To: House Health and Human Services Committee

From: Chad Austin
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Re: House Bill 2169

Over the course of the past four years, the Kansas Hospital Association KanCare Technical Advisory Group (TAG) has held meetings with the three KanCare managed care organizations (MCOs) and staff from the Kansas Department of Health and Environment (KDHE) to review, discuss and provide input on implementation issues with the KanCare program. Over that period of time, some progress has been made to resolve the concerns associated with the transition to a fully Medicaid managed care program. However, hospital providers remain concerned about the administrative burdens of KanCare, the time needed to properly adjudicate correct claims payments, lack of standardization among the three managed care organizations (MCOs) and the length of time needed to implement policy changes.

In 2015, the Kansas Department of Health and Environment reached out to the TAG to solicit input and recommendations to the Agency's contracts with the MCOs. In July of 2015, the TAG provided a number of recommendations to KDHE that would help to relieve the inconsistencies in the program and to reduce the burdens to provide care. In April of 2016, KDHE provided a response to the TAG's recommendations indicating that the Agency would incorporate recommendations gathered from stakeholders to make appropriate changes to their contracts with the MCOs, however, detailed information regarding any changes the State's contracts with the MCOs was never provided to the TAG. KHA supports House Bill 2169, as it will promote the needed relief of administrative burdens as well as ensure certain payment protections for the providers of KanCare. We have asked Bob Finuf, Vice President, Children's Mercy Kansas City and Executive Director of Children's Mercy Integrated Care Solutions and a member of KHA's KanCare TAG, to provide some additional insight regarding the on-going issues and concerns that this bill will address.

Payment Integrity and Protections

KanCare providers continue to struggle with appropriate claims payment for services provided to the Medicaid patients. This bill directs KDHE to:

- Require reimbursement at no less than the Kansas Medical Assistance Program fee-for-service rate for the initial screening, treatment and stabilization of patients in the emergency department without regard to the hospital's contracting status, and without reduction in payment from emergent to non-emergent status.

  Hospitals have a highly complex metric that is used to determine the level of emergency room service provided to each patient, which includes acuity, resources used, length of time to treat the patient, etc. The practice of "down coding" or changing the level of service provided in the emergency room is a practice that is not done by any other payer of health care services other than KanCare. The State's policy for "Always, Sometimes and Never" coverage of emergency room services has long been the State's policy for determining payment of services rendered in the emergency room. Visits with a diagnosis code that is listed as "Always" should pay at the emergent rate assigned by the hospital. However, visits with a diagnosis code that is listed as "Sometimes" may require hospital records to determine whether the service is considered emergent. Visits with diagnosis codes of "Never" are down coded to non-emergent. The State's policy for "Always, Sometimes and Never" is an outdated method for determining coverage of emergency room services, especially in light of the very low reimbursement offered by KanCare, as shown below:

ED CPT Code for Hospital (Physician is Separate)	KMAP Fee Schedule	Medicare
99281 Self-limited, minor (non-emergent)	$ 16.58	$ 61.34
99282 Low to moderate	$ 25.56	$111.42
99283 Moderate severity	$ 47.29	$201.17
99284 High severity	$ 73.29	$332.27
99285 High severity, threat to life	$113.99	$488.53

- Provide quarterly education for participating healthcare providers regarding basic Kansas Medical Assistance Program (KMAP) billing guidelines as well as policies and procedures. KDHE must be present at the meetings to provide oversight and to ensure consistent interpretation and implementation of the billing guidelines, policies and procedures. This education would be considered "all MCO" training on the basic KMAP program, and would not diminish the requirements for MCO-specific training.

Standardization

The transition to a fully Medicaid managed care program brought a number of administrative burdens to hospitals due to lack of standardization of basic elements of providing health care. House Bill 2169 will bring about efficiencies and reduce the costs of providing care to the Medicaid patients in the following ways:

- Develop a uniform process and to standardize the requirements for credentialing of healthcare providers, thus eliminating the need to repeat the process multiple times for the same provider. KDHE has created a Credentialing Work Group to provide input from provider groups as well as to guide the Agency in the development of their electronic portal. With the

help of the Work Group, a standardized Disclosure of Ownership was developed, however, other processes and forms are still not standardized.

- Standardization of denial reasons and remark codes which are consistent with HIPAA requirements. This will also ensure the MCOs can report meaningful data metrics regarding the number of claims denials, reasons for denials, etc.
- Standardization of requirements and timelines for prior authorization of healthcare services, as well as a reduction in the number of prior authorization requirements for basic medical services and treatment.
- Development of the standardization of the claims appeal processes and timelines to protect the provider's rights to appropriate payment. The legislation also adds an external independent thirty-party review, at the provider's discretion, and that would be available prior to the State Fair Hearing process.

Data Transparency

KDHE must require and the MCOs must supply encounter data in a consistent manner within reasonable timelines to ensure proper accounting of Medicaid expenditures.

- KDHE must require consistent claims encounter data to be able to provide information for hospitals required for completing the Medicaid Disproportionate Share Hospital (DSH) survey. The legislation outlines specific data elements that must be included in the encounter data to reconcile KDHE's data with the hospital's data.
- Requests for encounter data must be furnished to participating healthcare providers within 30 calendar days.

Fiscal Note

The fiscal note provided for House Bill 2169 for fiscal year 2018 is $23.5 million in state general funds and $47 million all fund. We would like to provide some further comments on the fiscal note.

1) Hiring and retaining an auditor for independent review provider disputes would increase expenditures by over $40 million per year. Hospitals provide care to the KanCare beneficiaries at well below their costs to provide the services, ordered and monitored by a group of highly trained medical staff and using high-cost equipment to diagnose and treat patients. Each of the MCOs have implemented a number of reviews on inpatient claims (claims that reach certain dollar thresholds; claims for patients that are readmitted within 30 days; and for validation of the inpatient DRG assigned) requiring hospitals to appeal more claims. Because of the time and dollar resources required, providers only appeal claims for which they believe they should be reimbursed. Fair and equitable reimbursement without increased costs to justify medical decisions is paramount to continued participation in the KanCare program. The $40 million fiscal impact for an independent review might suggest that claims are being aggressively denied. If structured properly, KHA would be supportive of a "loser pay" approach, which would eliminate the projected $40 million fiscal impact.

2) Paying for emergency room rates for non-ER services is estimated to add approximately $6.4 million per year. As referenced by the chart on page 2, there is only $8.98 difference between 99281, the non-emergent rate, and 99282, the lowest level emergent rate for the

use of an emergency room. The $6.4 million fiscal impact seems to indicate a high number of emergency room claims are being down coded from emergent to non-emergent. Hospitals are required to provide a medical screening exam to all patients that report to the emergency department. The non-emergent rate of $16.58 is not sufficient enough to cover even costs to register the patient and develop a medical record let alone provide screening, testing, and basic overhead costs to diagnose the patient's condition in an unscheduled setting.

The Kansas Hospital Association appreciates the opportunity provide testimony in support of House Bill 2169. We strongly urge the committee to take action and favorably adopt House Bill 2169. We would be happy to stand for any questions.