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Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight
KanCare Reimbursement
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Madam Chair and members of the Committee, thank you for the opportunity provide this testimony regarding KanCare reimbursement. I am Kathy Hunt, RDH, a member of the Board of Directors of Oral Health Kansas. Our organization is the statewide advocacy organization dedicated to promoting the importance of lifelong dental health by shaping policy and educating the public so Kansans know that all mouths matter. Founded in 2003, we achieve our mission through advocacy, public awareness, and education. Oral Health Kansas has over 1,100 supporters, including dentists, dental hygienists, educators, safety net clinics, charitable foundations, and advocates for children, people with disabilities and older Kansans.

Kansas Cavity Free Kids

In addition to serving on the Oral Health Kansas board, I also am the coordinator for the Kansas Cavity Free Kids (KCFK), which is a grant funded statewide oral health initiative through the Kansas Head Start Association. In our 6th year, KCFK's goal is to have children reach Kindergarten cavity free and ready to learn. Strategies to meet this goal include development of resource materials and workshops for professional development, literacy appropriate educational materials for families, and increasing access to dental services for the families we serve: pregnant woman, children birth to five, and their families in Kansas who experience barriers to accessing dental care.

Based on statewide needs assessments, KCFK established new dental care models that improve access to dental services for the underserved -- especially those procedures designed to identify and prevent dental disease.

This model of care is supported by Medicaid policies that were in place prior to KanCare:

- Access to Medicaid funds through organizations that do not have a dentist on staff. Several organizations have been able to receive Medicaid Dental Provider numbers without having a dentist on staff including Head Start Programs, county health departments, and safety net clinics.
- Access to entire complement of CDT (dental billing) codes. These organizations were permitted to bill for any of the CDT codes as long as it was within the scope of practice for the professional providing the services.
- Ability for dental services to be billed under facility provider code, not a dental provider.

Medicaid system of dental care for young children

The Medicaid policies detailed above enable local Head Start programs to provide needed dental services through the following system:

- Head Start programs whose enrollees experience barriers to dental care contract with Extended Care Permit (ECP) dental hygienists for on-site services. These dental services include dental cleaning, fluoride varnish application, assessments to determine need for referral to a dentist, and patient/family education.

- The hygienists also provide services at local health departments, seeing pregnant women, infants and toddlers enrolled in Early Head Start other early childhood programs, as well as other health department clients. ECP hygienists also provide services to Medicaid-enrolled children who remain on waiting lists for early childhood programs. The hygienists provide their full scope of services, which also include sealants and adult cleanings.

- In some cases, local dentists (who do not accept Medicaid in their practice) agree to come to Head Start programs to provide examination services needed to fulfill federal obligations in the Head Start Performance Standards.

- All services provided are filed electronically through KMAP utilizing the Head Start dental provider number. Head Start pays the dental professionals for their services.

Transition to KanCare

KCFK has been actively working with KanCare dental subcontractors since October 2012. With the transition to KanCare, a variety of issues have kept any of our Head Start programs from being fully integrated into the system. In order to maintain the level of essential dental services available prior to the implementation of KanCare, these elements need to be in place:

- **A Medicaid application for facilities that is independent of a dental provider**
- **Simplified credentialing policy for dental hygienists and dentists providing care under facility contract**
- **Permit billing for any legally provided service by a dentist or dental hygienist**
- **Approval for use of all CDT codes payable under Kansas Medicaid**

On behalf of three Head Start Programs in Kansas, the Kansas Head Start Association worked from October of 2012 to June 2013 to assist the Head Start programs with transitioning their existing dental services to KanCare. They met with significant barriers along the way. Those include:

- Lack of appropriate and accurate applications for facilities without a dentist
- No policy in place for whether or not hygienists needed to be credentialed and how that process would function
- Indecision and new limitations on what Medicaid dental codes could be billed by the facilities
- Initial denial of Kansas specific ECP code for dental assessment for children under age three

- Refusal by United Healthcare to pay for any cleanings or sealants provided by ECP hygienists working directly with Head Start programs.
- Neither the state or MCOs accepting responsibility when codes are denied incorrectly or not transferred appropriately
- Multiple failures to return messages
- Conflicting or incorrect answers both within the MCOs and between the MCOs and KDHE

Working through these issues took many, many hours that neither the Head Start programs nor the association had budgeted for.

In 2010, CMS asked each state to increase the number of children receiving preventive services by 10 percentage points by 2015. At that time, Kansas was in the bottom quartile of all the states, with less than 41% of children able to access those services. With forecasted workforce shortages and low levels of provider participation, it makes sense to be looking at ways we can increase the models that can improve access to the preventive services that will save our state money and maintain good overall health for our children. Providing dental services through Head Starts is one way of meeting that CMS benchmark.

