{As Amended by Senate Committee of the Whole}

Session of 2017

Substitute for SENATE BILL No. 69

By Committee on Public Health and Welfare

2-21

AN ACT concerning the Kansas program of medical assistance; process and contract requirements; claims appeals.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) The secretary of health and environment shall require that any managed care organization providing state medicaid services pursuant to a contract with the Kansas program of medical assistance:

(1) Provide accurate and uniform patient encounter data to a participating healthcare provider, or as directed by such provider, upon request, to include at a minimum the:

(A) Managed care organization claim number;

(B) patient medicaid identification number;

(C) patient name;

(D) type of claim;

(E) amount billed by revenue code;

(F) managed care organization paid amount and paid date; and

(G) ~~provider~~*{ hospital}* patient account number; and

(2) provide quarterly education for participating healthcare providers regarding billing guidelines, reimbursement requirements and program policies and procedures on a regularly scheduled basis utilizing a format approved by the secretary.

(b) Upon receiving a request for patient encounter data pursuant to subsection (a)(1), a managed care organization shall furnish to the participating healthcare provider all requested information within 30 calendar days after receiving the request for data. The managed care organization may charge a reasonable fee for furnishing requested data, including only the cost of any computer services, including staff time required.

(c) The secretary shall develop standards to be utilized uniformly by each managed care organization providing state medicaid services pursuant to a contract with the Kansas program of medical assistance regarding:

(1) A uniform process and forms for credentialing and re-credentialing healthcare providers who have signed contracts or participation agreements with any such managed care organization;

(2) documentation to be provided to a healthcare provider by all

managed care organizations when such managed care organization denies any portion of a claim for reimbursement submitted by such provider, to include a specific explanation of the reason for denial, that may not be subsequently changed by the managed care organization, and utilization of ***{HIPAA}*** standard denial reason codes and remark codes;

(3) procedures, requirements and ~~limitations for~~ ***{periodic review and reporting of reductions in}*** prior authorization for healthcare services and prescriptions;

(4) internal claims grievance and appeal processes and timelines for resolving a grievance, not to exceed 90 calendar days from the date such grievance is filed, and for resolving an appeal, not to exceed 45 calendar days from the date such appeal is filed. Such processes and timelines shall provide that, if the managed care organization exceeds the time limit for resolving a grievance or appeal, then the participating healthcare provider shall automatically prevail in the grievance or appeal; and

(5) retrospective utilization review of re-admissions, prohibiting such reviews for any recipient of medical assistance who is readmitted ***{with a medical condition}*** as an inpatient ~~or for observation~~ to a hospital more than ~~72 hours~~ ***{15 days}*** after the recipient patient's discharge.

(d) Any contract or agreement between the Kansas program of medical assistance and a managed care organization to provide state medicaid services commencing on or after July 1, 2017, shall establish a definition of and cap on administrative spending such that:

(1) Administrative spending does not include any profit greater than the contracted amount;

(2) administrative spending does not include contractor incentives;

(3) any administrative spending is necessary to improve the health status of the population to be served pursuant to the contract; and

(4) administrative spending shall not exceed 10% of the managed care organization's total expenditures to provide state medicaid services pursuant to the contract. The managed care organization shall report quarterly to the secretary of health and environment such spending and percentage.

(e) The secretary shall adopt rules and regulations as may be necessary to implement the provisions of this section prior to January 1, 2018.

Sec. 2. (a) (1) Any managed care organization providing state medicaid services pursuant to a contract with the Kansas program of medical assistance shall include in any letter to a participating healthcare provider reflecting a final decision of the managed care organization's internal appeal process:

(A) A statement that the provider's internal appeal rights within the managed care organization have been exhausted;

(B) a statement that the provider is entitled to an external independent third-party review pursuant to this section; and

(C) the requirements to request an external independent third-party review.

(2) For each instance that a letter does not comply with the requirements of paragraph (1), the managed care organization shall pay to the participating healthcare provider a penalty not to exceed $1,000.

(b) (1) A provider who has been denied a healthcare service to a recipient of medical assistance or a claim for reimbursement to the provider for a healthcare service rendered to a recipient of medical assistance and who has exhausted the internal written appeals process of a managed care organization providing state medicaid services pursuant to a contract with the Kansas program of medical assistance shall be entitled to an external independent third-party review of the managed care organization's final decision.

(2) To request an external independent third-party review of a final decision by a managed care organization, an aggrieved provider shall submit a written request for such review to the managed care organization within 60 calendar days of receiving the managed care organization's final decision resulting from the managed care organization's internal review process. A provider's request for such review shall:

(A) Identify each specific issue and dispute directly related to the adverse final decision issued by the managed care organization;

(B) state the basis upon which the provider believes the managed care organization's decision to be erroneous; and

(C) provide the provider's designated contact information, including name, mailing address, phone number, fax number and email address.

