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2 89th General Assembly

A Bill

3 Regular Session, 2013

SENATE BILL 788

4

5 By: Senators Irvin, *Bledsoe*

6 By: Representatives *Ferguson, Nickels, Wardlaw*

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For An Act To Be Entitled

9 AN ACT TO AMEND THE MEDICAID FAIRNESS ACT TO CLARIFY
10 LEGISLATIVE INTENT, STRENGTHEN DUE PROCESS, AND
11 PROVIDE FOR INDEPENDENT ADMINISTRATIVE LAW JUDGES TO
12 HEAR APPEALS BY PROVIDERS WHO DELIVER SERVICES TO
13 BENEFICIARIES; TO DECLARE AN EMERGENCY; AND FOR OTHER
14 PURPOSES.

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Subtitle

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BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

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SECTION 1. Arkansas Code § 20-77-1702(2) and (3), concerning
27 definitions for the Medicaid Fairness Act, are amended to read as follows:

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(2)(A) "Adverse decision" means any decision by the Department
of Human Services or its reviewers or contractors that adversely affects a
Medicaid provider or recipient in regard to:

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(i) ~~receipt~~ Receipt of and payment for Medicaid
claims and services, including, but not limited to, decisions as to:

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~~(A)~~(a) Appropriate level of care or coding;

~~(B)~~(b) Medical necessity;

~~(C)~~(c) Prior authorization;

~~(D)~~(d) Concurrent reviews;



1 ~~(E)~~(e) Retrospective reviews;
2 ~~(F)~~(f) Least restrictive setting;
3 ~~(G)~~(g) Desk audits;
4 ~~(H)~~(h) Field audits and onsite audits; and
5 ~~(I)~~(i) Inspections or surveys; and
6 (ii) Payment amounts due to or from a particular
7 provider resulting from gain sharing, risk sharing, incentive payments, or
8 another reimbursement mechanism or methodology, including calculations that
9 affect or have the potential to affect payment.

10 (B) To constitute an adverse decision, an agency decision
11 need not have a monetary penalty attached but must have a direct monetary
12 consequence to the provider.

13 (C) "Adverse decision" does not include the design of or
14 changes to an element of a reimbursement methodology or payment system that
15 is of general applicability and implemented through the rule-making process;

16 (3) "Appeal" means an appeal ~~under the Arkansas Administrative~~
17 ~~Procedure Act, § 25-15-201 et seq.~~ of an adverse decision to an independent
18 administrative law judge as provided under this subchapter;

19
20 SECTION 2. Arkansas Code § 20-77-1702(11), concerning definitions for
21 the Medicaid Fairness Act, is amended to read as follows:

22 (11) "Medicaid" means the medical assistance program under Title
23 XIX and Title XXI of the Social Security Act that is operated by the
24 department, including contractors, fiscal agents, and all other designees and
25 agents;

26
27 SECTION 3. Arkansas Code § 20-77-1702(19), concerning definitions for
28 the Medicaid Fairness Act, is amended to read as follows:

29 (19)(A) "Technical deficiency" means an error or omission in
30 documentation by a provider that does not affect direct patient care of the
31 recipient.

32 (B) "Technical deficiency" does not include:

33 (i) Lack of medical necessity according to
34 professionally recognized local standards of care;

35 (ii) Failure to provide care of a quality that meets
36 professionally recognized local standards of care;

1 (iii) Failure to document a mandatory quality
 2 measure required for gain sharing or medical home or health home incentive
 3 payments as specified in a reimbursement mechanism or methodology;

4 ~~(iii)~~(iv) Failure to obtain prior or concurrent
 5 authorization if required by regulation;

6 ~~(iv)~~(v) Fraud;

7 ~~(v)~~(vi) Abuse;

8 ~~(vi)~~(vii) A pattern of noncompliance; or

9 ~~(vii)~~(viii) A gross and flagrant violation.

10
 11 SECTION 4. Arkansas Code §§ 20-77-1703 and 20-77-1704 are amended to
 12 read as follows:

13 20-77-1703. ~~Technical deficiencies~~ Recoupment.

14 (a)(1) The Department of Human Services shall not use a technical
 15 deficiency as grounds for recoupment unless identifying the technical
 16 deficiency as an overpayment is mandated by a specific federal statute or
 17 regulation or the state is required to repay the funds to the Centers for
 18 Medicare & Medicaid Services, or both.

19 (2) When recoupment is permitted, the department shall not
 20 recoup until there is a final determination identifying the funds to be
 21 recouped as overpayments.

