

Proposed

**State of Kansas
Department of Health and Environment**

Notice of Hearing on Proposed Administrative Regulations

The Kansas Department of Health and Environment (KDHE), Division of Health Care Finance, will conduct a public hearing at 9:00 a.m. Thursday, July 9, 2020, in the Room 560, fifth floor, Landon State Office Building, 900 SW Jackson, Topeka, Kansas, to consider the adoption of proposed permanent regulation K.A.R. 129-9-9.

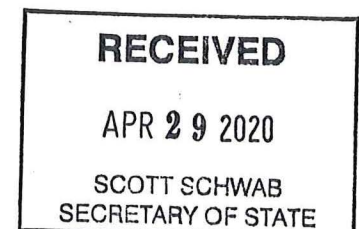
Summary of Regulation

K.A.R. 129-9-9 External independent third-party review for providers. The regulation provides procedure for implementing the statutory provisions of K.S.A. 39-709i involving the independent, third-party review of a denial by a KanCare managed care organization of a request for reimbursement of a claim for care provided to a Kansas Medicaid recipient or a request for a specific healthcare service.

Economic Impact

K.S.A. 39-709i provides that the loser of the review process, either the KanCare managed care provider or the KanCare managed care organization, will pay the costs for conducting the review. The decision to pursue the review process is at the discretion of the Kansas Medicaid managed care provider affected by the denial decision of the KanCare managed care organization. Since the decision of the independent, third party review can be appealed to the Kansas Office of Administrative Hearings, KDHE anticipates hiring additional staff to handle the workload. A detailed economic impact is provided in the economic impact statement that is available from the agency contact person listed below.

Notice and Contact



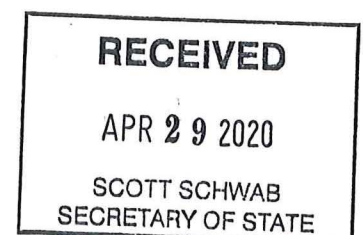
The time period between the publication of this notice and the scheduled hearing constitutes a 60-day public comment period for the purpose of receiving written public comments on the proposed regulation. All interested parties may submit written comments prior to 5:00 p.m. on the day of the hearing to Dorothy Noblit, Kansas Department of Health and Environment, Division of Health Care Finance, 900 SW Jackson, Suite 900, Landon State Office Bldg., Topeka, Kansas 66612, by email to Dorothy.noblit@ks.gov or fax to 785-559-4258. During the hearing, all interested parties will be given a reasonable opportunity to present their views orally on the proposed regulation as well as an opportunity to submit their written comments. It is requested that each individual giving oral comments also provide a written copy for the record. In order to give each individual an opportunity to present their views, it may be necessary for the hearing officer to request that each presenter limit an oral presentation to an appropriate time frame.

Complete copies of the proposed regulation and the corresponding economic impact statement may be obtained from the KDHE website or by contacting the contact person noted at the address, email or fax number above. Questions pertaining to the proposed regulation should be directed to the contact noted above.

Any individual with a disability may request accommodation in order to participate in the public hearing and may request the proposed regulation, economic impact statement, and environmental benefit statement in an accessible format. Requests for accommodation to participate in the hearing should be made at least five working days in advance of the hearing by contacting the contact person noted above.

Lee A. Norman, M.D.

Secretary



129-9-9. External independent third-party review for providers. (a) Effective with each denial issued by a managed care organization (MCO) on or after January 1, 2020, each provider who has been denied an authorization for a new healthcare service to an enrollee or a claim for reimbursement to the provider for a healthcare service rendered to an enrollee shall be entitled to an external independent third-party review pursuant to K.S.A. 39-709i, and amendments thereto. Each MCO denial reviewed by the external independent third-party reviewer shall have been issued pursuant to a contract between the MCO and the Kansas medical assistance program (KMAP). The contract shall have been effective January 1, 2020 or later.

