KENTUCKY DENTAL ASSOCIATION
EXECUTIVE BOARD MEETING

KDA Headquarters Building
Louisville, Kentucky
November 10, 2018
10:00 A.M.

1. **CALL TO ORDER. Dr. Bill Lee** called the meeting to order at 10:15 a.m. The following members of the KDA Board were present:

Dr. Paul Boyd
Dr. Thomas Carroll (representing Dr. Andy Burt)
Dr. Stephen Clark (representing Dean Bradley (UL Dean))
Dr. Ansley Depp
Dr. Andy Elliott
Dr. H. Fred Howard
Dr. Laura Hancock Jones
Dean Stephanos Kyranides (UK Dean)
Dr. Beverly Largent
Dr. Bill Lee
Dr. Joe McCarty
Dr. Julie McKee
Dr. Matt Milliner
Dr. Mark Moats
Dr. Charles Montague
Dr. Jonathan Rich
Dr. Sharon Turner

Guest included Drs. Garth Bobrowski, and Mike Johnson. Student members Monali Haldankar and Benjamin George were present. Mr. Justin Perron of Commonwealth Technology was present. Ms. Mahak Kalra of KOHC was present. Staff members present were Mr. Todd Edwards, Mrs. Melissa Nathanson, Mrs. Janet Glover, and Mr. Richard Whitehouse.

2. **INVOCATION. Dr. Garth Bobrowski** gave the invocation.

3. **ELECTION OF CHAIRMAN. Dr. Bill Lee** discussed the position of the Chairman of the Board. Since **Dr Darren Greenwell** is the KDA's second vice president, it was necessary to elect a new Chairman. **Dr. Bill Lee** recommended **Dr. Jonathan Rich** for the position.

   MOTION: Dr. Fred Howard moved elect **Dr. Jonathan Rich** to the position of KDA Chairman of the Executive Board. **Dr. Andy Elliott** second the motion.

   ACTION: ADOPTED.

4. **APPROVAL OF MINUTES.** The minutes of the June 10, 2018, meeting of the Executive Board was approved.

   NOTE: All reports are presented in the minutes as they were submitted by their authors. No editing in the form of spelling or grammar has been attempted.

5. **COMMONWEALTH TECHNOLOGY PRESENTATION**. **Mr. Justin Perron** made a presentation to the Board concerning their HIPPA and technology support programs.

6. **KENTUCKY ORAL HEALTH COALITION. Dr. Laura Hancock-Jones** & **Ms. Mahak Kalra** gave a presentation on KOHC. They discussed the funding of KOHC, which is mostly received from the Dental Quest Foundation. They talked about Medicaid and the soda tax. They also announced their upcoming meeting. December 14, 2018 in which Deputy Secretary Putnam will speak about Medicaid.

7. **CONFLICT OF INTERST. Mr. Rick Whitehouse** discussed the conflicts that may interfere with duties of any board member. Each board member explained any conflict they may have.

   Dr. Mark Moats **AGD President and on a Board of Health**
   Dr. Fred Howard **Consultant for Avesis and part time professor at UK**
   Dr. Jonathan Rich **Consultant for Avesis and Guardian**
   Dr. Matt Milliner **Member of Kentucky Association of Orthodontists**
   Dr. Beverly Largent **Editor of the KDA Today**
   Dr. Laure Hancock Jones **Chairman of KOHC**
   Dr. Charles Montague **None**
   Dr. Andy Elliott **Eastern KY Dental Director for Avesis.**
   Dr. Garth Bobrowski Chairman of the TAC and KDA Governmental Affairs Committee
   Dr. Sharon Turner **part time faculty at UK**

8. **KDA BOARD OREINTATION. Dr. Bill Lee** gave a presentation of the responsibilities of the KDA Board and the components.

9. **REPORT OF THE TREASURER. Dr. Sharon Turner** gave the following report for information.

KENTUCKY DENTAL ASSOCIATION
GENERAL FUND REVENUE & EXPENSE
BUDGET PERFORMANCE REPORT
For the nine months ending September 30, 2018

	Year to Date Actual	Annual Budget
REVENUES		
Budgeted Revenues		
KDA dues	447,797.06	415,374.00
KDA Assessment	81,449.64	90,100.00
Annual Session net revenue	53,354.69	80,000.00
Interest Income	1,494.77	2,500.00
Rental Income-	46,800.00	62,400.00
Rental Income-LDS	5,100.00	5,100.00
ADABEI (ADA)	20,710.46	25,000.00
Association gloves	2,079.78	2,000.00
Officite	2,942.57	4,000.00
KDAIS	0.00	12,500.00
KDA Insurance Services	10,032.51	12,500.00
Womens Forum Income	0.00	1,050.00
ADA Dues Rebates	0.00	500.00
Label Sales	500.00	0.00
SMILE KY income	144.50	0.00
Other Revenue	264.05	3,000.00
Total Budgeted Revenue	672,670.03	716,024.00
Non-Budgeted Revenues		
Gain/Loss on Investments	11,538.00	0.00
Reserve Fund Expenses	(2,000.00)	0.00
Journal Fund Expenses	0.00	19,706.00
ADA Grants	53,000.00	0.00
Total Non-Budgeted Revenue	62,538.00	19,706.00
TOTAL REVENUE	**$ 735,208.03**	**$ 735,730.00**

	Year to Date Actual	Annual Budget
EXPENSES		
Budgeted Expenses		
A. Fixed disbursements over which the HOD has no control but must have approval		
Utilities & Maintenance:		
	$	
Telephone	9,509.76	$ 8,000.00
Gas, Electric & Water	20,397.23	24,000.00
RENT	58,488.65	84,630.00
Maintenance Expense	20,265.21	23,000.00
Janitorial Expenses	4,429.35	5,000.00
Total Utilities & Maintenance	113,090.20	144,630.00
Audit & Accounting Services	14,685.00	14,500.00
Attorney Fees	172.00	4,000.00
Insurance	475.86	13,500.00
Printing and Postage	2,188.29	3,000.00
Miscellaneous	7,862.99	2,500.00
	$	
A. TOTAL	**138,474.34**	**$ 182,130.00**
B. Items Controlled by the House Of Delegates		
General Administrative Expenses:		
	$	
Equipment Maint & Rent	7,024.16	$ 10,000.00
Technological Support	13,458.03	10,000.00
Membership Dues & Subs	700.00	750.00
Support Staff Expense	2,215.95	3,500.00
Office Supplies	2,830.44	5,000.00
KOHC Membership	0.00	300.00
Presidents Expense	0.00	5,000.00
1st Vice President's Expenses	0.00	3,000.00
Executive Board Expense	1,226.73	2,000.00
ADA Delegates Expense	3,600.00	45,000.00
Ex. Dir. Discretionary Expense	0.00	750.00
SMILE KY program expense	6,090.18	0.00
Auto Expense	1,789.75	4,000.00
Total Administrative Exp.	**38,935.24**	**89,300.00**

	Year to Date Actual	Annual Budget
Council/Work Group Expenses:		
Council on Annual Session	0.00	500.00
Council on Ethics, Bylaws		
Council on Governmental Affairs		
Budget & Finance Committee		
Long Range Planning Committee		
New Dentists Committee	545.79	7,750.00
General Council Expense	0.00	250.00
UK-UL-KSDS Support	1,550.00	1,300.00
Total Council/Committee/Work Group Steer	**2,095.79**	**9,800.00**
B. TOTAL	**$ 41,031.03**	**$ 99,100.00**

	Year to Date Actual	Annual Budget
C. Disbursements Annually Approved and Controlled by the House of Delegates		
	$	
Executive Directors Expense	12,342.90	$ 12,000.00
Secretary - Treasurer Expenses	0.00	2,000.00
Salaries-Executive Staff	270,553.10	350,000.00
Executive Staff Benefits	33,541.40	45,000.00
Retirement Plan Contributions	7,170.40	14,500.00
Personal Payroll Taxes	21,150.23	25,000.00
	$	
C. TOTAL	**344,758.03**	**$ 448,500.00**
	$	
Total Budgeted Expenses	**524,263.40**	**$ 729,730.00**
D. Fund Contributions		
	$	
Capital Expenditures	0.00	$ 5,000.00
	$	
D. TOTAL	**0.00**	**$ 5,000.00**
E. Non-budgeted Expenses		
	$	
Investment Fees	324.00	$ 1,000.00
	$	
E. TOTAL	**324.00**	**$ 1,000.00**
	$	
TOTAL EXPENSES	**524,587.40**	**$ 735,730.00**

KENTUCKY DENTAL ASSOCIATION
INVESTMENTS ACCOUNT BALANCES
September 30, 2018

GENERAL FUND		
General Cash Operations	29,888.91	
Stifel Nicolaus Money Market	13,983.86	
Stifel Managed Funds	103,429.53	
Total General Fund		147,302.30
CAPITAL PROJECTS FUND		
Stifel Managed Funds	69,249.21	
Total Capital Projects Fund		69,249.21
JOURNAL FUND		
Stifel Managed Funds	84,899.72	
Total Journal Fund		84,899.72
LEGISLATIVE FUND		
Stifel Managed Funds	(47,491.39)	
Total Legislative Fund		(47,491.39)
RELIEF FUND		
Stifel Managed Funds	40,866.74	
Total Relief Fund		40,866.74
RESERVE FUND		
Stifel Managed Funds	297,585.71	
Total Reserve Fund		297,585.71
WILLIAM MARCUS RANDALL MEMORIAL FUND		
Stifel Managed Funds	50,726.67	
Total William Marcus Randall Memorial Fund		50,726.67
Total Investments		643,138.96

10. **REPORT OF THE SECREARY/TREASUER. Dr Sharon Turner** gave the following report on the 2018 ADA meeting.

2018 ADA Meeting Highlights

The 2018 ADA Meeting was held at the Honolulu Convention Center in Honolulu, Hawaii from October 19 to the 22. As is the custom for this meeting, Thursday, Friday, Saturday, and Sunday morning there were multiple high quality continuing education courses available. The House of Delegates (HOD) met on Friday and Monday, with the four Reference Committee Meetings held on Saturday, October 21 to consider the ninety or so resolutions that were submitted to the HOD for consideration. Elections for President-Elect and Second Vice President were held on Monday, October 22, and Dr. Chad Gehani of Queens, New York, was elected President-Elect and Dr. Craig Herre of Kansas, was elected Second Vice President.

All of your KDA Delegates were in attendance for all proceedings of the HOD: Delegates Bill Lee, Fred Howard, Andy Elliot, Dennis Price and Kevin Wall. Executive Director Rick Whitehouse and Secretary/Treasurer Sharon Turner were also seated on the delegate floor, but hand no voting rights. Sixth District Trustee Roy Thompson of Murfreesboro, Tennessee was also present for the entire meeting. The Sixth District Caucus was held on Sunday from 7AM to 4PM and was chaired by our own Dr. Bill Leslie of West Virginia, it being West Virginia's turn to host both the pre-meeting district caucus and chair the district caucus during the ADA Meeting. Alternate delegates Barry Curry, Mark Moats, and Jonathan Rich also attended meetings of the HOD. Alternate Delegate Ansley Depp was not able to attend.

Attendance at the meeting was again reported to less than number of persons that were anticipated who would attend, and there was some speculation that the cost of attending the meeting in Hawaii may have been partially responsible for the decreased attendance.

The Treasurer's Report was presented by Treasurer Ron Lemmo, who is completing his sixth and final year in this position. He indicated that he felt that it was his job to be totally transparent with regard to budgetary matters and to consider how best to position the ADA so as to achieve goals from its strategic plan. He reported that 2017 ended with a positive bottom line, but that has continued to decline impacting dues revenue, and that non dues revenue has not grown at the level anticipated. The budget presented for 2019 reflects revenues of roughly $133 million dollars and expenditures and taxes of roughly $135 million dollars, thus showing a deficit budget without the proposed $22 dues increase. Dr. Lemmo pointed out that the problem with not having continuous small dues increases to keep up with inflation is that when dues increases then are levied, they are larger in amount and more difficult for members to budget in their own personal budgets. Dr. Lemmo reported that the three reserve funds balances as of July of 2018 were as follows: Capital Replacement $5 million dollars; Investments $85 million dollars; and Membership Royalty from Great West, $46 million dollars. He pointed out however that the Membership Royalty Reserve is an account that is designated for saving, not spending, and that the strategic plan calls for growing this fund to $100 million and then

designating the investment income from the account for use in the annual operations budget so that dues increases can be minimized. The projected annual investment income from the Royalty Reserve is estimated to be about $7 millions dollars once its balance reaches $100 million dollars. The budget includes a new $2 million dollar line item for search engine optimization. Expenses are currently growing at the rate of 2.8% per year, whereas nondues revenue is growing at a rate of 1.5% per year and dues revenue is growing at a rate of 0.2% per year. ADA policy requires that uncommitted liquid assets in the amount of 50% of the annual operating expenses must be maintained, and this target has been easily met. Reserve accounts have been used the last two years to finance the Find-A-Dentist marketing program at $6 million dollars per year. The Treasurer and the Board of Trustees unanimously recommended that rather than draw down the reserve accounts for a third straight year, that a one time special assessment of $58 per member be collected to finance the program for the third year of its pilot period, and that thereafter, this expense be folded into the annual operations budget if the program is to continue. The program appears to be highly successful for those member dentists who have submitted profile information to the ADA.

