SESSION OF 2017

SUPPLEMENTAL NOTE ON SUBSTITUTE FOR SENATE BILL NO. 69

As Amended by Senate Committee of the Whole

Brief*

Sub. for SB 69 would change the Kansas Program of Medical Assistance (KPMA) by amending law and creating in law processes for managed care organizations (MCOs) providing Medicaid services and by creating an external independent third-party review process (external review).

Managed Care Organization Processes

Data and Education

The bill would require the Secretary of Health and Environment (Secretary) to compel the MCOs to do the following:

- Provide accurate and uniform patient encounter data to participating healthcare providers upon request within 30 calendar days (the bill would authorize the MCO to charge a reasonable fee for furnishing the data); and
- Provide quarterly education for participating healthcare providers regarding billing guidelines, reimbursement requirements, and program policies and procedures utilizing a format approved by the Secretary.

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*Supplemental notes are prepared by the Legislative Research Department and do not express legislative intent. The supplemental note and fiscal note for this bill may be accessed on the Internet at http://www.kslegislature.org

Standards

The bill would require the Secretary to develop standards to be utilized uniformly by the MCOs as follows:

- A uniform process and forms for credentialing and recredentialing healthcare providers who have signed contracts or participation agreements with any MCO;

- Documentation to be provided to a healthcare provider by all MCOs when a MCO denies any portion of a claim for reimbursement, to include a specific explanation of the reason for denial that may not be subsequently changed by the MCO, and utilization of Health Insurance Portability and Accountability Act (HIPAA) standard denial reason and remark codes;

- Procedures, requirements, and periodic review and reporting of reductions in prior authorization for healthcare services and prescriptions;

- Internal claims grievance and appeal processes and timelines for resolving a grievance, not to exceed 90 calendar days from the date such grievance is filed, and for resolving an appeal, not to exceed 45 calendar days from the date such appeal is filed. The bill would require the processes and timeline provide that if the MCO exceeds the time limit for resolving a grievance or appeal, the participating healthcare provider would automatically prevail; and

- Retrospective utilization review of re-admissions, prohibiting such reviews for any individual covered by KPMA who is readmitted with a medical condition as an inpatient to a hospital more than 15 days after the patient's discharge.

Administrative Spending

Any contract between KPMA and a MCO on or after July 1, 2017, would be required to establish a definition of and cap on administrative spending. The bill would prohibit the definition of administrative spending from including any profit greater than the contracted amount or contractor incentives. The bill would state any administrative spending shall not exceed 10 percent of the MCO's total expenditures to provide Medicaid services and any administrative spending must be necessary to improve the health status of the population to be served pursuant to the contract, and the MCO would be required to report quarterly to the Secretary regarding such spending and percentage.

Additionally, the Secretary would be required to adopt rules and regulations as necessary to implement the requirements regarding data production and training, standardization, and administrative spending, prior to January 1, 2018.

External Independent Third-Party Review Process

The bill would require implementation of an external review process for providers who have received denial of KPMA services and have exhausted the MCO's internal appeals process.

Managed Care Organizations Notification Requirements

Any letter from a MCO to a participating healthcare provider reflecting a final decision of the MCO's internal appeal process would be required to state:

- The provider's internal appeal rights within the MCO have been exhausted;

- The provider is entitled to an external review; and
- The requirements to request an external review.

MCOs would be subject to a penalty paid to the provider, not to exceed $1,000, for failing to meet the above requirements in a final decision letter.

Eligibility

A provider who has been denied a healthcare service to a recipient of medical assistance or a claim for reimbursement to the provider for a healthcare service rendered and who has exhausted the MCO internal written appeals process would be entitled to an external review of the MCO's final decision.

Request for External Review

To request an external review, an aggrieved provider would be required to submit a written request to the MCO within 60 calendar days of receiving the final decision resulting from the MCO's internal review process. The written request would be required to include each specific issue and dispute directly related to the adverse final decision issued by the MCO, the basis upon which the provider believes the MCO's decision to be erroneous, and the provider's designated contact information.

Within five business days of receiving a request, the MCO would be required to:

- Confirm with the provider, in writing, receipt of the request;
- Notify the Kansas Department of Health and Environment (KDHE) of the request; and

- Notify the recipient of the medical assistance of the request, if related to denial of the healthcare service.

If the MCO fails to satisfy the notification requirements, the provider would automatically prevail in the review.

Within 15 days of receiving a request, the MCO would be required to submit to KDHE all documentation submitted by the provider in the course of the MCO's internal appeal process and provide the MCO's designated contact information. If the MCO fails to satisfy these requirements, the provider would automatically prevail in the review.

