

Substitute for SENATE BILL No. 69

By Committee on Public Health and Welfare

2-21

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

3
4 *Be it enacted by the Legislature of the State of Kansas:*

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

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

11 (A) Managed care organization claim number;

12 (B) patient medicaid identification number;

13 (C) patient name;

14 (D) type of claim;

15 (E) amount billed by revenue code;

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

17 (G) provider patient account number; and

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

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

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

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

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

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

6 (3) procedures, requirements and limitations for prior authorization
7 for healthcare services and prescriptions;

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

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

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

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

25 (2) administrative spending does not include contractor incentives;

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

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

33 (e) The secretary shall adopt rules and regulations as may be
34 necessary to implement the provisions of this section prior to January 1,
35 2018.

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

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

43 (B) a statement that the provider is entitled to an external independent

1 third-party review pursuant to this section; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

43 (B) provide the managed care organization's designated contact

1 information, including name, mailing address, phone number, fax number
2 and email address.

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

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

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

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

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

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

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

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

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

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

42 (c) (1) Multiple appeals to the external independent third-party
43 review process regarding the same recipient of medical assistance, a

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

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

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

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

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

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

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

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

1 the third-party reviewer within 45 calendar days of entry of the final order.

2 (g) A managed care organization providing state medicaid services
3 pursuant to a contract with the Kansas program of medical assistance shall
4 not discriminate against any licensed pharmacy or pharmacist located
5 within the geographic coverage area of the managed care organization that
6 is willing to meet the conditions for participation established by the
7 Kansas program of medical assistance and to accept the prevailing
8 medicaid fee schedule.

9 (h) The department of health and environment shall adopt rules and
10 regulations to implement the provisions of this section prior to January 1,
11 2018.

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