There were three Resolutions related to the budget. **Resolution 34** was presentation of the 2019 Budget. It was passed. **Resolution 35** was for the $22 due increase, and it passed. **Resolution 36RC** was substituted for Resolution 36, by **Reference Committee A: Budget, Business Membership, and Administrative Matters.** The original resolution called for payment for the Find-A-Dentist program via a one-year special assessment of $58 per member. The substitute resolution changed the funding source to be from ADA reserve accounts. The substitute resolution passed after much debate. At some point, this Find-A-Dentist program is going to have to be either discontinued or funded by the operations budget with a dues increase!

Other Resolutions of interest from **Reference Committee A** included defeat of **Resolution 18**, submitted by the Board of Trustees (BOT), which called for all resolutions having a financial impact to be submitted at least ten days before commencement of the last regular board meeting prior to the annual session so that it can be assessed in light of the association's strategic plan and finances. This resolution was on the Consent Agenda for this committee and therefore was not discussed by the House. It appeared to have been unpopular in the various district caucuses because of the time of the pre-caucus meetings in many districts. However, it appears that the BOT is again thinking of long-term fiscal responsibility.

Resolution 56 amends the *ADA Governance and Organization Manual* to strike fee waivers of 25% and 75% and 50% or all of a current year's dues to be waived in the case of financial hardship of a member and urges state and local societies to remove the limit on the number of hardship waivers that a member can receive.

Resolution 70 calls for a change in the method of election of the ADA President- Elect and as such would require a change in the Constitution and By-laws, which in turn requires a one-year notice. The proposal is to have the President-Elect elected by the

BOT rather than the HOD and was submitted by the First Trustee District. This is therefore a notice resolution for next year.

All resolutions referred to **Reference Committee B: Dental Benefits, Practice and Related Matters** were originally placed on the consent agenda. Several resolutions were removed from the consent agenda for discussion on the floor. **Resolution 25RC**, which was substituted by Reference Committee B for Resolution 25, was adopted after debated and calls for the establishment of a comprehensive clinical data warehouse/registry to support development of health policy, treatment guidelines, medical necessity rules and to define population health and quality of care with a report back to the 2019 HOD. In a similar vein, **Resolution 75B**, was also adopted and calls for a study outline for measuring quality of care and access to care to allow future comparison studies of the effectiveness of different practice delivery models with a report back to the 2019 HOD. Both of these resolutions are aimed at developing proprietary association data that is not skewed by insurance company coverage biases so that evidence based dentistry and dental practice can be advanced.

Resolution 82 was amended from the floor by its proponent, Dr. Prabu Raman, from the Sixth Trustee District, in order to get a favorable vote. It proposed the development of a free smart phone app for use by consumers or employer benefits' selection personnel that would allow a rating of dental insurance plans based on coverage parameters. The questions used to drive these rating are already available on the ADA website, but are not easily available and not quantified based on comparisons of plan elements. After much debated, the resolution was defeated.

Resolution 33RC, substitute by Reference Committee B for Resolution 33 with a recommendation to refer to an ad hoc committee for consideration and report back to the HOD in 2019 received a great deal of comment in the reference committee. This amended resolution calls for the ADA President to appoint an ad hoc committee with relevant expertise to review and rewrite Res. 5H-2006, Comprehensive Strategy on Elder Care, to identify an implementation plan and timeline to address financing of dental care for elders, to include the possibility of including dental coverage in Medicare. The original resolution was driven in part by a push from Oral Health America, which has elicited the support of ADA in pursing dental care benefits coverage under Medicare. Oral Health America has indicated its intention to move forward in this direction with our without the participation/support of the ADA. Many members voiced strong opposition to the inclusion of dental benefits in Medicare, while others were strongly in support of this. Others requested that other funding mechanisms be pursued. As somewhat of a compromise between the two positions, **Resolution 33B** was also referred to the same ad hoc committee. This resolution outlines the minimal elements of dental benefits coverage that should be required IF Medicare were to include a dental benefit.

Reference Committee C: Dental Education, Science, and Related Matters handled quite a few "housekeeping" resolutions to change wording in the *Governance* manual to make certain that the Commission on Dental Accreditation (CODA) maintains the autonomy necessary to be at the appropriate arms length distance from the ADA to

satisfy the US Department of Education. By far the most discussion on resolutions referred to this committee related to **Resolution 26 and Resolution 26S1**, the latter having been submitted by the Second Trustee District. This resolution is entitled Comprehensive Policy on Dental Licensure and comes from a two-year study and development process by the Council on Dental Education and Licensure. The original resolution was adopted after significant debate. The substitute resolution had inserted a requirement that any remaining live patient licensure examinations be administered only with the Curriculum Integrated Format whereby dental students are evaluated on their own patients of record with on going sequenced treatment plans. While this format is ideally the most ethical way to conduct a live patient examination, it is simply a logistical nightmare for most schools. Dr. Henry Gremillion, President of the American Dental Education Association (ADEA) and Dean of Louisiana State University School of Dentistry spoke out against the amended resolution. The ADA remains on record as opposed to live patient high stakes examination for licensure. This is a policy and value statement that has no impact on licensure laws among the states. Implementing this stated value would require strong grass roots advocacy at the state level where licensure laws are passed and would require organized opposition to the regional examination boards who are making a lot of money administering these one shot high stakes examinations.

Resolution 53 urges dentist to support the use of the Human Papillomavirus (HPV) as recommended by the CDC and to encourage appropriate external agencies to support research to improve understanding of the natural history of the oral HPV infection, transmissions risks, screening and testing. This resolution was adopted, but there was considerable debated about **Resolution 53RC**, which would additional urge that dentist be urged to administer the vaccine in their offices. Because the vaccine has not been approved for oral pharyngeal cancer prevention, dentists using the vaccine for this purpose would be using it "off label," which could create liability issues, especially if a patient experience a severe adverse reaction to the vaccine. Also, the HOD heard testimony that there is currently no mechanism for drug companies to sell vaccine vials to dentists directly.

Resolution 71 urged the creation of an ADA Taskforce on Student Debt, but was defeated with delegates from the American Student Dental Association speaking against it. They did not believe that it would be helpful to them.

Resolution 83 requested that the Council of Dental Education and Licensure (CEDL) explore the feasibility of requesting development of an accreditation process and accreditation standards advanced education programs in geriatric dentistry by CODA. This resolution was referred to CEDL or other appropriate committees, councils or workgroups for discussion.

The most significant resolution referred to **Reference Committee D: Legislative, Health, Governance and Related Matters**, was **Resolution 32**, which was submitted by the Washington State Dental Association from the Eleventh Trustee District and amended on the floor to call for the creation of a task force to minimize the interference of third party payer in dentist/patient relationships in lieu of legislation passed in Georgia,

Louisiana, California, Delaware, South Dakota, Pennsylvania, and Washington of the based two years. This district believes strongly that support needs to be developed for state public affairs support. This resolution was adopted after being amended. Also of interest is **Resolution 81**, which was adopted. It urges the ADA to pursue federal legislative or regulatory efforts to require financial support for dental care be included in child custody as is done for medical care AND that the ADA pursue individual state legislative efforts to require support for dental care in child custody orders as an obligation.

For additional details about the meeting, send questions to Sharon Turner, Rick Whitehouse, or Bill Lee.

11. **GROUP PURCHASING PROJECT. Mr. Michael Wilgus** of The Dental Supply Company gave presentation about TDSC. It is a buying group for dental supplies. They are growing the business eastward from California. Kentucky will eligible to join in May of 2019. They have approximately 40,000 products available for sale with more to be added in the future.

12. **REPORT OF THE PRESIDENT. Dr. Bill Lee** submitted the following report:

President's Report
November 10, 2018

Things have been very busy since I assumed office, but first, I want to again commend Dr. Ansley Depp for a magnificent year. You were the right person at the right time.
I'm going to follow our Executive Director's lead and offer my report as it relates to our Strategic Plan. We'll see how it goes.

Goal I – Advocate for Dentistry in the Commonwealth

We've had several meetings with state officials;

- Department of Finance – Our efforts were to educated them on the effects of a Provider Tax on Medicaid providers and to offer options to fund the projected shortfall in Medicaid. More information in another report.
- Director of Provider Relations – This is a newly created position in the administration to help bridge the gap in providers communicating with the government, and vice versa. Ideally, we will no longer get a "deer in the headlights" look, but someone who will respond.
- Department of Insurance – We wanted to determine the best way to ask the state to enforce the existing statute on non- covered services. We were told that the Department of Insurance can only respond to written complaints, but the person watching for them has two dentists in his immediate family, so he is fully aware of the issues and wants to rectify the problems. Send your complaints to ----------
- Legislative agenda – We are closely watching what bills may be introduces that will affect dentistry and we are developing our talking points for Legislative Day. We are also trying to get a feel from other organizations on their thoughts of a potential Provider Tax or Soda Tax

Action Item: Does the KDA want to take a position concerning a Soda Tax?

Goal II – Serve and Support the Needs and Success of Members

- Membership – We can't keep doing what we've been doing and expect to survive. For the good of the profession, we must figure out how to bridge the gap. In my opinion, we need to do two things: find out *why* someone isn't a member, and then find a way to overcome their objections. For me, it takes a face-to-face conversation to really get the answers. I'm making a huge push for this in my component visits. My first Journal article focused on it also.
- Annual Session – It will be at the Galt House in Louisville on (DATE) and the Council is working hard to make it a great, young, entertaining meeting. We should have a dynamic Keynote speaker to kick things off so mark your calendars now.

- Communication – It's quite obvious that the KDA isn't using the communication avenues that much of the younger generations are using. I have reached out to several students and new dentists to help in this regard and I have several meetings set up over the next few months. There is no magic wand and it will take work, but the process is started and as it grows it will become more formalized.

Goal III – Promote Oral Health through Community Service and Public Relations

- We will continue to liaison with various groups, KOHC, KYA, KMA, etc. especially if there is any movement on a Provider tax or a Soda tax.

Goal IV – Lead the Profession through the ADA Tri-Partite Structure

- Component Workgroup – We will continue the activities of this important workgroup. They are working the ADA to promote membership efforts in our components and improve our presence in the dental schools. This is an active group and should make a difference over the next couple of years.
- Executive Board Orientation/Manual – Renewed this year. It's been quite a while since we've had an Executive Board Orientation and I think it's a good idea to inform the new members and to remind the returning members what the roles and responsibilities are of being a member of the KDA Executive Board. An Executive Board Manual could not be found to be updated, so it has been rewritten. I would like to see a similar orientation conducted at the first Board meeting following the Annual Session each year and the Manual updated accordingly.
- Bylaws/Policies and Procedures Manual Workgroup – We will have revisions to present at the next Board meeting.
- Joint meeting with the Tennessee Dental Association – At the KDA House of Delegates I asked that we meet with officials of the TDA to discuss the possibility of merging our state dental meetings. In conversations with the ADA and with the TDA, both organizations believe there are too many obstacles to clear to make merged state meetings a reality. However, both organizations were open to partnering in a joint venture as a source of non-dues revenue. Those discussions will continue.
- ADA meeting – The ADA House of Delegates will have met by the time of this report. Five Delegates, three Alternates, our Executive Director and our Secretary/Treasurer are there representing the KDA. I'll give a verbal report when we meet.
- eTidings – This goes to the officers and committee/council members of the KDA and the components. It is designed as a leader's communication tool, separate and different from the Executive Director's, that can be read in a few seconds, but keeps the President in touch with the most active members of the KDA.

Respectfully submitted,
Bill Lee
President, KDA 18-19

13. REPORT OF THE EXECUTIVE DIRECTOR. Mr. Richard Whitehouse submitted the following report:

MEMORANDUM

To: KDA Executive Board
From: Richard A. Whitehouse, Executive Director
Re: Executive Director's Report for November 2018 meeting
Date: October 12, 2018

Presentations for November 10th meeting

- Justin Perron, Commonwealth Technology (Platinum Patron/Partner)
- Dr. Laura Hancock-Jones & Mahak Kalra, Kentucky Oral Health Coalition

The following is a summary of significant activities since my last report. It is broken down according to our strategic goals.

ADVOCACY

- advocate for dentistry in the commonwealth -

Strategic Plan for Oral Health in Kentucky

I attended this meeting on behalf of the board. Organized dentistry was also represented by Dr. Hancock-Jones, Dr. McKee, and ULSD Dean Bradley. The purpose of the meeting was to look back on the plan a year after release and consider stakeholder suggestions for possible changes.

Non-Covered Services

Dr. Lee and I met with Deputy Commissioner Patrick O'Connor with the Kentucky Department of Insurance. In light of previous experience with the department, we were considering possible statutory or regulatory changes to address this issue for members. The prior administration had advised us to have our members file complaints. But, nothing occurred as a result of those filings because of the department's interpretation of the law. That seems to have changed with the current administration. This would be a significant event for our members. We must continue to advise members to read their contracts. But, it appears that the department will no longer permit insurance companies to dictate charges for services that are not covered by the insurance company. We need to have any member experiencing this problem to file a detailed complaint with the department's new online complaint system.

