether it's through state quarterly annual reports that report network adequacy information, geo access, etc. But also, there's a variety of secret shopping that occurs both

with the MCOs doing secret shopping, DMS doing secret shopping, and there's certainly been efforts around looking at providers that are in the network have a contractual relationship, but have not submitted a claim for a Medicaid patient in the past year or two to understand if there is variation there that needs to be addressed as well. So just to assure you that not only are the MCOs providing oversight, DMS, Chelsea and her team specifically, do a lot of work day in and day out to make sure that the MCOs are meeting their contractual obligations.

MR. DEARINGER: And I did want to allude to what Ms. Parker talked about earlier. So there is a project that we've -- currently still working on with looking at each provider and not just if they have been billing but are they taking new patients currently. So we have providers listed and not just any particular one MCO, but multiple MCOs, fee-for-service that, you know, are enrolled but don't provide care or they may only have a few members that they're billing for, but they're not taking

new members. So we're checking all of those things to ensure network adequacy is there and try to find ways to increase availability of providers to our members. And I do understand, and we're going to get you some more information on the foster children, but if their -- we have a member that has an issue at their dentist with their provider not taking a certain managed care organization, all they have to do is let us know and we try to change that if they, you know, wanted to stay with their current provider within 24 hours.

DR. PETREY: Thank you. And I think, Justin, you -- I mean, we've alluded to it at many TAC meetings, and I know it was a pet project of Garth's, and that is that network adequacy is not just number of dentists per population, but who's actually seeing these patients. So -- and I know you all recognize that, and we appreciate that you all are helping to -- well, you're not helping, you're doing the work to determine that, and that is -- that's important to us as a TAC. So thank you.

DR. MILLAY: And that's going into kind of our next topic that was we always want to talk about network adequacy, and, you know, one of the things to look at, and it's oftentimes a touchy subject, but reality of small businesses versus hospitals is that people who sign up for Medicaid know they're not going to become millionaires or anything taking Medicaid. They do it because they truly want to help the population they live in but even wanting to help the population you want to live in, you still have to provide for your families, your employees, your -- you have bills. And facing reality, fees are not keeping up with inflation and the overall expenses that providers out there are facing. And no matter how nice people want to be, and, you know, when you look at the grand scheme, dentists really do try to help their communities a great deal. They have specific skill sets that can get people out of pain immediately. You know, you look at all of the new evidence that's come out with systemic oral health relationships, you look

at the importance of decreasing biofilms in the mouth and how that applies to heart disease and diabetes and all these things that increase overall healthcare costs. And the fees just don't keep up with all the things that we can benefit society.

Since COVID, you think about all the drastic increase that there's been from masks, supplies, just general expenditures, normal businesses pass those fees on. You know, if you go to Walmart, they have to pay five more dollars for a product, they just charge you another seven. Dentistry doesn't have that option to be able to do that, to help pass on any kind of fees. So how -- and this is going in the same thing, how can we all work together to try to figure out solutions in, you know, fees that are acceptable for providers to try to increase networks?

MR. DEARINGER: So this is Justin Dearinger again, and I -- you know, I understand that, you know, fees are big issue. We've heard it multiple times from -- specifically from all of our providers,

but especially in the dental provider community. I think it's important to know this is a Medicaid issue overall, and not just a dental provider issue. Most of our provider types have not had an increase in fees in many, many years. Some of them haven't had an increase up to five or six years. They've had no increase in their fees. We did increase several dental fees not that long ago, I think maybe two years ago. We also try to drastically increase our oral surgeon rates in order to try to help build our oral surgeon provider network.

In addition to that, we had some new codes come out where we increased those rates on those new codes. So we do have several rates right now that are a lot more than any other state, they're a lot more than any private insurance. We have some -- a lot of codes that we don't bundle that every other state and every private insurance bundles that when unbundled and put together, sometimes they're double what any other state allows for. But because

those things aren't plain and clear, we're currently trying to rework those a little bit to make those -- reduce those rates to be about the same as what other states are paying for those codes, bundle those things together like other states do so that -- and whatever savings we can get there, add to some of our codes that are lower so that it makes more sense when people compare codes to codes. So we are working on a project to be able to do that.

But as again, like I said, overall, a lot of our providers have had 0 increases, and so it is a 100 percent funding issue. Your legislators determine how much funding that we get for Medicaid and so I encourage you to, you know, ask for more funding from your legislature for us so that we can increase the budget specifically for increases in fee schedules. You know, we can't increase those fee schedules if we don't have the money to do it, so I think that's kind of where we are. We're dependent on that budget.

In the meantime, we're trying hard to

reduce burden for you all, provider burden, and increase services that add codes, do some things that will help you all. And again, with the rate project, trying to -- the rates that we way, way overpay for, and believe it, we hear it from our MCO medical directors trying to bring those back to normal and maybe increase some of the other rates that are a little lower so that it looks, you know, more normal on paper. But, you know, we're doing the best we can with the budget we have, and, you know, that's kind of where we're at with the budget is, you know, we need to have some more money allocated in our -- from our state funding to be able to increase those things.