(b) The request for an external independent third-party review shall apply only to denials for which the provider has completed the internal written appeals process of an MCO on or after January 1, 2020. Each provider shall have the right to submit a request for an external independent third-party review following receipt of the MCO's adequate notice of appeal resolution or remittance advice.

(c) The MCO shall send an adequate notice of appeal resolution to the provider when the MCO reviews the request for an appeal of an action or adverse benefit determination. Each adequate notice of appeal resolution shall meet the requirements of the secretary and shall include the following:

- (1) The date of the adequate notice of appeal resolution;
- (2) the action or adverse benefit determination that is the subject of the appeal;
- (3) the results of the resolution process and the date of the appeal resolution;
- (4) the reasons for the appeal resolution, including an explanation of the medical basis for the resolution, application of policy, or accepted standard of medical practice to the enrollee's

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medical circumstances, if the MCO based its resolution upon a determination that the service is not medically necessary;

(5) the statute, regulation, policy, or procedure supporting the appeal resolution;

(6) a statement that the provider has completed the appeal process with the MCO;

(7) a statement of the provider's right to request an external independent third-party review following receipt of the adequate notice of appeal resolution;

(8) a statement of the required procedures by which a provider may request an external independent third-party review with the MCO issuing the decision to be reviewed within 60 days of the date of the adequate notice of appeal resolution. Pursuant to K.S.A. 77-531 and amendments thereto, three days shall be added to the 60-day response period if the notice is served by U.S. mail or by electronic means. The statement shall include the address and contact information for submission of the request;

(9) a statement that if the provider does not request an external independent third-party review, the provider has a right, pursuant to K.S.A. 39-709h(e)(4) and amendments thereto, to request a state fair hearing within 120 days of the date of the adequate notice of appeal resolution. Pursuant to K.S.A. 77-531 and amendments thereto, three days shall be added to the 120-day response period if the notice is served by U.S. mail or by electronic means;

(10) the procedures by which the provider may request a state fair hearing and the address and contact information for submission of the request or, for an action based on a change in law, the circumstances under which a state fair hearing will be granted;

(11) a statement of the provider's right to have self-representation or use legal counsel, a relative, a friend, or a spokesperson; and

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(12) any other information required by Kansas statute or regulation that involves the MCO's adequate notice of appeal resolution.

(d) Each provider receiving an adequate notice of appeal resolution from an MCO that does not include the information specified in paragraphs (c)(6) through (c)(8) shall be entitled to a penalty fee of \$333.00, \$666.00, or \$1,000.00 pursuant to paragraphs (d)(1)(A) through (C). The provider shall notify the secretary of the deficient notice.

(1) The penalty fee for each deficient notice of appeal resolution shall be calculated by the secretary according to the following fee structure:

(A) A notice failing to include one of the three requirements specified in paragraphs (c)(6) through (c)(8) shall incur a penalty fee of \$333.00.

(B) A notice failing to include two of the three requirements specified in paragraphs (c)(6) through (c)(8) shall incur a penalty fee of \$666.00.

(C) A notice failing to include three of the three requirements specified in paragraphs (c)(6) through (c)(8) shall incur a penalty fee of \$1,000.00.

(2) The MCO issuing the deficient notice shall pay the penalty fee to the provider receiving the deficient notice within 10 business days of the secretary's notification to the MCO of the deficient notice.

(3) The provider shall notify the secretary of any dispute that arises regarding the penalty fee. This dispute shall be resolved by the secretary and shall not include the right to request a reconsideration, an appeal, or a state fair hearing.

(e) Any provider may submit a written request for an external independent third-party review to the MCO issuing the decision to be reviewed. The provider's request for this review

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shall include the following:

(1) Identification of each specific issue and dispute directly related to the adverse appeal decision issued by the MCO;

(2) a statement of the basis upon which the provider believes the MCO's decision to be erroneous; and

(3) the provider's designated contact information, including name, postal mailing address, telephone number, fax number, and electronic-mail address.