The KanCare Promise

The new KanCare system seems to have put in place barriers that were not previously in existence. Limiting the types of codes that can be billed under Head Start and eliminating Health Departments and other possible access points prevents the ECP legislation from being fully utilized.

During the KanCare planning process, state officials repeatedly shared their vision for KanCare during public forums, noting that through KanCare, Medicaid beneficiaries will be able to receive the same services. A July 2012 KanCare Frequently Asked Questions document that was distributed during the educational forums noted:

Q: Will the State continue to contract with existing providers?

- The KanCare contracts require that contractors use established community partners to deliver care and services.

We have found that this promise has not been kept, as dental services are not readily available in Head Start and health department settings any longer.

How KanCare has affected other ECP service delivery models

Other models that use ECP dental hygienists seem to have had different experiences:

- FQHCs experienced a rough start, but everything is going great now. There may be some future concerns when FQHCs try to integrate medical and dental care.

- Fee for Service Dental Clinics also had a rough start, but things are going perfectly now. We see the MCOs going above and beyond to assist these providers, and payments are being made within one week.
- ECP hygienists working through private dental offices have had an easy transition and have not experienced payment issues.
- Dental clinics with no dentist on staff were not able to get facility only Medicaid provider number. This model includes several volunteer and very part-time dentists, as well as several hygienists on staff. The barriers began occurring when the clinics asked dentists to help in the clinic, because all dentists need to be separately credentialed in order for the clinic to receive payment.
- Health Departments are no longer eligible to have a dental provider number. (DentaQuest)
- Head Starts have had a very, very slow start. None of the MCOs was set up for this model of dental care provision. There has been a great deal of confusion on what applications to use, who needed to be credentialed, and what codes the MCOs would pay for. Most programs have radically reduced their services as a result. One MCO (United) will cover assessments and fluoride varnish, which means they are missing a great opportunity for pregnant women to receive preventive dental services in the Head Starts.

Update from a KanCare dental provider

A fellow Oral Health Kansas board member is a private practice dentist who has served as a Medicaid provider for many years. His office is experiencing many challenges with the KanCare system regarding denials of claims, changing coverage for individual procedures without notification to providers, and requesting tedious additional information to accompany claims. A few of those challenges are outlined here and then detailed in the attached document.

- All three MCOs have had changes in their manuals recently regarding benefits/coverage and preauthorization requirements. The dental office has had several claims denied under the new guidelines, but *the treatment was completed prior to the date that the guidelines changed.*

- There are three different MCOs, but within each of these MCOs are multiple sub-plans with different coverage, different requirements for payment on treatment codes and different preauthorization requirements. The dental office has patients in each of these different sub-plans, so keeping straight what is covered, what needs preauthorized and what information is required is *extremely* difficult.

- The MCOs and dental subcontractors tend to deny claims and asking for different information; then the claims are denied again, and more new information is requested. Some claims are taking three or more months to be paid.

- The dental office also is seeing changes made in benefits provided to adults that seem to be designed to reduce dental care to adults on Medicaid.

Thank you for the opportunity to provide this testimony. I am happy to stand for any questions.

KANCARE ISSUES
Office of Dr. John Fales

1. Enrollment was a huge inconvenience; time consuming; several documents were requested a 2nd, 3rd & sometimes 4th time. We had to enroll in each of the 3 MCO's separately, plus enroll with CAQH Credentialing; which in itself was very time consuming, especially when we were given the initial instructions for applying & then were given different instructions and had to go back and redo the original applications.
2. There are 3 different MCO's, but within each of these MCO's are 6 or more sub-plans with different coverage, different requirements for payment on treatment codes and different preauthorization requirements. We have patients in each of these different sub-plans, so keeping straight what is covered, what needs preauthorized and what information is required is *extremely* difficult.