DR. PETREY: Yeah, we --

DMS: Yeah, can I just pile on for just a second, and especially coming off of MOAB earlier this week, I want to demystify something a bit as well. And that is the compensation then going through MCOs.

So Justin articulated the fee schedule, when the rates are set to pay to MCOs, those capitation payments are made on

a monthly basis. Actuaries set those rates based on the fee schedule of the state, so it's based on historical utilization times the fee schedule from DMS of those various codes, and that creates the baseline that actuaries then do their modeling of what's going to change going forward. But the basis of it is, in fact, that the DMS schedule as well.

I would also just highlight, I think one of the reasons MOAB was generated is, you know, everybody across the Commonwealth I think is concerned about the budget pressure cuts that Medicaid will experience in the coming years after the One Big, Beautiful Bill was signed into law on July 4th. And so more money is not magically coming from D.C., and I'm not sure where it comes from in the state budget either. I do think it's going to take groups like this working in partnership across DMS, across the dental community, and across the MCOs and our dental providers to figure out where might we find efficiencies because I think most of us get into this

business because we have a passion for helping people live healthier lives and caring for those that are the most vulnerable in our communities, and that is a real challenge. We are going into a budget-pressured environment, and I don't think there's a magic pot of money sitting either at DMS in their budget, or certainly in the MCOs based on our capitation rates and some real underfunding we had in the plan last year as well.

So I just, again, I'm happy to put my contact information in chat as well if folks are confused around how the dollars flow or how actuarial rates are set or any of those real nerdy things. I'm happy to do my best to demystify that so that we can get on the same page on the fact base and figure out how we pull in the same direction together.

DR. PETREY: I think -- we appreciate that. I think, though, when we want to talk about these things, we also need to factor in a couple things. One of which is, and, Justin, you're right, there's been a number of providers across medicine and dentistry

that have not had major swings. The majority of medicine, though, and correct me if I'm wrong, is tied to an inflationary act that allows those fees to move as Medicare moves. Dentistry doesn't have that benefit. So when we look at our fees and those actuarial numbers that you talk about are brought up and we look at and say, "Well, this is the DMS fee." Well, the DMS fee for the majority of dental services is based on 75 percent of the 19 -- 1987 fees. So 75 -- and it was in 1997 that was done. So the fees that we're looking at for the majority are things in 2025 were what was determined to be 75 percent of a fee 28 years ago. So there's no question why this is a problem. There's no question why there's network inadequacies. From a straight financial aspect, there's no question why providers are struggling to be able to even be able to treat population because they simply can't afford to.

But if we only talk about, you know, this is the DMS number, well, the DMS number was set, and it was set in a number, at such

a -- at such a difficult time in '97 off 75 percent of the '87 fees, and it never moved. So I get into analogies, but that was a small rock then, and today, that rock is massive to get fees to an appropriate level because we are at such a -- there's been such a disparity. Inflation, post COVID, post life, post -- BJ has put some things in here about the cost of bread in 1987 and the cost of McDonald's hamburgers. And remember, our fees were 75 percent then, and that's still what we're working with for the majority today. There are some things, and we appreciate, especially with oral surgeons, with the pediatric dentists, the changes that were made. But we're still -- I mean, the numbers bear out if you compare to other states how ridiculously low the numbers are for practitioners.

My question on top of that is, Justin, when you all are determining those and you're looking at appropriate fees, who from a provider perspective is involved with saying, "Well, these are appropriate numbers"? Or are we simply just looking at

other states, or are we looking at people that are actually boots on the ground that are treating these cases? Why isn't the TAC involved in helping determine what is an appropriate fee for service?

MR. DEARINGER: So yeah, the first thing I wanted to address, there are -- you are correct. There are a few, very few, provider groups -- and I think that's a large misconception, a large misinformation. A lot of people believe that most provider groups are reimbursed through their fee schedules based on Medicare rates that go up every year. That is false. In the state of Kentucky, there are very few provider groups that are directly tied to Medicare rates. We do have a few that are directly tied, and they are tied up and down. So when I get the Medicare report for those provider types, half of the rates go up, half of the rates go down every year. I'm sure over a 10, 20-year span, those rates generally gravitate up, but there are only a very few. Most of the provider groups -- we have about 60 provider groups in the state of Kentucky.

