

STATEMENT OF CONSIDERATION RELATING TO
907 KAR 17:010

Department for Medicaid Services
Amended After Comments

(1) A public hearing regarding 907 KAR 17:010 was not requested and; therefore, not held.

(2) The following individuals submitted written comments regarding 907 KAR 17:010:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Kathy Adams, Director of Public Policy	The Children's Alliance; Frankfort, KY
William S. Dolan, Staff Attorney Supervisor	Protection & Advocacy; Frankfort, KY
Nancy C. Galvagni, Senior Vice President	Kentucky Hospital Association; Louisville, KY

(3) The following individuals from the promulgating agency responded to comments received regarding 907 KAR 17:010:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Christina Heavrin, General Counsel	Cabinet for Health and Family Services
Stuart Owen, Regulation Coordinator	Department for Medicaid Services

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Section 1: Foster Care Children

(a) Comment: Regarding Section 1(4)(b), Kathy Adams, Director of Public Policy of The Children's Alliance, stated the following:

"The Children's Alliance requests that the regulation be amended to allow for limited exceptions to this requirement when it is in the child's best interest to allow an exception (for example, a child is placed outside of a region where the MCO operates and therefore does not have access to providers within a reasonable traveling distance).

Suggest (4)(b) be re-written to state:

'(4)(b) **Unless an exception is provided by Department of Community Based Services staff**, a child in foster care shall be enrolled with an MCO in the county where the child's DCBS case is located.'":

(b) Response: The Department for Medicaid Services (DMS) does not oppose the amendment; however, DMS's contracts with the managed care organizations which establish the terms and conditions of participation do not contain this exception. The matter is complicated by the fact that two managed care organizations are responsible for enrollee care in only one of the eight statewide regions.

DMS intends to discuss the issue with the managed care organizations.

(2) Subject: Section 4: MCO Internal Appeal Process

(a) Comment: William S. Dolan, Staff Attorney Supervisor at Protection & Advocacy, stated the following:

“Section 4, sub-section (14)(a) of 907 KAR 17:010 requires MCOs to continue to provide benefits to an enrollee upon request until the enrollee withdraws the appeal or after 14 days following an unfavorable resolution that is not further appealed. Section 3, sub-sections (1), (2) and (3) of 17:030 address mandatory recoupment. We read the recoupment sub-sections of 17:030 to apply only when an enrollee is determined ineligible for Medicaid due to fraud. Could you please confirm that there is no recoupment exposure for an appeal filed pursuant to an MCO's 907 KAR 17:010 internal appeal process and that 907 KAR 17:030 recoupment is applicable only in cases of fraud.”

(b) Response: Though not addressed in 907 KAR 17:010 or 907 KAR 17:030, enrollees are subject to recoupment of expenses for the costs of services provided during an appeal if the enrollee loses the appeal. 907 KAR 17:025 establishes the MCO's requirement, pursuant to 42 CFR 438.404, to notify an enrollee regarding this potential obligation. DMS is inserting language in an “amended after comments” regulation to address this issue.

(c) Comment: Nancy C. Galvagni, Senior Vice President of the Kentucky Hospital Association, stated the following:

“KHA and hospitals have concerns with provisions contained in Section 4 of this rule. Specifically, (4) would prohibit a provider from being an authorized representative of an enrollee without the enrollee's written consent for the specific action that is being appealed or is the subject of a state fair hearing. It would also prevent a consent from being dated earlier than the date of the MCO's action. We agree that a provider must have a patient's consent to act as their representative; however, we object to the proposed rule's requirement that the consent must address the specific denial and be dated after the date of the MCO's action. These changes to the consent will serve to put up roadblocks to providers being able to assist patients in appealing denials of services. The requirements for obtaining consent for each specific denial after receipt of the MCO's action is contrary to hospital existing policies and procedures as they pertain to private insurance wherein a hospital obtains a patient's general consent to act

