

Provider and Operational Issues Workgroup

Minutes

L SOB 900 SW Jackson Suite 900, Topeka KS

March 12, 2015 10:00am – 12:00pm

Those attending in person:

Tara Price, Daniel Dubois, Tiffany Wilson, Doug Klise, Kelly Burns, Jerry Delashaw, Lianne Vickers, Keith Derks, Jeremy Whitt, Carrie Kimes, Ruth Williams, Sharon Johnson, Cathy Taylor-Osborne, James Bart, Kerrie Bacon, Dr. John Fasbinder

Those attending by telephone:

Dr. Mike Weitzner, Allen Schmidt, Carrie Fritz, Charmaine Christian, Ric Dalke

Review of last meeting minutes:

James Bart, KDADS

Good morning everyone my name is James Bart I am the Director of Managed Care at KDADS and am the Co-Chair of the POI Group. Are there any corrections or adjustments to the minutes for the December 11, 2014 meeting? The previous minutes are available on the KanCare website under the POI Workgroup. If you have any suggestions your contact would be Dawn Lawson.

MCO Updates:

James Bart: We are going to start the meeting with provider updates. Each of the Managed Care Organization's has a committee and we would like to have a report of recent developments regarding the provider's committees and we will start with Amerigroup. Frank had provided an update last meeting. Next we will start with Sunflower

Doug Klise, Sunflower: For Sunflower we like to point people to our website. Our bulletins are online and we also have online sign-up for the bulletins so we can send the bulletin directly to the provider. The new provider manual will be posted out there sometime this month we are just waiting for final comments. We have a new manager of provider relations Tiffany Wilson who will be servicing Brian Swan's providers and assisting with Sunflower activities.

Carrie Kimes, United: We work with our provider committees as a way to get some feedback from providers. Those continue to go well as they give us feedback about how we can better service our provider community. As 2015 rolls in we are focusing on working with providers on an individual basis to resolve any outstanding issues. As most of our global systemic issues have resolved so now we are working through Joint Operations Committees with individual providers to work through any individual claims or training needs they may have. This will continue to be our focus through 2015 as we work with providers either through a committee basis or individual meetings with providers.

James: For those of us that may not be familiar with the provider committee at United could you give us a breakdown of the composition and how often you meet?

Carrie: I believe they meet quarterly, I am not familiar with what the current composition is. I know they have a broad base of multiple provider types. It includes some of our hospitals, physicians, ancillary providers, as well as HCBS. I know they are constantly updating that so I don't have the exact mix but if that is something that you are interested in we can put together who is sitting on our committees for this quarter and you can have that for review.

James: I would like to go back to Amerigroup regarding your website. Could you describe the provider information that is available on your website?

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Keith Derks, Amerigroup: On our provider website we have an abundance of information. We are currently working on our Newsletter's for 2015. We will have those out there and we have information for the services that we provide. We have access to the provider directory and the provider manual. For most of the communications that we send out to providers that is the one that is the most current and updated. We push a lot of the provider information and provider communications to our website. That is the primary source of access for things they need.

I/DD Waiver Implementation Updates:

James Bart, KDADS

There has not been any substantial updates since our last meeting. Prior to that meeting we discussed monitoring I/DD through the KKMAR reports that the MCO's provides to KDADS specifically pertaining to the I/DD waiver claims and processing results. We continue to monitor these reports and have good feedback from providers about their billing and I/DD waiver inclusion in KanCare. If there are any I/DD individuals that are a part of this group please contact me if you have any questions our concerns regarding implementation of the I/DD waiver into KanCare.

Links to KanCare Information

James Bart, KDADS

I went ahead and accessed these links this morning. There are some updates on these links. KDADS has revised their website so this link is no longer active for the I/DD bulletin. The updated link for the I/DD bulletins is http://www.aging.ks.gov/HCBSPProvider/IDD_Provider_Index.html. The most recent bulletin is from December 24, 2014. Those will be updated periodically. Does anyone have questions about accessing the informational linking to KanCare?

Guest Speaker:

Cathy Taylor Osborne, D.D.S., M.A.