Medicaid

Dr. Lee and I met with CHFS Director of Provider Relations David Gray. He is taking on a new position to hear concerns of Medicaid providers around the state. He indicated he would not be assisting us in increasing fees or developing better data/reporting regarding provider coverage. However, he wants to hear our concerns and will presumably communicate them up

the chain of command. He also attended a component meeting in Pikeville a few days after this meeting where I understand he received a good deal of feedback on the *MyRewards* program.

Water Fluoridation

Dr. Neal Rush and I met with Representative Hart to discuss his interest in pursuing legislation that would make fluoridation a local option rather than a state mandate. One of his constituents is promoting fluoridation as a violation of body autonomy. The representative urged us to discuss potential compromise rather than scientific evidence. We countered that another meeting with other stakeholders (i.e. governor's office, dental director, public health officials, etc.) would be in order before he proceeded with such a bill.

MEMBER SUPPORT

- serve and support the needs and success of members -

Membership Concierge Position

This proposal was approved and we are moving forward. We are precluded from engaging a contractor to assist. The ADA Board of Directors prefers that we bring on an FTE dedicated to membership. A position description was created (See **Attachment A**). The proposed timeline is set forth below:

Fall 2017	ADA staff begin presenting proposal to board
3.2.18	Written request made to ADA Board of Trustees
6.28.18	Grant agreement received
6.29.18	Grant agreement signed
8.xx.18	Position description created
9.14.18	Posted on Zip-Recruiter
10.1.18	Posted on Indeed
10.4.18	Posted on Association Forum
11.10.18	Identify potential candidates and update KDA Exec Board
By end of November	Interview candidates
12.1.18	Identify finalists
By mid-December	Interview finalists
By end of December	Extend offer of employment
By mid-January	Start date

KDA Association Success Challenge Coin

As I mentioned in my remarks to the General Assembly at our annual meeting, we are creating a challenge coin to recognize and encourage service in support of KDA. There will be two ways to earn this coin:

1. *ADVOCATE FOR ORGANIZED DENTISTRY* - Attend our 2019 KDA Legislative Day and meet with your legislator.

   OR

2. *GET A MEMBER / FIND A VENDOR* – Attend our 2019 KDA Annual Meeting and:
   a. Recruit a non-member to join KDA before April 1, 2019
   b. Refer a new vendor willing to become a patron or purchase a booth in our exhibit hall at the meeting no later than July 1, 2019.

ADA Quarterly Report on Membership

The 2018 Q3 report has not been released as of this writing. It will be at the table for review at the meeting. However, as of today, we have 1,146 members of which 815 pay full active dues. In Kentucky, there are currently more licensed dentists (2,315/+26) and less dues paying members (1,146/-33) than this time last year. Our market share is 49.5% (2% below this time last year).

KDA Annual Meeting

The Council on Annual Session recently met to discuss the 2018 meeting and plans for the future.

I provided council members with a dashboard of key performance metrics for the 2018 meeting (See **Attachment B**). I also provided notes regarding those metrics (See **Attachment C**). This tool will help us measure those items that go into planning a successful meeting and better understand the relationship of decisions on these variables.

While we fell short of my hopes, it was a successful meeting. Attendance was slightly up. CE attendance was somewhat down. But, moving the exhibitors closer to the registration area seemed to help breathe life into our exhibit hall. We received generally good feedback on traffic and sales. Importantly, we met our hotel obligations in terms of room block, food, and beverage. We made slightly over $50K. We cut expenses $20K over last year. In fact, our expenses are actually 56% of what they were in 2015. We would have met our budget projection if it had been the same as last year. But, because we raised that budget projection to $80K, we had a budgeted loss of $30K this year.

I shared with members of the council the financial challenges we are facing this year at the Galt House – and most venues in Louisville. However, our program is coming together. I am working with staff to determine how we might continue to offer events and activities to attract new members and students. We are working to make 2019 as successful as possible. I am hoping that our challenge coin initiative also helps us get more new vendors in the exhibit hall next year.

Along with the new KPM Dashboard and notes, I provided council members with 20 questions to ponder regarding our annual meeting (See **Attachment D**). After the council meeting adjourned, many members stayed to discuss these. There was robust discussion regarding potential changes in our future meeting from course offerings to pricing structure. Consensus among the group is that a resort venue works well in attracting members and encouraging them to stay, take more CE, and help us meet hotel obligations. But, they want to stay in Louisville.

The council was unable to propose a budget or specific venue for 2020. The convention center has reopened in Louisville and hotel space in many of the hotels is either new or being remodeled. However, due to the size of our meeting and some uncertainty regarding potential future business for the hotels, we have been told not to expect to be able to book a site until 12-15 months from our proposed date.

Finally, Dr. Lee and I have been talking about other opportunities to generate revenue and provide member value. One of those was to merge our meeting with another state. After meeting with Tennessee leaders and considering other factors, we believe that is not a viable solution at this time. However, we are looking at the possibility of organizing a standalone event in the future.

Joint Negotiations Concept

At our March 2017 meeting, the board decided to create a working group to study this issue and draft language to be presented to our house of delegates at our recent meeting. No action was taken and nothing was presented to our House of Delegates. Unless there is renewed interest, I will no longer include this issue in future reports.

PUBLIC AWARENESS

- promote oral health through community service and public relations –

The Garth Channel

I received a call from an investigative TV reporter from WLKY in Louisville who hosts a show entitled *State of Addiction*. The show highlight news and events primarily focusing on the opioid epidemic. The reporter wanted to know what dentists were doing about this problem. I informed him about our recent pamphlet and booklet on the topic as well as our recognition by the Kentucky House of Representatives. He wanted an on-camera interview and our Government Affairs Chair Dr. Garth Bobrowski stepped up to represent dentists on this issue. Dr. Bobrowski was interviewed after a Medicaid TAC meeting for about an hour. The result was better than we could have ever hoped for. See the video and article on the WLKY website at https://www.wlky.com/article/state-of-addiction-kentucky-dental-association-publishes-guide-for-dentists-when-prescribing-opiates-to-patients/22866412.

ASSOCIATION EXCELLENCE

- lead the profession through the ADA tri-partite structure -

KDA App

There have been informal discussions between other associations and the ADA for an association app similar to what we have discussed. This is not high on the list of things to do at the ADA. But, over time, this should be as common as web-branded templates. Unless there is renewed interest, I will no longer include this issue in future reports.

ADA Business Model Project Pilot

Maine and Wisconsin were selected as a pilot state for this project. Kentucky was in contention right to the end.

Meet the Externs

I have been approached by two University of Louisville undergraduate students interested in possibly working at our office as externs in 2019. I will be meeting with them after the ADA Annual Meeting to talk about potential assignments that would help them fulfill requirements for their capstone projects.

6th District Caucus

We had a good discussion on issues upcoming before the ADA House of Delegates as well as general issues impacting dentistry and associations. Unfortunately, neither our trustee nor candidates were present. But, we are scheduled to hear from them at the ADA meeting in

Honolulu. It was determined that due to timing and expense that the 6th District Pre-Caucus will be held one day before the annual meeting in San Francisco next year.

Kentucky Board of Dentistry

At its last business meeting, the KBOD voted to terminate the contract of their executive director. If you know a potential candidate to fill this position, please let me know.

Component Meetings

Dr. Lee and I met with Southeastern Dental Society last week. It was the first of our component visits around the state since our annual meeting and the bar was set pretty high. Members were very engaged on the issues and interested in how they could support the KDA legislative agenda. They were particularly concerned over a proposed Medicaid provider tax. As a result of this discussion, one member was moved to donate $1K to KDPAC.

Recent Meetings

Since my last report, Dr. Lee and I attended the ADA Management Conference as well as the Mid-States Dental Meeting.

Upcoming 2018 Meetings

October 18-22	ADA Annual Meeting
November 29 – December 1	ADA Lobbyist Conference

Current KDA Patrons

- Bowman Insurance – Platinum Patron/Partner (renewed)
- Commonwealth Technology – Platinum Patron/Partner (upgraded)
- PCIPIPAA – Silver Patron
- Lifetime Financial Growth of Kentucky (Guardian) – Silver Patron
- Anthem – Bronze Patron
- Avesis – Bronze Patron
- PNC Healthcare Business Banking – Bronze Patron

Respectfully submitted,

Richard A. Whitehouse
Executive Director

ATTACHMENT

KENTUCKY DENTAL ASSOCIATION
Position Description: Member Concierge

The Kentucky Dental Association (KDA) is an association whose mission is to help members succeed and serve. KDA needs an enthusiastic team player with the skills necessary to increase our market share through improved relationship-building and increased communication with both members and potential members. The successful applicant will work under the direction of the executive director and with a committed staff and dedicated member dentists to advance the profession of dentistry and help improve oral health outcomes for all Kentuckians.

Application Instructions:

In order to be considered for this position, applicants should email a cover letter and resume with three professional references to whitehouse@kyda.org.

Direct Report:

The Member Concierge will report to the KDA Executive Director.

Job Overview:

The member concierge will work under the direction of the KDA Executive Director and with staff, members, stakeholders and others as the primary point of contact for members and potential members on issues concerning professional practice and member benefits. The member concierge will focus on efforts to better communicate with students, new dentists, and current members. Working with existing staff, the member concierge will focus on issues related to recruitment and events to bring new members into the fold as well as retain existing members.

Responsibilities and Duties

- Direct member relations activity.
- Coordinate membership recruitment and retention programs.
- Develop member on-boarding program.
- Communicate with members and potential members via telephone, e-mail, social media, etc.
- Create and contribute to publications.
- Serve as liaison to schools and local component societies.
- Provide periodic reports of activity to executive director and report to executive board as necessary.
- Assist with website management.
- Assist with meeting planning.
- Assist with budget planning.
- Perform other administrative duties as directed
- Ability to travel as needed (occasional evening work)

Qualifications:

- Bachelor's degree in an applicable field.
- Customer relations experience. (Experience with another membership organization or association is a plus.)
- Proficiency in Microsoft Office Suite.
- Digital and social media expertise.
- Excellent written and oral communication skills
- Must be willing to work occasional nights and weekends.
- Valid driver's license and access to a reliable vehicle are required.
- Must perform basic job functions including but not limited to learn quickly, act decisively, perform desk and computer work, walk, drive, speak in public, and lift up to 25 lbs.

The Ideal Candidate will have:

- Positive and outgoing personality.
- Ability to work within a team and independently.
- Ability to work with diverse stakeholders.
- Drive to find solutions and solve problems.
- Experience with a state dental association and Aptify association management software.

Compensation and Benefits

The salary range for this position is $35,000.00 – 50,000.00 depending upon qualifications. A benefits plan is negotiable.

The KDA office hours are 9:00 am to 5:00 pm on Monday Through Friday.

This position is made possible through grant funding for a period of two years. Continued employment will be dependent upon demonstrated success and a significant increase in market share.

ATTACHMENT
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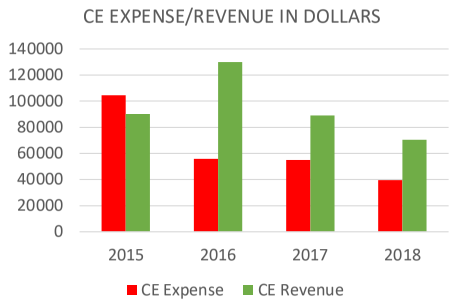

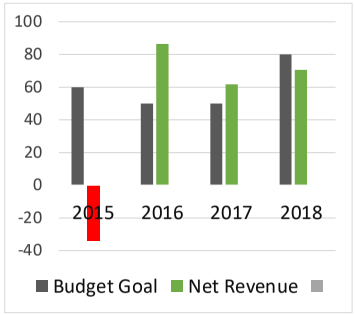

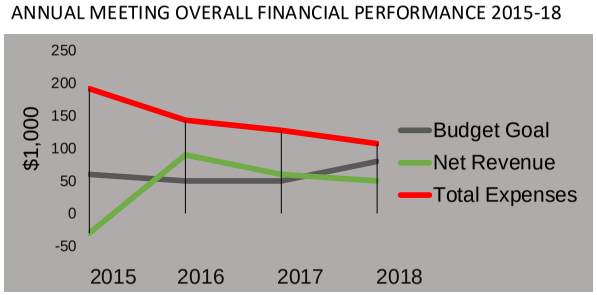

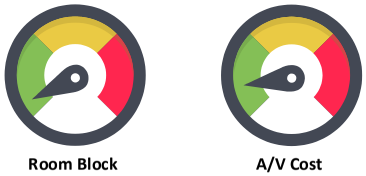

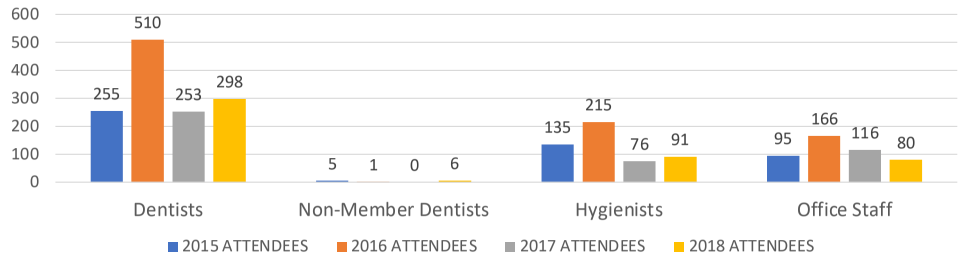

CE Expense (Per Person)	Venue Expense	Hotel Rooms (contracted / sold)	Exhibitors
$15.88	**$55,801**	**797 / 777**	**62**
HI $32.20 (2015)	**HI** $104,114 (2015)	**HI** 581 / 807 (2017)	**HI** 86 (2015)
LO $12.88 (2016)	**LO** $55,801 (2018)	**LO** 409 / 295 (2015)	**LO** 62 (2018)

ATTACHMENT ~

2018 ANNUAL MEETING TAKE-AWAYS

CE EXPENSE REVENUE IN DOLLARS

- Methodology: CE expenses are based upon honoraria, speaker expenses, and A/V. It does not include room cost or exhibit booths given away as part of sponsorship.
- 2015 - Spent more on the program than we made.
- 2016 - Model CE program / controlled expenses.
- 2017 - Despite a 50% decrease in dentist attendance, we made money because of the venue and a generally solid program. (We learned that at a resort, people will stay longer and take more CE.)
- 2018 - While still profitable, we made less money with 30 more dentists over the prior year.
    - Speaker selection/mix?
    - Catapult speaker did better than Hornbrook!
- Note: Future sponsorships must not detract from patron program, pre-existing contributors, or opportunities to sell exhibit booths/sponsor events.