as their representative in the event a service is denied to assist the patient in appealing the denial. The Department's proposed rule to require that the provider obtain a specific consent for each and every denial, dated after the MCO's action, will serve to prevent many denials from being appealed because, in many cases, it will be impossible for the provider to reach the patient to obtain the necessary consent. Specifically, a provider may have already discharged a patient when they receive a notice of a service or coverage denial from the MCO. If the enrollee is no longer a patient in the facility, it will be nearly impossible for the hospital to track down the patient to be able to obtain the patient's written consent. This is particularly true for patients who do not even reside in the same area as the treating hospital. The Department should not be imposing new regulatory burdens on patients and providers that create barriers to their ability to appeal denials of services. This weakens both patient and provider due process to challenge MCO actions that the patient and their treating provider disagree with. For these reasons, we request that subsection (4)(a) and (b) of Section 4 be deleted in their entirety. The process for a Medicaid enrollee to give consent to a provider for purposes of appeal should be no different than it is currently for privately insured patients.”

(d) Response: The requirement that the authorization to represent an enrollee/patient should be signed after the denial is necessary to confirm that the appeal is actually on behalf of the enrollee and not on behalf of the provider. Generally, services have been received by the enrollee and the denial only addresses the amount of payment received by the provider. The appeal process available for an enrollee regarding service denials should not be used by a provider to be paid for a service that has already been provided – this is an inappropriate use of this appeal process. Reimbursement for a service that has already been provided is a matter between the provider and the managed care organizations (which have a contractual relationship which addresses such matters.)

(3) Subject: Section 5: State Fair Hearing

(a) Comment: William S. Dolan, Staff Attorney Supervisor at Protection & Advocacy, stated the following:

“Section 5 of 907 KAR 17:010 Department’s State Fair Hearing for an Enrollee reads that an enrollee shall have a right to a KRS 13B state fair hearing “only after exhausting an MCO’s internal appeal process.” The Center for Medicare and Medicaid Services (CMS) has approved Kentucky’s 1915(b) Waiver for Managed Care Organization Program (KYMCO). Part IV: Program Operations E. 3. a. is marked “[t]he State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a fair hearing.” (emphasis original). Section 5 of 907 KAR 17:010 is inconsistent with the CMS approved KYMCO Waiver. KYMCO does not expire until October 31, 2013.

It is our understanding that Kentucky’s MCO contracts also do not require exhaustion. For example, Kentucky Spirit Health Plan Inc.’s contract states on page 84 that “[t]he Contractor shall provide Members, separately or as a part of the Member handbook, information on how they or their representative(s) can file a grievance or an appeal, and

the resolution process. The Member information shall also advise Members of their right to file a request for a state fair hearing with the Cabinet, upon notification of a Contractor action, or concurrent with, subsequent to or in lieu of an appeal of the Contractor action.”

<http://finance.ky.gov/services/eprocurement/Documents/Medicaid%20Managed%20Care%20Contracts/FinalKentuckySpiritMCOContractwithsignature.pdf>

We suggest that the Cabinet change the regulation to allow an enrollee the option of starting with the MCO internal appeal and grievance process or a 13B fair hearing or pursuing concurrent appeals. “(1) An enrollee shall have a right to a state fair hearing administered by the department in accordance with KRS Chapter 13B. **[only after exhausting an MCO’s internal appeal process.]** (2) **An enrollee shall not be required to exhaust the MCO or PIHP grievance and appeal process before requesting a fair hearing.**” Requiring exhaustion of the internal appeal and grievance process limits enrollee choice and it violates both the assurances Kentucky has given to CMS in the KYMCO and the MCO contracts themselves.”

(b) Response: The Department for Medicaid Services has remedied the oversight by filing an amendment to the 1915(b) waiver with the Centers for Medicare and Medicaid Services.

(c) Comment: Nancy C. Galvagni, Senior Vice President of the Kentucky Hospital Association, stated the following:

“Section 5 of this rule sets out the Department's procedures for providing a state fair hearing for an enrollee. This rule provides an option to exercise a state fair hearing only to an enrollee, and not to a provider to challenge an MCO's denial of coverage and payment for services rendered to a patient. Under federal rules that govern Medicaid managed care, states are afforded the ability to permit providers to have access to a state fair hearing themselves to appeal MCO denials. We urge the Department to amend this rule to permit providers to have a direct right to a state fair hearing to challenge egregious MCO denials. Hospitals believe this is an issue of fairness, since without this right, hospitals and other providers have no recourse after exhausting an MCO's internal appeals process.”