Most of those provider groups are not tied directly to Medicare. So an example with that would be our largest provider group, which is the largest fee schedule, which is the Physicians Fee Schedule. One of the provider groups that I mentioned earlier is not having an increase in fees within the last five years or so or more, and so, you know, it's -- again, it's not just dentists. I agree it's a problem, it's an issue, but it's not a unique one to this provider type or provider group. And --

DR. PETREY: You keep saying "five years," though, Justin. I'm sorry to interrupt. You keep saying "five years" like that's a long time for a group of physicians to not have a change in fees. Since the MCOs came on board, what we received was a 10 percent cut, so -- and that's been a little bit more than 5 years, and '97 is quite a long way from 5 years, and 75 percent of the '87 fee, I mean, that's getting to be numbers that it's insane. And then when you see reports from the KDA talking about things such as review

on cost to treat a single filling being -- and comparing that to the DMS fee in that providers are doing that in up to a 50 percent loss by doing the treatment, you know, where -- you have providers out there that are subsidizing with private fee -- private patients to subsidize being able to treat a Medicaid population. We're all doing that. We're doing that because we want to treat these people, but in that same time, I mean, it's not sustainable because at the end of the day, as Justin said, we all are businesses. We're not major hospitals. We're not pro bono organizations. We would -- that 75 percent of the '87 fees -- 75 percent of the 1987 fees is still the majority of our DMS fee structure, and that is just not cutting it to bring new providers on or to keep the good providers that we have still on.

DR. PATEL: And I know specifically for me, one thing that directly affects me are like -- and most of the general dentists that I've spoken to are those restorative codes. Like, those for a fact have not been

raised since those fees, and those fees were adopted when I was four. So I think about that, like, I was four years old when these fees were accepted, and I've been in practice five years now. And it's just completely not -- I'm not able to let alone break even, I lose money every single time I do a filling, which is the majority of my practice.

DR. PETREY: And --

DR. KOLASA: Justin, what's the resistance from DMS to raise the fee schedule? I mean, it just seems like this persistent issue where, you know, you know what the problem is, it sounds like all these other people base it off that, what's to stop you from raising the fee schedule to be at least consistent with our surrounding states? You know, you talked about those expanded services, you know, I have tried and tried and tried to find who was communicated with in that situation. You know, if I never placed another Medicaid dental implant so that general dentists could do restorative work, I'd be great with

that. Matter of fact, I don't know that I've placed but one. And so, you know, how much of those expanded codes are being utilized, and should they even have been expanded versus taking -- you know, Medicaid is trying to treat disease, and so, you know, an implant doesn't treat disease. And then I stand to lose here, right?

But these people need restorative work, basic restorative care, extractions, things to get them out of infection and pain. And so I really am having a hard time seeing my providers dropping off. I had one text me two weeks ago, and says, "I'm not doing it anymore." And he is younger than me and in practice, and, like, what do I say to that? It seems very disingenuous to talk about network adequacy when we fail and fail and fail to do anything about the fee schedule when everyone acknowledges that's a problem. And I look up the road, and I see UK HealthCare, and it looks like the Taj Mahal. I see ARH commercials on UK basketball games; they can afford that level of advertising because obviously they're

doing pretty well off those Medicaid dollars that came in when the getting was good through these federal expansions. You know, now that's going away, but nothing was done for dental all through that. And so here we are talking about '87 fee schedules, and nobody will step up and say, "Hey, we need to fix the fee schedule." Like we know it's a problem.

I do not understand, I cannot grasp why DMS will not raise the fee schedule to be consistent with at least the people around us. I mean, it's -- you know, it's hard for me to do anything to try to recruit people to take Medicaid when I can't get -- you know, it won't even budge, and, you know, that's just -- and I hate to be that way, but it's getting to a breaking point, and I'm really concerned that our network is near collapse, and, you know, it's only getting worse. You know, our health insurance costs went up 20 percent this year. So we provide health insurance to our employees, so where is that 20 percent going to be made up, you know? And a lot of these

private insurances follow your all's lead, too, so that kind of puts us under the rock a little bit. They look at that Medicaid fee schedule and that's what they base their contracts off of, so it's not like I can even make it up there.

So, you know, it's really under a cracking point here, and I'm really concerned if we don't do something, and that's why I feel like it's super important as a TAC, and I think this is why all these members of the TAC are being so vocal is it feels like there's a pressure right now that, you know, has always been there, but it's really starting to sort of exponentially grow that we're at a cracking point where this network is about to collapse. And I genuinely am concerned about it because I care about these people. I'm from rural Kentucky. You know, my wife grew up in Section eight housing, she was on Medicaid. You know, it's personal to me, and we take these MCOs, we take all of them for a reason, you know, because we want to treat as many people as we can. But, you

know, there's gotta be something that happens from the state level, and I think it starts with raising the fee schedule.

DR. MILLAY: And that kind of goes in piggyback -- these fees that you keep talking about, "Oh, we added," I know when they were added, what state dentist or dental group looked at to help do that because no matter what kind of fee you add and go "look at what we're paying," if it's not getting utilized, you're not losing any money, you're not gaining any money. Actuarially, it's a wash. So it's not doing any good for the patients or for the program adding a random fee.

