COMMONWEALTH OF KENTUCKY

CABINET FOR HEALTH AND FAMILY SERVICES

FOR MEDICAID SERVICES

IN RE: DENTAL TAC

HELD VIA ZOOM

DATE:

FEBRUARY 9, 2024

2:00 P.M.

A T T E N D E E S:

Garth Bobrowski, DMD, Chairman

Joe Petrey, DMD

Kimberly Hughes, DMD

Carol Jean Braun, DMD

(and many more were on ZOOM)

February 9, 2024

2:00 p.m.

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MS. BICKERS: Well, we have three out of five, so that's still a quorum.

DR. BOBROWSKI: Okay. Well, are we ready to go then?

MS. BICKERS: I'm ready when you are.

DR. BOBROWSKI: Okay. Well, I want to welcome everyone to the Dental TAC Meeting for February the 9th. And just remind everybody that it is Valentine's weekend, so get your cards and meals lined up here.

But we've got a quorum established then, and first order of business is we want to approve the minutes from November of '23 TAC Meeting. So make a motion to approve those and we need a second.

DR. HUGHES: I'll second.

DR. BOBROWSKI: All in favor aye?

(All members voted "Aye.")

DR. BOBROWSKI: Okay, thank you.

And I want to take a minute just -- I know Commissioner Lee couldn't be on the meeting today, but I wanted to thank her and

her team for all the work that they do in, you know, helping -- it's not only our TAC, but there's 19 or 20 other TACs that they work with and help. And I just wanted to thank all of you for your support and information. And if you get a question, they are usually back right on top of it pretty quick. So I just wanted to say a word of thanks.

And we are going to go to Old Business. There was a rule of change on dental fillings. It went from replacement code from six months to 12 months, and I was wanting to just follow up with that. We had asked about getting that moved back to the six months. I never did hear anybody say anything else about it, but, you know, it's kind of like either move it all the way back to six months or just eliminate that, and let the dentist be the judge on when that breaks, a filling, or -- so many times folks -- we're doing fillings on top of fillings. And that's why they come to us because something's broken and chipped. And we might fix something five months ago, and

so now I've got to make them wait seven months to fix it back or else do a more expensive procedure like do a crown on it, which that's fine, but some folks just can't do that due to their health situation, so I would request, recommend that this be moved back or eliminated.

The other thing is Item 5b. Just due to severe cost increases in staff, supplies, whatever, we continue to do these fillings at really a ridiculously low price, and a lot of times we do these things below cost, so that's another recommendation that I would like to put forth.

And the third thing -- and I'll let some other TAC members comment on these here in just a minute -- was I don't know if we ever heard back on the -- what the plan was if you get a root canal started, or a denture started, what's the plan on getting folks finished up if they were to lose coverage or whatever reason. Or if say you started a root canal and, of course, technically you can't really bill for it until it's finished, but you get into it and

you work an hour or two on it and everything's going along fine. The patient goes home and they say, well, I've decided just to take it out. No hurt or nothing, but there's certain circumstances that come up in dentistry that change your treatment plan. And so far, Dr. Carol or Dr. Joe, have you got any comments on any of those three items to start with?

DR. PETREY: Sorry, took me a second to unmute there.

Just to follow up on the third point there, Garth, is we have run into that in orthodontics quite a bit, and we do that with in-treatment cases that have lapse in coverage. Used to, cases were -- under the old system cases were if you started the case you were able to finish the case and be compensated for it. Commissioner Lee -- I think it was maybe a year or so ago when this came out, when we were looking at people that aged out, turned 21, and could no longer have the orthodontic benefit, we were told that they could not -- could not continue -- could not pay out the case,

which obviously puts the practitioner in a very difficult position, because you have already started a case with a patient, and then you don't have the ability to through either -- through their Medicaid to be able to get coverage, so -- but I understand the pitfalls there. It's made us really change the way that we interact with patients and what we're able to treat, which is challenging, because if you -- if you have an orthodontic need, much like if you have a need for certainly a root canal or other instances such as that, if you're in the middle, or if they have the need but for whatever reason they age out or they have other reasons that they no longer have coverage, then you're going to be -- you're going to be in a bind and you may end up, what we do in orthodontics, and that is finishing the case without additional compensation, which you can do occasionally, but it can be quite -- quite taxing to do that very often.

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

Ms. Kelli, would these need to be just

kind of referred on to the Commissioner Lee for follow-up?

MS. BICKERS: I can take -- this is Erin with Medicaid. I can take that back to the Commissioner. I'm not sure if anyone is on today that wants to speak on that currently, but I can definitely take that back and follow-up.

Justin Dearinger is here.

MR. DEARINGER: Okay. Hello, my name is Justin Dearinger. I'm the director for the Division of Healthcare Policy. As you know, or may not know, dental providers fall in my division, so I'm more than happy to answer each one of these questions today.

5a, the rule change, we had talked to a group of dentists, and I apologize, I was thinking it was some dentists from the TAC, but it may not have been. Right after the August 2023 TAC is when we had talked about these fees, and last I believe was then, and I think we had a meeting with a group of dentists about these fees. This was actually -- the change from six months to 12

months was a typo when we redid the -- all the different rates, and adult to child fee schedule. And so those were changed August -- looks like August the 24th, I believe. Let me make sure I'm not -- yeah, August 24, 2023. We had told -- actually, I think we have told multiple groups of dentists, so I apologize that I didn't send that back to the TAC. But we've sit and talked to multiple groups of dentists about it, mostly at the end of August and September of 2023.

So that's been changed for some time. As a matter of fact, that change order was made effective to backdate and rebill everything from January 1st, 2023. So if somebody had sent a bill in for restorative work that was two in a 12-month period and it was denied because of that limitation, then it was automatically rebilled and credited to them.

That's been on the fee scheduled since August 24th of 2023.

DR. BOBROWSKI: We just never did hear back from anybody on that, so that was why I

brought it back up.

MR. DEARINGER: Sure. So the 5b, we have got -- we've done multiple studies and reports, and looked at the dental fees from the reimbursement from the state of Kentucky, cost of living in the state of Kentucky, and then we've looked at multiple other states comparatively, put those together. So we've got those right now with our -- in upper management's areas, to review and look at in accordance with our budget. And so whenever we have something one way or another, we can come back with any kind of increase in codes. As you know, any kind of increase has to be budgeted for, so we're trying to -- trying to see where there's any extra funds to give increases in any -- any code for any types of coding.

C -- so this is kind of a -- we're targeting this multiple ways. The first one you know we increased coverage to not just be children, but for adults as well. And so that eliminates those situations where -- that the doctor talked about earlier where

you had a child receiving some care, and then they were some becoming an adult and so you have to stop that treatment. So we've eliminated that, those issues.

And then we are working right now on some modifiers. Not necessarily modifiers, but some modifier type coding that would -- that dentists would be able to use when you start a procedure. Like you said, you start a root canal and then the patient decides they just want it pulled. And so that's -- we're looking at some different coding to be able to pay percentages based on percentage of work done. So we're working on that.

We should have that out sometime about the middle of the year. So that will take care of all of those issues. The only issue that we still don't really have an answer for and we're still waiting on CMS to give us a little more guidance. We talked to them twice about this issue and they are supposed to get back with us, is when an individual has Medicaid coverage, they start on a treatment and then at some point during that treatment process they lose Medicaid

coverage. Now, if they end up getting Medicaid coverage back, that coverage is almost always retroactive back to when they lost it. Say an individual forgot to, you know, sign a paper, send in some documentation, proof of income, something like that. Then as soon as they get their Medicaid restored, that's almost always backdated. The problem is if that individual truly loses coverage because of something substantive. Say they got a new job, start making too much money, or they got a new job that provides them insurance, either case they would lose their Medicaid coverage, and in those cases we don't have any way to cover those individuals. So any work done after they lose coverage, we wouldn't have any way to cover that. CMS would not allow us to cover that.

So we're still working it out with them on some different things as far as dentures and some other procedures that are in question. And it's not just dental. It's DME issues as well with trachs and some other equipment that are personalized and

created for the individual. So that we're working with them on some different ways that we can kind of compensate and come up with a solution in that area. I don't think there's a ton of those cases, but there's enough to where we need a solution. So we're still working with CMS on that one, but hopefully we've lessened the amount of them with some of the other solutions we've come up with.

DR. BOBROWSKI: Okay. Thank you for working on those -- for that.

Now, I've got another question. At our last meeting we brought up there's -- on the children's stainless steel crowns, it looked like whichever group that you-all had of dentists that were looking at these on all crowns, whether they are the stainless steel crowns for children or the adult crowns, there's -- a criteria was changed on the children's that was -- the criteria was that you could only replace it once every five years. Well, on children -- and, again, you know, it happens. It's not a big, big happening, but it happens, is like

these stainless steel crowns, children, you know, get ahold of some taffy or some tootsie rolls, or some form of candy, or food, and they pop them off. But in the process, they chew on them and bend them, break them, and they're not useable again. So, you know, the dentist or the pediatric dentist needs to replace that. But according to this new add-on rule we can't replace it for five years. So, you know, sometimes --

DR. PETREY: Garth?

DR. BOBROWSKI: Yes.

DR. PETREY: Garth, I might add to that, too. I wouldn't even characterize it as the kids eating candy or things that almost put the onus onto the child. These are inherently temporary -- essentially temporary crowns until they are of an age in which they can have a more permanent restoration. These are not intended to be long-term crowns, so they are designed to not, to not -- they are set from the beginning to know that they are going to have an expiration date. So setting a

five-year window on that is challenging, as you are alluding to.

DR. BOBROWSKI: We were just, as TAC members, and other dental groups have contacted us, like pediatric dentists and just general dentists that do a lot of these, they were just requesting that that five-year rule be taken off, and that's, I guess, Codes D2930, D2931, D2932.

But, Justin, did you-all talk to your group of dentists on that item?

MR. DEARINGER: No. I don't have anything in front of me on that one. I know there were multiple codes that we had looked at that there had been some errors made, and I'm not sure if that's one of them or not. We kind of -- we completely redid the fee scheduled several different ways.

As you-all know that we had -- we added adult and then we increased quite a few fees for adults and children on those fee schedules. And then in addition to that, we added multiple codes to those fee schedules. And then we also had a fee schedule project where we added all the

limitations that would go along with that code to the actual fee schedule, so that you didn't have to flip over between regulations and billing procedures manual and then the fee schedule, and you had it all in one spot.

And so in doing all that, we had a few errors that were made, and so that six months to 12 months was one of them. And then we created -- or we corrected -- during that August review that we had, we corrected probably 20 or 30 different areas. But let me look into this one. I'll get back to Erin and have her send it out to you-all. I don't remember it off the top of my head, but I'll look into it and see.

