HGC
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House Health and Human Services Committee
Testimony re: HB 2169
Presented by Ronald R. Hein
on behalf of
HCA, Inc.
February 14, 2017

Mister Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for HCA, Inc. which is one of the nation's leading providers of healthcare services, composed of locally managed facilities that include more than 250 hospitals and freestanding surgery centers located in 20 U. S. states and in the United Kingdom, including in Kansas: Wesley Healthcare, Wichita; Overland Park Regional Medical Center, Overland Park; and Menorah Medical Center, Overland Park. HCA, Inc. is concerned about all issues relating to the health care industry.

HCA supports HB 2169. Wesley's CEO, Bill Voloch, testified at the interim committee regarding our recommendations for accomplishing changes that need to be made to the current KanCare system. His testimony and the recommendations for KanCare are attached. We recommend these changes be made through the passage of HB 2169.

Thank you very much for permitting me to submit written testimony.

WESLEY
Healthcare

To: Robert G. (Bob) Bethell Joint Committee on Home and Community-Based Service and Oversight

From: William J. Voloch, President and CEO
Wesley Medical Center

Date: November 17, 2016

Re: Written Comments: Improvements to the KanCare Program

On behalf of Wesley Medical Center and all of our Kansas hospitals we appreciate the opportunity to share with the committee our commitment to the state of Kansas, and to tell you about our experience with the KanCare program during the past four plus years.

HCA's Mission and Investment in Kansas

Wesley, as part of the HCA family of hospitals, has become an inseparable part of the communities we serve and the constituents you represent. Our mission, best said by our founder, Dr. Thomas Frist, Sr., has never wavered,

"Above all else, we are committed to the care and improvement of human life."
"In recognition of this commitment, we strive to deliver high quality, cost effective healthcare in the communities we serve."

Today HCA has ten facilities in Kansas including hospitals and surgery centers that provide care to 1000s of Kansans. Our primary facilities include Wesley Medical Center, Wesley Woodlawn, Overland Park Regional Medical Center, and Menorah Medical Center. Below are some of the highlights of our investment in Kansas and we have included our 2015 Investment by State Report for your review:

Facilities/Beds
10 Hospitals/Surgery Centers
1,360 Hospital Beds

Employees/Payroll
6,351 Employees
$460,641,062 Payroll and Benefits

Capital Investment
$64,976,706

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Uncompensated Care
$54,567,848

State Taxes
$39,746,577

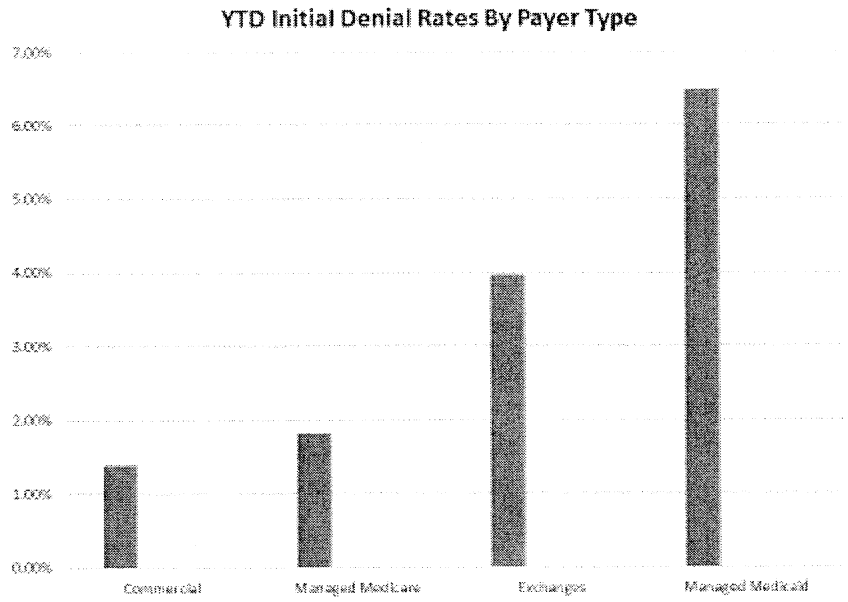
Since becoming the CEO of Wesley in 2015, we have continued to invest in advances that improve the quality and access to care for our patients. Earlier this year, we opened *Wesley Children's Hospital*, the region's first and only dedicated hospital designed, built and equipped exclusively for children. This is one of many new programs we have invested in to serve the region that will increase patient access. As always, our commitment is to the patients' care, and we will continue to explore ways to improve the quality, access, and outcomes for our patients.