22 (b)(1) The department shall recognize that an error or omission is a
 23 technical deficiency if:

24 (A) The error or omission meets the definition of
 25 "technical deficiency" in § 20-77-1702;

26 (B) The error or omission involved a covered service; and

27 (C) The provider can substantiate through other
 28 documentation that the medical assistance was provided.

29 (2) ~~Documentation~~ Other documentation under subdivision
 30 (b)(1)(C) of this section shall be:

31 (A) In accord with generally accepted health care
 32 practices; and

33 (B) Contemporaneously created.

34 (3) Other documentation under subdivision (b)(1)(C) of this
 35 section is not required to be equivalent in form to nor required to duplicate
 36 the documentation containing the error or omission, if all the documentation

1 taken together establishes that the claim is payable.

2 (c) This section does not preclude a corrective action plan or other
3 nonmonetary measure in response to technical deficiencies.

4 (d)(1) If a provider fails to comply with a corrective action plan for
5 a pattern of technical deficiencies, then appropriate monetary penalties may
6 be imposed if permitted by law.

7 (2) However, the department first must be clear as to what the
8 technical deficiencies are by providing clear communication in writing or a
9 promulgated rule when required.

10 (e) The department shall not issue a recoupment on a minor omission
11 such as a missing date or signature if the requirements of this section are
12 met.

13 (f) The department shall not rely on the denial of one (1) claim as
14 the sole basis for the denial of a subsequent claim and shall establish that
15 the subsequent claim is deficient.

16
17 20-77-1704. Provider administrative appeals allowed.

18 (a) The General Assembly finds it necessary to:

19 (1) Clarify its intent that providers have the *right to fair and*
20 *impartial*

21
22 administrative appeals; and

23 (2) Emphasize that this right of appeal is to be liberally
24 construed and not limited through technical or procedural arguments by the
25 Department of Human Services.

26 (b)(1) In response to an adverse decision, a provider may appeal on
27 behalf of the recipient or on its own behalf, or both, ~~under the Arkansas~~
28 ~~Administrative Procedure Act, § 25-15-201 et seq.,~~ regardless of whether the
29 provider is an individual or a corporation.

30 (B)(i) A provider appeal shall be governed by the Arkansas
31 Administrative Procedure Act, § 25-15-201 et seq., except as otherwise
32 provided in this subchapter.

33 (ii) Multiple appeals by the same provider may be
34 consolidated.

35 (C) An administrative law judge employed by the Department
36 of Health shall conduct all Medicaid provider administrative appeals of

1 adverse decisions under this subchapter.

2 (2) The provider may appear:

3 (A) In person or through a corporate representative; or

4 (B) With prior notice to the department, through legal
5 counsel.

6 (3)(A) A Medicaid recipient may attend any hearing related to
7 his or her care, but the department may not make his or her participation a
8 requirement for provider appeals.

9 (B) The department may compel the recipient's presence via
10 subpoena, but failure of the recipient to appear shall not preclude the
11 provider appeal.

12 (c)(1) An administrative law judge shall be guided by the need to
13 reach a just determination, and may depart from strict adherence to the
14 formal rules of evidence.

15 (2) An administrative law judge shall exclude irrelevant,
16 immaterial, and unduly repetitious evidence.

17 (3) An administrative law judge shall receive oral or
18 documentary evidence not privileged if the oral or documentary evidence is of
19 a type commonly relied upon by a reasonably prudent person in the conduct of
20 his or her affairs.

21 (4) An administrative law judge shall rule on each evidentiary
22 objection, and the objection and ruling shall be noted of record.

23 (d)(1)(A) If a provider submits evidence that the Department of Human
24 Services has not had an opportunity to consider before the hearing, an
25 administrative law judge shall continue the hearing for thirty (30) days to
26 allow the Department of Human Services to review the evidence.

27 (B) An administrative law judge may extend the thirty-day
28 continuation under subdivision (d)(1)(A) of this section for good cause.

29 (2) Before the end of a continuation under subdivision (d)(1),
30 the Department of Human Services shall send the provider and the
31 administrative law judge notice stating whether the Department of Human
32 Services will modify its decision with an explanation of the modification.

33 (3)(A) Unless the provider notifies the administrative law judge
34 and the Department of Human Services that the provider wishes to withdraw its
35 appeal, the administrative law judge shall notify the parties of the date and
36 time at which the hearing will continue.

1 (B) The date under subdivision (d)(3)(A) of this section
2 shall be no later than thirty (30) days after the Department of Human
3 Services' notification under subdivision (d)(2) of this section.