   Ex: M. Brown (special needs adult w/ multiple disabilities) needed sc/rp with anesthesia; preauthorization was done online with narrative included; rec'd approval 7/15/13 for anesthesia & sc/rp; treatment done 7/29/13; claim sent by paper with approval #, IV drugs used, perio charting, copy of treatment plan & sedation record; denial rec'd 9/12/13 for 4341's (anesthesia paid); called DentaQuest & spoke to Regina who said the procedure was denied in error-sees the approval in system so sent for review & reprocessing. This happens ALL the time.
3. All 3 MCO's have had changes in their manuals recently regarding benefits/coverage & preauthorization requirements. We have had several claims denied under the new guidelines, but *the treatment was completed prior to the date that the guidelines changed.* We have had this happen several times & some of the claims were for treatment with anesthesia. The claims with anesthesia were originally submitted with all required supporting information. They were then denied 2 or more times for information that had already been provided with the original claim. After multiple phone calls and resubmissions of claims, they are still outstanding at this time. In addition, some of these claims, at one point, were denied because no preauthorization had been done for the treatment. *At the time of treatment, the manual stated no preauthorization was required;* this changed with the new manual while the claims were still outstanding, but the treatment was completed prior to the new manual.
   There was no forewarning in the change of frequency limit for 1110 (adult prophy) under the UnitedHealthcare sub-plan Title 19 Adult. Every plan/sub-plan covers a prophy (adult or child) once every 6 months, which is standard for most insurance companies. Therefore, we would have no reason to check the manual each time before a standard 6 months cleaning appointment. When we received some denials for prophy limits, it was at that time we saw the frequency limit had changed (this is the Only sub-plan that has changed this frequency limit). Therefore, we are unable to collect the fee from the patient since we were unable to give advance notice to the patient and now Dr. Fales is required to write-off the full fee for these visits.

   Ex: R. Ashlock & S. Gutschenritter were seen in our office on 8/21/13 for their RAR visits & the 1110's were denied by UHC due to "maximum allowed." I looked at the new manual which said 1110's are covered "once per 12 months." We were unaware of the change. The old manual stated 1110's covered at "once per 6 months." *There were no notices in the document section of Scion's website.*
4. DentaQuest is denying claims with reason code 2104 ("does not meet benefit criteria"). For these claims, we call & speak to their representative to see what they need to process the claim since the reason code is so vague. The representative explains what they need; we resubmit with needed information; claims have been denied again; after another call to their

representative, we find that they are asking for something we have already submitted or they need something not told to us at prior phone call; and then we submit yet again (*with some of these claims taking 3 or more months to be paid).*

DentaQuest is also denying coverage of the code D4355. Our office always preauthorizes treatment plans that include this dental code. Of all the pre-authorizations we have done for our patients with this plan, this code has always been approved or approved as "authorization not required." The manual states under benefit limitations "one (D4355) per 12 month(s) per patient." However, after treatment is done & claim submitted, this code is denied. When we speak to a representative, they say it is denied because the D4355 treatment was done within 12 months of any other type of cleaning. It is not stated this way in the manual. Once again, Dr. Fales is required to write-off this fee since no advance notice could have been given to the patient (we have now changed our collection process with our patients with this code).

5. Scion's website (which is Amerigroup & UnitedHealthcare combined) does not post the patient's complete treatment history, according to their representative. We have had claims denied for a prophy due to frequency limit, but the website does not show all of the patient's history of treatment. One example: A patient's prophy was denied due to frequency limit; the website history showed the August 2013 prophy with our office, but only showed a history of an x-ray from June 2013 (not our office); we called Scion & the representative said the patient had a prophy in June 2013 elsewhere, but that their website doesn't show "all the patient's history" and that we can always call them to check on history. *What is the purpose of showing a PARTIAL history of treatment?* It would be cost prohibitive to us to call to receive treatment history for every patient for every cleaning because we see such a large volume of KanCare patients. *Many of the KanCare patients Dr. Fales sees have been referred to our office for treatment so having the complete history is vital not only for his initial assessment of care needed, but also from a financial standpoint for Dr. Fales to get paid for his dental services (x-ray, filling, prophy, exam limits, etc.).* From our conversation with Scion, complete history is not always listed. *Why is this?*
6. Recently, we have found out that there is a different process regarding submitting secondary insurance claims. The first time the claims were returned to us, the attached form indicated that a Group Code and an Adjustment Amount was missing on the claim. On 9/3/13, I called to ask what this meant. The representative said we needed to write a Claim Adjustment Group Code, a CARC code and the amount remaining due on the bottom of the primary insurance EOB that we attach to the paper claim. The representative said we did not have to write this coding per treatment line because it would be too confusing for them, but to just write it once at the bottom. I then resubmitted the claims with this "code." On 9/18/13, we received these claims back with the same form attached asking for the same information. I called again; the representative was viewing one of our claims/primary EOB copy and explained the coding again & told me we had the wrong code written on the EOB and that the codes had to be written line-by-line explaining why the primary insurance had not paid in full. She told me there would be 5 most commonly used CARC codes. I asked her why the dentist office has to do this and why KMAP couldn't read the primary EOB like every other insurance. She said that KMAP doesn't know why the balances are due for each line and this EOB "looked sketchy." She also said that KMAP was "not allowed to" read the primary EOB's anymore and this has been going on for 2 years now; said that they are doing this to be more "standardized" like a "normal" insurance company. We have never submitted secondary claims to KMAP in this manner before and they have always been processed/paid. Furthermore, after coding each line of the primary EOB (which is very time-consuming) many of the claim balances will be a provider write-off anyway.