KDHE

Thank you for inviting me here today. I am going to update everyone on the programs we have in the Bureau of Oral Health and explain them a little bit. Jennifer Ferguson is our Children's Program Manager. The two main programs that we have for our Children's Program is a school screening program that is throughout the State of Kansas. There is a Statute on the books that requires every school age child to have an annual dental screening. However, it is not a funded activity so through our Bureau we try to encourage and fund a lot of the activities as far as providing supplies and helping hygienists to go into the schools to provide this activity. In the 2013 – 2014 school year we screened over 154,000 school children ages K – 12. That is a great number but there are over 400,000 school children enrolled in the State that we want to expand that. We are working on the 2014 – 2015 school year right now. Collecting data and compiling that information.

The school screenings are a non-billable activity. There are a census of all of the oral health of the children in Kansas. We collect data in four areas which are treated decay, untreated decay, sealants present, and urgent need. It is not a billable activity; we are collecting a census to collect data for those four focus areas on the school children in the state of Kansas. We do have relationships with school nurses. We provide forms for the school nurses to communicate with parents. If there are urgent needs or if there are untreated decay issues that is done through the school nurse to the parents. We provide links to providers if schools need providers to refer to parents to help their child find a dental home.

Currently we are wanting to work harder on this because we have some schools who have chosen to do an opt-in choice versus an opt-out. Opt-out meaning we can go in and screen all children unless a parent has said they don't want to have a screening. An opt-in version of that is if superintendent, principal, or the school nurse choose an opt-in we have to have permission to go in and screen the children. For example, there is a large elementary school in Desoto that last year they were an opt-out; we screened over 500 students. This year they decided to do an opt-in and we screened 33 students.

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This summer after the school year ends we are going to make an effort to reach out to some of the superintendents and principals to explain that we are happy they have a dental home. We have some schools that say all of our students have a dentist so we don't need you to come in to do this screening. We are trying to communicate what we are actually doing and why we are doing it. The data that we collect is for anyone's use.

The second program that we do is the School Sealant Program. This is a funded program that we try to assist dentists and ECP hygienists to go into schools. The target schools that we address are over 50% free and reduced lunch which are large Medicaid populations. They go in with mobile units and they are able to provide preventative services, fluoride varnish and sealants to students. That is a billable activity so we are able to collect the data from those billable activities that are performed.

We had a HRSA grant previously that helped support these activities with equipment and supplies; which we lost that HRSA grant last year. We just submitted a new application for a new HRSA grant for this year which is going to help support the sealant and screening programs as well as dental student rotations through the western clinics in the state where they have not been able to access because of funding. Specifically from UMKC School of Dentistry and provide some scholarship grants for students who want to go out to underserved populations. Either minority students and/or students from rural communities that want to go back and practice in the communities. We are hoping to hear from HRSA within the next couple of months whether or not we receive that funding. Those are the two children's programs that we are very involved in.

A new thing we have gotten involved in this year is we were one of five states selected across the country to participate in the CMS Oral Health Initiative. It has given us a great opportunities to work with our external collaborators including all of the MCOs. I appreciate all of the input that I have received from the MCO's to questions that I have sent them to answer with the learning curve that I am experienced in learning what is provided, what are some of the gaps in the populations that are not being served, and how can we look at our data from the Bureau of Oral Health. The two aims that the CMS Oral Health Initiative is trying to achieve is: 1. to increase the proportion of children age 1 through 20 enrolled in Medicaid or CHIP for at least 90 continuous days who received a preventive dental service by ten percentage points in between fiscal years 2001 and 2015 and 2. increase the proportion of children age 6 through 9 enrolled in Medicaid or CHIP for at least 90 continuous days who receive a dental sealant on a permanent molar by ten percentage points. We collect data on all children so we are trying to focus in on that 6 to 9 age group that the CMS group is wanting to target.