DR. PETREY: I think to the discussion that the money's just not there is understandable. I mean, obviously there is -- there's an amount that is allocated and that is what it needs to go. But if we don't start somewhere, where do we start? We -- you know, post COVID -- we've talked about five years back, and five years back is getting back to COVID, and we haven't had changes since then. And I appreciate BJ's

work on looking at numbers of costs, but if you look at costs to treat a patient today post COVID, the cost of masks, the cost of gloves, to Justin's point, the cost of insurance for your own staff, the cost of staff themselves, it's astounding.

It's also exasperated by we're in -- moving into more of a digital world. From an orthodontic perspective, we're -- we have some MCOs requiring that we have digital models submitted for cases. I love that. I think that's fantastic. I think that's where we should be. We're asking practices, however, to purchase $50,000 machines to take a digital scan to be able to get approved for a case that pays $2,800. That math doesn't math. And you're -- you had patients before in a previous version of how we got approvals with the state where it was alginate and stone, and you mailed it in. And that -- having the shift for what it costs for us to be able to treat these patients, or even in that case, to even submit a case for care, being so skyrocketing, and yet the fee is maintained

at the fee that it was 75 percent in 1987 fees. It -- I don't see how we're going to get new providers, and as Justin has pointed out, BJ stated, we have great providers right now that contact and talk to us that are dropping the system or telling us they are going to not be able to continue this at these current rates with the costs that we're dealing with.

And I -- I know we're all in a pickle with it, but we're -- I think we as a TAC are wanting to try to continue this conversation because this is the only fix to try to get a better network is to have an adequate fee schedule, which we do not have. And cherry-picking small things are good, but that does not -- all ships rise with the rising tide. We've got to make a wholesale change that brings dentistry up to where it should be, and had we been tied to an inflationary going back to '97 going back to those then, 75 percent of '87 fees, it wouldn't be much of a move if a move at all to be able to have an adequate fee schedule that keeps providers and gets new dentists

coming into the network. But where it hasn't moved in so long, much longer than the five years for the physicians, we have a big, a big boulder to push to try to bring that from those fees that we've all been struggling with that now, in 2025, just really don't function.

DR. MILLAY: So I -- my question is why would -- you have a group of individuals in the TAC that are dealing with generalists, specialists, and multi-field specialists, pediatrics, oral surgery, orthodontics, encompassing all aspects of dentistry, why would you not seek some guidance from those individuals in what fees should be raised, what would be acceptable fee schedules? Because once again, you're talking to a group of people who wouldn't be here on a Friday afternoon sitting in a meeting when the weather is beautiful outside trying to help solve a problem with Medicaid with super concerns, what are we going to do about our friends and family who are sitting there with Medicaid and no providers. So how can we help that

situation?

MR. DEARINGER: How can a TAC assist to increase the fee schedule? Is that what you're asking?

DR. MILLAY: Review the fee schedule, make recommendations to that because --

MR. DEARINGER: Yeah, we always -- we welcome the TAC making recommendations, reviewing the fee schedule. It's out there on our website. We would love to have any feedback that you all would -- could give us. You know, I hear you all talk about new codes. Those new codes when we put those on, go through an actuarial process to see -- and we do lean on other states a lot as far as utilization. You know, how many people are going to use this code based on what the price point is for the code, and that gives us a budgetary number for that item. And so adding a new code is a tiny, tiny little piece of a budget, so if we removed some of those codes, it still doesn't give -- you know, it's a drop in the bucket, right? It still doesn't give us enough money to even add a dollar to a

heavily utilized code. So I think it's important to know that.

Somebody had brought up implants. I mean, that's such small amount used that there's -- you're not saving any money at all by removing implants from the fee schedule because we hardly do any. They have to be medically necessary, so there's very few done. But for the very few members that do get that, it's a life-changing, you know, a service that we can provide to people.

So, you know, we have to find some money somewhere, I agree with that. If you all have suggestions on the fee schedule on how to do that, we would love to hear that. I know, again, like I said, we are looking at some of those codes where we pay two, sometimes three times more than anybody else, and we're trying to remove those things, seeing how much savings that will give us, if any. I'm sure it will give us some and seeing if we can add that to some of the codes that are too low. But, you know, when you talk about adding --

increasing the fee schedule, there has to be money there to be able to do that. It has to come from somewhere. So we would love to increase it.

Now, you did ask about new codes. So new codes, we look at all 50 other states to see what they're paying on that specific code that's new. We look at private insurance to see what they're paying on that specific code, and then we look at the American Dental Association to see if they have anything out about that code, and we look at all of those different price points when we set prices for new codes. So whenever you see a new code, that's been looked at as far as all of those different types of ways to look at it.

But yes, we would love the TAC's, you know, feedback, comments on ways we could save money, on ways we could find money. The Department for Medicaid Services, the Cabinet for Health and Family Services do not determine which provider groups are tied to Medicare. That is completely done through statute. Again, that's the

legislature that decides which groups, like hospitals -- I know somebody had talked about hospital funding are directly tied to Medicare, so -- but we encourage any support from you all from the legislation that we can get, and we encourage you all to review our fee schedules and provide feedback. You know, if there's a code that you're losing money on, let us know, and, you know, we do everything we can to try to get those codes as high as we can with the budget that we have.