(f)(1) Within five business days of receiving a provider's request for external independent third-party review, the MCO shall perform the following:

(A) Send to the provider's designated contact a written acknowledgement letter specifying that the MCO has received the request for review;

(B) notify the secretary of the provider's request for review; and

(C) send a copy of the written acknowledgement letter to the enrollee, if related to the denial of an authorization for a new healthcare service.

(2) If the secretary determines that the MCO failed to meet the requirements of paragraphs (f)(1)(A) through (C), then the provider who submitted the request for review shall automatically prevail in the review. Within five business days of receipt of the secretary's notification that the provider automatically prevails, the MCO shall issue an approval letter regarding the reversal of the MCO's appeal decision to the prevailing provider and the secretary. The MCO shall also issue an approval letter to the affected enrollee if the request for review is related to the denial of an authorization for a new healthcare service. The MCO shall not be required to reverse its decision for a request that does not include the information specified in

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paragraphs (e)(1) through (e)(3), is submitted by a provider who fails to complete the MCO's appeal process, is untimely, or does not involve a denied authorization for a new healthcare service or a claim for reimbursement.

(g)(1) Within 15 business days of receiving a provider's request for external independent third-party review, the MCO shall perform the following:

(A) Submit to the secretary all documentation submitted by the provider for the MCO's internal appeal process; and

(B) provide the MCO's designated contact information, including name, postal mailing address, telephone number, fax number, and electronic-mail address.

(2) If the secretary determines that the MCO failed to meet the requirements of paragraphs (g)(1)(A) and (B), then the provider who submitted the request for review shall automatically prevail in the review. Within five business days of receipt of the secretary's notification that the provider automatically prevails, the MCO shall issue an approval letter regarding the reversal of the MCO's appeal decision to the prevailing provider and the secretary. The MCO shall also issue an approval letter to the affected enrollee if the request for review is related to the denial of an authorization for a new healthcare service. The MCO shall not be required to reverse its decision for a request that does not include the information specified in paragraphs (e)(1) through (e)(3), is submitted by a provider who fails to complete the MCO's appeal process, is untimely, or does not involve a denied authorization for a new healthcare service or a claim for reimbursement.

(h) Each request for an external independent third-party review shall be approved or denied by the secretary. A request for an external independent third-party review that does not

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include the information specified in paragraphs (e)(1) through (e)(3), is submitted by a provider who fails to complete the MCO's appeal process, is untimely, or does not involve a denied authorization for a new healthcare service or a claim for reimbursement shall be denied by the secretary. A letter regarding the denial of the request for an external independent third-party review shall be issued by the secretary to the requesting provider and the MCO. A denial letter shall also be issued to the affected enrollee if the request for review is related to the denial of an authorization for a new healthcare service.

(i) The decision by the external independent third-party reviewer shall be based solely upon the documentation submitted by the provider during the MCO's appeal process.

(j) The parties to each external independent third-party review shall be the following:

(1) A provider or the provider's authorized representative; and

(2) the MCO that made the decision involved in the review.

(k) Upon the request of a party, the external independent third-party reviewer may determine in one action multiple requests made to the reviewer regarding the same enrollee, a common question of fact, a common interpretation of applicable regulations, or a common reimbursement requirement. The provider shall complete the MCO's appeal process and submit a request for external review for each denial of an authorization for a new healthcare service or denial of a claim for reimbursement that the reviewer determines in one action.

(l) Any provider that initiated a request for an external independent third-party review, or one or more other providers, may add other initial denials of claims to the review before the reviewer's decision if the claims involve a common question of fact, a common interpretation of applicable regulations, or a common reimbursement requirement. The provider shall complete

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the MCO's appeal process for each denial of a claim for reimbursement reviewed by the reviewer. The provider shall submit a request for external independent third-party review to the MCO that denied the claim, for each additional claim.