ANNUAL MEETING OVERALL FINANCIAL PERFORMANCE 2015-18

- 2015 - We lost $30K in refunds due to snow. Factoring out the weather, we made no money in a year we had budgeted for $60K. This was a budgetary loss of $90K.
- 2016-18 - Through new policies regarding CE and other expenses, trying to create excitement in the exhibit hall, and improving social events; we exceeded our budget goals in 2016 and 2017. We fell short in 2018 as the bar was raised to $80K.
    - We steadily brought down expenses.
    - Meetings were profitable despite low attendance in 2017 & 2018.

ATTENDEES 2015-18

- Focus on relevant attendee categories.
- Fluctuations in attendance across all categories.
- 50% drop in 2017 due to objection to FL.
    - Small increase in dentist and hygienist attendance between 2017 & 2018.

CE EXPENSE PER PERSON

- Success is a function of the right number of classes that meet the needs of dentists, hygienists, and office staff AND controlling expenses.
    - $3K all-inclusive. No expenses. No free exhibit booths for sponsorship.

VENUE EXPENSE (Note: Future financial challenge)

- Louisville is a difficult market for us.
    - We are a small fish in a big pond.
    - Can't get contract till between 12-18 months out.
    - Risk of being bumped.
    - We may now be held to meeting food & beverage as well as room block minimums. (Hyatt overlooked a lot.)
    - No resort-style, all-inclusive sites in Louisville.

HOTEL ROOMS

- Problem: We don't sell hotel rooms in Louisville.

EXHIBITORS

- Note: 2015 figure is artificially inflated due to free exhibit space.

GAUGES

ROOM BLOCK – Good (Important to meet contractual obligation.)
A/V – Good (This is an often-overlooked expense.)
FOOD & BEVERAGE COST – Good (Important to meet contractual obligation.)
EXHIBIT HALL TRAFFIC – Moving closer to registration area made a difference.

Note: In the last few years of our meeting in Louisville, we were not required to meet certain contractual obligations related to food & beverage, room blocks. We cannot depend upon this in the future.

ATTACHMENT

20 Questions

1. How do we make our meeting grow?

2. How can we lower the cost of our annual meeting?

3. What are we wasting time and/or money doing?

4. How do we increase traffic in the exhibit hall?

5. How do we increase attendance at our meeting across all categories (member-dentist, non-member dentists, hygienists, and officer staff; women, minorities, different areas of the state, etc.)?

6. What CE's sell? What don't?

7. Should we shorten our meeting?

8. Do we use enough Catapult speakers?

9. How do we ensure we meet the contractual obligations (food & beverage, room block) with our host hotel?

10. How do we make our meeting a real money maker?

11. Should we rotate our annual meeting between Louisville, Lexington, and French Lick?

12. How can we involve more students in our meeting?

13. What can we offer new dentists?

14. How can we increase engagement between vendors and attendees?

15. What type of meeting venue works best for us?

16. How can we increase volunteerism at the meeting?

17. How do we identify new KDA patrons or sponsors for our meeting?

18. How do we offer the proper mix of CE offerings to ensure member value and fill classrooms?

19. What do we offer academia? How can we better involve the dental schools?

20. What are Kentucky dentists telling us?

14. REPORT OF UNIVERSITY OF KENTUCKY COLLEGE DENTISTRY.

University of Kentucky College of Dentistry
Kentucky Dental Association Executive Report
June 2018

Admissions

- The 2019 admissions cycle is currently underway (October 1 was the priority application deadline).

Student Updates:

- S.M.I.L.E. Week, an event for incoming first-year students, August 1-3, allowed students to meet their classmates, learn about resources, and gain early exposure to UKCD prior to starting classes. The returning students began the academic year on August 6.
- The annual ASDA "welcome back" picnic took place on August 15.
- The AAWD annual fashion show and silent auction event called "Strut Your Smile," took place on September 7, raising money for Greenhouse 17.
- The White Coat Ceremony, honoring the Class of 2022, was held on September 21, 2018 at Memorial Hall.

Alumni Affairs

●The Annual UKCD Alumni Association Golf Scramble was held Saturday, August 18, at the University Club of Kentucky. We had 24 teams consisting of UKCD alumni, faculty, students and friends.

●The Alumni Association hosted a reception for alumni and friends at the KDA Meeting in French Lick, Indiana on Friday, August 24. During the meeting, we had a booth in the exhibit hall where we were able to connect with many of our alumni attending the meeting.

●The 42nd Annual Fall Symposium and Alumni Weekend will be held October 19 and 20 in Lexington. Friday events include a continuing education program with Dr. Mark Nation, Keeneland racing and luncheon, College Reception at Kroger Field where all reunion year classes will be recognized and the Distinguished Alumni of the Year, Dr. Craig Adams and Dr. Frank Allara, will be honored. At the CE program, the Alumni Association will award scholarships to two 4th year dental students. On Saturday, we will host the UKCD Class of 1968 at the College with a brunch and tours of our renovated facility. All alumni are invited to tours of the College on Saturday. Later that day, we will have a tailgate party prior to the UK v. Vanderbilt football game.

●The UKCD Alumni Association Board continues to have quarterly meetings. All alumni are invited to attend.

Oral Health Practice:

Full Time Faculty

- Luciana Shaddox, Periodontics
- Mark Schachman, Endodontics

Part Time Faculty

- Cheryl Pearson, Restorative
- Brittany Camenisch, Periodontics

Retirements

- Richard Mitchell

Resignations

- Michael Piepgrass

Awards and Publications

- **Omami G, Miller CS.** Odontoid fracture depicted on a panoramic radiograph. Dentomaxillofac Radiol. 2018 Apr 11:20180060. doi: 10.1259/dmfr.20180060 [Epub ahead of print] PMID: 29616823

Oral Health Science:

Full Time Faculty

- Mohamed Bazina, Orthodontics
- Hideaki Nagaoka, Orofacial Pain
- Molly Smith, Oral Pathology

Part Time Faculty

- None

Retirements

- Doug Damm
- David Nash

Resignation

- Craig Fowler, Oral Pathology

Awards and Publications

- **Dr. Ehab Shehata** passed the Diplomate exam for the American Board of Oral and Maxillofacial Surgery.

- Castro-Núñez J, Clifton T, **Van Sickels J**.: Subacute Granulation Tissue of the Fornix after Resorbable Orbital Implant: An Unusual Case and Review of the Literature Craniomaxillofac Trauma Reconstr. 2018; 11:224-229.

- Virtual Surgical Planning for the Management of Severe Atrophic Mandible Fractures. Castro-Núñez J, Shelton JM, Snyder S, **Sickels JV**. Craniomaxillofac Trauma Reconstr. 2018 Jun;11(2):150-156. doi: 10.1055/s-0037-1601865. Epub 2017 Apr 19

- Testing of a bioactive, moldable bone graft substitute in an infected, critically sized segmental defect model. Matt E. Brown,1 Yuan Zou,1 Rebecca Peyyala,2 Sarandeep S. Huja,3 **Larry L. Cunningham**,4 Todd A. Milbrandt,5* Thomas D. Dziubla,6 David A. Puleo1

Philanthropy:

- The University of Kentucky announced its largest fundraising campaign in the history of the Commonwealth. The campaign will seek to raise $2.1 billion. Each college have their own individual goal. The College of Dentistry has set a goal of $20.3 Million. As of September 1, 2018, the UK College of Dentistry has raised $9,783,550.
- Dr. Joseph O'Neil, DMD-Class of 1971, has made a commitment to purchase a Dental Cone Beam CT for the student clinic.
- Dr. Aaron Card, Oral Surgery – Class of 2012, has made a gift for 2018 and a five-year pledge, starting in 2019, to support the Dr. Robert D. Marciani Endowed Professorship.
- The College changed the format of its scholarship appreciation event to an evening dinner. Donors were invited to meet their scholarship recipients for the 2017-2018 year and have their picture made together. New scholarships were recognized that would be awarded during the academic year of 2018-2019. Over 160 people attended the event.
- Dean Kyrkanides and the Director of Philanthropy hosted seven alumni on campus for a visit, including a tour of the renovations and new initiatives. The alumni were visiting from California, Colorado, North Carolina, Tennessee, and Lexington.
- The Director of Philanthropy made visits to alumni in Corbin, Danville, Harlan, Lexington, Louisiana (Baton Rouge and New Orleans), Louisville, Owensboro/Henderson and Paducah.

15. GOVERNMENTAL AFFAIRS. Dr. Garth Bobrowski presented the following report.

Council on Governmental Affairs Report
EXECUTIVE BOARD MEETING
November 10, 2018

1. On 9-29-18 Rick Whitehouse , Dr. Bill Lee and Dr. Garth Bobrowski met with State Finance Secretary: Mr. Wm. Landrum. Purpose of the meeting was to discuss the estimated $200-$300 million Medicaid shortfall in funding for '19-'20 and to look at ideas for funding: Look at the contracts for the MCO's to decrease their profit margin, Look at the PBM's contracts(Pharmacy) to decrease their profit margin, Provider Tax, Soda tax, Fix the disparity of tax on tobacco per pack($1.15) vs per can($0.15) of smokeless tobacco.

Action Item: Vote to be for/against the Proposed Provider Tax (see Courier Journal attachment for info),

Action item:

Vote on next steps of a Soda Tax (see AGD white paper attachment for info).

2. On 10-5-18 Rick Whitehouse, Dr. Bill Lee, Dr. Garth Bobrowski and John McCarthy(McCarthy Stategic Solutions - KDA lobbying firm) met with Mr. David Gray, the new Director of Provider Relations for the Cabinet of Health and Family Services (CHFS). The purpose of the meeting was to make introductions and open the door for dialogue.

Action Item: Mr. Gray asked that the KDA get him a list of 3-4 issues that Medicaid dentists are having.

3. Participate in bi-weekly conference calls with the executive committee.

4. At our local Dental Society meetings this fall remind attendees of their needed support at the Legislative Day next spring.

5. Be active and knowledgeable on the upcoming bills.

6. Two KDA/Medicaid Dental offices have been chosen to come to Frankfort to preview the IT apparatus of the My Rewards Program the first week of November 2018. The purpose is to look at the eligibility screens and to evaluate the process of getting a patient in the dental office for treatment. The dental offices are sending front office staff at their own expense to Frankfort. A report will be sent to the KDA Executive Board.

Respectfully Submitted,
Dr. Garth Bobrowski

Health tax could fund Kentucky Medicaid, new group says

https://www.courier-journal.com/story/news/2018/08/22/health-tax-could-fund-kentucky-medicaid-new-group-says/1064096002/

New group offers a proposal to save Kentucky's Medicaid expansion

Deborah YetterUpdated 5:07 p.m. ET Aug. 22, 2018

FRANKFORT, Ky. — Saying Kentucky's expansion of Medicaid to about 500,000 Kentuckians must be preserved, a group led by hospital executives has launched a campaign to get lawmakers to consider broadening a state tax on health care providers to help pay for it.

Norton Healthcare Vice President Riggs Lewis, the group's president, said Wednesday that the plan would generate revenue to fund the expansion as Medicaid costs rise in future years.

"Our group believes that conservative, comprehensive health care tax reform can make that a reality," Lewis said in a news conference at the Capitol Rotunda.

The group, called "Balanced Health Kentucky Inc.," asks lawmakers to consider expanding a "provider" tax now paid by hospitals, nursing homes and a few other health providers to others that don't pay, such as physicians, dentists and mental health counselors. That would boost state funds available to draw federal money, which covers most of Kentucky's Medicaid costs, Lewis said.