DR. BOBROWSKI: Okay. Well, I appreciate you looking at that one.

Does any other TAC member have any other Old Business?

Let's move to New Business. I brought a few items today just as a -- some of it is an FYI to be looking at. Just this week the American Dental Association in conjunction with medical physicists through the ADA, the

FDA, and the American Academy of Oral and Maxillofacial Radiology have said now that due to the use of digital X-rays and the precise collimation of the X-ray unit, that the use of lead aprons and thyroid collars are no longer needed for dental radiology. And I got the wording that they brought out from the ADA on that, and then I also looked up the regulation on that, and it's 902 KAR 100:130 Dental. It says the Cabinet for Human Resources is authorized by KRS 211.844 to provide administrative regulation for the registration and lasting of the possession of, and use of any source of ionizing or electronic product radiation in the handling and disposal of radioactive waste. And it's Section 5, Paragraph 4, and you can look it up, but it's just kind of what I've already said.

But we might need to have the Cabinet look at that, you know, just to follow other recommendations from the radiology groups, because we've checked with the Kentucky Board of Dentistry and it's mostly a regulation coming from the Cabinet for Human

Resources. So, Justin, I don't know, we might need to add that one on your list possibly just to look at. But I just wanted to bring that to your attention that that just happened just the other day.

DR. McKEE: Dr. Bobrowski?

DR. BOBROWSKI: Yes.

DR. McKEE: It's Julie McKee. Can you send that article, attach it to the chat, send it back to our contacts at Medicaid? I'd like that. Just how we can get it.

DR. BOBROWSKI: Okay. Let's see.

MS. BICKERS: Dr. Bobrowski, this is Erin. I was copied on all those e-mails. I can forward it for you.

DR. McKEE: Thank you. Thank you very much.

MS. BICKERS: You're welcome.

DR. BOBROWSKI: Dr. Julie, I was looking real quick. I don't believe I have ever attached an e-mail after I --

DR. McKEE: Don't worry about it. I'm going to get it.

DR. BOBROWSKI: All right. I'm trying to look and see if I can figure out how to do

it real quick for you, but we got it.

Now, is there any other -- any comments on that one from other TAC members?

DR. PETREY: Garth, on that same point, I'm wondering what impact as far as radiation hygiene in new X-ray units, and what the requirements, state requirements will be as far as new facilities, new offices, new practices. I'm not sure that that's really going to end up being the purview of this committee, but it's far reaching with that as well because of the requirements now in construction and any time a new unit with radiation is installed.

DR. BOBROWSKI: In that administrative regulation Section 6 deals with filtration and Section 7 deals with linearity. Then Section 4 is operator protection, and then the Section 2 is source to skin distance. So that regulation itself has got quite a bit within that regulation, so that whole reg will probably have to be looked at, you know, in terms -- like you was just talking about new installations, that's a good point.

DR. McKEE: Dr. Bobrowski, a point, please. This is Julie McKee.

DR. BOBROWSKI: Yes.

DR. McKEE: The Radiation Branch -- I think it's still a branch -- is in the Department of Public Health, but it's way over, not in my department at all. It's in Environmental -- what's it called? Environment Protection. I'll be glad to reach out to them. I've talked to them about other things anyway, usually forwarding money to them that comes to me for their -- for the licensing of dental radiation units. I'll be glad to get an update on where they are, new developments.

Contrary to probably public comment here in this group, they really do work to stay up-to-date with industry standards. And so if they are aware of industry standards, I know they would be glad to address them.

DR. BOBROWSKI: And thank you. I know periodically they come through every dental office.

DR. McKEE: Yeah.

DR. BOBROWSKI: And they test the equipment, and I think that's a great function, you know, to follow up on that. I'm not saying anything bad about that. Like I said, some of this is FYI. Some of this just happened this week, you know, so...

All right. Well, thank you, Dr. McKee.

Go ahead, Dr. Joe.

DR. PETREY: Sorry, Garth. I keep doing that to you.

I would agree with your comment that I don't think that we all think they are not -- not up to the standard. I mean, this is a new standard. It's something that we have all been wishing for for some time because of the less-ing of the amount of radiation, and all of the previous regs were based on non-digital radiography. So it's -- you know, you don't turn the Titanic quickly, but you would like to miss the iceberg if you can turn at all. So I think this is a good start to it, but it will encompass multiple phases of what we do.

I think the biggest thing for the TAC is we just -- we would like to be able to tell members and have -- that they are following appropriate protocols, when the ADA is saying that these are not required, that it's not still a requirement for general safety, for patients to be able to do it. In orthodontics we -- since Dr. Oz, we constantly get asked about the thyroid collar, which actually blocks some very important things that we like to see on our radiographs, but it's almost a few-times-a-week situation for us that that comes up. So getting it from the ADA and then trickling down and knowing that not only are we doing best practice, but also that the regs match best practice. This would be a great start to get that to move in that direction.

DR. BOBROWSKI: Yes, thank you.

The next item -- I'm going to kind of skip over that request letter, but I know -- and, Justin, I know, and I've talked with Commissioner Lee several times about how the fees are looked at and established, and

she's mentioned looking at other states around us, but I -- I would like to have you-all also look at the state of Missouri's Medicaid fees.

But the other new thing I'd like to bring up is Item C, it's a Dental Health rankings. And I know we've been talking about how what are we going to do in Kentucky to move from the 49th position. And I printed this off.

DR. McKEE: With the passage of House Bill 141, we are going to move from 49th to 50th.

DR. BOBROWSKI: That's going in the wrong direction.

DR. McKEE: I'm just telling you.

DR. BOBROWSKI: I know it.

Well, this new report here, and I brought it out because it was -- again, I just got this in and -- oh, where's that page? It was written -- been researched by several authentic people that I thought -- even one of them was a researcher from Murray State University, so one of our own Kentuckians was in on this report. And it

listed the states in order and it was based on 25 key indicators of dental wellness. Let me turn the page here. They've got us a score of 42.83, with a rank of 48 and then an oral health rank of 41. And this was based on 25 criteria. So maybe we're already starting to do some good things, Dr. McKee. But you know how it is when you do one report and somebody else does another report, sometimes it's hard to compare apples to apples. But that was just another FYI for everybody.

The other thing that's coming up, got a new report on, was the -- through the American Dental Association was dental insurance reform. And I know, you know, Medicaid has their own medical insurance, and I know at times have talked about just great dental insurance. We're kind of more familiar with the medical loss ratio, but it's -- I just wanted to read you part of a paragraph here. Setting a dental loss ratio can be a game changer for putting adequate -- quality dental care within patient's reach, and ensures that more of

the patient's dental insurance premiums go toward the care they need and not toward an insurance -- insurer's administrative cost. And in a sense that can apply to Medicaid because Medicaid dollars are taxpayer dollars, and that's where we would like to see that, you know, those monies go towards care. But I just wanted to bring that up as a new item just for your information that these are political or legislative things that are being worked on.

Now, any TAC member got any comment on those FYI items?

MS. BICKERS: Justin Dearinger has his hand raised.

DR. BOBROWSKI: Justin?

MR. DEARINGER: Yes, sir, I appreciate it. I was just going to reference back. You had asked about -- or looking at the report it says what is the Department for Medicaid Services doing to move Kentucky's oral health from 49th U.S. position. I wanted to talk about that. Last calendar year, 2023, we expanded coverage from only children to adults. We also made sure that

that coverage included dentures, crowns, bridges, all kinds of different restorative services and other services that would help individuals to be able to have a healthier lifestyle and improve oral health. That is a huge step forward. It's a major accomplishment and something that is going to pay extreme dividends in the coming years as those services are utilized.

We also created a new provider type in community health workers, or a new service for provider types to use in community health workers who we hope will be used in all provider types to assist with individuals on education, prevention, healthcare, coordination of healthcare services, transportation, decreasing no show rates, all those different things.

And then the two other issues where we have worked in 2023 was, as you-all know, increase multiple rates. We're studying those rates, that we increased, hard to see if increasing those rates improved the quality of dental care in that area, those rates that were improved. And then the last

thing, we have worked to reduce multiple areas of red tape and administrative burden for providers. So you'll notice in the -- when you go look at this fee schedule, you will notice there are a lot of prior authorizations that are gone, that are not there now that were there in 2022's fee schedule. You will notice multiple limitations on different items missing that were there in 2022. They are not there in 2023. And so there's a lot of different things that we -- as we research ways to assist providers to make things easier, those are all things that we feel like we have done in 2023.

We have a lot of different projects that are going on in 2024 as well to try to move the needle even more. So that's just a few of the things that we are doing here in the Department for Medicaid Services to try to move that needle. In addition to that, we also have a certain percentage in our MCO contracts of money that we pay, and I don't know it off the top of my head, I apologize, but I can get that to you, of money that we

pay that goes directly to care and not the administration for the insurance. And so that's a very high percentage. I can get you that, though, after the call.

DR. BOBROWSKI: Thank you. And I appreciate that, Justin. And I appreciate your efforts, because I know that's some of the things you have been working on and it does not go unnoticed. It's very well done, and like you said when we did -- I think, Dr. McKee, you did a study last year, or year before, that I think some of the main criteria that people were having trouble with with Medicaid was kind of just, Justin, what you said, was the rates, the failed appointments, and the administrative burden were about the top three categories. And so it sounds like you are looking at those and addressing them, and I wanted to thank you for your efforts on that. It is appreciated.

MR. DEARINGER: Well, we appreciate you-all as providers, and so we listen to all of our providers on what those -- and same three issues for all providers. So we're

working across through those fee schedules for all provider types to try to do all of those different things.

DR. BOBROWSKI: Now, I've got some other questions to -- well, you're talking about -- I was at the -- at a community board of public health meeting last night for almost three hours, and one of the topics that you just mentioned I brought up and was bragging on, you know, for doing that, was the community health workers, and not very many people knew about that yet. I think maybe one of the whole group did. But that -- I think that will be a good thing in the future and the -- the other thing I wanted to bring up there was the -- you were talking about the codes. We might need to look at adding a code for -- I know you cover implants and you cover dentures, but the code for the implant-supported denture is not in there, and it's a D6110 and a D6111. It's an upper and a lower. So you might add that to your list, just evaluate and look, because right now I know the MCOs apparently, I don't believe, can

even approve -- they can approve the implants for the placement to have implants, but you really can't just put a denture on top of that without the corresponding attachments that make it what's called an overdenture, an implant-supported overdenture.

MR. DEARINGER: I'll absolutely get on that.

DR. BOBROWSKI: Let's see, those are the two items that you mentioned.

There was one other code, Justin, that you may want to look at is -- I know that Medicaid now is paying for immediate dentures.