(m) The external independent third-party reviewer shall conduct an external independent third-party review of any denial of authorization for a new healthcare service or denial of a claim for reimbursement submitted to the reviewer.

(n) The external independent third-party reviewer shall issue the reviewer's final decision in a letter to the provider's designated contact, the MCO's designated contact, and the department within 30 days from the date of receipt of the appeal documentation forwarded by the secretary. The reviewer may extend the time to issue a final decision by 14 days upon agreement of both parties to the review. The reviewer's letter shall include the following:

- (1) The date of the reviewer's decision letter;
- (2) the date of receipt of the provider's appeal documentation from the secretary;
- (3) the date of the reviewer's decision and, if an extension was requested by the reviewer, the date of the extension request;
- (4) the name and address of the requesting provider. If the reviewer determines in one action multiple provider requests or requests involving multiple claims, the reviewer shall issue a separate decision letter for each MCO, enrollee, and provider as required to protect health information;
- (5) a summary statement of the reason the provider requested the external independent third-party review;

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(6) the specialty or professional certification of each individual reviewing the provider appeal documentation;

(7) a summary statement of the reviewer's rationale for affirming or reversing the MCO's appeal decision. The statement shall include citation to the applicable policies, research articles, medical necessity criteria, or any other documentation relied upon by the reviewer in reaching its decision;

(8) the name of the medical director who reviewed and approved the reviewer's decision;

(9) a statement directing the losing party of the review to pay an amount equal to the costs of the review to the reviewer and the due date for payment. The statement shall include the following:

(A) A statement that if the decision of the external independent third-party reviewer is reviewed in a state fair hearing, the payment due to the reviewer under this subsection shall be delayed until the decision of the state fair hearing has been issued in the initial order;

(B) a statement that the losing party of the state fair hearing's initial order shall pay the costs of the review to the reviewer within 45 days of service of the initial order;

(C) a statement that if the decision in the initial order is reviewed by the state appeals committee, the payment due to the reviewer under this subsection shall be delayed until the decision by the state appeals committee has been issued in the final order; and

(D) a statement that the losing party of the state appeal committee's final order shall pay the costs of the review to the reviewer within 45 days of service of the final order;

(10) the unique number assigned by the MCO to each provider appeal;

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(11) the unique number assigned by the reviewer to each request for external independent third-party review; and

(12) a statement that the provider will receive an additional notice from one or more MCOs that includes the right to request a state fair hearing regarding the reviewer's decision.

(o) Within 10 business days of the MCO's receipt of the external independent third-party reviewer's decision letter, the MCO shall issue a notice of the reviewer's decision to the provider and the department. The MCO shall also issue a notice of the reviewer's decision to the affected enrollee if the request for review is related to the denial of an authorization for a new healthcare service. The notice shall include the state fair hearing rights for the enrollee and the provider.

(p) Each request for an external independent third-party review shall automatically extend the deadline to request a state fair hearing pending the outcome of the review. Any party, including the affected enrollee, may request a state fair hearing within 30 days of the date of the MCO's notice of the reviewer's decision. Pursuant to K.S.A. 77-531 and amendments thereto, three days shall be added to the 30-day response period if the notice is served by U.S. mail or by electronic means.

(q) The decision of the external independent third-party reviewer shall be reviewed by the secretary or the secretary's designee. If the MCO is the losing party of the review, a determination regarding a review by OAH of the reviewer's decision shall be made by the secretary.

(r) The scheduling of any state fair hearing that involves a denial of an authorization for a new healthcare service or a claim for reimbursement for which the provider has requested an external independent third-party review shall be delayed until after the reviewer's decision has

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been issued. The reviewer's decision letter, the documents relevant to the reviewer's decision, and the MCO's notice of the reviewer's decision shall be included in the state fair hearing case file for consideration by the presiding officer, together with any other facts of the case.