(d) Response: Hospitals and providers enter into contracts with managed care organizations which establish the terms and conditions of their relationship. If a managed care organization denies a valid claim through its internal appeal process, a hospital or provider does have recourse for the denial. Some contracts provide for arbitration or either party could sue for breach of contract. Ultimately, the issue will hinge upon the terms and conditions of the contract between the parties which could certainly land in court regardless of what interim process is employed.

(4) Subject: Section 8: Member Handbook

(a) Comment: Nancy C. Galvagni, Senior Vice President of the Kentucky Hospital Association, stated the following:

“Section 8 of the rule sets out requirements for a Member Handbook. KHA requests that the regulation address MCO provider directories. Specifically, we request that the rule require MCOs to maintain an up-to-date provider directory of all participating providers on the MCO's website. We further request that the Department require that such provider directory be updated at the end of each month to reflect provider terminations, issued either by the MCO or the provider. The regulation should require that the MCOs identify the date upon which such provider termination is scheduled to take effect. This transparency is needed in order to fully inform new Medicaid enrollees, and all enrollees during an open enrollment period, of the status of the MCO's network. It is certainly important for enrollees to know if their local physicians, hospitals, and other providers that they use are in network, or if they are terminating participation, in order to make an informed choice about selecting an MCO.”

(b) Response: The contracts between the Department for Medicaid Services and the managed care organizations which establishes the terms and conditions of Medicaid program participation for the managed care organizations do not contain the requirements recommended in the comment. DMS does not wish to impose requirements on the managed care organizations which exceed those established in the contracts.

(5) Subject: Regulatory Impact Analysis and Tiering Statement

(a) Comment: Kathy Adams, Director of Public Policy of The Children's Alliance, noted that subsection (4)(c) quoted the statements indicating that the administrative regulation establishes definitions (which it does not) and stated the following:

“This regulation does not establish definitions; it establishes managed care organization requirements and policies relating to enrollees. The Children's Alliance requests that the Regulatory Impact Analysis and Tiering Statement be corrected accordingly.”

(b) Response: DMS is correcting the Regulatory Impact Analysis and Tiering Statement in the “amended after comments” regulation it is filing with the Legislative Research Commission.

(6) Subject: Section 17: Enrollees with Special Health Care Needs

(a) Comment: Kathy Adams, Director of Public Policy of The Children's Alliance, stated the following:

“It is unclear if Subsection (5) requirements, which includes specifics for foster children, is in addition to (1)(b) requirements or in lieu of (1)(b) requirements. The Children's Alliance requests that these provisions be reviewed and clarified as necessary.”

(b) Response: Subsection (1)(b) establishes the managed care organization requirements for identifying individuals with special health care needs and then subsection (5) establishes additional, unique requirements for two (2) subsets of that population – children in foster care or who are receiving adoption assistance. The service plan referenced in subsection (5)(a) is completed prior to the child in foster care being enrolled with a managed care organization; thus, those individuals will already have been identified as having a special health care need before being enrolled. If any of the service plan requirements satisfy a requirement in subsection (1)(b), the MCO shall be considered to have met the requirement. DMS is clarifying the matter in an “amended after comments” regulation.

(c) Comment: Kathy Adams, Director of Public Policy of The Children’s Alliance, stated the following:

Subsection (5)(c) states:

“The MCO shall be available to meet with DCBS at least once a month to discuss the health care needs of the child as identified in the service plan.”

The Children’s Alliance requests that this provision be amended accordingly to include the foster child’s caretaker as foster children are placed with either a relative, foster parents or a private child caring or child placing agency. The child’s caretaker needs to be involved in any discussions regarding the child’s health care needs as identified in the service plan.