One activity that I will discuss briefly is our Community Fluoridation Activity that we are very active in. Salina, KS has a big issue in the fall that went to the ballot and the Community Fluoridation that has been in place since 1968 had a ballot issue to remove that water fluoridation from the system. It was voted down by a 2 to 1 margin to keep the fluoride in the water. One of the interesting things about that was instead of going into a community that never had fluoride that wanted to implement fluoride for the first time this was the first time they had gone into a community that had a long standing tradition of Community Fluoridation and were trying to remove it. We are pleased with not only the efforts of the local community working with the City Council but also the local Dental Society, Bureau of Water, and our Bureau of Oral Health with Pam Smith who is our fluoridation specialist.

Keith Derks: What was driving the need or interest to change that?

Cathy: There is a group of anti-fluoridationists on a national level that try and find communities that may be vulnerable. This particular group came in and to get a ballot issue they have to have so many signatures. Looking back they stated they wished they would have looked at the signatures closer to make sure they were valid local community signatures. A lot of times these are not local community people who come in. They may address a Council member who may be on the fence whether this is a good or bad thing. It may be a community that is getting ready to update their water systems and need to decide if they are going to maintain the fluoridation.

Jeremy Whitt: What is their platform?

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Cathy: Water fluoridation is a public health coercion that you are forcing the public to have a public health measure that they are not consenting too. It causes lower IQ in children, osteoporosis, AIDS, autism, it is a poison, so they have some radical emotionally charged platforms that they present. A lot of public health measures you have to have justification in the conditions that you are imposing public health measures on the public so it has to be something that the benefits override the negative adverse effects. Community Fluoridation is still in that same realm. It is a known public health benefit that in a utilitarian way it benefits a great number of people with little adverse effect. So what they do is they go in and they say this is not the least resistant thing you can do; you can use fluoride mouth rinses or fluoride toothpaste so you don't need to mass fluoridate. First, it serves communities that are underserved communities that don't have access to a lot of fluoridated mouthwashes, toothpastes, and maybe don't see the dentist but they are receiving benefits of water fluoridation. With systemic fluoride when you take fluoridation in systemically especially for children the fluoride ion combines with calcium and it creates a stronger more resistant substance in the forming tooth that is forming in the jaw as the child is growing and developing. That is why Community Water Fluoridation is so important is because they are ingesting fluoride ion that is helping create a stronger more resistant tooth structure.

Doug Klise: Is Wichita still non-fluoridated?

Cathy: That is correct.

Doug: Have you looked at the data for Wichita compared to the rest of the State for outcomes?

Cathy: One thing that is interesting about that is one of the State grades that we get as far as oral health is based on Community Water Fluoridation percentages and as long as Wichita is not fluoridated our State is not going to achieve a very high grade because it is such a large community. Sixty-four percent of Kansas is fluoridated right now.

Doug: It would be interesting to see the data on the children of Wichita versus other communities that are fluoridated.

Cathy: I can probably get that information for you.

Ruth Williams: I believe they put that together because last year when it was on the ballot in Wichita there was a lot of work done to try and get that data. Oral Health of Kansas, Sedgwick County Oral Health Coalition, and another agency worked to get data such as treated decay versus untreated decay.

Cathy: That is another reason our school screening programs are so important; that is another piece of data that we can look at for school districts to see how that looks.

Kerrie Bacon: Since we were discussing dental I brought information that I share with consumers. The top piece is probably what you will want to look at first. It is dental assistance that I give to people who either have high spend downs or don't have dental insurance. You will probably recognize some of this information because it is the Kansas Association of Medically Underserved (KAMU) clinics and safety net clinics. It is a combination of both clinics but it is also the Mission of Mercy Dental Services which some of you may have heard of. Marion Clinic and Donated Dental Services through the Kansas Dental Association are also on here. If you flip this over most of the time people are wanting a doctor so we have doctors, pharmacy which are the pharmacy cards, vision, and then we have dental.

Daniel Dubois: Douglas County Dental Clinic does free services one day a year which I believe is scheduled for September this year. UMKC also partners with KU and they do free dental services every Tuesday evening.

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Kerrie: That is something that I am coming across there are some very specific one night a week such as one in Topeka that is partnering with Health Homes so they don't want to be on this list yet. Anything that you hear about that could be added to this list please let me know.