The tax currently generates about $300 million a year, with hospitals paying the largest share.

More headlines: How a Florida pastor and his wife became Bevin's adoption advisers

Board members of the group include executives from Norton, Baptist Health, Appalachian Regional Healthcare, Manchester Memorial Hospital and St. Elizabeth Healthcare.

Lewis said the Medicaid expansion is essential for hospitals, particularly smaller ones in rural areas that previously had high rates of people with no health insurance. Under the 2014 Medicaid expansion authorized by the Affordable Care Act, Kentucky experienced one of the sharpest declines in the nation of people with no health coverage, dropping from about 14 percent to 5 percent.

That led to more patients being able to pay for care and a reversal of fortune for many rural hospitals that had been struggling, said Adam Edelen, who as state auditor had examined their finances prior to the Medicaid expansion.

"It's been their salvation," said Edelen, who attended Wednesday's news conference. "You can't overstate how important the Affordable Care Act has been to rural hospitals."

Lewis said the final decision on any tax changes rests with lawmakers — the group simply wants to provide them with information to use if they consider reforming the health care tax. Hospitals currently pay about $182 million a year under the tax.

"We do not have a position on what the rate should be other than it should be lower and broader," he said.

Kentucky uses proceeds from the provider tax to supplement the state's share of money it uses to attract federal Medicaid dollars. The federal government now provides about 80 percent of the $11 billion a year Kentucky spends on Medicaid.

The campaign got mixed reviews Wednesday.

Column: Why not require Kentucky's public schools to post 'In Allah We Trust'?

Jason Bailey, executive director of the Center for Economic Policy, a progressive policy and research group in Berea, said his organization doesn't oppose considering a tax on other health providers. But he said hospitals already benefit from a "freeze" that lawmakers placed on what hospitals must pay in 2006 and suggested that lawmakers consider lifting that freeze.

While the provider tax for Kentucky hospitals hasn't increased in 12 years, hospitals' revenue has greatly increased, especially after the 2014 expansion of Medicaid, he said.

"They aren't contributing more than they were 12 years ago and they're making a lot more money," Bailey said.

State Sen. Morgan McGarvey, a Louisville Democrat, who attended Wednesday's news conference, said the proposal could lead to a sound basis of funding the Medicaid expansion.

"The alternative is unplugging it," he said. "You can't just take 500,000 people off health care."

But Jim Waters, president of the Bluegrass Institute, which promotes smaller government and lower taxes, said his organization would prefer ways to downsize Medicaid by getting more people into jobs with health coverage.

"I think the goal should be reducing that number," he said.

And Emily Schott, a spokeswoman for the Kentucky Medical Association, provided a cautious statement about the proposal of adding the tax to other providers, such as physicians.

"The Kentucky Medical Association will review any research and data presented on provider taxes to determine the impact on physicians and their patients," she said.

A spokesman for the Senate Republicans, who hold a majority in their chamber, said leaders had no immediate comment. Nor did leaders of the Republican majority in the House.

But Lewis said the group has been presenting the information in recent days to legislative leaders and they have expressed interest, though no commitment.

See also: John Schnatter sends his love to workers. Papa John's returns to sender

The group has created an interactive website it demonstrated Wednesday to show lawmakers how many people benefit from Kentucky's expansion of Medicaid as well as how changes to the provider tax would affect money available to fund it.

Lewis said the group doesn't have a timetable for the health tax proposal, saying that's up to the General Assembly.

The proposal comes at an uncertain time for Medicaid in Kentucky.

Federal authorities are reviewing an overhaul proposed by Gov. Matt Bevin to add work requirements of at least 20 hours a week and premiums, changes aimed largely at "able bodied" adults added through the 2014 Medicaid expansion.

The Trump administration had approved Bevin's proposal in January but a federal judge in Washington struck down the plan in June, saying federal officials hadn't sufficiently considered public comments about it or the fact that more than 95,000 Kentuckians were projected to lose Medicaid coverage under the plan.

Bevin has issued an executive order that would dismantle the expansion should it fail to withstand a court challenge after all appeals are exhausted.

Members of the group promoting the provider tax changes had no comment on Bevin's Medicaid changes other than to say they believe the expansion is vital to the health and well-being of Kentucky.

"It's critical," Lewis said. "If you unplug Medicaid expansion for rural hospitals, it's devastating."

Deborah Yetter: 502-582-4228; dyetter@courierjournal.com; Twitter: @d_yetter.

Healthier Kentuckians through a Tax on Sugar-Sweetened Beverages

A White Paper Exploring the Feasibility of a Soda Tax

Kentuckians disproportionately suffer from obesity, tooth decay, and diabetes; funding for Medicaid is predicted to decline, and the state has a geographic maldistribution of dental health professionals, including dentists, oral surgeons, pediatric dentists and dental hygienists. A nominal tax on Sugar-Sweetened Beverages (SSBs) could help correct these three situations. This paper projects the impact of a tax on SSBs.

Introduction

Kentucky's dental illnesses are reaching epidemic proportions across the lifespan of its citizens, representing a huge burden on society. Overall, Kentucky has a very high rate of tooth loss due to decay and/or gum disease [1][2] and ranks seventh in the nation in its percentage of senior citizens that are completely toothless. [1] Dental problems do not start in adulthood, but rather begin in childhood and even early childhood. Kentucky's young children have an untreated decay rate of almost 43% [3] and a recent survey by a dental insurance company found that our school-aged children also have high rates of decay. [4] In fact, although dental insurance coverage has improved over the past 15 years, the children's dental health has declined, and their need for immediate dental care has increased since the last surveillance study in 2001. [4]

Kentucky almost certainly has a maldistribution of dental professionals. Kentucky does not have enough dentists and dental specialists participating in the state's Medicaid program. Some counties have only one dentist available to serve every 3,000 residents; the national ratio is two dentist to 3,000 residents [5]. Additionally, there are not sufficient funds available to improve the oral health status of the state at the individual level or with population-based interventions.

The small number of dentists participating as Medicaid providers is attributable to the low Medicaid reimbursements rates; they are less than 37% of the prevailing rates dentists receive for their work. With high adrninistrative costs of running a dental practice, dentists cannot meet their offices' expenses with this reimbursement. With recent Medicaid expansion, many practices saw a major shift from cash-paying patients to Medicaid beneficiaries. This shift increased the financial loss taken by the Medicaid dental providers in their community.

Changes in the benefits for Kentucky's Medicaid population remains undefined as of the release of this paper. As the US Congress is addressing repeal/replace/repair issues of the Affordable Care Act, Kentucky's Governor is awaiting approval from the Centers for Medicare and Medicaid Services for a waiver program for Medicaid, which contains significant changes in the dental coverage.

Premiums for dental insurance has skyrocketed over the last thirty years and the maximum annual benefit remains at $1,000 with the more progressive dental insurance companies allowing $1,500. With full coverage dental crowns and dental implants costing between $2,000 and $4,000 each, preserving a single tooth can quickly exhaust a policy's annual benefit.

The Kentucky Department for Public Health's Oral Health Program is updating the state's strategic plan for oral health. In May 2017, Kentucky stakeholders held a conference to address the issues impacting oral health in Kentucky. The attendees strongly recommended that the state plan include increasing preventive dental programs through expansion of the public health registered dental hygienist in both geographic footprint and scope of practice. They also suggested changes in the Medicaid program that would result in better access to care for the Medicaid beneficiary. Finally, there needs to be educational programs to increase or improve oral health literacy for Kentuckians to make better decisions relative to dental health and dental care for not only themselves but also for their children.

Obesity is another burden on our society and health care systems. Almost 35% of Kentucky adults are obese [6] and 18.5% of our adolescents are obese as well.[7] Much of the basis for obesity is rooted in behavior choices. Kentuckians are not frequently engaged in significant physical activity.[6] In fact, nearly a third of adults are not engaging in any leisure physical activity [6] and almost two-thirds of the state's youth spend less than an hour of physical activity per day. [7] Nearly half of our citizens consume less than one serving of fruit per day. [6][7]

Diabetes, especially Type 2 diabetes, is also a chronic disease that costs Kentuckians in quality of life and healthcare costs. In addition to weight gain, higher consumption of SSBs is associated with development of metabolic syndrome and type 2 diabetes [10]. SSB intake has also been positively associated with markers of inflammation and insulin resistance, which might increase risk for cardiovascular disease and diabetes *independently* of obesity [10].

Along with the above inactive lifestyles, Kentuckians also have a high consumption of SSBs. According to calculations using population data from the Kentucky Behavioral Risk Factor Surveillance System and the Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Survey, Kentuckians consume over *one billion cans of* SSBs each year.

High-Level Solution

By implementing a nominal tax on SSBs, Kentucky could address the challenges of poor oral health, obesity, and diabetes. A tax on SSBs was strongly supported by the stakeholders that shaped "Kentucky's Strategic Plan for Oral Health" as a vehicle to meet the oral health needs of the state. The 2014 Kentucky Health Issues Poll revealed that 51% of Kentuckians favor taxing the sale of soda and other sugary drinks if the revenue was used for school programs addressing nutrition and physical activity. [11] The funding from such a tax could impact the oral health status of all Kentucklans, focusing on the underserved and vulnerable citizens. Part of the tax revenues could be spent to fight the impact of obesity in our state. Obesity, along with dental decay, is one of the chronic conditions long associated with Kentucky's poor health rankings.

Definitions

According to the CDC, SSBs are any liquids that are sweetened with addition of various forms of sugars like brown sugar, corn sweetener, corn syrup, dextrose, fructose, glucose, high-fructose corn syrup, honey, lactose, malt syrup, maltose, molasses, raw sugar, and sucrose. Examples of SSBs include, but are not limited to, soda (not sugar-free), fruit drinks, sports drinks, energy drinks, sweetened waters, dairy, coffee and tea beverages with added sugars [12].

While this is the definition from the CDC, each jurisdiction that has implemented a tax on SSBs has its own specific definition. If this proposal comes to fruition, Kentucky will have to adopt its own definition of a SSB. The tax on SSBs will be levied at the wholesaler, providing a similar basis for taxation used in tobacco and alcohol in Kentucky. The proposed tax is based on per ounce of SSB. Since a 12-ounce can of soda is most commonly associated SSBs, the illustrated calculation of tax on SSBs shown below in Table 1 is based on this volume of SSB.

TABLE 1

Soda Tax Calculations		
Taxable Servings Consumed per year		
926,342,857		
Rate per 12 ounce can (Nominal Rate)	**Annual Yield**	**Rate per ounce**
0.005	$ 4,631,714.29	$.00042/oz
0.01	$ 9,263,428.57	$.00083/oz
0.015	$ 13,895,142.86	$.00125/oz
0.02	$ 18,526,857.14	$.00166/oz
0.025	$ 23,158,571.43	$.00208/oz
0.03	$ 27,790,285.71	$.0025/oz
0.04	$ 37,053,714.28	$.0033/oz
0.05	$ 46,317,142.85	$.0042/oz

The calculations are based on the lowest number of servings consumed according to BRFSS statistics: "none," "less than one" and "one or more." Kentucky has a culture of consuming more than one 12-ounce can of soda per day. Because of the lack of exact numbers for adults having more than one serving per day, the lower frequency of "less than one" or "one or more" is used. The reality is that, based on the number of high schoolers who consume three or more "sodas" or "pops" every day (13.2%) [7], the revenues realized through implementation will be significantly higher than these calculations illustrate.

Seven states have implemented a tax on sugar-sweetened beverages [9]. These states had two different reasons for implementing such as tax: 1) to fund programs or other special intents in the jurisdiction of taxation or 2) to reduce the consumption of SSBs with the goal to improve the overall status of the jurisdiction's population by improving oral health and reducing obesity.

Arkansas (population size, demographics and health status similar to Kentucky) currently has a two cents per can rate. Mexico's new tax on SSBs is equivalent to five cents per can.

The tax proposed in this white paper is not a rate that will reduce the consumption of SSB. The expected revenue from taxation consumption of SSBs will programs to counteract the impact of SSBs consumption on the individual and population health in relation to their effect on oral health and obesity.

If policy makers choose the route of a more robust tax (ranging from a penny-and-a-half to a nickel per ounce of soda), it would impact the population in the several ways. It would reduce health care costs, prevent various chronic diseases, reduce premature birth rates, reduce the rate of new cases of diabetes and would promote longer lives, unburdened by preventable diseases that begin or are impacted by SSB consumption. The tax on SSBs will be additional funding to the existing minimal funding for public health/government based programs. [13]

Solution Details

By implementing a tax on SSBs that equals the rate of two cents per 12-ounce can, based on current consumption, Kentucky would realize a revenue of at least $18.5 million a year through the implementation of a tax of two cents per 12-ounces of sugar-sweetened beverage. This amount could fund public health programs to fight the negative impact of excessive sugar consumption.

Impacts -Revenue-Funded Proposals

At a rate of two cents per 12-ounces of sugar-sweetened beverage, this nominal tax would generate $18.5 million for Kentucky. It would support the following needs:

- All local public health departments could support a public health hygiene team with non-dependence on Medicaid revenues. This would acclimate local dentists and other dental health specialists to Kentucky's Oral Health Program and state partnerships, and eliminate all sense of competition for the Medicaid dollar. It would support the addition of teams in those counties that currently have a public health hygiene team. Up to 200,000 children could be seen through this expansion of the program.