Review by Office of Administrative Hearings

The bill would require an external review automatically extend the deadline to request a hearing before the Office of Administrative Hearings (OAH) of the Department of Administration pending the outcome of the external review and, upon conclusion of the external review, the external independent third-party reviewer (reviewer) would be required to forward a copy of the decision and new notice of action to the provider, recipient, applicable MCO, KDHE, and the Kansas Department for Aging and Disability Services (KDADS). When a deadline to request a hearing before the OAH has been extended pending the outcome of an external review, all parties would be granted an additional 30 days from receipt of the review decision and notice of action to request a hearing before the OAH.

The bill would require KDHE and KDADS to immediately request a continuance from the OAH if a recipient of medical assistance or participating heath care provider files a request for a hearing before the OAH regarding a claim for which the provider has filed a request for external review. KDHE and KDADS would also be required to forward the decision of the review to the OAH for consideration by the hearing officer together with any other facts of the case.

KDHE Requirements

Upon receiving notification of a request for an external review, KDHE would be required to:

- Assign the review to a reviewer;
- Notify the MCO of the identity of the reviewer; and
- Notify the provider of the identity of the reviewer.

KDHE would be required to deny a request for external review if the requesting provider fails to exhaust the MCO's internal appeal process or submit a timely a request for an external review.

Multiple Appeals

Multiple appeals to the external review process regarding the same recipient of medical assistance, a common question of fact, or interpretation of common applicable regulations or reimbursement requirements would be allowed to be determined in one action upon request. The bill would allow other initial denials of claims to be added to such review prior to final decision and after exhaustion of the MCO internal appeals process if the claims involve a common question of fact or interpretation of common applicable regulation or reimbursement requirements.

Reviewer Limitations and Requirements

The reviewer would be allowed to review only the documentation submitted by the provider in the course of the MCO's internal appeal process. The reviewer would be required to conduct a review of any claim submitted to the reviewer and issue a final decision to the provider, the MCO, and KDHE within 30 calendar days from receiving the request for review from KDHE and the documentation submitted by the provider during the MCO internal review process. The

reviewer would be allowed to extend the time to issue a final decision by 14 calendar days upon agreement of both parties.

Final Decision

Within ten business days of receiving a final decision of the external review, the MCO would be required to notify the impacted recipient of the medical assistance and the participating healthcare provider of the final decision, if related to the denial of the healthcare service.

A party would be allowed to appeal the final decision to the OAH within 30 calendar days from receiving the final decision of the reviewer.

The final decision of any external review would direct the losing party of the review to pay an amount equal to the costs of the review to the reviewer. Any payment ordered would be stayed pending any appeal of the review. If the final outcome of any appeal is to reverse the decision of the external review, the losing party of the appeal would be required to pay the costs of the review to the reviewer within 45 calendar days of entry of the final order.

Licensed Pharmacy or Pharmacist

On and after July 1, 2017, a MCO would be prohibited from discriminating against any licensed pharmacy or pharmacist located within the geographic coverage area of the MCO that is willing to meet the conditions for participation established by the KPMA and to accept the prevailing Medicaid fee schedule.

Rules and Regulations

KDHE would be required to adopt rules and regulations to implement the provisions of the external review process prior to January 1, 2019.

Background

The bill was introduced by the Senate Committee on Public Health and Welfare at the request of Senator Kelly. In the Senate Committee hearing, representatives of the ARJ Infusion Services, Association of Community Mental Health Centers of Kansas, Inc., Disability Rights Center of Kansas, KanCare Advocate Network, Kansas Association for the Medically Underserved, Kansas Hospital Association, Kansas Medical Society, National Multiple Sclerosis Society, and Via Christi Health testified in favor of the bill. The proponents stated the bill will bring about efficiencies and reduce the costs of providing care to Medicaid patients by requiring MCOs to develop standard procedures for credentialing healthcare providers, standardize denial reason and remark codes, standardize requirements and time lines for prior authorizations for health care services, and standardize the claims appeal process.

Written-only proponent testimony was provided by Interhab, Kansas Academy of Family Physicians, Kansas Association of Osteopathic Medicine, Kansas Healthcare Association and Kansas Center for Assisted Living, Kansas Pharmacists Association, LeadingAge Kansas, and the University of Kansas Health System.

Neutral testimony was provided by the Director of the Division of Health Care Finance and State Medicaid Director, KDHE. The Director stated several of the provisions in the bill are currently being addressed by KDHE.

Opponent testimony was provided by the Director of the Budget, Division of the Budget. The Director stated the fiscal impact of implementing an external review process and other provisions of the bill would be significant.