MS. BICKERS: Dr. Bobrowski, you're on mute.

MR. DEARINGER: I can hear him.

MS. BICKERS: Okay.

DR. BOBROWSKI: I didn't see my little red button down there that was lit up. Can you hear me still?

DR. McKEE: Yes, I can hear you.

DR. BOBROWSKI: Justin, another thing to maybe look at is when we do the immediate

dentures, one of the common problems is after about three to four weeks, the denture gets extremely loose. I hear somebody else.

MS. O'BRIEN: I think somebody is not on mute, Dr. Bobrowski.

MS. BICKERS: You're good to go, Dr. Bobrowski.

DR. BOBROWSKI: Okay, thank you.

Justin, I don't want to start all over again, but just when we do an immediate denture, in about three or four weeks that denture is so loose they can't put enough adhesive in them to hold them. There is a code for a -- it's a temporary realign, or a soft liner while that is in the healing, but it helps it to fit better for the patient. And I'm sorry I did not look that code up real quick here, but that might be just another thing to look at just to help the patients going through that treatment.

MR. DEARINGER: Sure. Absolutely.

DR. BOBROWSKI: All right. Any other comment on those from TAC members?

A minute ago, Justin, you had

mentioned something about the administrative cost versus the care cost, and this is something we can talk about. So I think we did ask about it at the last meeting, but I apologize, the way we asked it might have been a little confusing, but we were talking about the value-added benefits that the MCOs provide. And are the value-added benefits considered part of the medical loss ratio within each MCO?

MR. DEARINGER: I don't know the answer to that. When I respond with the percentages, I'll let you now that as well.

DR. BOBROWSKI: Okay.

MR. DEARINGER: And I can have Erin e-mail those answers to the TAC when I send them to her.

DR. BOBROWSKI: Okay. Now, I know the TAC members -- I don't believe we got those reports on those value-added benefits until this morning, and I may not have had time to look at that, but we can -- if there's any questions from any TAC members, we can look at that now or bring it up, or we might, since we just got all that data, we

can, you know, add that to our agenda at our next TAC meeting.

MS. BICKERS: And, Dr. Bobrowski, this is Erin. I apologize for getting that to you a little late. We got it all gathered a little late and out the door. And then we still do have your outstanding data requests from DMS that is still in the works of being fulfilled. So that is on our radar. We just don't have that one complete and reviewed yet.

DR. BOBROWSKI: And that's fine. I know some -- and I think, like I said a minute ago, I think sometimes the way we might ask a question may not be clear what we're actually looking for. And there was one error and I think you had e-mailed me back about, and to be honest with you there was one of those, I think the way I said it, I looked back on it and I couldn't figure it back out again myself. So I'll have to look back on one of those and get our wording right with our other TAC members and stuff.

But we do appreciate you-all and the

MCOs gathering up that data and that information, and I'll add that to our next meeting to discuss that some more. And I put on here just some -- a time for some general discussion. Let me see. I've got two things that I wanted to bring up on that, but did the any of the TAC members have any other questions specific for the MAC -- I'm sorry, for the MCOs?

DR. BRAUN: I do not.

DR. BOBROWSKI: All right. Thank you.

I brought this up at the MAC meeting the other day, and let me get this -- and, again, at last night's board of public health meeting. One of the public health coordinators brought up the fact that diabetes in Kentucky has more than doubled since 2000 up to 2021. Over 16 percent of the people in Appalachia have some form of diabetes compared to 13 percent in the rest of the state. Kentucky has the 13th highest mortality rate from diabetes in the United States. Diabetes alone costs Kentucky over $5.16 billion a year. This was data they brought up last night from 2017.

And you know what I worry about is what's causing a doubling in about 20 years of the rate of diabetes. And it just makes you think what's going on out there, and the thing that I brought up at the MAC meeting the other day is should we somehow have additional educational opportunities to help people with their nutritional needs, their diet? I'm just kind of throwing this out there as a question. Should we even form a Nutrition TAC? So I'm just putting that out there for discussion. If anybody has a comment on it, we'll -- if not, we'll move on.

Okay. The --

MS. O'BRIEN: Dr. Bobrowski, this is Jean O'Brien from Anthem.

DR. BOBROWSKI: Yes, Jean.

MS. O'BRIEN: You know, some of the things that you-all -- I was digging -- I'm digging in e-mails and I'm trying to find it. But many of the MCOs, and I will talk about Anthem in general, is that we do a lot of that's kind of included, those valued-added benefits. I know we have like

a flier that we just recently put together, but it talks about like programs that we have that's around the subject. Also, like fruits and vegetables, that we can provide vouchers for our members to get fruits and vegetables, exercise programs. So there's a list that -- and it's probably out on all the MCOs' site of the valued-added benefits, and there's also some prediabetic programs that we have, and then also some programs around the diabetic members, so they can have some one-on-one training and education. So there are some things around that. I'd be glad to send that to you if you'd like to have at least what Anthem has done, and I'm sure that other MCOs have the same thing.

DR. BOBROWSKI: That would be good.

MS. O'BRIEN: That would be education -- would be education for you and for others.

DR. BOBROWSKI: Yes, because that's -- you know, I guess when they brought that up at our meeting last night that diabetes has doubled in Kentucky --

MS. O'BRIEN: Yes. Yes, sir. And so --

and we're trying to tackle that, because we see that, too. I mean, we see the numbers. I finally found it. So it looks like we have, like, fruits and vegetable program. We even do some medically-tailored meals. We have Weight Watchers, fitness coach program, healthy families program. And, of course, around the dental we do -- we have a dental kit which has tooth brush and floss, and those types of things that a member can get from us.

I was trying to look around here. There was one -- let me get down here a little bit. And then I'm not -- I can't find those programs. But there are some programs that are directly for members that they can connect with our case managers and get involved in. So there are some things that the health plans are doing. I just don't think that this group is probably as aware.

DR. BOBROWSKI: Right. I hear some of this because I'm on the MAC also and --

MS. O'BRIEN: Yes, we do talk about it there. Yeah.

DR. BOBROWSKI: We hear about it a little bit more there than on this group. But, you know, I appreciate your information, Ms. Jean on that, what you-all are doing there with helping those situations.

MS. O'BRIEN: Yes, sir.

DR. BOBROWSKI: Let me see.

MS. BICKERS: Dr. Bobrowski, Angie Parker, excuse me, put in the chat the value-added benefits are included in the MLR calculation.

DR. BOBROWSKI: Okay. Thank you. I was clicking on that, the chat, and it was kind of covering up. I don't know, it had like a little add-on thing there and it was covering up the answer and I couldn't see it. So, yes, thank you for that information.

Does any of the TAC members feel like we have any recommendations that we need to bring before the MAC?

DR. PETREY: Not at this time.

DR. BOBROWSKI: I think those codes and things will be all. I think Justin sounded like he will be able to handle all that.

So I believe we're good.

Is there anything else that any TAC member needs to bring up for discussion for our meeting? Because we're getting close.

All right. Our next meeting will be May the 10th, it's a Friday, same time, same channel. And I want to wish everybody a Happy Valentine's Day, and that's all I've got.

* * * * * * *

THEREUPON, the Dental TAC meeting was concluded.

* * * * * * *

STATE OF KENTUCKY)
COUNTY OF FAYETTE)

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

My commission expires: August 24, 2027.

IN TESTIMONY WHEREOF, I have hereunto set my hand and seal of office on this the 9th day of April 2024.

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

DR. BOBROWSKI: [41]
DR. BRAUN: [1] 34/10
DR. HUGHES: [1] 3/19
DR. McKEE: [10] 18/6 18/8 18/16 18/22 20/1 20/4 20/25 23/11 23/16 30/23
DR. PETREY: [6] 6/10 14/12 14/14 19/4 21/11 38/22
MR. DEARINGER: [10] 8/10 10/2 15/12 25/17 28/22 30/8 30/18 31/22 32/11 32/15
MS. BICKERS: [11] 3/4 3/8 8/3 18/13 18/18 25/14 30/16 30/19 31/7 33/3 38/8
MS. O'BRIEN: [7] 31/5 35/16 35/19 36/19 36/25 37/24 38/6

$

$5.16 [1] 34/24
$5.16 billion [1] 34/24

'

'23 [1] 3/16

1

100:130 [1] 17/10
10th [1] 39/6
12 [3] 4/13 8/25 16/9
12-month [1] 9/18
13 percent [1] 34/20
13th [1] 34/21
141 [1] 23/12
16 percent [1] 34/18
19 [1] 4/3
1st [1] 9/16

2

20 [3] 4/3 16/12 35/2
2000 [1] 34/18
2017 [1] 34/25
2021 [1] 34/18
2022 [1] 27/10
2022's [1] 27/7
2023 [9] 8/21 9/6 9/12 9/16 9/23 25/24 26/20 27/11 27/15
2024 [4] 1/16 3/1 27/17 40/16
2027 [1] 40/12
21 [1] 6/22
211.844 [1] 17/11
24 [2] 9/6 40/12
24th [2] 9/4 9/23
25 [2] 24/2 24/6
2:00 [2] 1/17 3/2