- A fully supported surveillance system housed in the Oral Health Program. This would offer statistical data on oral health conditions that will result in stronger program establishment and more effective policy development. Having the funding to empirically and statistically assess issues such as dental decay, periodontal disease, oral cancers, birth outcomes relative to dental disease, emergency room dental presentation, aspirational pneumonia hospital admissions due to oral conditions, dental visits across all age strata, dental attitudes and workforce characteristics will give valuable information to the program and all oral health stakeholders. Having a sustainable system over time will allow progress (or regress) to be measured and trends to be recognized. This information will also assist other non-oral health programs and/or interests to understand the body-mouth relationship.

- A program coordinator for the Oral Health Program that specializes in oral health messaging. Oral health literacy for most Kentuckians would increase with a sustainable messaging program targeting dental health decisions.

- A robust loan repayment program for University of Louisville and University of Kentucky dental program graduates to be placed in underserved areas of Kentucky. This program would be designed to support eight dentists per year at an award of $50,000 for four years.

- Reduce the tuition cost of in-state students. These tax revenues could be granted to each dental school at an amount of one million dollars per year. The intent of this grant would be to reduce tuition for each Kentucky student $20,000 to $25,000 annually.

- Support a statewide, dentist-based volunteer program that provides adult dental treatment for uninsured or underinsured residents. This program could complete dental treatment on at least 800 vulnerable Kentuckians.

- Fund walk/bike infrastructure projects that result in more non-motorized transportation, both for work or leisure.

- Expand farmers' market "double dollars" program that increases the purchasing power of tax-funded food dollars by doubling the value of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Senior Farmers' Market Nutrition Program, and Supplemental Nutrition Assistance Program (SNAP) when purchasing locally grown produce and other farmers' market products. This also helps to sustain local farmers and their efforts in their farm-to-table business plans.

- Expand healthy eating programs and physical activity in early childcare education programs.

- Expand farm-to-preschool and farm-to-school programs that will result in better school-day nutrition and support and sustain local farmers.

Impacts – Community Health Status

This white paper proposes a tax that probably would not result in significant reduction in the consumption of SBBs. Changes in health status as a result of a tax on SSBs occur when the tax on SSBs is significantly greater than proposed in this paper.

The rate of two cents per 12-ounces of sugar-sweetened beverage is just one that could be considered for this proposal that would fund the programs above.

However, to 'close the circle' on the idea of higher taxes, Table 2 contains taxes on SSBs from municipalities that enacted a SBBs tax primarily to reduce consumption, reduce healthcare costs and improve overall health, versus than a funding stream for specific programs.

TABLE 2

Rate per ounce of soda (Robust Rate)	Annual Yield for Kentucky	Rate per can
Cook County IL tax: 1 cent	$ 111,161,142.84	$0.12
Philadelphia, PA tax 1.5 cent	$ 166,741,714.26	$0.18
Seattle, WA tax 1.75 cents	$ 194,531,999.97	$0.21
Boulder, CO tax 2 cents	$ 222,322,285.68	$0.24

The California cities of Berkeley, San Francisco and Oakland carry the one-cent per ounce rate found in Cook County, IL.

If policy makers chose consumption reduction as a reason for tax implementation, a study exists that models the health effect in a city in Kentucky. The Harvard Model Project used Kentucky's most populated city, Louisville, as one of their case-study cities regarding the ten-year impact of a penny per ounce tax on SSBs [13][15]. It is estimated that this effort would reach 600,188 citizens and while decreasing soda consumption by almost 100 cans of soda for each person, the tax would yield the city $30 million in its first year. At one cent per ounce (the rate currently enacted in Cook County, IL and several California cities), this tax would cause a nine percent reduction in the incidence of diabetes, with 448 cases of diabetes prevented over a one-year period once the tax reaches its full effect. This program would prevent over 6,700 cases of obesity and add over 607 years of life by reducing premature mortality. For every dollar yielded from the tax and reinvested in specific programs, over the course of ten years, it would save almost $52.00 [15].

Other Aspects to Consider

Detractors of a tax on SSBs will offer many negative aspects of this tax:

"Soda taxes Cost Jobs" It only cost jobs when the tax is large enough to significantly influence overall consumption of SSBs. After two months of the enactment of Philadelphia's tax on SSBs (1.5 cents per ounce of sugar-sweetened beverage), supermarkets and distributors report a decrease in SSB sales between 30% and 50%. The local Canada Dry distributor had plans to lay off 300 workers last spring. [18] But, an analysis of the Berkeley tax showed that the food sector jobs increased since the implementation of the tax. [19]

"New Government Programs Cost Money to Implement and Oversee" This is a reality of any newly implemented program. The policy change will involve start up and ongoing labor costs for municipal and/or tax department administrators. To implement the intervention, government agencies will need to process tax statements and conduct audits. Businesses will also need to prepare tax statements and participate in audits, which will require labor from private tax accountants. The statewide impact has not yet been estimated, but based on the Harvard Model Projections, Louisville's annual implementation cost were estimated at about $81,000. Exact costs would be affected by the final conditions of the implementation of this proposed tax [13][15].

"Tax Revenues Will Change Annually" While the fact is that SSB consumption is waning in Kentucky (and across the nation more profoundly) [16], the revenues from a tax on SSBs would follow consumption trends and that revenues would shrink with this trend. This has historic precedent: Kentucky's public health programs that benefit from the Tobacco Master Settlement Agreement have experienced reduced funds over the years due to the reduction in overall tobacco product sales and the resulting 'tobacco funds' it yields. Their programs continually adjust to the new revenue streams; the programs that would benefit from a tax on SSBs would adjust as well.

"This is a Tax on the Poor." Currently, the purchases made with Supplemental Nutrition Assistance Program (SNAP) benefits are exempt from taxes. [17] Soda purchases by any economic demographic is an optional activity as soft drinks are not essential to life and their consumption has no or little nutritional value.

"This Should be a Local Option Decision, Like Wet/Dry Options." The impact of SSBs on Kentucky's health is a statewide problem and should be addressed on a statewide level. A statewide tax would be more effective than a local tax, as people will travel to other jurisdictions to avoid taxes, but that is reduced when the tax is levied on a statewide basis [20].

"A Soda tax Should Be a Percentage of Cost." This would be an easy way to generate and collect this tax, but it would not reflect the intent of the tax. It is not the cost per serving that increases the morbidity of chronic diseases such as dental decay, diabetes and obesity; it is the ounces of the soda that impacts health. This is why this proposal is per fluid ounce of SSB.

Summary

SSBs are consumed at a rate of over one billion servings annually in Kentucky. A nominal tax rate on SSBs of two cents per 12-ounces of SSB would yield over $18.5 million for public health programs that would reduce the impact of excessive sugar consumption. This rate is not one that is proven to impact overall consumption of Sugar-Sweetened Beverages. [22]

Conclusion

This white paper was requested as a part of the Governor's overall efforts in comprehensive tax reform. It is presented with a proposed tax NOT designed to impact the chronic diseases that soda consumption can contribute to, but to outline a scenario that is in the spirit of tax reform to assign taxes where they are appropriate. A tax on SSBs meets that spirit. To best impact the reduction of chronic diseases through a tax on SSBs, it would take a tax of about 27 cents per 12-ounce can to lower obesity rates. [23] Currently, that appears to be unpalatable to Kentuckians and their policymakers.

Call to action

The "Call to Action" is clear and simple: By implementing the suggested nominal tax on Sugar-Sweetened Beverages, Kentucky could implement programs to offset the health impact of SSB consumption. Public support for such taxes generally increases with earmarking for prevention activities [21] [22]. By implementing a more robust rate, this could be viewed as more than tax reform to correct tax application to where it is most appropriate. Rates of a tax on SSBs that are much greater (ranging from 12 to 24 cents a can) are what has proven to reduce consumption. By implementing a rate similar to Philadelphia, almost $150 million could be used to offset the expense of Medicaid state matching funds.

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What You Should Know about Sugar-Sweetened Beverage Taxes

By Jeanie Kennedy

Due to the increasing role of sugar-sweetened beverages (SSB) as a contributor to obesity and other diseases, SSB tax measures have been proposed or passed in localities across the United States and in other nations and territories such as Canada, Australia, France, Mexico, South Africa, the United Kingdom and more. These taxes are being passed for a variety of reasons, including to raise revenue, influence healthy beverage consumption, decrease incidence of disease, and fund pre-K or public health programs, among other rationales.

Yet the passage of these taxes has led to the rise of questions about their purpose, the efficacy of health programs the taxes are intended to fund, the measurements of success and the unintended consequences of imposing the taxes. In addition, public health officials are seeking to know if these taxes contribute to better dental health, decrease obesity rates or forestall diabetes.

The following explores the impact of SSB taxes, as well as their pros and cons, and how they relate to the dental health of your patients.

Supporters and Opponents of SSB Taxes

Individual public health advocates are nearly unanimous in support of the adoption of taxes on SSBs.[1-3] Moreover, taxes are advocated to decrease consumption of SSBs and to fund public health education efforts aimed at promoting healthy nutritional behaviors and choices.

According to a 2016 Vox Media poll, men, women, conservatives, moderates and liberals are equally supportive and opposed to SSB taxes. The poll could not identify any natural constituency but noted that self-identified liberals favored a tax by the widest margins in the poll.

In its 2016 report, "Fiscal policies for diet and the prevention of noncommunicable diseases," the World Health Organization came out in support of SSB taxes to prevent obesity, diabetes and tooth decay. The American Public Health Association also supports SSB taxes, whereas the American Heart Association supports educational efforts and a warning label on SSBs.

According to a 2016 Vox Media poll, men, women, conservatives, moderates and liberals are equally supportive and opposed to SSB taxes.

Pros and Cons of SSB Taxes

Imposing SSB taxes has the potential to decrease consumption of these beverages and may decrease the incidence of caries, obesity, heart disease and diabetes.[4] In addition, SSB taxes provide revenue to cities and municipalities, which could potentially be used to fund public health programs.

Yet many citizens are opposed to these taxes fearing loss of personal revenue and loss of new business. In Cook County, Illinois, which includes Chicago and its suburbs, there was tremendous public opposition, as well as legal challenges and other problems, which quickly led to a repeal of the new ordinance. Arguments against the tax came from establishments such as Culver's Restaurants, Valli Produce and Boz Hot Dogs, who, according to an editorial published in the Sept. 15, 2017, edition of the *Chicago Tribune*, stated they had decided not to open new locations or expand current business in Cook County in part due to the soda tax. The *Washington Free Beacon* reported that PepsiCo cited a local SSB tax in its decision to lay off up to 100 workers in Philadelphia.

In addition, not all SSBs are taxed in some locations; for instance, barista-made drinks were not taxed in Cook County. Diet drinks are taxed in Philadelphia, Berkeley, and Seattle. In Philadelphia, beer is now less expensive than SSBs. Cook County also taxed popular health drink kombucha

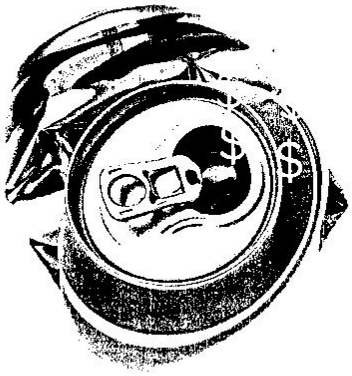
because it contains a small amount of sugar to stimulate the fermentation process. Taxing healthy drinks with an SSB tax may lead to less consumption of these healthier choices. Also, residents may need to travel significant distances if they want to avoid the tax.

Additionally, a common message opposing SSBs is that the government is acting as a "nanny state" that restricts an individual's personal choice.[5] Another common complaint is that singling out SSBs for taxation is not fair when unhealthy foods are not similarly taxed. Lastly, policy makers ponder if the tax proves to be successful in decreasing consumption of SSB, then tax revenues will not be stable.

Sugar Subsidies

Over the past 80 years, federal tax policies led to higher U.S. sugar prices.[6] In order to circumvent increased sugar prices, food scientists created a product from corn, known as high fructose corn syrup (HFCS). The introduction of HFCS, which consists of both glucose and fructose, allows for rapid absorption in the blood stream and is widely used in SSB. Consumption of HFCS is associated with numerous diseases, including tooth decay. If the U.S. had not engaged in artificially manipulating the sugar market for nearly a century, public health might be in better stead today. The American public has a right to engage in a policy debate on federal trade policy aligning with public health.

AGD has a new policy statement on the adverse health effects derived from the consumption of sugar. The AGD statement contends that "evidence supports the correlation that the consumption of added sugars leads to myriad human health problems." Furthermore, "Sugar consumption is the most important contributing factor of caries, which is the most prevalent of worldwide diseases."



At this juncture, there is a lack of data to demonstrate that SSB taxes actually improve public health, yet the data is starting to show that consumption of SSB decreases with taxation.

