February 6, 2017

Senator Vicki Schmidt
Chair of Senate Public Health and Welfare Committee
State Capitol, Room 441-E
Topeka, KS 66612

Dear Senator Schmidt and Committee Members:

This letter is to provide comments to the February 2 testimony provided by Mike Randol, Director of the Division of Health Care Finance, regarding Senate Bill 69. In addition, there are some comments concerning the fiscal note presented to the Committee by Shawn Sullivan, Director of the Budget.

The Kansas Hospital Association formed the KanCare Technical Advisory Group (TAG) at the end of 2012, when the Kansas Department of Health and Environment (KDHE) was finalizing the State's plan to transition the Medicaid program to a fully managed care program. The TAG is comprised of 12 or more representatives from KHA's member hospitals with a wide range of hospital expertise in the areas of credentialing, billing, reimbursement and other vital healthcare operations. The TAG members also include multiple representatives from each of the KanCare managed care organizations (MCOs) and staff from KDHE.

Over the course of the past four years, the TAG has held 20 regular meetings as well as a number of other ad hoc meetings to address issue-specific concerns. During the very first meeting of the TAG on March 6, 2013, the TAG identified the following top priorities: a) Standardization of credentialing, pre-authorization requirements, and billing guidelines; b) Provider education of basic Kansas Medical Assistance Program (KMAP) policy and program requirements; c) Appropriate reimbursement for services rendered.

The hospital representatives of the TAG have remained very diligent in their pursuit of the top priorities identified in 2013, and have added a number of other issues to the list of priorities. Some of the accomplishments of the TAG include:

- Developed a KanCare Prior Authorization Guide for Hospital Services. This document is an 11-page summary of the prior authorization requirements for the primary hospital services (see attached document). This document was developed by an ad hoc group of member hospitals with specific expertise in the admissions areas of hospitals and has been modified several times over the past four years. While this Guide helps to summarize the prior authorization requirements, it is still too complicated and very staff intensive to monitor and implement.

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Attachment____________________

- Identified and discussed billing and reimbursement issues inherent to the transition of a new Medicaid program.
- Worked with KDHE to develop the KanCare Issues Log, which tracks identified claims processing issues by each of the MCOs and the status of the resolution of the issue. This Log is maintained by KDHE and is available on their Website.
- Developed educational programs and updates for KHA-sponsored Webinars on KanCare issued for hospitals, such as inpatient reviews, KMAP fee schedules, calculation of updated inpatient DRG rates and critical access hospital (CAH) rates.
- Monitored and trended KanCare accounts receivable over 90 days to identify payment trends and potential claims processing issues specific to hospitals and/or the MCOs.
- Provided input and recommendations for KMAP Policy changes.
- Advocated for general education on basic KMAP billing requirements and assisted in the development of the "All MCO" training program offered in 2016.

While progress has been slow, this TAG has remained committed and has allowed a more collaborative effort between hospital providers, the MCOs and KDHE to effect the changes needed to relieve the administrative burden placed on hospitals and other providers as a result of the transition to KanCare.

Comments Regarding Testimony Provided by Mike Randol

Section 1

- Page 1 – Line 8. MCOs provide the encounter data to KDHE.
  As Mike Randol indicated, the state does have a process in place for providers and other entities to request data through an external data request form. However, the data requests have at times become backlogged, causing an extreme delay in receiving the requested information. In addition, the data is frequently flawed and includes data that was not billed by the provider, contains duplicate entries or has missing data, and with inaccurate payment information. The primary reason that hospital providers request data from KDHE is in an attempt to validate or reconcile data that hospitals receive from KDHE in their applications for Medicaid Disproportionate Share Hospital (DSH) payments, to ensure proper payment for claims that must be re-processed due to KDHE's errors in rate setting, or to verify claims processing issues by the MCOs.

  KDHE annually updates/re-calibrates the inpatient DRG rates for hospitals as well as the CAH cost adjustment factors (CAFs) with a budget neutral process. An ad hoc group of the TAG challenged the inpatient DRG rates for 2015 and ultimately KDHE required the MCOs to re-process all of the inpatient claims impacted. The TAG requested that KDHE allow an ad hoc group review the preliminary rates for 2016 prior to publication, and an error was again found in the rate setting process by the state's actuary. The TAG has also identified discrepancies in the annual rate setting process for the CAH Cost Adjustment Factors, an add-on rate established in lieu of the cost settlement prior to KanCare.

  Hospitals have become skeptical of any data received from KDHE and has caused questions regarding the Agency's ability to accurately reflect spending in the KanCare program.