3

30 [1] 16/12

4

41 [1] 24/5
42.83 [1] 24/4
48 [1] 24/4
49th [3] 23/9 23/12 25/22

5

50th [1] 23/13
5a [1] 8/17
5b [2] 5/8 10/2

9

902 [1] 17/9
9th [2] 3/11 40/15

A

ability [1] 7/4
able [9] 6/18 7/5 7/9 11/8 11/13 22/2 22/7 26/4 38/25
about [35] 4/15 4/17 8/21 8/24 9/10 10/25 11/15 11/21 18/22 19/24 20/11 21/4 22/9 22/24 23/8 24/18 25/19 25/23 28/17 29/6 29/12 29/17 31/2 31/12 32/1 32/3 32/4 32/7 33/18 35/1 35/2 35/23 36/2 37/24 38/1
absolutely [2] 30/8 31/22
Academy [1] 17/1
accomplishment [1] 26/7
accordance [1] 10/11
according [1] 14/9
accurate [1] 40/9
across [1] 29/1
actual [1] 16/2
actually [4] 8/25 9/6 22/10 33/16
ADA [4] 16/25 17/8 22/5 22/14
add [7] 14/9 14/14 18/2 29/23 33/1 34/2 38/15
add-on [2] 14/9 38/15
added [9] 15/20 15/23 15/25 32/7 32/8 32/20 35/25 36/8 38/9
adding [1] 29/18
addition [2] 15/22 27/21
additional [2] 7/20 35/7
address [1] 20/21
addressing [1] 28/19
adequate [1] 24/24
adhesive [1] 31/14
administration [1] 28/2
administrative [6] 17/12 19/15 25/3 27/2 28/17 32/1
adult [4] 9/2 11/2 13/19 15/20
adults [3] 10/23 15/21 25/25
Advisory [1] 40/10
after [5] 8/20 12/17 18/21 28/4 31/2
again [6] 13/24 14/6 23/19 31/11 33/21 34/14
age [2] 7/15 14/19
aged [1] 6/22
agenda [1] 33/1
ago [4] 4/25 6/20 31/25 33/14
agree [1] 21/13
ahead [1] 21/10
ahold [1] 14/2
all [47]
allow [1] 12/19
alluding [1] 15/2
almost [5] 12/3 12/8 14/16 22/12 29/8
alone [1] 34/23
along [2] 6/2 16/1
already [3] 7/3 17/18 24/7
also [11] 15/24 17/8 22/16 23/3 25/25 26/10 27/22 36/3 36/9 36/10 37/23
always [2] 12/3 12/8
American [3] 16/24 17/1 24/15
amount [2] 13/8 21/18
Angie [1] 38/8
another [7] 5/13 10/13 13/13 24/9 24/11 30/24 31/20
answer [4] 8/15 11/18 32/11 38/16
answers [1] 32/16
Anthem [3] 35/17 35/23 36/15
any [27] 6/8 6/8 10/14 10/15 10/17 10/18 10/18 10/18 12/16 12/16 12/18 16/19 16/19 17/14 19/2 19/2 19/13 25/12 25/12 31/23 32/23 32/23 34/7 34/8 38/19 38/20 39/2
anybody [3] 4/16 9/25 35/12
anyone [1] 8/5
anything [4] 4/17 15/12 21/4 39/2
anyway [1] 20/11
apologize [5] 8/18 9/8 27/24 32/5 33/4
Appalachia [1] 34/19
apparently [1] 29/25
apples [2] 24/11 24/11
apply [1] 25/4
appointments [1] 28/16
appreciate [7] 16/17 25/17 28/6 28/6 28/22 33/25 38/3
appreciated [1] 28/21
appropriate [1] 22/4
approve [4] 3/16 3/17 30/1 30/1
April [1] 40/16
aprons [1] 17/5
are [47]
area [2] 13/4 26/24
areas [3] 10/10 16/12 27/2
around [6] 23/2 36/3 36/11 36/13 37/8 37/12
article [1] 18/9
as [29] 7/13 8/12 9/14 10/14 10/23 12/7 12/7 12/21 12/21 12/24 14/15 15/1 15/3 15/19 16/22 19/5 19/5 19/7 19/8 19/12 25/8 26/9 26/20 27/12 27/17 28/23 32/13 35/10 37/20
ask [2] 32/4 33/14
asked [4] 4/15 22/9 25/19 32/5
assist [2] 26/14 27/13
Association [2] 16/24 24/15
attach [1] 18/9
attached [1] 18/21
attachments [1] 30/5
attention [1] 18/4
August [8] 8/21 9/4 9/4 9/6 9/11 9/23 16/11 40/12
August 2023 [1] 8/21
August 24 [1] 9/6
August 24th [1] 9/23
authentic [1] 23/22
authorizations [1] 27/6
authorized [1] 17/11
automatically [1] 9/20
aware [2] 20/19 37/21
aye [2] 3/20 3/21

B

back [22] 4/7 4/15 4/18 5/2 5/7 5/18 8/4 8/8 9/9 9/24 10/1 10/13 11/22 12/2 12/3 16/13 18/10 25/18 33/17 33/20 33/21 33/22
backdate [1] 9/15
backdated [1] 12/9
bad [1] 21/4
based [4] 11/13 21/20 24/1 24/6
be [38] 3/24 4/20 5/6 6/18 7/5 7/17 7/18 7/22 7/25 10/15 10/23 11/8 11/12 14/21 15/8 16/23 19/7 19/22 20/9 20/14 20/20 22/2 22/7 22/18 24/23 26/4 26/13 29/14 31/19 33/15 33/18 36/14 36/18 36/19 36/20 38/24 38/25 39/5

B

because [16] 4/24 7/2 7/10 9/19 12/10 17/23 19/12 21/18 23/19 25/5 28/7 29/24 36/21 37/1 37/23 39/4
becoming [1] 11/2
been [9] 8/20 9/13 9/22 15/15 21/17 23/7 23/21 28/8 32/6
before [2] 28/12 38/21
beginning [1] 14/24
being [3] 19/10 25/11 33/9
believe [6] 8/22 9/5 18/20 29/25 32/19 39/1
below [1] 5/12
bend [1] 14/5
benefit [1] 6/23
benefits [6] 32/7 32/8 32/20 35/25 36/9 38/10
best [2] 22/16 22/17
better [1] 31/17
between [1] 16/3
big [2] 13/25 13/25
biggest [1] 22/1
bill [3] 5/24 9/17 23/11
billing [1] 16/4
billion [1] 34/24
bind [1] 7/18
bit [4] 6/14 19/21 37/14 38/2
blocks [1] 22/10
board [3] 17/24 29/7 34/14
Bobrowski [10] 2/7 18/6 18/13 20/1 30/16 31/6 31/8 33/3 35/16 38/8
bragging [1] 29/10
branch [2] 20/4 20/5
Braun [1] 2/10
break [1] 14/6
breaks [1] 4/21
bridges [1] 26/2
bring [8] 18/4 23/6 25/8 29/16 32/24 34/6 38/21 39/3
broken [1] 4/24
brought [11] 10/1 13/14 16/21 17/7 23/19 29/9 34/12 34/16 34/25 35/5 36/22
brush [1] 37/9
budget [1] 10/12
budgeted [1] 10/16
burden [2] 27/2 28/17
business [4] 3/15 4/11 16/20 16/21
button [1] 30/21

C

CABINET [4] 1/3 17/10 17/20 17/25
calculation [1] 38/11
calendar [1] 25/23
call [1] 28/4
called [2] 20/8 30/6
came [1] 6/21
can [32] 7/21 7/22 8/3 8/4 8/7 10/13 13/3 14/20 17/17 18/8 18/11 18/14 18/25 21/23 24/23 25/4 27/25 28/3 29/25 30/1 30/18 30/21 30/23 32/3 32/15 32/22 32/23 33/1 36/4 36/12 37/11 37/17
can't [6] 5/4 5/24 14/9 30/3 31/13 37/14
canal [4] 5/19 5/23 7/12 11/10
candy [2] 14/3 14/16
cards [1] 3/13
care [8] 11/1 11/17 24/24 25/2 25/8 26/24 28/1 32/2
Carol [2] 2/10 6/7
case [7] 6/18 6/18 6/25 7/3 7/20 12/14 37/17
cases [5] 6/15 6/16 6/17 12/15 13/5
categories [1] 28/18
causing [1] 35/2
CCR [1] 40/19
certain [2] 6/5 27/22
certainly [1] 7/12
certify [1] 40/8
Chairman [1] 2/7
challenging [2] 7/10 15/1
change [6] 4/11 6/6 7/7 8/17 8/25 9/14
changed [3] 9/3 9/13 13/20
changer [1] 24/23
channel [1] 39/7
characterize [1] 14/15
chat [3] 18/9 38/9 38/13
checked [1] 17/23
chew [1] 14/5
child [3] 9/2 11/1 14/17
children [6] 10/23 13/19 13/23 14/1 15/21 25/25
children's [2] 13/15 13/21
chipped [1] 4/24
circumstances [1] 6/5
clear [1] 33/15
clicking [1] 38/13
close [1] 39/4
CMS [3] 11/19 12/18 13/7
coach [1] 37/6
code [8] 4/13 10/18 16/2 29/18 29/20 30/12 31/15 31/18
codes [6] 10/14 15/9 15/14 15/23 29/17 38/23
coding [3] 10/19 11/7 11/12
collar [1] 22/10
collars [1] 17/5
collimation [1] 17/4
come [6] 4/23 6/5 10/13 13/3 13/10 20/23
comes [2] 20/12 22/14
coming [3] 17/25 24/13 26/8
comment [6] 5/16 20/16 21/13 25/12 31/24 35/13
comments [2] 6/8 19/3
commission [1] 40/12
Commissioner [5] 3/24 6/19 8/1 8/5 22/24
committee [2] 19/11 40/10
common [1] 31/1
COMMONWEALTH [1] 1/2
community [4] 26/11 26/12 29/6 29/11
comparatively [1] 10/8
compare [1] 24/10
compared [1] 34/20
compensate [1] 13/3
compensated [1] 6/19
compensation [1] 7/21
complete [1] 33/11
completely [1] 15/17
concluded [1] 39/12
confusing [1] 32/6
conjunction [1] 16/24
connect [1] 37/17
considered [1] 32/9
constantly [1] 22/9
construction [1] 19/13
contacted [1] 15/5
contacts [1] 18/10
continue [2] 5/10 6/25
contracts [1] 27/23
Contrary [1] 20/16
coordination [1] 26/16
coordinators [1] 34/16
copied [1] 18/14
corrected [2] 16/10 16/11
corresponding [1] 30/5
cost [6] 5/9 5/12 10/6 25/3 32/2 32/2
costs [1] 34/23
could [5] 6/22 6/24 6/24 6/25 13/22
couldn't [3] 3/24 33/20 38/16
COUNTY [1] 40/4
course [2] 5/23 37/8
cover [5] 12/16 12/18 12/19 29/19 29/19
coverage [14] 5/22 6/16 7/6 7/17 10/22 11/23 12/1 12/2 12/2 12/10 12/15 12/17 25/24 26/1
covering [2] 38/14 38/16
created [3] 13/1 16/10 26/10
credited [1] 9/21
criteria [4] 13/20 13/21 24/6 28/13
crown [1] 5/3
crowns [8] 13/15 13/18 13/19 13/20 14/1 14/19 14/22 26/1
currently [1] 8/7