DR. KOLASA: Let me give another example, Justin. I really do appreciate that. The Rural Health Transformation Plan, so the grant to the Big, Beautiful Bill, you know, it seems like the Dental TAC, since there's an oral health push, would be a great place for suggestions on that. I get this information because I sit at some hospital committees, and it looks like that the request is for mobile vans, and we've been through the mobile vans series. I'm just curious, like, where are you getting these ideas for the grant request? Because

it seems like if network adequacy was going to be a grant request -- and, you know, I'm a little ignorant to the subject, so forgive me. But it seems like expanding network adequacy, like a true network versus these mobile vans that come and go, would have been a good focus for expansion of rural health on this grant request.

So again, with the KDA, with the TAC, where is that -- you know, was it KDPH, Julie McKee, where is that coming from and who has all that leverage to dictate what we're asking for? Because, you know, we're talk -- network adequacy to me is the biggest problem with dental Medicaid, and putting vans is not a true solution in my opinion, and maybe people will differ, but talking to the people who are boots on the ground every day would seem to be a good start for when we're trying to find this money. And so maybe this rural health grant access through the Big, Beautiful Bill would've been a good way to find some of that. Where did that decision come from for what to request?

MR. DEARINGER: So the Kentucky Department for Public Health was in charge of that request, and I believe that the Kentucky Dental Association was on a lot -- or were on a lot of those calls. We were on a couple, but they were -- took the priority in that area. So we could definitely get a Kentucky Department for Public Health representative on for next meeting, and maybe someone from the Kentucky Dental Association as they were involved with a lot of those meetings as well.

DR. PETREY: I think that -- I think that's a good suggestion. The only concern that I have -- well, as a hand comes, we have a member of the KDA --

DR. MILLAY: Yeah.

DR. PETREY: -- on, but --

DR. MILLAY: Dr. Robertson?

DR. ROBERTSON: I was going to try to just be a fly on the wall. Well, we were -- the oral health request that was sent in was from our -- you know, initially, we were in the group that was queried for ideas, and our initial proposal was a statewide

telehealth program hubbed at the dental schools. And we were -- after that letter, we were shut out of the process. So I literally have no input on where we are.

DR. MILLAY: I think --

MR. DEARINGER: Okay, so maybe somebody from Kentucky Public Health. I was -- I thought that you all were involved. I was misinformed.

DR. ROBERTSON: We -- Justin, I appreciate it because we would've loved to have been involved.

MR. DEARINGER: Okay.

DR. MILLAY: And Justin, I'm sorry to interrupt. I thought I saw Krista something raise their hand. I saw a hand come up that said "Krista," and then it went right back down on my screen. It was --

MS. HENSEL: It wasn't me. I was just changing devices.

DR. MILLAY: Okay.

MS. HENSEL: I apologize, earlier I was in the car trying to get kiddos after school, so I'm back in front of a computer.

DR. MILLAY: Okay. Not a problem.

No, I just saw the -- I thought it said "Krista something" a hand, then it vanished real quick on me, so thank you.

DR. PETREY: I would like to comment on that though, too, BJ. One aspect of that is the time at which Dr. Stack and his team had to put that together was a very tight window, so that also, I'm sure, played into it. But certainly, from a TAC perspective and where they have proposed, and remember, they're requesting, so they're not receiving or enacting, but where they proposed, I'm not sure that we would have felt that the allocation or the planned allocation of funds would be best for network adequacy.

Justin, I appreciate what you're saying on fees, and I appreciate what you're saying as far as having some fees that are even double. I'm not aware of what those are. I'm sure you can elaborate on that at some point, but I'm just looking at things like D2391, one surface composite in the state of Kentucky is at $57.20. States around us: Ohio, 97.86; Indiana, 82.45; Missouri, 94.14; Louisiana, 87.71. Looking

at that group, we're at an 85.9 percent lower fee for a one surface composite. I mean, that's -- unfortunately, we want prevention to be what we're focusing on, but when we're looking at what people are doing out there and what Kayla alluded to, you know, when you're at $57 on a composite restoration and it's 87 percent lower than peer states pay in their communities, we know that's not -- that's not feasible. And it may be that some things are double, but things that are out there being done are at such a low fee that we can point out individual, single things, but the things that are the majority of what we do, when those are so low, and that's all of restorative dentistry. They really don't have a fee that is applicable to the cost to do those treatments.

MR. DEARINGER: Yeah, I don't have -- I mean, that's -- I know they're low. I mean, I'm with you. I mean, I agree. They're low for you all in a lot of codes, they're low for physicians in a lot of codes, they're low for physical therapists,

occupational therapists, speech therapists. They're low for a lot of our providers that aren't directly tied in legislature -- or in legislation to the Medicare fee schedule.