(s) Any provider requesting an external independent third-party review may withdraw the request for review and request a state fair hearing within 123 days of the date of the MCO's adequate notice of appeal resolution. (Authorized by and implementing K.S.A. 2019 Supp. 39-709i, K.S.A. 65-1,254, and K.S.A. 75-7403; effective, T-_____, _____; effective P-_____.)

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**Kansas Administrative Regulations
Economic Impact Statement
For the Kansas Division of the Budget**

Kansas Department of Health and Environment
Agency

Brian M. Vazquez (785) 296-0696
Dorothy Noblit (785) 296-8903
Agency Contact

Proposed 129-9-9 (P)
K.A.R. Number(s)

Submit a hard copy of the proposed rule(s) and regulation(s) and any external documents that the proposed rule(s) and regulation(s) would adopt, along with the following to:

Division of the Budget
900 SW Jackson, Room 504-N
Topeka, KS 66612

I. Brief description of the proposed rule(s) and regulation(s).

This involves the managed care program of Kansas Medicaid. The proposed regulation implements the provisions of K.S.A. 39-709i that authorized the use of a third-party independent reviewer when a Kansas Medicaid managed care medical provider receives from a Kansas Medicaid managed care organization (MCO) a denial of either a prior authorization (a request to provide a healthcare service to a recipient of Kansas Medicaid in the future) or a claim for reimbursement for healthcare services already provided to a Kansas Medicaid recipient. Kansas Medicaid MCO's all have internal review process for denied requests. Before requesting a third-party review, the Kansas Medicaid managed care provider would need to exhaust the internal written appeals process of the MCO as a prerequisite. The proposed regulation provides procedure not fully explained or mentioned by the statute.

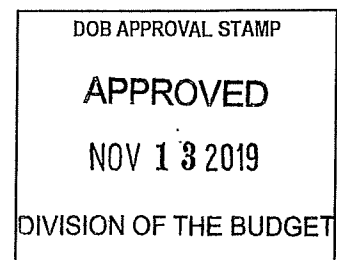
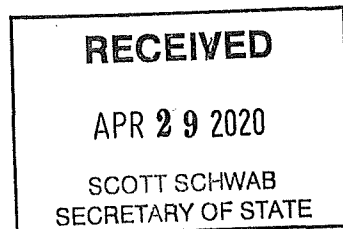
II. Statement by the agency if the rule(s) and regulation(s) is mandated by the federal government and a statement if approach chosen to address the policy issue is different from that utilized by agencies of contiguous states or the federal government. (If the approach is different, then include a statement of why the Kansas rule and regulation proposed is different)

This is not based on federal requirements.

III. Agency analysis specifically addressing following:

A. The extent to which the rule(s) and regulation(s) will enhance or restrict business activities and growth;

The Division of Health Care Finance (KDHE / DHCF), the division within KDHE that administers Kansas Medicaid, does not anticipate any enhancement or restriction of business activities. This is primarily due to the voluntary nature of this process. While K.S.A. 39-709i provides that the loser of the review process will pay the costs for conducting the review, the decision to use the review process is solely at the discretion of the Kansas Medicaid managed care provider.



- B. The economic effect, including a detailed quantification of implementation and compliance costs, on the specific businesses, sectors, public utility ratepayers, individuals, and local governments that would be affected by the proposed rule and regulation and on the state economy as a whole;**

Implementation:

KDHE/DHCF anticipates hiring 3 additional administrative staff to handle the paperwork generated by the third-party review. KDHE/DHCF prefers administrative assistant staff with, at least, 1-2 years of experience. The additional annual staff cost is projected as:

- Salary 3 x \$35,000 (cost for administrative assistance w/ experience) =	\$	105,000
- Fringe 3 x (.30 x \$35,000) =	\$	31,500
	Total	\$ 136,500

New staff will be added to currently used office space in the Landon State Office Bldg. so any costs for office space, telecommunications, office supplies, etc. will be absorbed by KDHE/DHCF as part of current budget allocations for those specific costs.