D

D2930 [1] 15/9
D2931 [1] 15/9
D2932 [1] 15/9
D6110 [1] 29/21
D6111 [1] 29/22
data [4] 32/25 33/7 34/1 34/24
date [3] 1/15 14/25 20/18
day [5] 18/5 34/13 35/6 39/8 40/15
deals [2] 19/16 19/17
Dearinger [3] 8/9 8/11 25/14
decided [1] 6/3
decides [1] 11/10
decreasing [1] 26/17
definitely [1] 8/7
denied [1] 9/19
dental [24] 1/7 3/10 4/12 8/13 10/4 12/23 15/4 16/24 17/6 17/10 20/13 20/23 23/6 24/2 24/15 24/15 24/19 24/22 24/24 25/1 26/24 37/8 37/9 39/11
dentist [3] 4/20 14/7 14/8
dentistry [2] 6/6 17/24
dentists [10] 8/18 8/19 8/24 9/8 9/10 11/8 13/17 15/5 15/6 15/11
denture [6] 5/20 29/21 30/4 31/3 31/12 31/13
dentures [5] 12/22 26/1 29/19 30/15 31/1
department [4] 20/5 20/7 25/20 27/20
designed [1] 14/22
developments [1] 20/15
diabetes [6] 34/17 34/20 34/22 34/23 35/3 36/23
diabetic [1] 36/11
did [9] 4/16 9/24 15/10 28/10 28/11 29/13 31/18 32/4 34/7
didn't [3] 9/8 16/3 30/20
diet [1] 35/9
different [12] 9/2 11/12 12/21 13/2 15/18 16/12 26/2 26/18 27/9 27/11 27/16 29/3
difficult [1] 7/2
digging [2] 35/20 35/21

D

digital [2] 17/3 21/20
direction [2] 22/19 23/15
directly [2] 28/1 37/16
director [1] 8/11
discuss [1] 34/3
discussion [3] 34/5 35/12 39/3
disposal [1] 17/16
distance [1] 19/19
dividends [1] 26/8
division [2] 8/12 8/14
DMD [4] 2/7 2/8 2/9 2/10
DME [1] 12/24
DMS [1] 33/8
do [28] 4/1 5/2 5/3 5/5 5/10 5/12 6/14 7/19 7/21 7/22 15/6 18/25 20/17 21/25 22/8 23/8 24/7 24/9 29/2 30/25 31/11 33/7 33/25 34/10 35/23 37/5 37/8 37/24
doctor [1] 10/25
documentation [1] 12/6
does [4] 16/19 24/9 28/9 38/19
doing [9] 4/22 16/7 21/11 22/16 25/21 27/19 29/10 37/19 38/4
dollars [2] 25/5 25/6
don't [20] 5/17 7/4 11/18 12/15 13/4 15/12 16/15 18/1 18/20 18/22 21/14 21/21 27/23 29/25 31/10 32/11 32/19 33/10 37/20 38/14
done [6] 10/3 11/14 12/17 27/15 28/10 36/16
door [1] 33/6
doubled [2] 34/17 36/24
doubling [1] 35/2
down [3] 22/15 30/21 37/13
Dr [4] 18/6 18/13 21/9 31/6
Dr. [14] 6/7 6/7 7/24 18/19 20/1 21/10 22/8 24/8 28/11 30/16 31/8 33/3 35/16 38/8
Dr. Bobrowski [6] 20/1 30/16 31/8 33/3 35/16 38/8
Dr. Carol [1] 6/7
Dr. Joe [3] 6/7 7/24 21/10
Dr. Julie [1] 18/19
Dr. McKee [2] 24/8 28/11
Dr. Oz [1] 22/8
due [3] 5/5 5/8 17/3
during [2] 11/24 16/10

E

e-mail [2] 18/21 32/15
e-mailed [1] 33/17
e-mails [2] 18/14 35/21
each [2] 8/15 32/10
earlier [1] 10/25
easier [1] 27/13
eating [1] 14/16
education [4] 26/15 36/13 36/19 36/20
educational [1] 35/7
effective [1] 9/15
efforts [2] 28/7 28/21
either [3] 4/18 7/5 12/14
electronic [1] 17/15
eliminate [1] 4/19
eliminated [2] 5/7 11/4
eliminates [1] 10/24
else [5] 4/17 5/2 24/9 31/4 39/2
encompass [1] 21/25
end [4] 7/18 9/11 12/1 19/10
enough [2] 13/6 31/13
ensures [1] 24/25
Environment [1] 20/9
Environmental [1] 20/8
equipment [2] 12/25 21/2
Erin [5] 8/3 16/14 18/13 32/15 33/4
error [1] 33/17
errors [2] 15/15 16/8
essentially [1] 14/18
established [2] 3/14 22/25
evaluate [1] 29/24
even [6] 14/15 23/23 27/18 30/1 35/10 37/5
ever [2] 5/18 18/20
every [2] 13/22 20/23
everybody [3] 3/12 24/12 39/7
everyone [1] 3/10
everything [1] 9/16
everything's [1] 6/2
excuse [1] 38/9
exercise [1] 36/6
expanded [1] 25/24
expensive [1] 5/3
expiration [1] 14/25
expires [1] 40/12
extra [1] 10/17
extreme [1] 26/8
extremely [1] 31/3

F

facilities [1] 19/8
fact [2] 9/14 34/16
failed [1] 28/16
fall [1] 8/14
familiar [1] 24/20
families [1] 37/7
FAMILY [1] 1/3
far [5] 6/7 12/21 19/5 19/8 19/11
favor [1] 3/20
FAYETTE [1] 40/4
FDA [1] 17/1
FEBRUARY [3] 1/16 3/1 3/11
fee [11] 9/2 9/22 15/17 15/22 15/23 15/24 16/2 16/5 27/4 27/7 29/1
feel [2] 27/14 38/19
fees [6] 8/22 8/24 10/4 15/21 22/25 23/4
few [5] 15/21 16/7 16/22 22/13 27/19
figure [2] 18/25 33/20
filling [1] 4/21
fillings [4] 4/12 4/22 4/23 5/10
filtration [1] 19/16
finally [1] 37/3
find [2] 35/21 37/15
fine [3] 5/4 6/2 33/12
finish [1] 6/18
finished [2] 5/21 5/25
finishing [1] 7/20
first [2] 3/15 10/21
fit [1] 31/17
fitness [1] 37/6
five [6] 3/5 4/25 13/23 14/10 15/1 15/8
five-year [2] 15/1 15/8
fix [2] 4/25 5/2
flier [1] 36/1
flip [1] 16/3
floss [1] 37/10
folks [3] 4/22 5/4 5/21
follow [6] 4/14 6/12 8/2 8/8 17/21 21/3
follow-up [2] 8/2 8/8
following [1] 22/4
food [1] 14/4
forgot [1] 12/4
form [3] 14/3 34/19 35/10
forth [1] 5/14
forward [2] 18/15 26/6
forwarding [1] 20/12
found [1] 37/3
four [2] 31/2 31/12
Friday [1] 39/6
front [1] 15/13
fruits [3] 36/4 36/5 37/4
fulfilled [1] 33/9
function [1] 21/3
funds [1] 10/17
future [1] 29/15
FYI [4] 16/23 21/5 24/12 25/13

G

game [1] 24/23
Garth [6] 2/7 6/13 14/12 14/14 19/4 21/11
gathered [1] 33/5
gathering [1] 34/1
general [4] 15/6 22/7 34/5 35/23
get [23] 3/13 4/6 5/19 5/25 7/6 11/22 12/7 14/2 16/13 18/11 18/23 20/14 22/9 22/18 27/25 28/3 30/8 33/22 34/13 36/5 37/11 37/13 37/18
gets [1] 31/3
getting [6] 4/15 5/20 12/1 22/14 33/4 39/4
give [2] 10/18 11/19
glad [4] 20/9 20/14 20/20 36/14
go [9] 3/7 4/10 16/1 21/10 25/1 25/7 27/4 28/9 31/7
goes [2] 6/3 28/1
going [16] 4/10 6/2 7/17 7/18 14/24 18/23 19/10 22/21 23/8 23/12 23/14 25/18 26/7 27/17 31/21 35/4
gone [1] 27/6
good [7] 19/24 21/24 24/7 29/14 31/7 36/18 39/1
got [21] 3/14 5/1 6/8 10/3 10/9 12/11 12/13 13/13 17/7 19/1 19/20 23/20 24/3 24/13 25/12 29/4 32/19 32/25 33/5 34/5 39/9
great [3] 21/2 22/18 24/19
group [8] 8/18 8/23 13/16 15/11 20/17 29/13 37/20 38/2
groups [4] 9/7 9/10 15/4 17/22
guess [2] 15/9 36/22
guidance [1] 11/20

H

had [20] 4/14 8/17 8/21 8/23 9/6 9/17 11/1 13/16 15/14 15/15 15/19 15/24 16/5 16/7 16/11 25/19 31/25 32/21 33/17 38/14
hand [2] 25/14 40/15
handle [1] 38/25
handling [1] 17/15
happened [2] 18/5 21/6
happening [1] 13/25
happens [2] 13/24 13/25
happy [2] 8/14 39/8
hard [2] 24/10 26/22
has [11] 10/15 11/23 19/20 24/17 25/14 34/17 34/21 35/12 36/15 36/23 37/9

H

have [64]
having [1] 28/13
he [1] 38/25
head [2] 16/15 27/24
healing [1] 31/16
health [14] 1/3 5/5 20/6 23/6 24/5 25/22 26/5 26/11 26/13 29/7 29/11 34/15 34/15 37/19
healthcare [3] 8/12 26/16 26/16
healthier [1] 26/4
healthy [1] 37/7
hear [8] 4/16 9/24 30/18 30/22 30/23 31/3 37/22 38/1
heard [1] 5/18
HELD [1] 1/12
Hello [1] 8/10
help [4] 4/4 26/3 31/20 35/7
helping [2] 4/2 38/5
helps [1] 31/17
her [4] 3/25 4/1 16/14 32/17
here [12] 3/13 5/16 8/9 20/17 23/18 24/3 24/22 27/19 31/19 34/4 37/12 37/13
hereunto [1] 40/14
high [1] 28/3
highest [1] 34/21
him [1] 30/18
his [1] 25/14
hold [1] 31/14
home [1] 6/3
honest [1] 33/18
hope [1] 26/13
hopefully [1] 13/8
hour [1] 6/1
hours [1] 29/8
House [1] 23/11
how [5] 18/11 18/25 22/24 23/8 24/8
huge [1] 26/6
Hughes [1] 2/9
Human [2] 17/11 17/25
hurt [1] 6/4
hygiene [1] 19/6