DR. PETREY: Completely understand that. I'm going to beat the horse again and say, but they have not -- those others, I do not believe, have been waiting since '97 and using '87 -- 75 percent of '87 fees. From that though, I would say that I would love to have comments from you all and others and at what I can take to the MOAB to make it better for all of us at what I can try to help from because we're -- I'm one voice on there in a big project. And, you know, I would -- you know, I like big tents, and I like big people, big groups helping that, and so we as a TAC want to see this change, but if the change is at a legislative level, then we need to address it there as well. And I appreciate any and all comments and help for me in that aspect. Don't everybody jump in to help at once. Thank you.

DR. KOLASA: This is just a knowledge question for Justin. When pharmacy got

their big bump, and optometry got theirs, was there a legislative change that allowed for that?

MR. DEARINGER: Pharmacy's directly tied to legislation. The optometry, I'd have to see exactly what you're asking. You're asking on -- for prices based on what?

DR. KOLASA: Well, I just -- I'm not -- you know, I don't have the most knowledge of that.

MR. DEARINGER: Ophthalmologist, or -- so, I mean, I'd have to go back and look at their fee schedules and see exactly what went up, but optometry is not directly related, pharmacy is. So I'd have to look and see. I mean, we -- we were able to increase some things for optometric about the same time we did for dental when we increased some of those rates. I think those were simultaneously with our expansion where, you know, Kentucky Medicaid used to only treat children for dental, and we had our -- you know, half of our Medicaid population that had zero dental care, which,

you know, massive amount of emergency room usage --

DR. KOLASA: Yeah.

MR. DEARINGER: -- and just poor health overall as you could imagine. So I think that was around the same time. I'd have to go back and look. I'm not sure. I can't answer it right now.

DR. KOLASA: That's okay. I guess it's like, do we need to push for legislative change? Are your hands tied? If -- I mean, if you're saying that your hands are completely tied, then that's what I want to know, because then I need to start knocking on other doors that this is not -- if this is not the avenue for it.

MR. DEARINGER: Well, for Department for Medicaid Services on fee schedule increases, it's directly tied to the budget, our budget that we received from the legislature. The only time we can automatically do that without budgetary increases is if it's when legislation directs us to that we have to do that, that we have to tie it directly to the Medicare

fee schedule.

DR. KOLASA: So DMS decides within the amount of money what they give it to. So ultimately, they give you that money, and you guys continue to say, "This is how much dental should receive of that budget?

MR. DEARINGER: Yes, that's correct. So we get an amount of money set from the legislature, we have statutory requirements that we have to provide funding directly tied to statutes on certain provider types, on certain things, and then we -- the rest of that money goes to what we can have for our fee schedules and if there's any money available for increases in the fee schedule.

DR. MILLAY: So is that -- and this is kind of just not for my information, too. So is that based on a percentage? You're looking at this money is coming in and we're responsible for X percentage to be sent to dental procedures, or how is that determined?

MR. DEARINGER: So it's a lot -- I'm not a budget person, so if I'm -- you know, I'm speaking a lot out of context on the

issue as far as Medicaid's budget. It's complex system, but, I mean, to my understanding, they look at the current -- you know, current fee schedules and what we're currently paying for dental, and the amount of members that -- you know, the amount of services that we provide for dental on a historical basis, and then that's the amount of money that is kind of set in the budget for dental. And so then if there's any additional funding, then they look at that to see if they can increase fees for any provider type, which again, I don't -- I'm not thinking that we've done that for -- since we increased them for you all. We -- you know, for dental, vision, and hearing, we were able to increase those fees when we expanded services to adults. Everything else I think's been tied to Medicare with legislation, and I'd have to get maybe somebody from budget to go into detail about exactly how those things are set and done. I'm not a budget person.

DR. PETREY: I think -- I think one of the things -- the comments that we have

is we -- we're wondering, and you said you would appreciate it, but we'd like to have a voice, whether that's through the TAC or whether that's some other way that DMS involves practitioners that are treating patients, in looking at this fee schedule. Because you're absolutely right that those -- there have been a smattering of increases. There has been the addition of adult -- you know, as an orthodontist, and we have a pediatric dentist on the TAC, those adult changes are -- they -- while they allow -- provide services for those adults, they don't allow for any aspect of what we do. So it's not helping grow our networks in any way with those changes.

That being said though, the fact that we're not part of the discussion in any way is a challenge because it's -- when we just compare numbers, we don't really know -- I don't know that other than practitioners, anyone really has a handle on what the cost to treat truly is and what is an appropriate fee. So if money comes available, I think we need to -- we'd like to be a part of the

process in understanding how to make that fee schedule better.