Compliance:

As noted in A above, KDHE/DHCF does not view this process as a compulsory process on the Kansas Medicaid managed care providers that triggers mandatory additional compliance costs. Since the independent third-party review process is only able to be triggered by a Kansas Medicaid managed care provider, the review process is at the provider's discretion.

- C. Businesses that would be directly affected by the proposed rule and regulation;**

Kansas Medicaid managed care providers, Kansas Medicaid MCO's

- D. Benefits of the proposed rule(s) and regulation(s) compared to the costs;**

N/A

- E. Measures taken by the agency to minimize the cost and impact of the proposed rule(s) and regulation(s) on business and economic development within the State of Kansas, local government, and individuals;**

N/A

- F. An estimate, expressed as a total dollar figure, of the total annual implementation and compliance costs that are reasonably expected to be incurred by or passed along to business, local governments, or members of the public.**

\$0 Kansas Medicaid managed care providers do not pay Kansas Medicaid for participation or licensure in the Kansas Medicaid program. As a result, KDHE/DHCF does not envision any method for imposing implementation costs on the providers. Similarly, KDHE/DHCF does not envision the imposition of any compliance costs since this is not a compulsory process. See A & B above.

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An estimate, expressed as a total dollar figure, of the total implementation and compliance costs that are reasonably expected to be incurred by or passed along to business, local governments, or members of the public.

\$ 0

Do the above total implementation and compliance costs exceed \$3.0 million over any two-year period?

YES ☐ NO ☒

Give a detailed statement of the data and methodology used in estimating the above cost estimate.

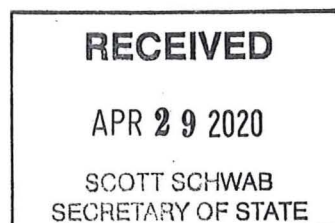
KDHE/DHCF reviewed salary structure for the administrative assistant category with KDHE Human Resources. Compensation for administrative assistants (unclassified) with some experience fall in a range from \$13 - \$17 per hour across the state. This equates to \$27,000 - \$35,000 per year. KDHE used the top of the range for computations. See B above for computation of implementation costs.

Prior to the submission or resubmission of the proposed rule(s) and regulation(s), did the agency hold a public hearing if the total implementation and compliance costs exceed \$3.0 million over any two-year period to find that the estimated costs have been accurately determined and are necessary for achieving legislative intent? If applicable, document when the public hearing was held, those in attendance, and any pertinent information from the hearing.

YES ☐ NO ☒

- G. If the proposed rule(s) and regulation(s) increases or decreases revenues of cities, counties or school districts, or imposes functions or responsibilities on cities, counties or school districts that will increase expenditures or fiscal liability, describe how the state agency consulted with the League of Kansas Municipalities, Kansas Association of Counties, and/or the Kansas Association of School Boards.

N/A



- H. Describe how the agency consulted and solicited information from businesses, associations, local governments, state agencies, or institutions and members of the public that may be affected by the proposed rule(s) and regulation(s).**

These regulations implement K.S.A. 39-709i. Originally, the statutory provisions were introduced as Senate Substitute for House Bill 2026 in the 2017 legislative session at the request of providers, providers' associations, and advocacy groups. In hearings on the bill, Via Christi Healthcare, University of Kansas Health System, Kansas Hospital Association, Kansas Medical Society, Disability Rights Center, Leading Age Kansas, Kansas Academy of Family Physicians, Kansas Healthcare Association, and Association of Community Mental Health Centers of Kansas, Inc. supported the legislation. KDHE/DHCF has maintained communications with most of these providers and groups as it worked to implement this regulation.

- I. For environmental rule(s) and regulation(s) describe the costs that would likely accrue if the proposed rule(s) and regulation(s) are not adopted, as well as the persons would bear the costs and would be affected by the failure to adopt the rule(s) and regulation(s).**

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