I

I'd [3] 18/10 23/5 36/14
I'll [10] 3/19 5/15 16/13 16/16 20/9 20/14 30/8 32/13 33/21 34/2
I'm [22] 3/8 8/5 8/11 8/14 9/5 15/16 18/22 18/24 19/4 19/9 21/4 22/21 23/16 31/18 34/9 35/9 35/11 35/20 35/21 36/16 37/14 37/23
I've [9] 5/1 6/3 13/13 17/18 20/10 22/23 29/4 34/5 39/8
iceberg [1] 21/23
immediate [3] 30/14 30/25 31/11
impact [1] 19/5
implant [2] 29/20 30/7
implant-supported [2] 29/20 30/7
implants [3] 29/19 30/2 30/3
important [1] 22/11
improve [1] 26/5
improved [2] 26/23 26/25
included [3] 26/1 35/24 38/10
income [1] 12/6
increase [3] 10/14 10/15 26/21
increased [3] 10/22 15/20 26/22
increases [2] 5/9 10/18
increasing [1] 26/23
indicators [1] 24/2
individual [4] 11/23 12/4 12/10 13/1
individuals [3] 12/16 26/4 26/15
industry [2] 20/18 20/19
information [5] 4/6 25/9 34/2 38/3 38/18
ing [1] 21/18
inherently [1] 14/18
installations [1] 19/24
installed [1] 19/14
instances [1] 7/13
insurance [7] 12/13 24/16 24/17 24/19 25/1 25/3 28/2
insurer's [1] 25/3
intended [1] 14/21
interact [1] 7/8
involved [1] 37/18
ionizing [1] 17/14
is [57]
issue [2] 11/17 11/21
issues [5] 11/4 11/17 12/24 26/19 28/25
it [84]
it's [30] 4/2 4/17 5/25 7/7 12/23 12/24 13/24 17/9 17/16 17/18 17/24 18/8 19/11 20/5 20/6 20/7 21/16 21/21 22/6 22/12 23/6 24/10 24/21 26/6 28/9 29/21 29/22 31/15 36/7 39/6
item [5] 5/8 15/11 22/21 23/6 25/9
items [5] 6/9 16/22 25/13 27/9 30/11
itself [1] 19/20

J

January [1] 9/16
January 1st [1] 9/16
Jean [4] 2/10 35/16 35/18 38/4
job [2] 12/12 12/13
Joe [4] 2/8 6/7 7/24 21/10
JOLINDA [2] 40/6 40/19
judge [1] 4/20
Julie [3] 18/8 18/19 20/2
just [55]
Justin [14] 8/9 8/11 15/10 18/1 22/23 25/14 25/16 28/6 28/15 30/12 30/24 31/10 31/25 38/24

K

KAR [1] 17/9
keep [1] 21/11
Kelli [1] 7/25
Kentuckians [1] 23/25
KENTUCKY [11] 1/2 10/6 10/7 17/23 23/9 34/17 34/21 34/23 36/24 40/3 40/8
Kentucky's [1] 25/21
key [1] 24/2
kids [1] 14/16
Kimberly [1] 2/9
kind [14] 4/18 8/1 10/14 10/15 10/20 13/3 15/17 17/18 22/21 24/19 28/14 35/9 35/24 38/13
kinds [1] 26/2
kit [1] 37/9
knew [1] 29/12
know [50]
knowing [1] 22/15
KRS [1] 17/11
KY [1] 40/19

L

lapse [1] 6/15
Large [2] 40/8 40/19
last [10] 8/22 13/14 25/23 26/25 28/11 29/7 32/4 34/14 34/25 36/23
lasting [1] 17/13
late [2] 33/5 33/6
lead [1] 17/5
least [1] 36/15
Lee [4] 3/24 6/19 8/1 22/24
legislative [1] 25/10
less [1] 21/18
less-ing [1] 21/18
lessened [1] 13/8
let [10] 4/20 5/15 9/5 16/12 24/3 32/13 34/5 34/13 37/13 38/7
Let's [3] 16/21 18/12 30/10
letter [1] 22/22
licensing [1] 20/13
lifestyle [1] 26/5
like [32] 4/18 5/3 5/14 7/11 9/4 11/9 12/7 13/16 13/25 15/5 18/11 19/23 21/5 21/22 22/2 22/11 23/2 23/5 25/6 27/14 28/10 28/18 33/13 35/25 36/2 36/3 36/15 37/3 37/4 38/14 38/19 38/25
limitation [1] 9/19
limitations [2] 16/1 27/9
linearity [1] 19/17
lined [1] 3/13
liner [1] 31/16
list [3] 18/2 29/23 36/7
listed [1] 24/1
listen [1] 28/23
lit [1] 30/21
little [8] 11/20 30/20 32/6 33/5 33/6 37/14 38/1 38/15
living [1] 10/6
long [1] 14/22
long-term [1] 14/22
longer [3] 6/23 7/16 17/6
look [19] 10/11 16/13 16/16 17/17 17/21 18/3 18/25 23/3 27/4 29/18 29/24 30/13 30/25 31/18 31/20 32/22 32/24 33/22 37/12
looked [8] 10/4 10/7 13/16 15/14 17/8 19/22 22/25 33/20
looking [10] 6/21 11/12 13/17 16/18 16/23 18/19 23/1 25/19 28/19 33/16
looks [2] 9/4 37/3
loose [2] 31/3 31/13
lose [4] 5/21 11/25 12/14 12/17
loses [1] 12/10
loss [3] 24/20 24/22 32/9
lost [1] 12/4
lot [6] 5/12 15/6 27/5 27/11 27/16 35/24
low [1] 5/11
lower [1] 29/22

M

MAC [5] 34/9 34/12 35/5 37/23 38/21
made [5] 7/7 9/15 15/15 16/8 25/25
mail [2] 18/21 32/15
mailed [1] 33/17
mails [2] 18/14 35/21
main [1] 28/13
major [1] 26/6
make [5] 3/17 5/1 9/5 27/13 30/5

M

makes [1] 35/3
making [1] 12/12
management's [1] 10/10
managers [1] 37/17
manual [1] 16/4
many [4] 2/16 4/21 29/12 35/22
match [1] 22/17
matter [1] 9/14
Maxillofacial [1] 17/2
may [7] 7/18 8/13 8/20 30/13 32/21 33/15 39/6
maybe [4] 6/20 24/6 29/13 30/25
McKee [5] 18/8 20/2 21/9 24/8 28/11
MCO [2] 27/22 32/10
MCOs [6] 29/25 32/7 34/1 34/9 35/22 36/16
MCOs' [1] 36/8
me [13] 6/10 9/5 15/13 16/13 20/12 24/3 30/22 33/17 34/5 34/13 37/13 38/7 38/9
me back [1] 33/17
meals [2] 3/13 37/5
mean [2] 21/15 37/2
MEDICAID [17] 1/4 7/5 8/4 11/23 11/25 12/2 12/8 12/14 18/10 23/4 24/17 25/4 25/5 25/20 27/20 28/14 30/14
medical [4] 16/25 24/17 24/20 32/9
medically [1] 37/5
medically-tailored [1] 37/5
meeting [17] 3/10 3/17 3/25 8/23 13/14 29/7 32/4 33/2 34/3 34/12 34/15 35/5 36/23 39/4 39/5 39/11 40/10
member [4] 16/19 25/12 37/11 39/3
members [14] 3/21 5/16 15/4 19/3 22/3 31/24 32/19 32/23 33/23 34/7 36/5 36/11 37/16 38/19
mentioned [4] 23/1 29/9 30/11 32/1
middle [2] 7/14 11/16
might [10] 4/25 14/14 17/20 18/2 29/17 29/23 31/19 32/5 32/25 33/14
minute [4] 3/23 5/17 31/25 33/13
minutes [1] 3/16
miss [1] 21/22
missing [1] 27/9
Missouri's [1] 23/3
MLR [1] 38/10
modifier [1] 11/7
modifiers [2] 11/6 11/6
money [4] 12/12 20/12 27/23 27/25
monies [1] 25/7
month [1] 9/18
months [10] 4/13 4/13 4/16 4/19 4/25 5/2 8/25 9/1 16/9 16/9
more [11] 2/16 5/2 8/14 11/20 14/20 24/19 24/25 27/18 34/3 34/17 38/2
morning [1] 32/21
mortality [1] 34/22
mostly [2] 9/11 17/24
motion [1] 3/17
move [9] 4/18 16/21 22/18 23/9 23/12 25/21 27/18 27/21 35/13
moved [2] 4/15 5/6
Ms. [2] 7/25 38/4
Ms. Jean [1] 38/4
Ms. Kelli [1] 7/25
much [3] 7/11 12/12 18/17
multiple [11] 9/7 9/10 10/3 10/7 10/21 15/14 15/23 21/25 26/21 27/1 27/8
Murray [1] 23/24
mute [2] 30/17 31/6
my [8] 8/10 8/14 16/15 20/7 27/24 30/20 40/12 40/15
myself [1] 33/21

N

name [1] 8/10
necessarily [1] 11/6
need [11] 3/18 7/11 7/12 7/14 7/25 13/6 17/20 18/2 25/2 29/18 38/20
needed [1] 17/6
needle [2] 27/18 27/21
needs [3] 14/8 35/8 39/3
never [2] 4/16 9/24
new [18] 12/11 12/13 14/9 16/21 19/6 19/8 19/8 19/8 19/13 19/24 20/15 21/16 23/5 23/18 24/14 25/9 26/10 26/11
next [4] 22/21 33/2 34/2 39/5
night [3] 29/7 34/25 36/23
night's [1] 34/14
no [6] 6/4 6/23 7/16 15/12 17/6 26/17
non [1] 21/20
non-digital [1] 21/20
not [42]
Notary [2] 40/7 40/19
nothing [1] 6/4
notice [3] 27/3 27/5 27/8
November [1] 3/16
now [16] 5/1 10/9 11/5 12/1 13/13 17/2 19/2 19/12 25/12 27/7 29/4 29/24 30/14 32/13 32/18 32/24
numbers [1] 37/2
Nutrition [1] 35/11
nutritional [1] 35/8

O

O'Brien [1] 35/17
obviously [1] 7/1
occasionally [1] 7/21
off [5] 14/4 15/8 16/15 23/10 27/24
office [2] 20/24 40/15
offices [1] 19/8
often [1] 7/23
oh [1] 23/20
Okay [14] 3/6 3/9 3/22 7/24 8/10 13/11 16/17 18/12 30/19 31/9 32/14 32/18 35/15 38/12
old [3] 4/10 6/17 16/20
once [1] 13/22
one [27] 8/15 10/13 10/21 13/7 15/13 15/16 16/5 16/9 16/13 16/18 18/2 19/3 23/23 23/24 24/9 29/8 29/13 30/12 31/1 33/10 33/16 33/19 33/22 34/15 36/12 36/12 37/13
only [5] 4/2 11/17 13/22 22/16 25/24
onus [1] 14/17
operator [1] 19/18
opportunities [1] 35/7
Optometric [1] 40/10
oral [4] 17/1 24/5 25/21 26/5
order [3] 3/15 9/14 24/1
orthodontic [2] 6/23 7/11
orthodontics [3] 6/14 7/19 22/8
other [31] 4/3 5/8 5/16 7/12 7/16 10/8 12/22 12/25 13/9 15/4 16/19 16/20 17/21 18/5 19/2 19/3 20/11 23/1 23/5 24/13 26/3 26/19 29/4 29/15 30/12 31/23 33/23 34/8 34/13 35/6 36/16
others [1] 36/20
our [20] 4/2 10/10 10/11 13/14 18/10 22/11 23/24 27/22 28/24 33/1 33/2 33/10 33/22 33/23 34/2 36/5 36/23 37/17 39/4 39/5
out [19] 3/4 6/4 6/21 6/22 6/25 7/15 11/15 12/20 16/14 17/7 18/25 20/10 23/19 33/6 33/21 35/4 35/9 35/11 36/7
outstanding [1] 33/7
over [6] 16/3 20/6 22/22 31/10 34/18 34/23
overdenture [2] 30/6 30/7
own [2] 23/24 24/17
Oz [1] 22/8

