

Date: 1/31/2017

Subject: Testimony on Senate Bill 69

Submitted By: Mike Randol, Kansas Department of Health and Environment – Director of the Division of Health Care Finance – State Medicaid Director

**Bill Description:** KDHE appreciates the opportunity to give testimony on SB 69. This act concerns the Kansas program of medical assistance; process and contract requirements; claims appeals.

**Agency/Program Impact:**

Section 1

Page 1 – Line 8. MCO’s provide the encounter data to KDHE – The state has a process in place for Providers/other entities to request data through an external data request form. Concerns regarding HIPAA violations - The encounter data is based on the provider’s claims submission so in essence they are receiving the same data that they submitted. Also, providers are only entitled to their individual member’s data.

Page 1 – Line 18. Provider quarterly education for participating healthcare providers. Is it the intention of this bill to require quarterly training for all providers? There are more than 20,000 Medicaid providers. This would not be realistic for the MCO’s to conduct such training. We are, however, as a result of the amended contract, providing targeted training to specific provider types on a quarterly basis.

Page 1 – Line 22. Current contract requires all providers, in network, to be reimbursed at minimum the FFS amount. This language would only require hospitals to be reimbursed at the 100% FFS amount. The inability to adjust on post-care determinations prevents review of appropriate billing and service, a fundamental managed care and program integrity pillar. State policy requires payment reduction of ER claims based on a set of diagnosis code restrictions. Basically, if the diagnosis code was not an emergency, hospitals are not reimbursed an emergency room fee amount. It is already a federal requirement for MCO’s to pay for emergency stabilization, regardless of network participation status. Additionally, a couple of the MCO’s have provider contracts in which they have negotiated ER case rates which could present challenges related to this requirement.

Page 1 – Line 31. Providers are only entitled to their members’ data. The state currently has a process in place to provide requested data to providers and other entities.

Page 2 – Line 6. This is currently in process through a workgroup with KDHE and the Kansas Hospital Association. Additionally, further standardization will occur with the implementation of the new KMMS Provider Enrollment Portal. Phase 1 to be implemented October 2017 and Phase 2 in early 2019.

Page 2 – Line 9. All MCO’s currently use CMS CARC/RARC codes on remittance advices as a form of standardization. Standardization for explanation codes would prove to be problematic as each MCO utilizes a different claims system.

Page 2 – Line 17. The state’s current contract with the MCO’s requires resolution of grievance and/or appeal within 30 days of receipt. This bill would allow 90 days from date of receipt for a grievance and 45 days for an appeal. The state determined that a standardized timeline for both would be more appropriate. If the MCO’s fail to meet these standards less than 98% of the time, the contract allows for liquidated damages to be assessed.

Page 2 – Line 27. The bill is unclear on who would determine the definition of administrative expenses. And what would actually define administrative expense.

Page 2 – Line 29. The state does not have a contracted profit with the MCO’s. Also, it is unclear on the bill’s definition of profit.

Page 2 – Line 32. The bill is unclear on the definition of “necessary” and who would make the determination of “necessary.”

Page 2 – Line 34. The Capitated rates paid to MCO’s must be actuarially sound as developed by the state’s actuary. Administration expenses are a component of these rates and cannot be capped. If the actuary determines that to meet actuarial soundness the administrative rates must be 11% - then the MCO would be paid the 11%.

## Section 2

Page 3 - Line 4. This particular letter production requirement exists in the current contract with the MCO’s. These are also supported by the Code of Federal Regulations.

Page 3 – Line 13 The bill states, “A provider who has been denied a healthcare service to a recipient of medical assistance **OR** a claim for reimbursement . . .” If the first part of that sentence means that a provider submitted an authorization request to the MCO on behalf of a member and it was denied, that’s a denial to the member through their provider representative. Kansas has not provided members with the External Review option as it is not consistent with the managed care regulations. A denial of authorization does not provide an “injury” to the provider. It only provides an “injury” to the member. For the second half of the sentence, if the provider is denied their claim for reimbursement, that’s a denial to the provider and it does provide an “injury” to the provider. That will not fall under the federal managed care rules, but would be governed by our contract language and potentially State regulations.

This portion of the bill would be of a significant financial impact to the state of Kansas. For CY 15, approximately 2.8 million of the more than 17 million claims were denied. If we assume a modest 2.5% of these final disputable claims were to be appealed – the cost would be more than \$40 million dollars.

Page 3 – Line 21 Participation agreements already provide for arbitration should a provider not agree with the MCOs decision on payment. A two-step appeal process was previously rejected by CMS – and this process may appear to be similar. This review would further extend the member’s and provider’s timeline for resolution.

Page 3 – Line 39. This apparently allows the provider representative to request the External Review on behalf of the member. The managed care regulations in effect now doesn’t include that option.

Page 3 – Line 41. The bill states the provider shall automatically prevail (on behalf of the member). If this means that the provider representative prevails on behalf of the member and the authorization is automatically granted, there is no federal managed care regulatory language that supports that. If the request for review involves a denied claim, this would not be included in the federal managed care regulatory language, but could be written into our contract if this bill is signed.