MR. DEARINGER: I think that's a great idea. I think we're always looking for ways to utilize our technical advisory committees, you know, and I think that's a wonderful idea. Any funding at all to let you all kind of be a voice about where that would -- for dental be a voice about where that goes in our fee schedule, and then us trying to make it work budgetarily. So I think that's a great idea.

DR. PETREY: You really gotta unblur -- you really gotta put yourself -- we gotta see where you are, brother. Are you at the beach? What's going on?

MR. DEARINGER: Yeah, I'm at Dollywood actually, so.

DR. KOLASA: Nice.

MR. DEARINGER: Yeah, good place.

DR. KOLASA: Are you riding rides or are you just checking out the Christmas decorations?

MR. DEARINGER: Oh, all the grandkids are riding rides and doing all that fun

stuff.

DR. KOLASA: Very good.

MR. DEARINGER: Kind of supervising.

DR. MILLAY: Any other questions, comments at this point in time regarding the fees and possible movements forward?

(no response)

DR. MILLAY: If not at this time, we'll move to -- which I just lost my paper saying what was next. I don't think -- I think that was kind of the last topic in new business. It was just any other topics that may need to come up at this point in time. I think -- Ms. Wash, thank you very much.

MR. DEARINGER: Yeah, I think we at DMS had some pathology codes that we had received from some dentists saying that they aren't currently allowed by DMS to bill. And I think we were sending those to you all to kind of look at to see if that's something that we should consider adding to the 2026 fee schedule, and then what those rates would be.

DR. KOLASA: I'd be happy to look at those path codes. I do a lot of that, so.

MR. DEARINGER: All right. I will have Barb send that to the TAC, and we appreciate any advice and reviews that you all could give us on that.

DR. MILLAY: Thank you. And then we'll work on that and then get that back to you guys as soon as we can.

Any other general questions or discussion for the TAC at this time?

(no response)

DR. MILLAY: There we go. I was getting it off the screen share. Seeing none, is there any MAC recommendations that needs to be move forward from the TAC at this time?

(no response)

DR. MILLAY: I don't think we have any recommendations going --

DR. PETREY: Justin, can you tell us when the MAC -- next MAC meeting is?

DR. KOLASA: Yes.

MS. WASH: This is Barbara from DMS. We are actually in the process of getting --

DR. KOLASA: Oh, yeah.

MS. WASH: -- our January meeting

together. We had sent out a survey to everybody who attended the MAC.

DR. KOLASA: I filled mine out.

MS. WASH: Yay! That's great. Once we get that, we'll be putting those on the website.

DR. KOLASA: So --

DR. PETREY: Knowing that --

DR. KOLASA: -- just for information, so the way it'll work, Joe, is MAC will be January, so the odd months, and then the BAC is going to be the even months because by law, they have to do the BAC ahead of the MAC. And so we're -- what it sounds like -- this is not finalized, and Barb can correct me, but it sounds like the BAC, then the MAC, then, the BAC, then the MAC is how it'll run. So we should be odd months, and hopefully Monday afternoons, Barbara.

MS. WASH: I've been pushing for that.

DR. KOLASA: Thank you. I said if it's in the morning, it does kill a whole day, and since I serve a Medicaid population that's backed up six months, it would really

help if I could at least get through surgeries in the morning, so.

MS. WASH: Absolutely.

DR. PETREY: It seems then that we need to make sure that our TAC meetings are prior to your MAC meetings. So we need to kind of -- as we think about the 2026 schedule, we need to also look at the MAC 2026 schedule to help determine that.

MS. WASH: Well, the survey was filled out by everyone who was on the MAC, and again, Justin just said he filled his out. And also, any recommendations or formal recommendations, they get presented to the MAC, so -- and so as long as you send me a formal recommendation if you have one, you know, we send that over, and then MAC discusses that votes on it.

DR. MILLAY: So and as I'm new to this also, Barbara, and in this chair, we -- that does not have to come out of this meeting directly. If that was to come out with all members of the TAC signing off on it to give to the MAC as long as it was prior to the MAC meeting, or does it need to

be reported in official minutes if for some reason --

MS. WASH: It's official minutes.

DR. MILLAY: Okay, the TAC --

MS. WASH: And everybody votes -- yeah, the TAC has to --

DR. MILLAY: Okay.

MS. WASH: Yes.

DR. MILLAY: That's what I wanted to confirm because I would assume it had to be, but --

MS. WASH: Yes.

DR. MILLAY: So yeah, we would need to try to make sure our next meeting would be before the MAC.

MS. WASH: So the MAC has changed a little, and just to keep you in the loop of that, TAC, you have to have 50 percent of the quorum. So it's a little different with the MAC, and I'm not sure, they're still putting -- changing those bylaws. But if you're going to vote on it, you have to have at least 50 percent with yay, saying "yes."

DR. KOLASA: So is it --

MS. WASH: Any recommendations. And

it needs to be done formally. You need to submit formally the recommendation.