P

p.m [2] 1/17 3/2
page [2] 23/21 24/3
paper [1] 12/5
paragraph [2] 17/17 24/22
Parker [1] 38/8
part [2] 24/21 32/9
passage [1] 23/11
patient [4] 6/2 7/3 11/10 31/17
patient's [2] 24/25 25/1
patients [3] 7/8 22/7 31/21
pay [5] 6/25 11/13 26/8 27/23 28/1
paying [1] 30/14
pediatric [2] 14/7 15/5
people [6] 6/22 23/22 28/13 29/12 34/19 35/8
percent [2] 34/18 34/20
percentage [3] 11/13 27/22 28/3
percentages [2] 11/13 32/12
period [1] 9/18
periodically [1] 20/23
permanent [1] 14/20
personalized [1] 12/25
Petrey [1] 2/8
phases [1] 21/25
physicists [1] 16/25
pitfalls [1] 7/7
placement [1] 30/2
plan [3] 5/18 5/20 6/7
plans [1] 37/19
please [1] 20/1
point [5] 6/12 11/24 19/4 19/25 20/1
Policy [1] 8/12
political [1] 25/10
pop [1] 14/4
position [3] 7/2 23/9 25/22
possession [1] 17/13
possibly [1] 18/3
practice [2] 22/16 22/17
practices [1] 19/9
practitioner [1] 7/1
precise [1] 17/4
prediabetic [1] 36/9
premiums [1] 25/1
pretty [1] 4/8
prevention [1] 26/15
previous [1] 21/19
price [1] 5/11
printed [1] 23/10
prior [1] 27/5
probably [5] 16/12 19/22 20/16 36/7

P

probably... [1] 37/20
problem [1] 12/9
problems [1] 31/1
procedure [2] 5/3 11/9
procedures [2] 12/22 16/4
process [2] 11/25 14/5
product [1] 17/15
Professional [1] 40/7
program [3] 37/4 37/7 37/7
programs [6] 36/2 36/6 36/10 36/11 37/15 37/16
project [1] 15/25
projects [1] 27/16
proof [1] 12/6
protection [2] 19/18 20/9
protocols [1] 22/4
provide [3] 17/12 32/8 36/4
provider [4] 26/10 26/12 26/14 29/2
providers [6] 8/13 27/3 27/13 28/23 28/24 28/25
provides [1] 12/13
public [7] 20/6 20/16 29/7 34/14 34/15 40/7 40/19
pulled [1] 11/11
purview [1] 19/10
put [8] 5/14 10/8 14/17 30/3 31/13 34/4 36/1 38/9
puts [1] 7/1
putting [2] 24/23 35/11

Q

quality [2] 24/24 26/24
question [5] 4/6 12/23 13/13 33/15 35/10
questions [4] 8/15 29/5 32/23 34/8
quick [4] 4/8 18/20 19/1 31/19
quickly [1] 21/22
quite [5] 6/14 7/22 7/22 15/20 19/20
quorum [2] 3/5 3/14

R

radar [1] 33/10
radiation [6] 17/15 19/5 19/14 20/4 20/14 21/19
radioactive [1] 17/16
radiographs [1] 22/12
radiography [1] 21/20
radiology [3] 17/2 17/6 17/22
raised [1] 25/15
rank [2] 24/4 24/5
rankings [1] 23/7
rate [2] 34/22 35/3
rates [7] 9/2 26/18 26/21 26/22 26/23 26/25 28/15
ratio [3] 24/20 24/22 32/9
ray [2] 17/4 19/6
rays [1] 17/3
RE [1] 1/7
reach [2] 20/10 24/25
reaching [1] 19/11
read [1] 24/21
ready [2] 3/6 3/8
real [3] 18/20 19/1 31/19
realign [1] 31/15
really [7] 5/11 5/24 7/7 11/18 19/9 20/17 30/3
reason [2] 5/22 7/15
reasons [1] 7/16
rebill [1] 9/15
rebilled [1] 9/20
receiving [1] 11/1
recently [1] 36/1
recommend [1] 5/6
recommendation [1] 5/13
recommendations [2] 17/22 38/20
record [1] 40/9
red [2] 27/2 30/20
redid [2] 9/1 15/17
reduce [1] 27/1
reference [1] 25/18
referred [1] 8/1
reform [1] 24/16
reg [1] 19/22
Registered [1] 40/6
registration [1] 17/13
regs [2] 21/19 22/17
regulation [6] 17/9 17/12 17/25 19/16 19/20 19/21
regulations [1] 16/3
reimbursement [1] 10/5
remember [1] 16/15
remind [1] 3/11
replace [3] 13/22 14/8 14/10
replacement [1] 4/12
report [6] 23/18 23/25 24/9 24/10 24/14 25/19
Reporter [1] 40/7
reports [2] 10/4 32/20
request [2] 5/6 22/22
requesting [1] 15/7
requests [1] 33/8
required [1] 22/5
requirement [1] 22/6
requirements [3] 19/7 19/7 19/12
research [1] 27/12
researched [1] 23/21
researcher [1] 23/23
Resources [2] 17/11 18/1
respond [1] 32/12
rest [1] 34/20
restoration [1] 14/21
restorative [2] 9/17 26/2
restored [1] 12/8
retroactive [1] 12/3
review [2] 10/11 16/11
reviewed [1] 33/11
ridiculously [1] 5/11
right [12] 4/7 8/20 10/9 11/5 18/24 21/8 29/24 31/23 33/23 34/11 37/22 39/5
rolls [1] 14/3
root [4] 5/19 5/23 7/12 11/10
RPR [1] 40/19
rule [4] 4/11 8/17 14/9 15/8
run [1] 6/13

S

safety [1] 22/7
said [8] 11/9 17/2 17/19 21/5 28/10 28/15 33/13 33/19
same [5] 19/4 28/24 36/17 39/6 39/6
say [6] 4/8 4/16 5/22 6/3 12/4 12/11
saying [2] 21/4 22/5
says [2] 17/10 25/20
schedule [6] 9/3 15/25 16/2 16/5 27/4 27/8
scheduled [2] 9/22 15/18
schedules [3] 15/22 15/24 29/1
score [1] 24/4
seal [1] 40/15
second [3] 3/18 3/19 6/10
Section [5] 17/17 19/16 19/17 19/18 19/19
see [14] 10/17 16/16 18/12 18/25 22/11 25/7 26/22 30/10 30/20 34/5 37/2 37/2 38/7 38/16
send [7] 9/8 12/5 16/14 18/8 18/9 32/16 36/14
sense [1] 25/4
sent [1] 9/17
September [1] 9/12
service [1] 26/11
services [8] 1/3 1/4 25/21 26/3 26/3 26/9 26/17 27/20
set [2] 14/23 40/14
setting [2] 14/25 24/22
seven [1] 5/1
several [3] 15/18 22/24 23/22
severe [1] 5/9
she's [1] 23/1
should [3] 11/15 35/6 35/10
show [1] 26/17
sign [1] 12/5
since [4] 9/22 22/8 32/25 34/18
sir [3] 25/17 36/25 38/6
sit [1] 9/9
site [1] 36/8
situation [2] 5/5 22/13
situations [2] 10/24 38/5
six [5] 4/13 4/16 4/19 8/25 16/8
skin [1] 19/19
skip [1] 22/22
so [70]
soft [1] 31/16
solution [2] 13/4 13/6
solutions [1] 13/9
some [43]
somebody [4] 9/17 24/9 31/4 31/5
somehow [1] 35/6
something [8] 4/25 10/12 12/6 12/11 21/16 26/7 32/1 32/3
something's [1] 4/24
sometime [1] 11/15
sometimes [3] 14/11 24/10 33/14
soon [1] 12/7
sorry [4] 6/10 21/11 31/18 34/9
sounded [1] 38/24
sounds [1] 28/18
source [2] 17/14 19/19
speak [1] 8/6
specific [1] 34/8
spot [1] 16/6
staff [1] 5/9
stainless [3] 13/15 13/18 14/1
standard [2] 21/15 21/16
standards [2] 20/18 20/20
start [8] 6/9 11/9 11/9 11/23 12/12 21/24 22/18 31/10
started [5] 5/19 5/20 5/23 6/17 7/3
starting [1] 24/7
state [9] 10/5 10/6 19/7 23/3 23/24 34/21 40/3 40/8 40/19
states [4] 10/8 23/1 24/1 34/23
stay [1] 20/18
steel [3] 13/15 13/19 14/1
step [1] 26/6

S

still [10] 3/5 11/18 11/19 12/20 13/7 20/5 22/6 30/22 33/7 33/8
stop [1] 11/3
studies [1] 10/3
study [1] 28/11
studying [1] 26/21
stuff [1] 33/24
subject [1] 36/3
substantive [1] 12/11
such [1] 7/13
supplies [1] 5/9
support [1] 4/5
supported [2] 29/20 30/7
supposed [1] 11/22
sure [8] 8/5 9/5 10/2 15/16 19/9 25/25 31/22 36/16
system [1] 6/17