(3) Within five business days of receiving a provider's request for review pursuant to this section, the managed care organization shall:

(A) Confirm to the provider's designated contact, in writing, that the managed care organization has received the request for review;

(B) notify the department of health and environment of the provider's request for review; and

(C) notify the recipient of medical assistance of the provider's request for review, if related to the denial of a healthcare service.

If the managed care organization fails to satisfy the requirements of this paragraph, then the provider shall automatically prevail in the review.

(4) Within 15 business days of receiving a provider's request for external independent third-party review, the managed care organization shall:

(A) Submit to the department of health and environment all documentation submitted by the provider in the course of the managed care organization's internal appeal process; and

(B) provide the managed care organization's designated contact information, including name, mailing address, phone number, fax number and email address.

If the managed care organization fails to satisfy the requirements of this paragraph, then the provider shall automatically prevail in the review.

(6) (A) An external independent third-party review shall automatically extend the deadline to request a hearing before the office of administrative hearings of the department of administration pending the outcome of the external independent third-party review. Upon conclusion of the external independent third-party review, the reviewer shall forward a copy of the decision and a new notice of action to the provider, recipient, applicable managed care organization, department of health and environment and Kansas department for aging and disability services. When a deadline to request a hearing before the office of administrative hearings has been extended pending the outcome of an external independent third-party review, all parties shall be granted an additional 30 days from receipt of the review decision and notice of action to request a hearing before the office of administrative hearings.

(B) If a recipient of medical assistance or participating healthcare provider files a request for a hearing before the office of administrative hearings regarding a claim for which the provider has filed a request for external independent third-party review, then the department of health and environment and the Kansas department for aging and disability services shall immediately request a continuance from the office of administrative hearings. The department of health and environment and the Kansas department for aging and disability services shall forward the decision of the review to the office of administrative hearings for consideration by the hearing officer together with any other facts of the case.

(7) Upon receiving notification of a request for external independent third-party review, the department of health and environment shall:

(A) Assign the review to an external independent third-party reviewer;

(B) notify the managed care organization of the identity of the external independent third-party reviewer; and

(C) notify the provider's designated contact of the identity of the external independent third-party reviewer.

(8) The department shall deny a request for external independent third-party review if the requesting provider fails to:

(A) Exhaust the managed care organization's internal appeal process; or

(B) submit a timely request for an external independent third-party review pursuant to this section.

(c) (1) Multiple appeals to the external independent third-party

review process regarding the same recipient of medical assistance, a common question of fact or interpretation of common applicable regulations or reimbursement requirements may be determined in one action upon request of a party in accordance with rules and regulations adopted by the department of health and environment. The provider that initiated a request for an external independent third-party review process, or one or more other providers, may add other initial denials of claims to such review prior to final decision and after exhaustion of any applicable written internal appeals process of the applicable managed care organization if the claims involve a common question of fact or interpretation of common applicable regulations or reimbursement requirements.

(2) Documentation reviewed by the external independent third-party reviewer shall be limited to documentation submitted pursuant to subsection (b)(4)(A).

(3) An external independent third-party reviewer shall:

(A) Conduct an external independent third-party review of any claim submitted to the reviewer pursuant to this section; and

(B) within 30 calendar days from receiving the request for review from the department and the documentation submitted pursuant to subsection (b)(4)(A), issue the reviewer's final decision to the provider's designated contact, the managed care organization's designated contact and the department. The reviewer may extend the time to issue a final decision by 14 calendar days upon agreement of both parties to the review.

(d) Within 10 business days of receiving a final decision of an external independent third-party review, the managed care organization shall notify the impacted recipient of medical assistance and the participating healthcare provider of the final decision, if related to the denial of a healthcare service.

(e) A party, including the recipient of medical assistance or the participating healthcare provider, may appeal a final decision of the external independent third-party review process to the office of administrative hearings of the department of administration in accordance with the Kansas administrative procedure act within 30 calendar days from receiving the final decision of the external independent third-party review. A party may appeal an order of the office of administrative hearings in accordance with the Kansas judicial review act.

(f) The final decision of any external independent third-party review conducted pursuant to this section shall also direct the losing party of the review to pay an amount equal to the costs of the review to the third-party reviewer. Any payment ordered pursuant to this subsection shall be stayed pending any appeal of the review. If the final outcome of any appeal is to reverse the decision of the external independent third-party review, the

losing party of the appeal shall be required to pay the costs of the review to the third-party reviewer within 45 calendar days of entry of the final order.

(g) ***{On and after the effective date of this section,}*** A managed care organization providing state medicaid services pursuant to a contract with the Kansas program of medical assistance shall not discriminate against any licensed pharmacy or pharmacist located within the geographic coverage area of the managed care organization that is willing to meet the conditions for participation established by the Kansas program of medical assistance and to accept the prevailing medicaid fee schedule.

(h) The department of health and environment shall adopt rules and regulations to implement the provisions of this section prior to January 1, ~~2018~~ ***{2019}***.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.