The Senate Committee made the following amendments to the bill and subsequently agreed to insert the amended contents into a substitute bill:

- Deleted the requirement to reimburse, at no less than the Medicaid fee-for-service rate, all services provided by any hospital to initially screen, treat, and stabilize any individual covered by the KPMA who comes to such hospital's emergency department, without regard to the hospital's contracting status with the MCO or prior authorization by the MCO, and without reduction based upon a post-care determination by the MCO as to whether such individual required emergency services;

- Added retrospective utilization review of readmissions to the list of standards to be developed by KDHE and uniformly utilized by the MCOs;

- Inserted a requirement that an external review will automatically extend the deadline to request a hearing before the OAH, notification requirements to be completed by the reviewer, a time line to request a hearing before the OAH, and notifications duties of KDHE and KDADS regarding notifications to the OAH;

- Inserted a provision allowing a provider involved in the external review process to add other initial denials of claims to the review prior to final decision if the claims involve a common question of fact or interpretation of common applicable regulations or reimbursement requirements;

- Inserted a requirement directing the losing party of the external review to pay an amount equal to the costs of the external review to the reviewer; and

- Inserted a provision prohibiting a MCO from discriminating against any licensed pharmacy or pharmacist that is willing to meet the conditions for participation established by the Kansas program of

medical assistance and to accept the prevailing Medicaid fee schedule.

The Senate Committee of the Whole amended the bill to clarify a MCO would be prohibited from discriminating against any licensed pharmacy or pharmacist located within the geographic coverage area of the MCO that is willing to meet the conditions for participation established by the KPMA and to accept the prevailing Medicaid fee schedule on and after publication in the statute book and to change the date by which KDHE must adopt rules and regulations to implement the provisions related to licensed pharmacies and pharmacists and on the external review process from January 1, 2018, to January 1, 2019.

The Senate Committee of the Whole also amended the bill as it relates to the requirement of the Secretary to develop standards to be utilized uniformly by the MCOs as follows:

- Replaced "provider" patient account number with "hospital" patient account number in the provision related to the MCO requirement to provide accurate and uniform patient encounter data to participating healthcare providers;

- Inserted "HIPAA" to specify that HIPAA standard denial reason and remark codes are to be used;

- Replaced "limitations for" with "periodic review and reporting of reductions in" the existing provision regarding procedures, requirements, and limitations for prior authorization for healthcare services and prescriptions; and

- Specified standards related to retrospective utilization review of re-admissions will include prohibiting such reviews for any individual covered by KPMA who is readmitted with a medical condition as an inpatient to a hospital more than 15 days after the patient's discharge.

According to the fiscal note prepared by the Division of the Budget on the bill as introduced, KDHE states enactment of the bill would include three potential fiscal effects for Medicaid expenditures. First, KDHE estimates the cost associated with the independent review of MCO claims to be $40.0 million per year. [Note: The substitute bill included a provision for the losing party of the appeal to pay the costs of the appeal.] Second, KDHE estimates the change in emergency room rates would increase expenditures by $6.4 million per year. [Note: This provision was not included in the substitute bill.] Third, KDHE states no savings would be realized if the MCO administration costs were capped at 10.0 percent because the current MCO contracts include rates that equate to a 7.0 percent MCO administration rate. Any fiscal effected associated with the bill is not reflected in *The FY 2018 Governor's Budget Report*.

An amended fiscal note was prepared and submitted by the Division of the Budget after the Senate Committee amendments. According to the amended fiscal note, KDHE states enactment of the bill would include four potential fiscal effects for Medicaid expenditures. First, changing the allowed hospital re-admittance period from 30 days to 72 hours would require system changes [*Note*: The re-admittance period was amended to 15 days by the Senate Committee of the Whole.] and claims that were previously denied would now be accepted. The estimated cost related to this item is $5.1 million, including $2.2 million from the State General Fund, for FY 2018 and $5.0 million, including $2.2 million from the State General Fund (SGF), for FY 2019. Second, KDHE estimates the cost associated with the independent review of MCO claims to be $5.3 million, including $2.3 million from the SGF for FY 2018. KDHE states the cost would lag one year to allow the costs to be incorporated into the rates paid to the MCOs. Third, KDHE estimates oversight of the new independent review process would require 7.0 FTE positions at a cost of $420,000, including $210,000 from the SGF, per year. Fourth, as stated in the previous fiscal note, KDHE states no savings would be realized if the MCO administration costs were capped at 10.0 percent because the current MCO

contracts include rates that equate to a 7.0 percent MCO administration rate. Any fiscal effect associated with the bill is not reflected in *The FY 2018 Governor's Budget Report*. An updated fiscal note was not immediately available to reflect the Senate Committee of the Whole amendments to the bill.