Kansas Program of Medical Assistance—Medicaid (KanCare) Process and Contract Requirements; Senate Sub. for HB 2026

Senate Sub. for HB 2026 changes the Kansas Program of Medical Assistance (KMAP) by amending law and creating in law processes for managed care organizations (MCOs) providing Medicaid services by providing for the services of an independent auditor, and by creating an external independent third-party review process (external review).

Kansas Department of Health and Environment (KDHE) Processes

The bill requires the Secretary of Health and Environment (Secretary) to provide accurate and uniform patient encounter data to participating health care providers upon request within 60 calendar days, including, but not limited to, the amount billed by revenue code and procedure code. The bill authorizes KDHE to charge a reasonable fee for furnishing the data.

Managed Care Organization Processes

Education

The bill requires the Secretary to compel the MCOs to provide quarterly in-person education for participating health care providers regarding billing guidelines, reimbursement requirements, and program policies and procedures utilizing a format approved by the Secretary and incorporating information collected through semi-annual surveys of participating health care providers.

Each MCO is required to offer quarterly in-person training on remark codes and Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard denial reasons and any other denial reasons or remark codes specific to the MCO.

Documentation

The bill requires the Secretary to compel any MCO providing state Medicaid or Children's Health Insurance Program (CHIP) services under the KMAP to provide documentation to a health care provider when the MCO denies any portion of any claim for reimbursement submitted by the provider, including a specific explanation of the reasons for denial and utilization of remark codes, remittance advice, and HIPAA standard denial reasons.

Standards

The bill requires the Secretary to develop the following uniform standards to be utilized by the MCOs:

- A standardized enrollment form and a uniform process for credentialing and re-credentialing health care providers who have signed contracts or participation agreements with any MCO;

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

- Retrospective utilization review of readmissions that complies with applicable federal statutory or regulatory requirements for the Medicaid program or CHIP, prohibiting such reviews for any individual covered by KMAP who is readmitted with a medical condition as an inpatient to a hospital more than 15 days after the patient's discharge;

- A grievance, appeal, and state fair hearing process that complies with applicable federal and state statutory procedure requirements, including any statutory remedies for timely resolution of grievances, appeals, and state fair hearings, imposed upon MCOs providing state Medicaid and CHIP services; and

- Requirements that each MCO, within 60 calendar days of receiving an appeal request, provide notice and resolve 100 percent of provider appeals, subject to remedies, including, but not limited to, liquidated damages if provider appeals are not resolved within the required time.

Independent Auditor

The Secretary is required to procure the services of an independent auditor to review, at least once per calendar year, a random sample of all claims paid and denied by each MCO and the MCO's subcontractors. Each MCO and its subcontractors are required to pay any claim the independent auditor determines to be incorrectly denied. The bill provides each MCO and its subcontractors may be required to pay liquidated damages, as determined by KDHE. Each MCO and its subcontractors are required to pay the cost of audits conducted under the provisions for an independent auditor.

The independent auditor provisions in the bill expire on January 1, 2020.

Payment to Nursing Facilities with a Change in Ownership

Under the bill, the Secretary requires each MCO to pay 100 percent of the State's established *per diem* rate to nursing facilities for current Medicaid-enrolled residents during any re-credentialing process caused by a change in ownership of the nursing facility.

Licensed Pharmacy or Pharmacist

On and after July 1, 2017, a MCO providing state Medicaid or CHIP services under the KMAP is 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 KMAP and to accept reasonable contract terms offered by the MCO.

Rules and Regulations

Additionally, the Secretary is required to adopt rules and regulations as necessary to implement the requirements regarding data production and training, standardization, the provision of an independent auditor, payment to nursing facilities with a change in ownership, and non-discrimination against a licensed pharmacy or pharmacist, prior to January 1, 2018.

External Independent Third-party Review Process

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

Managed Care Organizations Notification Requirements

Any letter from a MCO to a participating health care provider reflecting a final decision of the MCO's internal appeal process is 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 are 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

On and after January 1, 2020, a provider who has been denied a health care service to a recipient of medical assistance or a claim for reimbursement to the provider for a health care service rendered and who has exhausted the MCO internal written appeals process is entitled to an external review of the MCO's final decision.

Request for External Review

To request an external review, an aggrieved provider is 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 is 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 is required to:

- Confirm with the provider, in writing, receipt of the request;

- Notify KDHE of the request; and

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

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

Within 15 days of receiving a request, the MCO is 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 automatically prevails in the review.

Review by Office of Administrative Hearings

The bill requires 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) is 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 are granted an additional 30 days from receipt of the review decision and notice of action to request a hearing before the OAH.

The bill requires 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 are also 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 is 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 is 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 request for an external review.

Multiple Appeals

The bill allows 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 to be determined in one action upon request. The bill allows 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 is allowed to review only the documentation submitted by the provider in the course of the MCO's internal appeal process. The reviewer is 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 is 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 is required to notify the impacted recipient of the medical assistance and the participating health care provider of the final decision, if related to the denial of the health care service.

A party is 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 directs the losing party of the review to pay an amount equal to the costs of the review to the reviewer. Any payment ordered is 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 is required to pay the costs of the review to the reviewer within 45 calendar days of entry of the final order.

Rules and Regulations

KDHE is required to adopt rules and regulations to implement the provisions of the external review process prior to January 1, 2020.