- Page 1 – Line 18. Provide quarterly education for participating healthcare providers.
  The KanCare TAG has continually stressed the importance of periodic provider education on basic KMAP billing, reimbursement, and policies, which is the basis for the KanCare program. Over the past four years, each of the MCOs have provided periodic education specific to their individual plan, however, the cost to send staff to three separate sessions to review three separate training platforms has been not only cost prohibitive, but also draining on staff resources. It was not until 2016, and with constant urging from the TAG as well as guidance on training topics, that basic "All MCO" education was provided. This "All MCO" education provided training on KMAP policy along with additional information to explain where the MCOs may differ from or expand upon the KMAP policy. Prior to KanCare, periodic education was provided by HP Enterprise, the state's contractor for the Medicaid Management Information Systems, to help Medicaid providers navigate the complexities of the program. This "All MCO" education was provided by the MCOs and fulfilled the basic KMAP education that has been sorely missed since the transition to KanCare. KDHE staff did not provide any comments or education at either of the training sessions held in 2016, and to our knowledge, no KDHE staff was present.

- Page 1 – Line 22. Reimbursement for emergency room services.
  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

Mike Randol also indicated that "a couple of MCOs have provider contracts in which they have negotiated ER case rates which could present challenges related to this requirement." I think further explanation must be provided how any such negotiated case rate for some hospitals would impact changing emergency room services for the majority of hospitals.

- Page 2 – Line 6. Uniform process for credentialing.
  As mentioned in the first part of this communication, the TAG identified standardization of the credentialing process as a high priority during their first meeting in 2013. Since that time, standardization of credentialing has been on every agenda of the TAG. It was only in 2015 that KDHE formally began meeting with KHA, the Kansas Medical Society and other provider groups to discuss standardization. Mike Randol indicated that Phase 1 of the process will be implemented in October of 2017, which is the last quarter of the current KanCare Waiver. There is a significant amount of work involving considerable input from various provider types and within established credentialing standards that must be done to meet this timeline to ensure a successful rollout of an overdue process.

- Page 2 – Line 9. Claims denial reasons.
  The MCOs may be using Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs), however, there is no consistent application of what constitutes a denial of service versus an adjustment or contractual write off. For example, one MCO may apply a denial reason code to a charge that is considered to be "content of service", while another MCO may apply an adjustment or contractual write off to that same charge. This inconsistency in application of CARC/RARC creates remittance advice posting challenges at the hospital level as well as a potential for inconsistent reporting to KDHE by the MCOs.

- Page 2 -- Line 17. Internal claims grievance and appeal processes.
  Lack of standardization of the appeals process in the KanCare program has been a concern for providers since the program began. Just recently, the State required all of the MCOs to have a reconsideration period that allowed communication from the provider to the MCO to review the claim denial to provide additional information and/or discussion of the claim submitted. If there was no resolution made during the reconsideration period, the provider then had to follow the appeals process of the individual MCO. Once the MCO appeal process was exhausted, the provider could take the denied claim to the State Fair Hearing process. Some of our larger hospitals have reported having 40 or more claims held up at the State Fair Hearing process, and have expressed concern about the costs involved to appeal through that process. Having a standardized appeals process with clear guidelines and parameters will protect the provider's right to ensure appropriate payment for services provided to the KanCare beneficiary. If structured properly, adding the option for an external independent third-party review of the MCO's final decision (as outlined on Page 3, Line 18) will allow additional protections without the increased administrative cost for the provider and the Agency outside of the State Fair Hearing process.

Comments Regarding Fiscal Note for Senate Bill 69

The KDHE Division of Health Care Finance indicates that the passage of Senate Bill 69 would include three potential fiscal effects for Medicaid expenditures. We would challenge two of these:

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 3, there is only $8.98 difference between 99281, the non-emergent rate, and 99282, the lowest level emergent rate. The $6.4 million fiscal impact seems to indicate a high number of emergency room claims 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.

Over the course of the past four years, the KanCare program has been wrought with inefficiencies, delayed implementation timelines and costs that have exceeded budgets to implement a number of initiatives that are vital to KanCare. These initiatives include the Kansas Eligibility Enforcement System, the front-end billing platform and Medicaid Presumptive Eligibility. The fiscal impact of these inefficiencies are troublesome.

If you should have any questions concerning this information, please contact either Chad Austin or Tish Hollingsworth at KHA at 785-233-7436.

Sincerely,

Chad Austin
Senior Vice President of Government Relations