U.S. LOCATIONS WITH SUGAR-SWEETENED BEVERAGE TAXES

1. Berkeley (California)
2. Philadelphia
3. San Francisco
4. Oakland
5. Albany (California)
6. Boulder (Colorado)
7. Seattle

Tax Structure

In U.S. locations, the SSB tax is based on the number of ounces in a beverage. For instance, in Philadelphia, the tax is 1.5 cents per ounce. This adds 24 cents to a 16-ounce SSB, not including any sales tax. In the United Kingdom, the tax is assessed by a tier mechanism, depending on the amount of added sugar in the beverage.[7] The greater the sugar content, the greater the tax.

Taxes in the United States are sometimes adopted at the distributor level or as a consumer excise tax. Nonetheless, the SSB taxes are passed onto the consumer, regardless of the structure. If applied in all U.S. states, it is estimated that a SSB tax would generate $12.5 billion in annual revenue.[8]

In Philadelphia, the tax, which went into effect in Jan. 2017, raised $5.7 million in the first month and just over $39 million during its first six months in effect, just under its originally projected goal. This revenue funds programs like the city's pre-K, parks and other projects.

Educating the Public

Organic food choices continue to proliferate, and "clean" eating has been adopted by a segment of the public, yet there are many who are not fully informed about the health consequences of sugar (including high fructose corn syrup).

At this juncture, there is a lack of data to demonstrate that SSB taxes actually improve public health, yet the data is starting to show that consumption of SSB decreases with taxation.[9] It also shows that SSB purchases increase in adjacent counties or cities, meaning that behavior is not changing for some and that consumers are merely going to a different location to avoid the tax. Whether decreases in consumption of SSBs will lead to better health or better dental health remains to be seen. ✦

Jeanie Kennedy is the manager of dental practice and policy at AGD. To comment on this article, email *impact@agd.org*.

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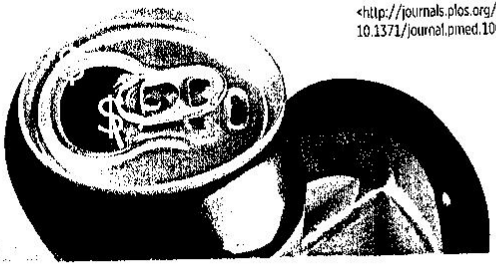

16. THE REPORT OF THE TECHNICAL ADVISORY TO KMAP.

Medicaid Dental TAC Agenda
8/29/18

Call in number : 877-746-4263, code #: 0259187

1. Call to order Dr. Garth Bobrowski, Chairman
2. Welcome, introductions and phone introductions
   A. New TAC member: Dr. Phil Schuler
3. MCO comments/questions
   A. Avesis (Thanks to Dr. Caudill and Nicole Allen and others)
   B. Dentaquest
4. Medicaid fee for service comments/questions
5. Old business
   A. MY REWARDS PROGRAM Update
      1. KDA letter to CMS—Ms. Seema Verma
      2. Kids showing up as suspended, inactivated or under My Rewards (eastern KY) on July 2, 2018
   B. Videoconferencing Rules/information
      -never heard back from the MAC on use of FaceTime option
      -who sets this up?
   C. http://chfs.ky.gov website status
   D. Other
6. New Business
   A. Co-pays and retro co-pays
      -18 year olds
      -yes, no, Aetna start 7/1/18 and stop 8/14/18
      -state said not to collect them
      -dentists said their MCO told them to collect them after 8/1/18
   B. Retro eligibility
   C. Computer updates, cybersecurity, HIPPA updates and required assessment
      1. high costs
      2. use of Avesis name (Avesis (a National Vision,Dental and Hearing Company); avesis(a Guardian company); Avesis 25; avesis (essential benefits)
   C. Termination letters — never received any form of prior notice
   D. Parent request : “WellCare wastefulness”, child dental appt. one month prior to 4 letters
   E. Avesis: look at restorative 6 month rule(New cavity, New broken area not covered by the original dentist, but will cover another dentist to repair the tooth)
   F. CareSource wastefulness : Ky Opioid notification form (x3)
   G. Thanks to the state for updating the screens on patient eligibility

H. Patient/Pharmacy situation on Rx
I. Opioid diversion-Veterinarian/pets — no way for the dentist to track or KASPER
H. Other

7. Public Comments
8. Dental or Hygiene comments
9. Next meeting: Nov. 14, 2018?
10. Adjournment

MEDICAL DENTAL TAC

NOVEMBER 10, 2018

The minutes of the last two TAC meetings are not available yet. Due to State staffing issues at our meetings reports/minutes have been late coming to us.
By state law, the minutes have to be approved by the TAC at the next meeting before the minutes can be released to the public.

Since August of 2017 the TAC is no longer receiving our standard reports from the MCO's. We do not know the reason for this change.

Any data info requests now have to be "Applied for" at this web site: https://redcap.uky.edu/redcap/surveys/?s=DNK3ATX9WD.

Currently, we have questions submitted to the state through this site.

1. We have sent in requesting info on different age groups of dentists providing Medicaid dental care at various paid claim levels.
2. We have asked to know the exact mechanism the MCO's are paid from the state.
3. We have asked to know the exact mechanism that Avesis and DentaQuest are paid from the state/MCO.
4. What is the current Medicaid Dental budget?
5. Does the dental budget stay the same each fiscal year?

We have submitted these questions because we cannot get answers from State staff or they do not know the answer.

Please review the meeting agenda enclosed as a separate attachment.

Respectfully submitted,
Dr. Garth Bobrowski

MEDICAID DENTAL TAC AGENDA
FEBRUARY 21, 2018

1. CALL TO ORDER—DR. GARTH BOBROWSKI,CHAIR

2. WELCOME AND INTRODUCTIONS (PHONE INTRODUCTIONS)

3. APPROVE MINUTES FROM NOV. 15, 2017

4. MCO COMMENTS/QUESTIONS
    A. AVESIS
    B. DENTAQUEST
        l. NEW STATE DIRECTOR?

5. MEDICAID FEE FOR SERVICE COMMENTS/QUESTIONS

6. OLD BUSINESS
    A. MEDICAID WAIVER HAS BEEN APPROVED BY CMS
    B. MY REWARDS PROGRAM —MR. GARRY RAMSEY REPORT
        GREENSBURG AT LONGHUNTER'S COFFEE AND TEA CO. 3/17/18
    C. MOBILE DENTAL UNITS
        l. LAST MEETING REPORTED THAT MANY DENTISTS ARE COMPLAINING ABOUT THE TRUE LACK OF FOLLOW UP CARE BEING PROVIDED BY THESE MOBILE PROGRAMS
        ll. REPORT BY CHARLOTTE NICHOLS R.D.H. (PRIVATE PRACTICE)
        lll. REPORT BY DR. JERRY CAUDILL

    D. DENIAL WORDING THAT GOES TO THE PATIENT FROM THE MCO: UPDATE
    E. OTHER

7. NEW BUSINESS

    A. MAC : NEW BYLAWS FROM 1/25/18
        l. SENT TO ALL TAC MEMBERS
        ll. TAC's ARE TO ELECT A CHAIR AND A VICE CHAIR
            NOMINATIONS :CHAIR——
                VICE-CHAIR——
        lll. FOR A QUORUM: EITHER BE PRESENT OR USE VIDEO CONFERENCING
        iv. SCHEDULE MEETINGS ONE YEAR IN ADVANCE
        v. USE KY OPEN MEETINGS GUIDELINES

    B. EPSDT —GUIDELINES FOR USE /PRE-AUTHORIZATION

    C. OTHER

8. PUBLIC COMMENTS

9. DENTIST COMMENTS

10. NEXT MEETINGS:

11. ADJOURNMENT

March 26, 2018

RE: My Rewards Program (MRP)

To Whom It May Concern:

At our last Medicaid Dental TAC (Technical Advisory Committee) meeting (Feb. 21, 2018) statements were made, which raises questions that are quite disturbing in the operations of the My Rewards Program.

(1)There are so many variables that the average dental office will be taking SO MUCH TIME to figure out what the patient actually has that it will not be worth participating in the My Rewards Program: Various available plans for the patient like a Premium plan or a copay plan, plans that are partially still paid by the MCOs and partially by the state My Rewards Program. In the dental office how are we to know if the patient does not pay their premium and they loose their dental benefits for 6 months? If they don't pay their premiums, how does the PREMIUM ASSISTANCE fit in? How does the dental office staff, who is checking in the patient, know all this? If the patient gets premium assistance, where is the incentive to EARN the dental benefit? In the dental office, look at the time it takes to 'check in' a Medicaid patient for eligibility that day: Check the MCO site , check the State site , and now check the MRP site. Then the dental office is NOT allowed to see what money the patient has in their MRP account (only the patient can see the $ amount). If the emergency patient comes in to the dental office, then it will also take EXTRA staff time to properly file the payments to that patients account files at the dental office (you have to do at least two payment applications — one from the State MRP and one from the MCO). How is the dental office going to get paid for this extra administrative cost? If you don't have enough providers for the MRP, what will happen to these patients? They will go to the Emergency Rooms at the hospitals. There are various estimates of the huge extra costs to the State ranging from about $800-$1600 per visit to the ER and what part of the state they are in. Is the Administration willing to pay for this, yet not pay the dentist and staff a reasonable fee rate to take care of the extra staff time? The patient will only receive palliative care at the ER , usually a cotton ball with Lidocaine and an injection of an appropriate antibiotic with a reference to go see their dentist for definitive care. So now you are paying twice.

(2) It was reported that since the Medicaid MRP patient was a Medicaid patient the dental office could NOT charge the patient for a non-covered service, for example, making the now edentulous patient a denture or partial denture. What about teeth bleaching? We could not offer this service, but they could go to Maui Bleaching Qiosks and get this done. When did this change? The Medicaid patient could go down the street to a **non-Medicaid dentist** and get this same procedure done at their normal fee. We Medicaid dentists have been able to help our patients with non-covered dental treatment options for decades. The patient knows up front what the fee will be. When did this change???

In terms of staff time it will be easier to have the MCO's cover the MRP patient on their emergency needs , i. e. emergency exam(which can at the present time only be used for trauma or infections, many people have toothaches that are not a true infection ,so we may not get paid for the diagnostic exam), necessary x-rays(but at the present time a dentist cannot get paid for a periapical x-ray and a panoramic x-ray taken on the same day) , all extractions, oralantral fistula closures, incise and drain an abscess(intraoral or extra oral), foreign body removal, osteotomies, palliative treatment, various sedative anesthesia methods. BUT, will the

MCO be paying the dentist at their 10% reduction in THEIR FEE SCALE, or will they be paying the meager regular Medicaid fee scale? The dental community has not had an increase in across the board fee reimbursement since 2002 and these fees (I am told) were based on the 1998 fee schedule. It is my understanding that other healthcare entities are paid at the 80th percentile yet dentistry continues to be paid at the 41.6th percentile . The number of dentists participating in the KY Medicaid/MCO program is declining.

We understand that the Administration wants to get this "right". The Kentucky Dental Association's South Central Dental Society has had two meetings scheduled in Feb. and in March 2018 to bring information to dentists and staff concerning the My Rewards Program. These informational meetings had to cancelled because the information still keeps changing and the Program is set to start on April 1, 2018, with full implementation on July 1, 2018. Time is of the essence to get our office staffs trained or just don't participate with this MRP. The TAC suggested that some training sessions be set up in the evenings or on Fridays or Saturdays , so the dental staff would not have to take so much time out of their offices for the informational/training meetings. In the Medicaid dental office time is critical especially with the low Medicaid reimbursement rates. Two of the MCO's have reduced their already low reimbursement rates to the dental providers by another 10%. Within the next week or so, we get a list of nine Training Forums. They are ALL on Mon. through Thurs. during the day. Many Medicaid dental offices have one staff member at the front office. Now they have to shut their office down for a day just to go get "trained" on a program they might not be involved with anyway. What about doing online webinars, that could be reviewed by the dentist and staff anytime?

The TAC members do not have a problem with certain groups of the expansion population earning dental benefits.

We are glad to see that the gym membership was removed from being on par with dental and vision benefits.

On February 1, 2018 a Medicaid dental office in a county near me **CLOSED**. The dentists went back to their home county and will not see any Medicaid patients going forward.

At the current time, after talking with several single dentist or small group dental offices, I have not heard of one dental office willing to participate with the My Rewards Program!!!! I, personally, am considering my options. If the State is going to provide a My Rewards Program and yet pay for the patient's premiums, why not just buy dental insurance for each patient at $20 -$30 per month and give the patient a $1000 yearly limit, with mandatory copays for certain treatment options on basic restorative or denture care.