History of Experience with KanCare

Through our experience in other states, we have come to know two certainties 1) Managed Medicaid would not be a panacea to address all the challenges of the state's Medicaid program; and 2) in the absence of strong accountability between the State and MCOs, resources intended to provide care would be reduced as manpower to address costly denials and appeals often increase. Often the result is that community hospitals are challenged to meet their obligation. In the years leading up to implementation, we shared our concerns and proposed measures (attached) that we believe would have helped to avoid many of the challenges we see in the current KanCare structure. We have provided an overview of these areas below and attached the detailed information:

- ✓ **Preauthorization/Utilization**
- ✓ **Payment and Appeals Protections**
- ✓ **Emergency Services and Care**
- ✓ **Out of Network Protections**

To help illustrate our concerns, we wanted to provide you a couple of examples of where we believe improvements could be made, please reference the graph below that reflects our Kansas hospitals current payer mix initial denial rates:



This graph outlines YTD our initial denial rate among the primary payer groups.

- ✓ **Managed Medicaid MCOs have a *6.49%* rate of initial denials on claims**
- ✓ **Commercial payers' rate of initial denial is just under *1.4%.***
- ✓ **The largest government payer Managed Medicare only has *1.82%* in initial denial rate.**

To further outline this example:

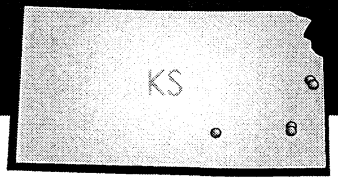
- Currently 45% of our Medicaid Managed Care claims go beyond 90 days before any payment is received;
- Of this 45%, 50% are denied Initially;
- Of this 50% denials, ultimately **99.71%** are paid.
- In overturning almost 100% of initial denials, the MCOs are acknowledging that the denials were inappropriate.
- When you factor in resources spent on both the MCO's side and the Hospital's side, an overabundance of Medicaid funding then ends up spent on administration.
- If the MCOs were held accountable for processing claims correctly the first time around, that would significantly reduce administrative waste.

It is important to note that the number of employees required to undertake processing these claims, and appeals is significant and as in our examples has resulted in a fraction of a percentage of services we provide are ultimately denied payment. We want a KanCare system that works on par with the rest of the payer markets with comparable accountability and efficiency.

We believe that the Managed Care Model can be successful if all those who are part of it are partners in care. To insure that providers are healthy, we need to adopt changes to the current program that do not unduly burden patients or providers. We also believe that the state should address the 4% reduction in reimbursement earlier this year. The combination of a KanCare program in need of greater accountability and efficiency has compounded the challenges we are working to address each day. We would ask that in your work you look to address this most recent reduction and find ways to restore these cuts. We have learned that if providers are not healthy, the health care system suffers and patients' access to life preserving and saving services can be put in jeopardy.

We urge you to consider these recommendations along with those provided by KHA and other providers as you develop the next steps for the KanCare program.

KANSAS



Facilities		
Hospitals		5
Surgery Centers		5
Number of Licensed Beds		1,360
Total Employees		**6,351**
Total Payroll and All Benefits	**$**	**461,641,062**
Total Capital Invested[1]	**$**	**64,976,706**
Total Uncompensated Care[2]	**$**	**54,567,848**
State Taxes Incurred		
Property Tax	$	8,882,347
Sales/Use Tax	$	13,273,219
Franchise Tax	$	0
License Tax	$	26,179
Provider Tax	$	10,021,885
Premium Tax	$	0
State Income Tax	$	6,153,477
State U.I. Tax	$	1,389,470
Total State Taxes	**$**	**39,746,577**
Total State Investment	**$**	**620,932,193**

[1] *Capital expenditures represent the total amount recorded for property, plant and equipment expenditures during the year.*

[2] *The estimated cost of total uncompensated care for the year is calculated by multiplying total annual uncompensated care by a cost-to-charges ratio. The cost-to-charges ratio is calculated by dividing annual patient care costs (salaries and benefits, supplies, other operating expenses and depreciation and amortization) by annual gross patient charges.*

Facilities

Allen County Hospital ..... Iola
Menorah Medical Center ..... Overland Park
Overland Park Regional Medical Center ..... Overland Park
Wesley Medical Center ..... Wichita
Wesley Woodlawn Hospital ..... Wichita

Kansas Medicaid Reform Recommendations

Kansas Medicaid is in the process of renewing its HealthWave managed care program, subsequently renaming it the KanCare program and significantly expanding its scope to include all Kansas Medicaid recipients (instead of and in addition to the much smaller subset of primarily young women and children who were covered under the legacy HealthWave program). Managed Care Organizations (MCOs) are in the throes of trying to develop preliminary provider networks in order to complete their bids for the new program that will be awarded later this year, with a start date of January 1, 2013.

