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Shawn Sullivan, Director of the Budget

Sam Brownback, Governor

February 1, 2017

The Honorable Daniel Hawkins, Chairperson
House Committee on Health and Human Services
Statehouse, Room 521-E
Topeka, Kansas 66612

Dear Representative Hawkins:

SUBJECT: Fiscal Note for HB 2169 by House Committee on Health and Human Services

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2169 is respectfully submitted to your committee.

HB 2169 would amend current law regarding the Kansas Program of Medical Assistance including process and contract requirements and procedures for claims appeals as administered by the Kansas Department of Health and Environment (KDHE). Any managed care organization (MCO) providing Medicaid services would be required to:

1. Provide accurate and uniform patient encounter data to a participating healthcare provider that would include the MCO claim number, patient Medicaid identification number, patient name and type of claim; the amount billed by revenue code; MCO amount paid and date paid; and the provider patient account number.

2. Provide quarterly education for participating healthcare providers regarding billing and reimbursement guidelines and program policies and procedures.

3. Reimburse, at no less than the medical assistance program fee-for-service rate, all services provided by any hospital to initially screen, treat and stabilize any individual covered by the Kansas Program of Medical Assistance who comes to a hospital 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 the individual required emergency services.

4. Upon receiving a request for patient encounter data, a MCO would be required to furnish to the participating healthcare provider all requested information within 30 calendar days of receiving the request. The MCO would be allowed to charge a reasonable fee for furnishing the requested data.

The Secretary of KDHE would develop uniform standards for all MCOs; uniform processes and forms for credentialing healthcare providers; requirements that documentation be provided by MCOs to healthcare providers when a claim or portion of a claim is denied; procedures, requirements and limitations for prior authorization for healthcare services and prescriptions; internal claims grievance and appeal processes and timelines for resolving a grievance within 90 days.

Any contract or agreement between the Kansas Program of Medical Assistance and a MCO that provides services on or after July 1, 2017 would establish a definition of and cap on administrative spending so that administrative spending does not include any profit greater than the contracted amount. Administrative spending could not include contractor incentives and would not exceed 10.0 percent of the MCOs total expenditures to provide Medicaid services. Each MCO would report on expenditures quarterly to the Secretary of KDHE.

Any MCO providing Medicaid services through a contract with the Kansas Program of Medical Assistance would be required to include a statement detailing its appeal process to participating healthcare providers, and that statement must include that the provider is entitled to an external independent third-party review. Any MCO would pay a penalty not to exceed $1,000 for any non-compliance with appeal process requirements. Any aggrieved provider must submit a written request appealing the final decision by a MCO within 60 calendar days of receiving the MCOs final decision. The bill includes specific information required to be included in the independent third-party review request, including the specific issues and disputes related to the adverse final decision issued by the MCO. The MCO must acknowledge the provider has requested an external independent third-party review and must notify the recipient of medical assistance that the provider has requested a review if it is related to the denial of a healthcare service. If the MCO fails to satisfy the above requirements, the provider would automatically prevail in the review.

An external independent third-party review would not be granted regarding a claim for which the recipient of medical assistance or the provider has already requested a hearing before the Office of Administrative Hearings of the Department of Administration. If a recipient or a provider requests an administrative hearing for which the provider had already requested an external third party review, the third-party review would be held in abeyance until the appeal has been fully adjudicated by the Office of Administrative Hearings.

An external independent third-party reviewer would conduct the review of any claim, and within 30 calendar days from receiving the request for review, issue the final decision to the provider, the MCO and KDHE. A party could appeal a final decision of the external independent third-party review process to the Office of Administrative Hearings of the Department of Administration. The bill would require KDHE to adopt rules and regulations to implement the bill's provisions by January 1, 2018.

Estimated State Fiscal Effect				
	FY 2018 SGF	FY 2018 All Funds	FY 2019 SGF	FY 2019 All Funds
Revenue	--	--	--	--
Expenditure	$23,505,496	$47,010,991	$24,119,120	$48,238,239
FTE Pos.	--	--	--	--

The KDHE Division of Health Care Finance indicates that the passage of HB 2169 would include three potential fiscal effects for Medicaid expenditures. First, hiring and retaining an auditor for independent review of MCO-closed provider disputes currently costs $150 per hour due to the need for clinical and Medicaid knowledge. While 1.4 percent of closed disputes get appealed through the current appeals/grievance process, the Division estimates that at least 2.5 percent of these claims will be appealed through a process that starts with the MCO. The Division estimates that this provision of the bill would increase expenditures by over $40.0 million per year. Second, the provision that pays emergency room (ER) rates for non-ER services at ERs is estimated to add approximately $6.4 million per year. Third, the current capitation rates have a component for administration and care coordination that equates to 7.0 percent of expenditures. There would be no savings realized if this cap is legally capped at 10.0 percent. Any fiscal effect associated with HB 2169 is not reflected in *The FY 2018 Governor's Budget Report.*

Sincerely,

Shawn Sullivan,
Director of the Budget

cc: Dan Thimmesch, Health & Environment
Cody Gwaltney, Aging & Disability Services
Jackie Aubert, Children & Families