Suggest (4)(b) be re-written to state:

(5)(c) The MCO shall be available to meet with DCBS **staff and the client’s caretaker** at least once a month to discuss the health care needs of the child as identified in the service plan.”

(d) Response: The Department for Community Based Services establishes the agenda for each of these meetings and has the authority to request that the enrollee’s caretaker attend the meetings.

(7) Subject: Section 10: Cost Sharing

(a) and (b) Comment and Response: DMS is amending Section 10 to establish that a managed care organization in region three shall impose no cost sharing on enrollees enrolled in region three until January 1, 2014.

SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 17:010 and is amending the administrative regulation as follows:

Page 26
Section 10, Title
Line 8

After “Non-Liability”, insert “and Liability”.

Page 26
Section 10(1)
Line 8

After “(1)”, insert “(a)”.

Page 26
Section 10(1)
Line 10

After “MCO.”, insert a return and the following:

(b) An enrollee may be liable for the costs of services received during an appeal process in accordance with:

1. 907 KAR 17:025, Section 2(4)(b)2g;

2. 42 C.F.R. 431.230; or

3. 42 C.F.R. 438.404.

Page 26
Section 10(2)
Line 11

After “(2)”, insert “(a)”.

Line 12

After “907 KAR 1:604.”, insert a return and the following:

(b) An MCO operating in Region 3 shall not impose cost sharing on an enrollee enrolled with the MCO in Region 3 prior to January 1, 2014.

Page 32
Section 17(1)
Line 14

After “(1)”, insert “(a)”.

Page 32
Section 17(1)(a)
Line 16

Insert “1.”, delete “(a)”.

Page 32
Section 17(1)(a)1.
Line 17

Insert “a.”, delete “1.”.

Page 32
Section 17(1)(a)2.
Line 18

Insert "b.", delete "2."

Page 32
Section 17(1)(a)3.
Line 19

Insert "c.", delete "3."

Page 32
Section 17(1)(a)4.
Line 20

Insert "d.", delete "4."

Page 32
Section 17(1)(a)5.
Line 21

Insert "e.", delete "5."

Page 32
Section 17(1)(a)6.
Line 22

Insert "f.", delete "6."

Page 33
Section 17(1)(b)
Line 1

After "(b)", insert "In accordance with 42 C.F.R. 438.208.".

Page 33
Section 17(1)(b)4.
Line 10

After "monitoring.", insert a return and the following:

(c)1. An enrollee who is a child in foster care or receiving adoption assistance shall be enrolled with an MCO through a service plan that shall be completed for the enrollee by DCBS prior to being enrolled with the MCO.

2.a. The service plan referenced in paragraph (a) of this subsection shall be used by DCBS and the MCO to determine the enrollee's medical needs and to identify if there is a need for case management.

b. The MCO shall be available to meet with DCBS at least once a month to discuss the health care needs of the child as identified in the service plan.

c. If a service plan identifies the need for case management or DCBS requests case management for an enrollee, the foster parent of the child or DCBS shall work with the MCO to develop a case management plan of care.

d. The MCO shall consult with DCBS prior to developing or modifying a case management plan of care.

e. If the service plan accomplishes a requirement stated in paragraph (b) of this subsection, the requirement stated in subsection (b) shall be considered to have been met.

Page 34

Section 17(5)(a) through (e) and (6)(a)

Lines 7 through 21

After “(5)(a)”, delete the following:

An enrollee who is a child in foster care or receiving adoption assistance shall be enrolled with an MCO through a service plan that shall be completed for the enrollee by DCBS prior to being enrolled with the MCO.

(b) The service plan referenced in paragraph (a) of this subsection shall be used by DCBS and the MCO to determine the enrollee’s medical needs and identify the need for case management.

(c) The MCO shall be available to meet with DCBS at least once a month to discuss the health care needs of the child as identified in the service plan.

(d) If a service plan identifies the need for case management or DCBS requests case management for an enrollee, the foster parent of the child or DCBS shall work with the MCO to develop a case management plan of care.

(e) The MCO shall consult with DCBS prior to developing or modifying a case management plan of care.

(6)(a)