Based on experiences in other state managed care programs outside Kansas, failure to address the following items results in significant collection / revenue shortfalls for providers – and the law clearly does not intend for Kansas providers to end up funding the exercise for the benefit of MCOs.

Authorization and Utilization Review Protections

Among others not listed here, providers need to be assured that they will enjoy the following protections under the KanCare program:

1. Clear guidelines that detail how MCOs will provide Authorizations to providers for patient care services to be rendered.
    a. Electronic connectivity for requesting and issuing authorizations that must be documented between the parties.
    b. Authorizations must be provided quickly (real-time basis) and cannot be delayed for any reason.
    c. No authorization should be required for emergency or post-stabilization care and services, including admissions from the Emergency Room. The definition of Emergency is critical, and must be consistent with the EMTALA regulations to which hospitals and physicians are legally subject.

2. Clear guidelines on Utilization Management practices by the MCO.
    a. MCOs should be required to pay for medically necessary care consistent with InterQual case management guidelines. The proper definition of Medical Necessity is critical.
    b. MCOs should not be allowed to unilaterally change the level of care authorized to or ordered by licensed physicians and actually rendered by providers pursuant to such orders.
    c. Licensed physicians' orders should prevail (over MCO edicts) when a patient has not been discharged.

3. Clear guidelines on approving and paying Emergency Services and Care
    a. Use of only prudent layperson standards for determination of coverage, consistent with State DOI regulations.
    b. MCO must pay for all services medically necessary to adequately screen, stabilize and treat a patient.
    c. MCO must pay for Emergency Services and Care, including all screening, stabilization and treatment services, even if an Emergency Medical Condition is later determined not to have existed.
    d. Coding, level-of-care and corresponding payments must be consistent with ACEP, CMS and NUBC criteria.

A regulatory requirement that the following language be included in MCO contracts would address the above concerns. It is strongly recommend that Kansas Medicaid adopt this as required language in standard template contracts between MCOs and hospitals.

Regardless of either party's clinical determination as to whether or not the Member was treated for an Emergency or Emergency Medical Condition, Plan will reimburse Facility for services rendered in the emergency department (ED) as outlined herein. Plan will reimburse all Facility claims based upon the attached Payment Rate schedule and will not deny downcode or otherwise underpay any claims billed relative to ED services. Plan will not have the right to change the CPT Code properly billed by Facility and/or change the payment for the CPT Code properly billed. This does not modify the current contractual rights associated with the determination of Member Eligibility in accordance with the Section of the Agreement but Members will be presumed to be covered for ED services and payments under the rate attachment if they were enrolled Members with Plan at the time of service.

Important Definitions

Emergency Medical Condition: *A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:*

a. *Serious jeopardy to the health of a patient, including a pregnant woman or a fetus and acute mental health conditions.*
b. *Serious impairment to bodily organ or part.*
c. *Serious dysfunction of any bodily organ or part.*

With respect to pregnant women, an emergency medical condition exists when there is:

a. *Inadequate time to affect safe transfer to another facility prior to delivery.*
b. *Transfer may pose a threat to the health and safety of the patient or fetus.*
c. *Evidence of onset of uterine contractions or rupture of the membranes.*

Emergency Services and Care: *Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician to determine if an Emergency Medical Condition exists and if it does, the care, treatment, or surgery for a Member by a physician necessary to relieve or eliminate the Emergency Medical Condition provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA").*

Medically Necessary*: The use of services and/or supplies provided by or to be provided to a Member under the provisions of this Agreement which are:*

a. *Appropriate for the symptoms, diagnosis or treatment of the Member's medical condition, disease, illness or injury as ordered by the treating physician;*
b. *In accordance with standards of accepted medical practice within the medical community in which the services are being rendered;*
c. *Not primarily for the convenience of the Member or his or her physician; and*
d. *Provided for the diagnosis/treatment or direct care of illness, disease or injury of the Member's medical condition as directed by the treating physician.*

Plan agrees, by law, that what constitutes medically necessary services (i) may be no more restrictive than that used in the Managed Medicaid Program as indicated in state statutes and regulations and other State policy and procedures and (ii) must address the extent to which the managed care organization is responsible for covering services related to the following: (a) the prevention, diagnosis, and treatment of health impairments; (b) the ability to achieve age-appropriate growth and development; and (c) the ability to attain, maintain, or regain functional capacity.