4 ~~(e)~~(e) A provider does not have standing to appeal a ~~nonpayment~~
5 decision denying payment or ordering recoupment of payments already made if
6 the provider has not furnished any service for which payment has been denied.

7 ~~(d)~~(f)(1) Providers, like Medicaid recipients, have standing to appeal
8 to circuit court unfavorable administrative decisions under the Arkansas
9 Administrative Procedure Act, § 25-15-201 et seq.

10 (2) The Department of Human Services may seek judicial review of
11 a final, appealable order issued by an administrative law judge.

12 (g) Burdens of proof shall be determined under the Arkansas
13 Administrative Procedure Act, § 25-15-201 et seq.

14 (h)(1)(A) A final decision by an administrative law judge in favor of
15 a provider is a final appealable order.

16 (B) A final decision under this section shall not be
17 overturned by the Director of the Division of Medical Services of the
18 Department of Human Services or another official within the Department of
19 Human Services.

20 (2)(A) Within thirty (30) days after the effective date of this
21 section, the Department of Human Services shall request a waiver from the
22 Centers for Medicare and Medicaid Services of the single state agency
23 requirement contained in 42 C.F.R. 431.10 to allow final decisions in
24 Medicaid provider administrative appeals to be issued by an administrative
25 law judge in a separate agency.

26 (B) An administrative law judge shall follow the rules
27 adopted by the Department of Human Services in making final decisions.

28 (3) The Department of Human Services shall make available to the
29 public all communications with regard to the waiver application under
30 subdivision (h)(2)(A) of this section and shall work jointly with provider
31 representatives to obtain and maintain approval for the waiver.

32 (i)(1) Until the waiver under subdivision (h)(2) of this section is
33 approved, an administrative law judge's decision shall constitute a
34 recommended decision to the Director of the Division of Medical Services.

35 (2)(A) The Director of the Division of Medical Services, upon a
36 review of the record submitted by an administrative law judge, shall adopt,

1 reject, or modify the recommended decision.

2 (B) A modification or rejection of an administrative law
 3 judge's decision shall state with particularity the reasons for the
 4 modification or rejection, shall include references to the record, and shall
 5 constitute the final decision.

6 (C) As an alternative to the process under subdivision
 7 (i)(2)(B) of this section, the Director of the Division of Medical Services
 8 may remand the decision to the administrative law judge with additional
 9 guidance on Medicaid policy.

10 (3)(A) The Director of the Division of Medical Services shall
 11 issue a final decision under this subsection within thirty (30) days after
 12 receipt of the administrative law judge's decision.

13 (B) Unless the Director of the Division of Medical
 14 Services modifies or rejects the recommended decision of the administrative
 15 law judge within thirty (30) days after receipt of the administrative law
 16 judge's decision, the recommended decision is the final decision.

17 ~~(e)(j)~~ If an administrative appeal is filed by both provider and
 18 recipient concerning the same subject matter, then the department may
 19 consolidate the appeals.

20 ~~(f)(k)(1)~~ This subchapter shall apply to all pending and subsequent
 21 appeals that have not been finally resolved at the administrative or judicial
 22 level as of April 5, 2005.

23 (2) The amendatory provisions of this act apply to a pending and
 24 subsequent appeal that has not been finally resolved at the administrative or
 25 judicial level on the effective date of this act.

26
 27 SECTION 5. Arkansas Code §§ 20-77-1707 and 20-77-1708 are amended to
 28 read as follows:

29 20-77-1707. Prior authorizations – Retrospective reviews.

30 ~~The Department of Human Services may not retrospectively recoup or deny~~
 31 ~~a claim from a provider if the department previously authorized the Medicaid~~
 32 ~~care If the Department of Human Services requires a provider to justify the~~
 33 ~~medical necessity of a service through prior authorization, the department~~
 34 ~~shall not later take the position that the services were not medically~~
 35 ~~necessary, unless: (1) The the retrospective review establishes that:~~

36 ~~(1)(4)~~ The previous authorization was based upon

1 misrepresentation by act or omission; ~~and or~~

2 ~~(2)(A) The previous authorization was based upon conditions that~~
3 ~~later changed, thereby rendering the Medicaid care medically unnecessary.~~

4 ~~(B) Recoupments based upon lack of medical necessity shall~~
5 ~~not include payments for any Medicaid care that was delivered before the~~
6 ~~change of circumstances that rendered the care medically unnecessary~~

7 (2) The services billed were not provided; or

8 (3) An unexpected change occurred that rendered the prior-
9 authorized care not medically necessary.