Sincerely,
Dr. Garth Bobrowski DMD, FICD, FACD, FPFA
Chair, KDA Medicaid Dental TAC

Chair, KDA Council on Governmental Affairs and Federal Dental Services

Medicaid Dental TAC Agenda
5/23/18

DENTAL TAC WEBSITE: http//chfs.ky.gov/dms/dentaltac.htm
call in number: 877-746-4263, code #: 0259187

1. CALL TO ORDER DR. GARTH BOBROWSKI, CHAIR

2. WELCOME AND INTRODUCTIONS, PHONE INTRODUCTIONS

3. MCO COMMENTS/QUESTIONS
   A. AVESIS
   B. DENTAQUEST
      -complaints from dentists not getting paid for pre-approved ortho TX
   C. REVIEW REPORTS REQUESTED

4. MEDICAID FEE-FOR-SERVICE COMMENTS/QUESTIONS

5. OLD BUSINESS
   A. MOBILE DENTAL UNITS REPORT—DR. JERRY CAUDILL
   B. TELE-DENTISTRY REPORT—DR. JERRY CAUDILL
   C. OTHER

6. NEW BUSINESS
   A. MY REWARDS PROGRAM REPORT/FORUMS REPORT—STEPHANIE BATES/ CINDY ARFLACK
      -What was the dental attendance at the Forums?
      -when will dental specific training start at each provider location?
      -Red Bird Mission vote for dental clinic
      -oral surgeon's comments on My Rewards Program
   B. VIDEOCONFERENCING RULES/INFORMATION
      - WHO SETS IT UP FOR EVERY MEETING?
      - WHO SETS IT UP FOR THE DOCTOR'S OFFICE?
      - WHY CAN'T FACETIME BE USED?
      - HOW LONG HAS THIS BEEN IN FORCE AND WHY WERE WE JUST NOTIFIED OF ITS USE LATE LAST FALL 2017?
      -OTHER ?'S
   C. TAC MEMBER RETIREMENT ANNOUNCEMENT
   D. OTHER

7. PUBLIC COMMENTS
8. DENTIST COMMENTS
9. NEXT MEETING AUGUST 29, 2018, WEDNESDAY (MY QUESTION 8-30-18??)
10. ADJOURNMENT

17. KENTUCKY DENTAL FOUNDATION.

DRAFT

KENTUCKY DENTAL FOUNDATION, INC.
BOARD MEETNG
French Lick Resort
French Lick, Indiana
August 23, 2018

1.CALL TO ORDER. Dr. Andy Elliott, Chairman, called the meeting to order at 3:05 p.m. The following members of the Board were present:

Dr. James Allen	Dr. Bill Lee
Dean Gerard T Bradley	Dr. Mark Moats
Dr. Ansley Depp	Dr. Terry Norris
Dr. Andy Elliott	Dr. Stephen Robertson
Mr. David Gardner	Dr. Sharon Turner
Dr. Fred Howard	Mr. Richard Whitehouse

Kentucky Dental Association staff members present were Mr. Todd Edwards and Ms. Melissa Nathanson.

2. **APPROVAL OF MINUTES**. The minutes of the meeting of August 24, 2017 were approved.

3. REPORT OF THE TREASURER. The Fund Balance for June 30, 2018 was reviewed.

Balance as of January 1, 2018		**260,584.14**
Entries for January 1 to March 31, 2018		
Interest		
Revenue	523.00	
loss on investments	-5688.14	
Balance as of March 31, 2018		**255,419.00**
Entries for April 1 to June 30, 2018		
Interest		
Revenue	1,012.00	
Balance as of June 30, 2018		**256,431.00**

4. **KDF BOARD OF DIRECTORS EXPIRATION TERM. Drs. Largent, Norris, and Turner's** term expires at the end of 2018**. Dr. Bill Lee** moved to recommend the persons whose terms were expiring at the end of the year be reappointed. **Dr. Bradley** seconded the motion.

   ACTION: ADOPTED.

5. **2018 PROJECTS TO BE FUNDED.** Interest available to spend on projects was $4,937.00. **Dr. Fred Howard** moved to fund the request from Smile KY in the amount for $2,000.00. **Dr. Jim Allen** seconded the motion.

   ACTION: ADOPTED.

6. **NEXT MEETING.** The next meeting of the Kentucky Dental Foundation will be February 9, 2018, at 11:00 p.m. at the KDA Headquarters Building.

The meeting was adjourned at 4:00 p.m.
Respectfully submitted,

Dr. Stephen Robertson
Secretary-Treasurer

The KDF Board asked for an explanation of loss on investments. Below is the explanation from the broker:

The differing performance between the KDA General Fund account and the KDA Foundation, was the result of the performance of the Fundamentals Investment Program during 56 days the Foundation assets were in the money market awaiting the update of all the KDA documents reflecting new board members and CEO change. The management folks had to have correct authorization before they could invest the KDA Foundation assets. The Fundamentals program performance outperformed the money market during that period.

Late January was the market high point during the first half of this year, which was when the Foundation assets were invested, so the reports from the second quarter show a loss vs the General Fund which had the benefit of be invested during the full month of the strong January.

Since January 24th 2018, the accounts have been invested identically, and going forward the investment results will reflect that.

18. COMPONENT REPORTS.

Report from Southeastern Kentucky Dental Society

H. Fred Howard, DMD

The SEKDS met on Thursday October 4, 2018 at the Depot Restaurant in Corbin, KY at 6:30 pm. Our speaker was Dr. Bill Lee, President of the KDA who was accompanied by Mr. Rick Whitehouse, KDA Executive Director, Ms. Libby Milligan and Mr. Skipper Martin, KDA Lobbyist with McCarthy Strategic Solutions. Dr. Bill Collins, KDA Past President was also a guest.

Dr. Lee made a power point presentation about past legislative issues and our legislative agenda for the upcoming legislative session. There was much discussion among our members, especially on the potential provider tax to make up for the projected $300 million Medicaid shortfall.

Dr. Lee discussed the importance of KDPAC in moving our legislative agenda forward. Several members pledged to join KDPAC, especially in light of the need to oppose a provider tax. Dr. Lee also discussed the importance of keeping our membership above 50% so the KDA can speak for dentistry in KY.

Mr. Whitehouse, Ms. Milligan and Mr. Martin made additional pertinent comments during the discussions.

The SEKDS committed to having a legislative meet and greet with our legislators in the future. Dr. Collins and Dr. Lee gave insight into how Kentucky Mountain Society and the Bluegrass Society had been successful in meeting with legislators at a society meeting.

Bluegrass Dental Society Report

We are switching our meeting schedule this year to try and increase attendance. Rather than having a dinner meeting with CE every month, we are going to have one every other month and then have executive board meetings on the off month.

We had our first CE dinner meeting on September 25th. It was our annual fish fry and we had about 50 members present. Patterson Dental sponsored the event to help keep cost down and they had different intraoral scanners set up so that members could try them out and ask questions. Dr. Bill Lee was in attendance and gave an update on the provider tax, membership numbers and asked that we all try to bring one new/non-member to the next meeting. We then had Dr. Gerald Grant from ULSD present a CE course entitled “Impact and Development of Digital Technologies on Dentistry”.

Our future dates for CE dinner meetings are:

November 8th Dr. Molly Smith presenting “50 Shades of Red: A Review of Pink and Red Lesions of the Oral Cavity”

January 8th Dr. Bill Lee with a KDA Legislative Update in preparation for Lobby Day

March 14th Dr. Roach with a topic to be determined

April 23rd Dr. Tom Larkin with a topic to be determined

Our future dates for Executive Board meetings are:

October 25th
December 4th
February 12th
April 11th

Respectfully submitted by:
Clifford Lowdenback

Nov. 10, 2018 Green River Dental Society report
KDA Execut Board

Jan. 11, 2018 - The GRDS me t The Brionp h , n
Owensboro. That evening we hosted Dr. Ansley Depp
and Mr. Rick Whitehous. The topic was
"KDA Update." We disc ed The shenanigens
in Fre
lobby plish.

March 23, 2018 - Dr. Brandon Taylor and S Gilbert
donated Their brand new dental office
Owensboro to host a charity ic fo
low incom patients. They were j by
Dr. Kelsey Johns n, Dr. Terry Ward,
McCarty, and Thei dental ass . When
The dust had settled The smoke
cleared, over 40, of dental servic_
ided For f
Jody Head pro ded Food &
Suppli . It was a blessed day.

April 17, 2018 - The GRDS met at

Opioi Addiction and KASPER Reporti g
The speaker s
M Gary He lecture

Sept. 20, 201 The GROS m the Briarpatch
in Owensboro. The topic was Lawsuit
Prevention Seminar. The speaker
Dr. Benjamin Dyches from the g
state of . He is an attorney
and a dentist. Asse protect'
was discussed in great l.

We hope to see a big turno on Friday, No 16, 18.
Patty Boness Byrd, R re ns to Kentucky Larges
Ghost Town for OSHA Updates and KASPER. She
will be at the Owensboro Christian Church Community Center.
This event is sponsored by Dr. Greg Adams The
Greater Oh Valley ental Hygiene Study Club. Breakfast
and lunch is stered by fri ly Folks at
Moonlite Barbec .
We also have a GROS m ng schedu
later on Jenuary 17, 201. will be hosting Dr.
Bill Lee and M. Rick tehouse at The Br rp .
Dress is Business/casual. Please be l .

Respectfully subm ,
Joe McCarty, DMD.

19. **KDPAC. Dr Mike Johnson** presented the following report.

With the election season in full-swing, KDPAC has been conducting membership campaigns. A new strategy was implemented in September and all licensed dentists in the state were emailed and a contribution was solicited. The results were encouraging with approximately $800 being raised which we considered a good start for a technique that had never been tried before. We are continuing the campaign with board members seeking contributions in their individual component societies. By the time of the KDA Board Meeting, the mid-term elections will be over. We will begin working with the Council of Governmental Affairs to identify legislators in the new general assembly who may have influential committee assignments. We will consider donations to those individuals who may share our interests and could potentially assist in advancing our interests. For your information, contributions cannot be made while the legislature is in session but that does not start until January 1.

The KDPAC Board discussed one topic that requires Executive Board input—funding for the Washington Leadership Conference (WLC) and identifying participants for attendance at this meeting. Traditionally the KDA has funded the rooms and meals and the ADPAC has reimbursed for travel. We can send eight dentists, one for each member of Congress, and our executive director. Recently, we have sent five dentists and our executive director. The usual attendees are the KDA President, KDA President Elect, KDPAC President, a new dentist and the Chair of Governmental Affairs. The KDA utilizes funds from the legislative fund to underwrite these costs. ADPAC has changed the number of attendees that they will fund, since they are adding a 'new dentist' category. This means that we could now send 10 dentists. The KDPAC Board feels that with the limited funds available in the legislative funds, the KDA should send as many dentists as possible to better educate our members about the many efforts that are being presented in the legislature on our behalf. This conference provides an opportunity for dentists to see how the process works and what their dues and support is doing to further the profession. Additionally, it is important that we send more younger dentists so that they have an opportunity to develop relationships with legislators that will be beneficial for our organization for years to come. Knowing that there are limited funds in the legislative funds, we recommend that only dentists' expenses be paid to attend the meeting. This should not be interpreted as a slight to the ED—just what we believe is a better use of limited resources. We are seeking Executive Board input about the funding and numbers for attendance at the WLC.

Respectfully submitted,
JMJ

20. NEW BUSINESS.

MOTION: Dr. Fred Howard moved to send 2 CE scouts to the upcoming Hinman meeting with reimbursement not to exceed $1,000.00 each. **Dr Laura Hancock Jones** seconded the motion.

ACTION: ADOPTED.

MOTION: Dr. Andy Elliott moved to accept the TDSC proposal and directed the Executive Director to follow up on signing an acceptable agreement between the two parties. **Dr. Laura Hancock Jones** seconded the motion.

ACTION: ADOPTED.

MOTION: Dr. Andy Elliott moved to pay $3,250.00 to the keynote speaker for 2019 KDA Annual Meeting at the Galt House. The keynote speaker is **Mr. Rex Chapman.** The balance of $3,250.00 will be paid at the 2019 KDA Annual Meeting. **Dr. Fred Howard** second the motion.

ACTION: ADOPTED.

MOTION: Dr. Andy Elliott moved to direct the Governmental Affairs Committee to suggest that a viable option for dealing with Medicaid shortfalls would be a soda tax in conversations with any legislative or Medicaid officials. **Dr. Fred Howard** second the motion.

ACTION: ADOPTED.
It was also reaffirmed the KDA is against the implementation of a provider tax.

MOTION: Dr. Joe McCarty moved to send the KDA Executive Director to the 2019 Washington Leadership Conference. **Dr. Fred Howard** second the motion.

ACTION: ADOPTED.

MOTION: Dr. H. Fred Howard moved to send 6 dentists to the upcoming Washington Leadership Conference that could be reimbursed by the KDA for food and room charges. Three other people can go at their own expense by contacting **Dr. Jonathan Rich** or **Dr. Mike Johnson**. **Dr. Matt Milliner** seconded the motion.

ACTION: ADOPTED.

21. **FUTURE BOARD MEETING DATES.** The next KDA Executive Board meetings will be, February 9th and June 8th, 2019, at the KDA Headquarters Building.

22. **EXECUTIVE SESSION.** The board moved into executive session to discuss personnel issues.

    MOTION: Dr. Andy Elliott moved the KDA Executive Board accept the amended recommendation of the Executive Committee of a bonus of $3,500 for the Executive Director for 2018 and a 2.0% salary increase for 2019 for the Executive Director. **Dr. Fred Howard** second the motion.

    ACTION: ADOPTED.

23. **Dr. Joe McCarty** moved to adjourn. The meeting was adjourned at 5:30 PM.

Respectfully submitted

Dr. Sharon Turner
Secretary/Treasurer