Facility will notify Plan of the presentation of a Member to Facility for inpatient services, including emergency admissions, for individuals who identify themselves as Members, within the longer of twenty-four (24) hours of the presentation or the end of the next business day.

Plan will issue an authorization number immediately upon notification that reflects Covered Services from the date of Member's presentation through the date of discharge consistent with physician orders as they relate to patient type (i.e., admission vs. observation) with confirmation by electronic transmission.

Requests for treatment authorization after notification cannot be pended with any authorization provided.

Regardless of any provision in this Agreement or Plan policy or procedure to the contrary, in the case of an emergency, Facility is not required to provide notice, obtain coverage verification or prior authorization from Plan prior to providing Emergency Services and Care and Post-Stabilization Care Services (specifically including, but not limited to, Observation Services rendered subsequent to and as a part of the emergency care episode) to a Member in accordance with 42 CFR §422.113.

Where services were previously authorized by the Plan, payment for those services cannot be retrospectively denied for any reason, other than as described in the Agreement Section relative to patients who are no longer eligible as Members.

Subject to Facility's policies and bylaws, Facility shall exert commercially reasonable efforts to cooperate with Plan's policies including but not limited to quality assurance, quality improvement, member grievance and appeal, medical records retention and credentialing criteria policies (the "Plan Policies"), provided that such Plan Policies have been provided to the Facility in writing sixty (60) days in advance of their effective date and Plan has made any reasonable modifications to such Plan Policies that are requested by Facility. Plan Policies shall be consistent with the terms of this Agreement, with Facility's policies and procedures, and with applicable Regulatory Requirements;

commercially reasonable; in writing; and changes thereto will be noticed in writing. To the extent Plan Policies conflict with this Agreement, the terms of this Agreement will prevail.

Payment and Appeal Protections

4. Clearly defined claims processing and payment guidelines.
    a. Reasonable timely filing requirements (at least 6 months, and subject to automatic exceptions and exemptions based on such things as the patient presenting the wrong ID card or with no ID card as a self-pay patient, COB cases in respect to which the provider filed its claim with a different payor reasonably thought to be primary or other cause that is not the fault of the provider).
    b. Properly completed UB should be considered a Clean Claim.
    c. Prompt pay rules that have teeth (e.g., meaningful late payment penalties, inability of Plans to delay payment by suspending claims for medical record reviews – i.e., Plan should be required to "pay first, ask questions later").
    d. Commitment to offer electronic billing, claims review, remit and payment (ERA, EFT, etc.).
    e. Reasonable appeal submission (12 months), denial overturn requirements placed on the MCO based on medical necessity, processing deadlines and required Plan response times.

It would be strongly recommended that Kansas Medicaid adopt this as required language in standard template contracts between MCOs and hospitals.

Important Definitions

Claim: *A paper or electronic billing instrument that consists of a complete UB-04 or CMS 1450, as applicable, data set, or their respective successor forms, with entries stated as mandatory by the National Uniform Billing Committee, and with respect to electronic claim forms, completed in the format and with the data content and data conditions specified in HIPAA.*

Covered Services: *Health care services and supplies that a Member is entitled to receive which are reimbursable by Plan pursuant to the rate attachment which sets out the Facility's reimbursement under the Managed Medicaid Program.*

Plan is liable and must pay Facility for any Covered Services provided to Members which are authorized by the Plan or its agent unless Facility knowingly provided false and misleading information upon which the authorization was granted.

Plan shall not deny a Claim for Emergency Services and Care because the condition, which appeared to be an Emergency Medical Condition under the prudent layperson standard, was subsequently determined not to be an emergent condition.