10
11 20-77-1708. Medical necessity.

12 (a) There is a presumption in favor of the medical judgment of the
13 performing or prescribing physician in determining medical necessity of
14 treatment.

15 (b) If an administrative law judge finds that the Department of Human
16 Services has overcome the presumption under subsection (a) of this section,
17 he or she shall state the manner by which the presumption was overcome.

18
19 SECTION 6. Arkansas Code § 20-77-1715 is amended to read as follows:
20 20-77-1715. Federal law.

21 (a) If any provision of this subchapter is found to conflict with
22 current federal law, including promulgated federal regulations, the federal
23 law shall override that provision.

24 (b) If under Titles XIX or XXI of the Social Security Act, the federal
25 government recovers an erroneous or improper medical assistance payment from
26 the Department of Human Services, the department may recover the erroneous or
27 improper medical assistance payment from the provider that received the
28 payment or from a successor in interest who is legally responsible for the
29 erroneous or improper medical assistance payment.

30
31 SECTION 7. Arkansas Code Title 20, Chapter 77, Subchapter 17, is
32 amended to add two additional sections to read as follows:

33 20-77-1717. Timelines for audits.

34 (a) If a Medicaid provider audit by the Medicaid Integrity Program or
35 Audit Medicaid Integrity Contractors is conducted, the Department of Human
36 Services or the contractor shall provide the audit report to the provider

1 within one hundred fifty (150) days after the completion of the audit field
2 work.

3 (b) If a provider requests an administrative reconsideration of an
4 audit finding or report, the department shall provide the results of the
5 reconsideration within sixty (60) days after the department's receipt of the
6 request for reconsideration.

7 (c) Additional provider records furnished by a provider in conjunction
8 with a provider's request for administrative reconsideration shall have been
9 contemporaneously created.

10 (d) If there is a failure to meet the timelines specified in this
11 section, no adverse decision based on the noncompliant audit shall be
12 enforced against the provider unless the department shows good cause for the
13 failure to meet the timelines.

14
15 20-77-1718. Termination – Appeals.

16 (a) A Medicaid provider that is aggrieved by an adverse decision of
17 the Department of Human Services with respect to termination of the
18 provider's certification or Medicaid provider agreement or an action by the
19 department that has the same effect as terminating the provider's
20 certification or Medicaid provider agreement for more than fifteen (15) days
21 may appeal the decision to Pulaski County Circuit Court or in a circuit court
22 in a county in which the provider resides or does business, regardless of
23 whether all administrative remedies have been exhausted.

24 (b) Pending a determination by the circuit court of the matter on
25 appeal, the provider is entitled to an injunction preserving the provider's
26 Medicaid participation upon showing that immediate and irreparable injury,
27 loss, or damage to the provider will result, unless the circuit court
28 determines that preserving the provider's participation is likely to pose a
29 danger to the health or safety of beneficiaries.

30 (c) This section does not apply to an adverse decision resulting from
31 the department's determination that there is a credible allegation of fraud
32 for which an investigation is pending.

33
34 ~~SECTION 8. EMERGENCY CLAUSE. It is found and determined by the~~
35 ~~General Assembly of the State of Arkansas that clarifications and changes in~~
36 ~~state law are needed for Medicaid providers to have a fair appeals process~~

1 ~~and to interact with the Medicaid program as envisioned under the Medicaid~~
2 ~~Fairness Act. It is further found and determined that Medicaid providers are~~
3 ~~entitled to a fair and impartial hearing with a neutral decision maker, that~~
4 ~~the most effective and efficient way to accomplish this is to utilize~~
5 ~~administrative law judges hired through the Department of Health to hear all~~
6 ~~provider appeals under the act, and that subdivision 20-77-1704(b)(1)(C)~~
7 ~~becomes effective on July 1, 2013. Therefore, an emergency is declared to~~
8 ~~exist, and this act being immediately necessary for the preservation of the~~
9 ~~public peace, health, and safety shall become effective on:~~
10 ~~_____ (1) The date of its approval by the Governor;~~
11 ~~_____ (2) If the bill is neither approved nor vetoed by the Governor,~~
12 ~~the expiration of the period of time during which the Governor may veto the~~
13 ~~bill; or~~
14 ~~_____ (3) If the bill is vetoed by the Governor and the veto is~~
15 ~~overridden, the date the last house overrides the veto.~~

16
17 */s/ Irvin*

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19 **Emergency clause failed of adoption.**

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21 **APPROVED: 04/02/2013**