T

TAC [24] 1/7 3/10 3/17 4/2 5/16 8/19 8/21 9/9 15/3 16/19 19/3 22/1 25/12 31/24 32/16 32/18 32/23 33/2 33/23 34/7 35/11 38/19 39/2 39/11
tackle [1] 37/1
TACs [1] 4/3
taffy [1] 14/2
tailored [1] 37/5
take [6] 3/23 6/4 8/3 8/4 8/7 11/16
taken [1] 15/8
talk [5] 15/10 25/23 32/3 35/22 37/24
talked [8] 8/17 8/21 9/10 10/25 11/20 20/10 22/23 24/18
talking [5] 19/23 23/7 29/5 29/17 32/6
talks [1] 36/2
tape [1] 27/2
targeting [1] 10/21
taxing [1] 7/22
taxpayer [1] 25/5
team [1] 4/1
Technical [1] 40/10
technically [1] 5/24
tell [1] 22/3
telling [1] 23/16
temporary [3] 14/18 14/19 31/15
term [1] 14/22
terms [1] 19/23
test [1] 21/1
TESTIMONY [1] 40/14
than [3] 8/14 34/17 38/2
thank [16] 3/22 3/25 4/5 7/24 13/11 18/16 18/16 20/22 21/8 22/20 28/5 28/20 31/9 34/11 38/12 38/17
thanks [1] 4/9
that [225]
that's [24] 3/5 4/23 5/4 5/13 9/13 9/22 11/11 12/8 15/8 15/16 19/9 19/24 21/2 23/14 24/13 25/6 27/18 28/3 28/7 33/12 35/24 36/3 36/21 39/8
their [8] 5/5 7/5 12/7 12/14 20/13 24/17 35/8 35/8
them [22] 5/1 9/21 11/21 12/13 12/21 13/2 13/9 14/4 14/5 14/5 14/6 15/16 16/9 20/10 20/10 20/12 20/21 23/23 28/20 31/14 31/14 32/16
then [27] 3/7 3/15 7/4 7/17 8/22 9/20 10/7 11/2 11/5 11/10 11/24 12/7 15/20 15/22 15/24 16/4 16/10 17/8 19/17 19/18 22/15 24/4 26/19 26/25 33/6 36/10 37/14
there [31] 4/11 6/11 6/13 7/7 15/13 15/15 19/2 27/5 27/7 27/7 27/10 27/10 29/16 29/21 30/12 30/21 31/14 33/16 33/18 35/4 35/10 35/12 36/13 37/13 37/15 37/18 37/25 38/2 38/5 38/15 39/2
there's [11] 4/3 6/5 10/17 13/5 13/5 13/14 13/20 27/11 32/22 36/6 36/9
THEREUPON [1] 39/11
these [14] 5/10 5/12 5/16 7/25 8/15 8/22 8/24 13/17 14/1 14/17 14/21 15/7 22/5 25/10
they [49]
they're [1] 14/6
They've [1] 24/3
thing [13] 5/8 5/15 22/1 23/5 24/13 27/1 29/15 29/16 30/24 31/20 35/5 36/17 38/15
things [20] 5/12 12/21 14/16 20/11 22/11 24/7 25/10 26/18 27/12 27/13 27/14 27/19 28/8 29/3 34/6 35/19 36/13 37/10 37/18 38/24
think [24] 6/20 8/23 9/7 13/4 20/4 21/2 21/14 21/14 21/23 22/1 28/11 28/12 29/13 29/14 31/5 32/3 33/13 33/14 33/17 33/19 35/4 37/20 38/23 38/24
thinking [1] 8/19
third [2] 5/15 6/12
this [40] 5/6 6/21 8/3 8/24 10/20 10/21 11/21 14/9 16/13 16/23 18/13 19/10 20/2 20/17 21/5 21/6 21/6 21/15 21/24 22/17 23/10 23/18 23/20 23/25 24/5 27/4 32/2 32/21 33/3 34/12 34/13 34/24 35/9 35/16 37/20 37/22 38/2 38/22 40/8 40/15
those [39] 3/18 6/8 9/3 10/8 10/9 10/24 11/4 11/17 12/15 12/16 13/5 13/12 15/21 15/23 18/14 25/7 25/13 26/9 26/18 26/22 26/23 26/24 27/14 28/19 28/24 29/1 29/3 30/10 31/24 32/16 32/19 32/20 33/19 33/22 35/24 37/10 37/15 38/5 38/23
though [1] 28/4
thought [1] 23/22
three [7] 3/4 6/9 28/18 28/25 29/8 31/2 31/12
through [7] 7/4 7/5 16/25 20/23 24/14 29/1 31/21
throwing [1] 35/9
thyroid [2] 17/5 22/9
time [7] 9/13 19/13 21/17 32/21 34/4 38/22 39/6
times [5] 4/21 5/12 22/13 22/24 24/18
Titanic [1] 21/21
today [4] 3/25 8/6 8/16 16/22
TODD [2] 40/6 40/19
together [2] 10/9 36/1
told [3] 6/24 9/6 9/7
ton [1] 13/5
too [3] 12/12 14/15 37/2
took [1] 6/10
tooth [1] 37/9
tootsie [1] 14/3
top [6] 4/7 4/22 16/15 27/24 28/17 30/4
topics [1] 29/9
toward [2] 25/2 25/2
towards [1] 25/7
trachs [1] 12/24
training [1] 36/12
transcript [1] 40/9
transportation [1] 26/17
treat [1] 7/9
treatment [6] 6/6 6/15 11/3 11/24 11/25 31/21
trickling [1] 22/15
trouble [1] 28/14
true [1] 40/9
truly [1] 12/10
try [3] 27/17 27/20 29/2
trying [6] 10/16 10/16 18/24 35/21 37/1 37/12
turn [3] 21/21 21/23 24/3
turned [1] 6/22
twice [1] 11/21
two [5] 6/1 9/18 26/19 30/11 34/6
type [2] 11/7 26/10
types [5] 10/19 26/12 26/14 29/2 37/10
typo [1] 9/1

U

U.S [1] 25/22
under [1] 6/16
understand [1] 7/6
unit [2] 17/4 19/13
United [1] 34/22
units [2] 19/6 20/14
University [1] 23/24
unmute [1] 6/11
unnoticed [1] 28/9
until [3] 5/25 14/19 32/20
up [39] 3/13 4/14 5/21 6/6 6/12 7/18 8/2 8/8 10/1 12/1 13/3 13/10 13/14 17/9 17/18 19/10 20/18 21/3 21/15 22/14 23/6 24/13 25/8 29/9 29/16 30/21 31/18 32/24 34/1 34/6 34/12 34/16 34/18 34/25 35/5 36/22 38/14 38/16 39/3
update [1] 20/15
upper [2] 10/10 29/22
us [10] 4/23 7/7 11/20 11/22 12/19 15/5 22/13 23/2 24/3 37/11
use [5] 11/8 17/3 17/5 17/14 26/12
useable [1] 14/6
used [2] 6/16 26/13
usually [2] 4/7 20/11
utilized [1] 26/9

V

Valentine's [2] 3/12 39/8
value [4] 32/7 32/8 32/20 38/9
value-added [4] 32/7 32/8 32/20 38/9
valued [2] 35/25 36/8
valued-added [2] 35/25 36/8
vegetable [1] 37/4
vegetables [2] 36/4 36/6
versus [1] 32/2
very [7] 7/2 7/23 18/16 22/10 28/3 28/9 29/12
VIA [1] 1/12
voted [1] 3/21
vouchers [1] 36/5

W

wait [1] 5/1
waiting [1] 11/19
want [7] 3/9 3/15 3/23 11/11 30/13 31/10 39/7
wanted [10] 3/25 4/4 4/8 18/3 24/21 25/8 25/22 28/20 29/16 34/6

W

wanting [1] 4/14
wants [1] 8/6
was [51]
waste [1] 17/16
Watchers [1] 37/6
way [9] 4/18 7/8 10/13 12/16 12/18 20/6 32/5 33/14 33/19
ways [4] 10/21 13/2 15/18 27/12
we [124]
we'll [2] 35/13 35/13
we're [18] 4/22 7/9 10/16 10/20 11/12 11/14 11/19 12/20 13/1 13/7 24/6 24/19 26/21 28/25 33/15 37/1 39/1 39/4
we've [10] 3/14 9/9 10/3 10/7 10/9 11/3 13/8 13/9 17/23 23/7
week [3] 16/23 21/6 22/13
weekend [1] 3/12
weeks [2] 31/2 31/12
Weight [1] 37/6
welcome [2] 3/10 18/18
well [16] 3/4 3/6 3/9 6/3 10/23 12/24 13/23 16/17 19/12 21/8 23/18 27/17 28/9 28/22 29/5 32/13
wellness [1] 24/2
went [1] 4/12
were [22] 2/16 5/21 6/16 6/17 6/18 6/21 6/24 9/3 11/2 13/17 15/3 15/7 15/14 16/8 21/19 26/25 27/7 27/10 28/13 28/17 29/17 32/6
what [15] 5/18 7/9 7/19 17/18 19/5 19/6 21/25 23/8 25/20 28/15 28/24 33/15 35/1 36/15 38/4
what's [5] 5/20 20/8 30/6 35/2 35/4
whatever [3] 5/10 5/22 7/15
when [18] 3/8 4/20 6/20 6/21 8/21 9/1 11/8 11/22 12/3 22/4 24/8 27/4 28/10 30/25 31/11 32/12 32/16 36/22
whenever [1] 10/12
where [8] 10/17 10/24 10/25 13/6 15/25 20/15 25/6 26/19
where's [1] 23/20
WHEREOF [1] 40/14
whether [1] 13/18
which [7] 5/4 7/1 7/9 7/21 14/20 22/10 37/9
whichever [1] 13/16
while [1] 31/16
who [1] 26/13
whole [2] 19/21 29/13
why [2] 4/23 9/25
will [12] 11/16 19/7 19/22 21/24 26/13 27/5 27/8 29/14 35/22 38/24 38/25 39/5
window [1] 15/1
wish [1] 39/7
wishing [1] 21/17
within [3] 19/21 24/24 32/10
without [2] 7/20 30/4
wondering [1] 19/5
word [1] 4/9
wording [2] 17/7 33/23
work [7] 4/1 4/4 6/1 9/18 11/14 12/17 20/17
worked [3] 25/11 26/20 27/1
workers [3] 26/11 26/13 29/11
working [8] 11/5 11/14 12/20 13/2 13/7 13/12 28/8 29/1
works [1] 33/9
worry [2] 18/22 35/1
would [19] 5/6 5/14 7/25 11/7 11/8 12/14 12/19 16/1 20/20 21/13 21/22 22/2 22/18 23/2 25/6 26/3 36/18 36/19 36/20
wouldn't [2] 12/18 14/15
written [1] 23/21
wrong [1] 23/14

X

X-ray [2] 17/4 19/6
X-rays [1] 17/3

Y

yeah [3] 9/5 20/25 37/25
year [8] 6/20 11/16 15/1 15/8 25/23 28/12 28/12 34/24
years [4] 13/23 14/10 26/9 35/2
yes [13] 14/13 18/7 20/3 22/20 25/17 30/23 35/18 36/21 36/25 36/25 37/24 38/6 38/17
yet [2] 29/12 33/11
you [117]
you'd [1] 36/15
you'll [1] 27/3
you're [7] 7/13 7/17 7/17 18/18 29/5 30/16 31/7
you-all [10] 13/16 15/10 15/19 16/14 23/3 26/20 28/22 33/25 35/20 38/4
your [13] 3/13 4/5 6/6 15/10 18/2 18/4 21/13 25/9 28/7 28/20 29/23 33/7 38/3

Z

ZOOM [2] 1/12 2/16