Dr. John Fasbinder: Your list does not include private this is just all public places correct?

Kerrie: So far correct. If there is a private doctor that wouldn't mind being on here that would be fine.

Dr. Fasbinder: To qualify to be on this list you just need to take patients that require dental assistance?

Kerrie: That is correct.

Dr. Fasbinder: I believe there are quite a few that could be on there. I believe that State has private names that would be willing to see those.

Kerrie: This is for people that do not have insurance.

Daniel Dubois: I believe that is why some of these are listed because they have a sliding scale for those people who may make too much to qualify for Medicaid but not enough to have private insurance.

Dr. Fasbinder: I would like to add one more thing about the Kansas Mission of Mercy that I participated in one of their events in Salina, KS. We did \$1,200,000 approximately of free dentistry in a two day period.

Cathy: January 29th and 30th of 2016 it is going to be here in Topeka which we believe it will be at the Expo Centre but am not sure.

Keith: How do you cut the number off?

Dr. Fasbinder: There is kind of a time limit after about 7 or 8 in the morning and it just opened at 6 or so we have met our limit to what we can do that day and we try to stick around the next day to get as many done as we can. There are 26 states now that do this.

Ruth: It was amazing how we got done with the children earlier this year. The adults are usually the ones who don't have the coverage. But, by 2:45 or 3:00 in the afternoon on Friday all of the children were done that they had let in. There were over 900 children we saw on Friday and 400 to 500 that we saw on Saturday.

Another one is the Sedgwick County Oral Health Coalition does Give Kids a Smile. We just did that last Saturday and saw over 100 children. We had 11 dentists that donated their time. We treated 56 children for restorative and the rest just needed preventative services. We have several pediatric dentists that could not be there that day but take referrals and will see them within the next month.

This is done once a year at Grace Med on the first Saturday of March in Wichita. This year they opened it up to four surrounding counties instead of just being for Sedgwick County like it was before so we saw kids from six counties.

James: We did not ask any of the managed care organizations to prepare any information but are there any brief comments regarding the value added benefits? I know the recent KanCare Oversight Committee had some statistics regarding the value added benefits and the success of the dental program. Are there any comments regarding those?

Keith: From Amerigroup perspective we keep track of how many are utilizing that benefit. From my perspective I believe there are still a lot of people who do not understand it. We participate in some different focus groups across the state and that is the number one concern we get; why isn't that covered through Medicaid for the

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adults. That is a program that we will be continuing and we will get the education component out on that. We have been talking to Dr. Taylor and that committee about new collateral in 2015 to promote the initiatives for the effort she is spear heading and tying that into some of the benefits for the value added benefits side that we can tie into it as well.

Dr. Fasbinder: As a provider who serves a lot of special needs patients for the state. A concern I have that is probably related more to the state than to the managed care organizations today with regard to the special needs patients. It seems like if they are in one kind of situation they get benefits like a child under 21 but, once they reach 21 the benefits are cutoff and these kids have no way of rehabilitating themselves. Like adults the only thing we can do is clean their teeth once or twice a year depending on what place they have been channeled to or take their teeth out. Is there any way we can structure something so we can take care of that? I wish we could do more for them and would like to see something else that we can do.

James: This is more of a policy issue that would need discussed on a state level. I appreciate the heart felt concern that you have shown there and your concern is heard.

Comments from the Chair:

James Bart, KDADS

Before the meeting I was speaking with Russell Nittler who runs the KanCare subcommittee for consumers and he noted that during the charter the participation for the POI members and the consumer members is a two year period. I believe during the interim between this meeting and the meeting in June Shirley and I will get together to determine how to solicit additional participation by providers to enhance this group. Any suggestions anyone has regarding the potential change of membership in this group we would be receptive to your ideas or questions.

The topic for our June 11, 2015 meeting will be Long-Term Care in Nursing Facilities. If the managed care organizations would invite some individuals with Long-Term Care and Nursing Facilities expertise we will bring some individuals from the State together and get some provider input on this topic.