Plan agrees that it will not deny payment solely because Facility fails to verify eligibility or obtain pre-authorization for services rendered to Members. This will not relieve Facility of its obligations in the normal course of business to make responsible attempts to obtain authorization for non-emergency services if so required by Plan's Policies.

If Facility's Claim is partially or totally denied in a remittance advice or other appropriate written notice, then Facility may submit an appeal to Plan within twelve (12) months of the receipt of the partial or total denial of the Claim. The appeal should include any documentation or information reasonably necessary to support the appeal for reconsideration. Plan must respond to the appeal within sixty (60) days after receipt of the request.

Notwithstanding any provision in the Agreement to the contrary, Facility may appeal and Plan shall review Claims that were totally or partially denied for Facility's failure to i) file a Claim within the time limit set forth in the Agreement; ii) provide a notice required by the Agreement; iii) follow Plan Policies; iv) determine eligibility; or v) obtain an authorization, to determine if the services rendered were Covered Services, were Medically Necessary and would have been authorized had prior authorization been sought. If in its evaluation of Facility's reconsideration request, Plan reasonably determines, following review by a physician licensed in the State of Kansas in the medical specialty most clinically applicable to the case in question, that the services provided by Facility were Covered Services, were Medically Necessary and appropriate for the Covered Person's condition, and would have been authorized by Plan, then Plan shall reverse its denial and reimburse Facility in accordance with terms outlined in the Agreement within ten (10) days of such determination.

Out of Network Protections

5. Clear guidelines for out-of-network (OON) payments.
   a. Should not unfairly advantage the MCOs over Providers.
   b. Providers should not be penalized for not being able to reach agreement with the MCOs.
   c. Thus, the 10% rate penalty contained in the current RFP needs to be stricken in its entirety.
   d. In its place, the regulations should require MCOs to reimburse out-of-network providers subject to a premium of 10% over the traditional Medicaid rates, (a) as a penalty for failing to develop an adequate provider network, and (b) to motivate MCOs to negotiate in good faith with providers.
6. The reasonable attempt to contract language in the RFP does not protect providers.

Other Suggested Contract Language Protections

Member Loss of Eligibility: *For a Member whose request for Facility services was authorized, and who later is determined to be ineligible for Plan benefits due to enrollment in another Medicaid Managed Care Plan, Plan must notify Facility within thirty (30) days of inpatient discharge or outpatient date of service that the Member became ineligible. Plan may request a refund of amounts paid for that Member within the above referenced thirty (30) day timeframe, regardless of any alternative time periods provided for under this Agreement. However, if Member returns to coverage under traditional Medicaid fee for service, Plan may request a refund of amounts paid so long as the Medicaid claims filing deadline has not expired, regardless of any alternative time periods provided for under this Agreement. Facility may collect from the Member any amounts for services rendered subsequent to the loss of coverage under the applicable Managed Medicaid Plan.*

Service Availability: *Plan acknowledges not all Covered Services are available on a 24 hour per day, 7 days per week basis (e.g. cardiac catheterization laboratory, outpatient surgery, certain diagnostic testing, etc.). Accordingly, Plan will not deny Claims or otherwise penalize Facility for services that are not made available and provided to Members on a 24 hour per day, 7 days per week basis consistent with standards of the Facility in question as are applied to all other of Facility's patients.*

Prompt Denial Process: *If Plan contests Facility's Claim or any portion of a Claim, Plan shall notify Facility in writing within thirty (30) days after Receipt of the Claim by Plan that the Claim is contested. The notice that*

the Claim is contested must specifically identify the contested portion of the Claim and the specific reason for contesting the Claim, and must include a request identifying the specific additional medical information required. If Plan requests additional medical information, Facility must, within thirty (30) days after receipt of such request, mail or electronically transfer the information to Plan. Plan shall pay the Claim or portion of the Claim within twenty (20) days after receipt of the requested information.

Timeframes for Under/Overpayment and no Offsetting: *With the exception of those extenuating circumstances set forth in Section 4(a), above (e.g., COB, Facility unable to timely identify a patient as a Plan member through no fault of Facility, etc.), and regardless of any provision to the contrary, no request shall be allowed for any alleged overpayment or underpayment made more than three hundred and sixty-five (365) days from inpatient discharge dates and outpatient service dates, as applicable. Neither party has a right of offset, any right of retroactive reductions in payment, or any right to demand a refund of alleged overpayment or underpayment unless performed in accordance with this Agreement or mutually agreed upon in writing by the parties.*