DR. KOLASA: So if we made a MAC recommendation -- you know, if we made a motion for a MAC recommendation here, then generally, could we get the details together prior to -- you know, make that a little more detailed in a written format to submit as long as it generally -- you know, we don't have the whole formal write up as much -- you know, just the general topic is approved.

MS. WASH: Exactly. Exactly, yes.

DR. KOLASA: So if we wanted to make a MAC recommendation about evaluation of fee schedule, we could make a motion for that, get it approved, and then we could formally write that up.

MS. WASH: And that would also be in your transcript as we're speaking right now.

DR. KOLASA: Perfect.

MS. WASH: Mm-hmm.

DR. KOLASA: TAC, is that something we want to do, or do we want to try to meet again and -- before the MAC, and --

DR. PETREY: Do you have a recommendation, Justin, as far as something that -- to bring to the MAC in your dual role?

DR. KOLASA: Well, it's still new to me, too, but, you know, kind of what Justin Dearinger had mentioned about, you know, maybe make it policy that integration of the TAC and we look at these fee schedules where there's, you know, part of this carve out and they're not tied to Medicare. You know, maybe the recommendation is that we are included in these discussions when they are made so that we know that in policy that we are going to be included. Or not, I mean it's --

DR. MILLAY: I know I think I would agree with you on that. I'm not the best at wording those things, so.

DR. PETREY: So would we then say that we would like to make a recommendation to the MAC that the fee schedule review be inclusive of the TAC as it relates to DMS?

DR. KOLASA: I think that sounds good. Barb, you're probably a professional

at these types of meetings. I would take input on how -- you know, the formation of a formal motion.

MS. WASH: So what you basically are recommending just needs to be sent to me in a formal letter, and I can send you a copy of that, and basically what you just stated would have to be listed in that letter. So it's an email, and it basically is just starting the process. And everybody has to vote on it, and as long as 50 percent say, "yay," then it moves forward. And I can send you an example.

DR. PETREY: BJ, you want to call a vote on that?

DR. MILLAY: Yeah, I mean, would the TAC members agree to accept and vote on the motion that was presented? And I'm assuming it would be worded as the recommendation that the MAC would -- all fees would be associated with the TAC. Is that how we would --

DR. PETREY: I think the recommendation -- I wish I could've written it down as I said it. Recommendation that

TAC be involved with fee review as it relates to DMS and dental services.

DR. KOLASA: Why don't you make that the formal motion, Joe?

DR. PETREY: I think that's -- I'd make that motion.

DR. KOLASA: Yeah, I'll second that.

DR. PETREY: Barb, we now just vote, yeah?

MS. WASH: Yes.

DR. PETREY: So Jay, can you get on camera? Can you get on camera, Jay?

DR. MILLAY: Kaitlyn, I think is off camera.

DR. MILLAY: Okay. Barb, with three of us on camera because I think Kayla was having some issues with her connection.

MS. WASH: One, two, three, four, five, so three out of five is more than fifty percent, so --

DR. PETREY: So we're good, right?

MS. WASH: -- you're good to go.

DR. MILLAY: Dr. Crews was -- is Dr. Crews off the call?

MS. WASH: No, Dr. Crews is on, he

just doesn't have his camera on.

DR. PETREY: Yeah. But it still -- so --

MS. WASH: Can you put your camera on, Dr. Crews?

DR. CREWS: I don't think I can at the moment. I'm driving, so --

MS. WASH: Okay.

DR. PETREY: It's okay, Jay. I think that if the three of us on camera because it has always been my understanding we have to be on camera for a formal vote.

MS. WASH: Okay.

DR. PETREY: But if the three of us vote "yay," then I think we can move that forward, and then we will work together to get a -- to get that formally written to you, Barb.

MS. WASH: That sounds great. Thank you.

DR. PETREY: So all in favor?

(Aye/Yay).

DR. PETREY: Yeah, okay.

MS. WASH: Okay.

DR. MILLAY: So motion passes.

DR. PETREY: Formal.

DR. MILLAY: All right. And so we will work that to get that you, Ms. Wash. And any other topics that need to be addressed on this meeting?

(no response)

DR. MILLAY: Hearing none, I seek for adjournment.

DR. PETREY: I do want -- I do just want to say put well-wishes out to Dr. Caudill. I know he's in a recovery right now, and we hope to see him back and back at it well. Sorry for slipping that in as you were getting ready to adjourn, but I meant to say it earlier, so.

DR. MILLAY: Motion for adjournment?

DR. KOLASA: Motion.

DR. PETREY: Second.

DR. MILLAY: All right. Thank you all for taking the time. Have a good weekend.

MS. WASH: Thank you. Have a good weekend.

DR. PETREY: Thank you.

(Meeting adjourns at 3:59 p.m.)

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C E R T I F I C A T E

I, TIFFANY FELTS, Certified Verbatim Reporter, herby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 2nd day of December, 2025.

Tiffany Felts, CVR

Tiffany Felts, CVR