Senate Substitute for HOUSE BILL No. 2026

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) Upon request by a participating healthcare provider under the Kansas medical assistance program, the secretary of health and environment shall provide accurate and uniform patient encounter data that complies with the federal health insurance portability and accountability act of 1996 and applicable federal and state statutory and regulatory requirements, including, but not limited to, the:

(1) Managed care organization claim number;

(2) patient medicaid identification number;

(3) patient name;

(4) type of claim;

(5) amount billed by revenue code and procedure code;

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

(7) hospital patient account number.

(b) Upon receiving a request for patient encounter data pursuant to subsection (a), the department of health and environment shall furnish to the participating healthcare provider all requested information within 60 calendar days after receiving the request for data. The department of health and environment may charge a reasonable fee for furnishing requested data, including only the cost of any computer services, including staff time required.

(c) (1) The secretary shall require any managed care organization providing state medicaid or children's health insurance program services under the Kansas medical assistance program to provide documentation to a healthcare provider when the managed care organization 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 health insurance portability and accountability act of 1996 standard denial reasons.

(2) Each managed care organization shall offer quarterly in-person training on remark codes and health insurance portability and accountability act of 1996 standard denial reasons and any other denial reasons or remark codes specific to the managed care organization.

(d) The secretary shall require managed care organizations providing state medicaid or children's health insurance program services under the Kansas medical assistance program to offer quarterly in-person education 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 healthcare providers.

(e) The secretary shall develop uniform standards to be utilized by each managed care organization providing state medicaid or children's health insurance program services under the Kansas medical assistance program regarding:

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

(2) procedures, requirements, periodic review and reporting of reductions in and limitations for prior authorization for healthcare services and prescriptions;

(3) retrospective utilization review of re-admissions that complies with any applicable federal statutory or regulatory requirements for the medicaid program or the children's health insurance program, prohibiting such reviews for any recipient of medical assistance who is re-admitted with a related medical condition as an inpatient to a hospital more than 15 days after the recipient patient's discharge;

(4) a grievance, appeal and state fair hearing process that complies with applicable federal and state statutory and regulatory procedure requirements, including any statutory remedies for timely resolution of grievances, appeals and state fair hearings, imposed upon managed care organizations providing state medicaid or children's health insurance program services; and

(5) requirements that each managed care organization, within 60 calendar days of receiving an appeal request, provide notice and resolve 100% of provider appeals, subject to remedies, including, but not limited

to, liquidated damages if provider appeals are not resolved within the required time.

(f) The secretary shall procure the services of an independent auditor for the purpose of reviewing, at least once per calendar year, a random sample of all claims paid and denied by each managed care organization and each managed care organization's subcontractors.

(1) Each managed care organization and each managed care organization's subcontractors shall be required to pay any claim that the independent auditor determines to be incorrectly denied. Each managed care organization and each managed care organization's subcontractors may also be required to pay liquidated damages, as determined by the department of health and environment.

(2) Each managed care organization and each managed care organization's subcontractors shall be required to pay the cost of audits conducted under this subsection.

(3) The provisions of this subsection shall expire on January 1, 2020.

(g) The secretary shall require each managed care organization to pay 100% of the state-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.

(h) On and after the effective date of this section, a managed care organization providing state medicaid or children's health insurance program services under the Kansas medical assistance program 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 medical assistance program and to accept reasonable contract terms offered by the managed care organization.

(i) 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) On and after January 1, 2020, 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) The department of health and environment shall adopt rules and regulations to implement the provisions of this section prior to January 1, 2020.

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

I hereby certify that the above BILL originated in the HOUSE, and was adopted by that body

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HOUSE adopted
Conference Committee Report _____

_____
Speaker of the House.

_____
Chief Clerk of the House.

Passed the SENATE
as amended _____

SENATE adopted
Conference Committee Report _____

_____
President of the Senate.

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Secretary of the Senate.

APPROVED _____

_____
Governor.