Rep Dan Hawkins, Chairman
KanCare Oversight Committee

November 12, 2016

Dear Representative Hawkins,

I am writing this testimony in an effort to help improve the Kansas Medicaid Program (KanCare) to provide equal access to care for those that are least likely to be able to provide for themselves; children and adults with special needs. These two populations are not able to determine their destiny and so not have the clout to advocate for themselves.

I am a general dentist that has practiced in Arkansas City, Kansas for over 38 years. I currently practice with two other dentists; my son, Scott Rogers and my daughter-in-law, Nicole Rogers. Our community is a lower socio-economic community with a disproportionate number of those persons with special health care needs as a result of the closure of the state hospital about 8 miles to the north in Winfield, Kansas, in 1985.

According to Dr. Ron Ballard, superintendent of Arkansas City schools, 71% of the children in Arkansas City are on free and reduced lunch program (61% free and 10% reduced). As we see a growth of the Mexican American population in our community, we also see that this segment of our population indeed does show a great need for dental care and intervention. National averages show that 80% of cavities come from 7% of the population; the lower socio-economic and minority sector. The majority of students in this category qualify for KanCare assistance.

Arkansas City, as in most of the nation, has a growing epidemic of early childhood caries (ECC). Tooth decay is the single most common chronic childhood disease-5 times more common than asthma, 4 times more common than early-childhood obesity, and 20 times more common than diabetes. ECC is disproportionately concentrated among socially disadvantaged children, especially those who qualify for Medicaid (KanCare) coverage.

With the above stated, our dental practice feels socially responsible to provide care for our friends and neighbors that are less fortunate than ourselves and therefore, are providers for the KanCare system and have been for years. Over the years, there have been many changes to the Title 19 and Title 21 (Medicaid) programs. Our office has accommodated these changes in spite of their disruptive administrative requirements combined with low reimbursement rates. In spite of the above, we have been able to either break even providing care to this population.

When KanCare was implemented in 2013, we reevaluated our involvement and our ability to provide care to friends and neighbors many having complex dental needs and little access to care. The concerns that we faced were:

Administrative Concerns:

We have found that the administrative burden from going from one payer to three payers has increased the amount of hours spent by our staff dealing with different policies and rules even though the statutes stated that this would not happen.

- The credentialing process has become extremely burdensome due to the lack of standardization amongst the three groups. The credentialing process is very time consuming.
- The authorization process to obtain clearance for treatment varies among the three groups. This requires our staff to spend additional time to determine the proper process for each group.
- Each group has its own deadlines for filing claims as well as different rules.
- Each group handles overpayments and underpayments differently, requiring more time on behalf of the staff.

Reimbursement Concerns:

- The reimbursement rates have fallen to about 38-40% of our normal fees. My office overhead is approximately 65% of me fees. This means that the KanCare reimbursement rates fall about 15% short of my overhead. There has not been an increase in the fee schedule since 2001.

Lack of Information:

- There has been delay or simply lack of information to track the benefits received by our KanCare patients.

We are now once again reconsidering our participation in the KanCare system as a result of the 4% cut in reimbursement rates that occurred last summer. That will possibly be the "final straw". As many of my colleagues have discontinued their involvement in the KanCare program, it has become more difficult to find specialists that will provide care for our patients.

Furthermore, as others cease to patriciate in KanCare, it has increased the burden for those of us that continue to do so. We receive requests regularly from care facilities for those with special health care needs from over two hours away, most from Wichita, an hour from our community. Although I am not a pediatric dentist, we get regular requests to accept new KanCare pediatric patients from miles beyond our normal market area.

These patients have the most complex needs, consume a disproportionate amount of our time, clinically and administratively, and have the lowest reimbursement. At some point in the near future, regardless of my social responsibility, we will be forced to discontinue our involvement as a result of low the reimbursement rates that have not kept up coupled with the increase demand will not allow us to continue from a pure business model perspective.

Good oral health is the cornerstone of good overall health. I truly believe that it is possible for Kansas to provide quality oral health care to those that represent the most fragile in our society and have no means to provide for themselves. Dentists in Kansas do care for the populations that they serve and give their services generously on a regular basis in their office, through many state wide and community events. I would ask that the legislator reevaluate the KanCare system in an effort to make it a system that will sustain access for those who most need the care.

Thank you for your consideration.

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