COMMONWEALTH OF KENTUCKY STATE FISCAL NOTE STATEMENT
LEGISLATIVE RESEARCH COMMISSION
2015 REGULAR SESSION

MEASURE

2015 BR NUMBER **1197** **SENATE** BILL NUMBER **120**

RESOLUTION NUMBER____ AMENDMENT NUMBER ____

SUBJECT/TITLE An ACT relating to provider appeals for reimbursement by Medicaid managed care organizations.

SPONSOR Senator Ralph Alvarado

NOTE SUMMARY

FISCAL ANALYSIS: ☒ IMPACT ☐ NO IMPACT ☐ INDETERMINABLE IMPACT

LEVEL(S) OF IMPACT: ☒ STATE ☐ LOCAL ☒ FEDERAL

BUDGET UNIT(S) IMPACT: **Department for Medicaid Services**

FUND(S) IMPACT: ☒ GENERAL ☐ ROAD ☒ FEDERAL ☐ RESTRICTED AGENCY ____ ☐ OTHER

FISCAL SUMMARY

FISCAL ESTIMATES	2014-2015	2015-2016	ANNUAL IMPACT AT FULL IMPLEMENTATION
REVENUES			
EXPENDITURES	Indeterminable	Indeterminable	Indeterminable
NET EFFECT	(Indeterminable)	(Indeterminable)	(Indeterminable)

( ) indicates a decrease/negative

MEASURE'S PURPOSE: SB 120 would create an administative appeals process within the Department for Medicaid Services (DMS) for providers who have exhausted the internal appeals process of a Medicaid Managed Care Organization (MMCO). SB 120 would allow appeals to be sought on the MMCO's final decision of denial, nonpayment, or the amount of reimbursement to the provider for a health care service rendered to an MMCO enrollee.

PROVISIONS/MECHANICS: SB 120 would create a new section of KRS 205 to define terms; and creates a process for providers to request an administrative appeals hearing from DMS for reimbursement by an MMCO.

FISCAL EXPLANATION: The fiscal impact is indeterminable because the number of MMCO provider appeals to DMS, and the disposition of such appeals, is unknown.

Although the fiscal impact is indeterminable, the Cabinet for Health and Family Services (CHFS) provides the following additional information:

Estimated costs for administering the requirements of SB 120 are: $500,000 for the Administrative

Hearings Branch and Office of Legal Services, and $500,000 for DMS. Administrative costs would be, at minimum, $1 million**.** As the administrative and related costs of MMCOs increase, the future costs to DMS for MMCO rates will increase as well. With respect to the potential cost to Medicaid Benefits, MMCO payments are approximately $6 billion annually.

If only one percent of total annual MMCO payments was contested, and half upheld in the opinion of the hearing officer, that would equate to $30 million annually in total funds. Depending on the volume of requests received, actual costs could be significantly more.

SB 120 impacts more than just DMS. There would be a significant increase in appeals which would affect the Hearings Branch and the Office of Legal Services, both housed in the CHFS Administration and Program Support (Office of the Secretary) appropriation unit. Additionally, CHFS administrative hearing officers do not have jurisdiction over private contract disputes, which is essentially what SB 120 addresses.

The Department of Insurance (DOI) currently licenses Medicaid MMCOs. DOI also has authority to review MMCOs with regard to prompt payment of claims and any willing provider issues. In fact, DMS currently pays DOI $800,000 annually to review provider complaints. While this bill would be somewhat duplicative of the process that DMS currently contracts with DOI to administer, the scope of SB 120 appears to be larger than the current DOI process. Increased costs in addition to the $800,000 DMS currently pays DOI are indeterminable at this time.

SB 120 requires that the provider exhaust the internal appeals process within the MMCO. Section 1(2) allows for the appeal of an MMCO's final decision of denial, nonpayment or the amount of reimbursement to the provider for a health care service rendered by the provider to a Medicaid enrollee. This language would appear to allow for the appeal of claims payment disputes, and thus creates a process that duplicates the process DOI is currently performing through a contract agreement with DMS.

SB 120 further requires an administrative hearing to be conducted in accordance with KRS 13B rather than as a second level appeal review by DMS. In the private health insurance market, DOI (or an independent review entity if the issue involves a question of medical necessity) conducts a review of second level appeals by providers and members. These reviews are conducted within statutory time frames, but do not require the DOI to hold an administrative hearing. A member may appeal a decision of an independent review entity to Franklin Circuit Court. Other determinations on a second level appeal are final actions of the DOI Commissioner and the aggrieved party may request an administrative hearing under KRS 13B.

Requiring an administrative hearing will result in significant costs for hearing officers, court reporters, etc. Further, the bill requires that the hearing officer issue a recommended order within 30 days from the date the appeal request is received by DMS. A 14-day extension is permitted. Administrative hearings are rarely final within 30-45 days; thus meeting the timeframe contained in the language is unrealistic and will be overly burdensome from an administrative appeal perspective.

DATA SOURCE(S): **Cabinet for Health and Family Services**
PREPARER: **Cindy Murray** **NOTE NUMBER**: **16** **REVIEW**: **GMR** **DATE**: **2/18/2015**