

1 State of Arkansas
2 89th General Assembly
3 Regular Session, 2013
4

As Engrossed: S3/8/13

A Bill

SENATE BILL 788

5 By: Senators Irvin, *Bledsoe*
6 By: Representatives *Ferguson, Nickels, Wardlaw*
7

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.

Subtitle

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18 TO AMEND THE MEDICAID FAIRNESS ACT TO
19 STRENGTHEN DUE PROCESS FOR PROVIDERS WHO
20 DELIVER SERVICES; AND TO DECLARE AN
21 EMERGENCY.
22
23

24 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
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26 SECTION 1. Arkansas Code § 20-77-1702(2) and (3), concerning
27 definitions for the Medicaid Fairness Act, are amended to read as follows:

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

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

- 33 ~~(A)~~(a) Appropriate level of care or coding;
- 34 ~~(B)~~(b) Medical necessity;
- 35 ~~(C)~~(c) Prior authorization;
- 36 ~~(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;
- 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; and
- 10 (iii) An agency decision that may have a monetary
- 11 penalty but does not have a direct monetary consequence to the provider.
- 12 (B) "Adverse decision" does not include the design of or
- 13 changes to an element of a reimbursement methodology or payment system that
- 14 is of general applicability and implemented through the rule-making process;
- 15 (3) "Appeal" means an appeal ~~under the Arkansas Administrative~~
- 16 ~~Procedure Act, § 25-15-201 et seq.~~ of an adverse decision to an independent
- 17 administrative law judge as provided under this subchapter;

18

19 SECTION 2. Arkansas Code § 20-77-1702(11), concerning definitions for

20 the Medicaid Fairness Act, is amended to read as follows:

21 (11) "Medicaid" means the medical assistance program under Title

22 XIX and Title XXI of the Social Security Act that is operated by the

23 department, including contractors, fiscal agents, and all other designees and

24 agents;

25

26 SECTION 3. Arkansas Code § 20-77-1702(19), concerning definitions for

27 the Medicaid Fairness Act, is amended to read as follows:

28 (19)(A) "Technical deficiency" means an error or omission in

29 documentation by a provider that does not affect direct patient care of the

30 recipient.

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

- 32 (i) Lack of medical necessity according to
- 33 professionally recognized local standards of care;
- 34 (ii) Failure to provide care of a quality that meets
- 35 professionally recognized local standards of care;
- 36 (iii) Failure to document a mandatory quality

1 measure required for gain sharing or medical home or health home incentive
 2 payments as specified in a reimbursement mechanism or methodology;

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

5 ~~(iv)~~(v) Fraud;

6 ~~(v)~~(vi) Abuse;

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

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

9
 10 SECTION 4. Arkansas Code §§ 20-77-1703 and 20-77-1704 are amended to
 11 read as follows:

12 20-77-1703. ~~Technical deficiencies~~ Recoupment.

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

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

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

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

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

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

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

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

32 (B) Contemporaneously created.

33 (3) Other documentation under subdivision (b)(1)(C) of this
 34 section may be equivalent in form to or duplicative of the documentation
 35 containing the error or omission, if the documentation taken together
 36 establishes that the claim is payable.

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

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

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

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

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

15
16 20-77-1704. Provider administrative appeals allowed.

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

18 (1) Clarify its intent that providers have the right to
19 administrative appeals; and

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

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

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

30 (ii) Multiple appeals by the same provider may be
31 consolidated.

32 (C) An administrative law judge employed by the Department
33 of Health shall conduct a Medicaid provider administrative appeal of an
34 adverse decision under this subchapter.

35 (2) The provider may appear:

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

1 (B) With prior notice to the department, through legal
2 counsel.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 (g) The burden of proof regarding recoupment shall be determined under
10 the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

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

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

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

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

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

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

32 (2)(A) The Director of the Division of Medical Services, upon a
33 review of the record submitted by an administrative law judge, shall adopt,
34 reject, or modify the recommended decision.

35 (B) A modification or rejection of an administrative law
36 judge's decision shall state with particularity the reasons for the

1 modification or rejection, shall include references to the record, and shall
2 constitute the final decision.

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

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

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

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

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

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

23
24 SECTION 5. Arkansas Code §§ 20-77-1707 and 20-77-1708 are amended to
25 read as follows:

26 20-77-1707. Prior authorizations – Retrospective reviews.

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

33 (1)(A) The previous authorization was based upon
34 misrepresentation by act or omission; and

35 (B) If the facts had been known, the specific level of
36 care would not have been authorized; or

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

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

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

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

9
10 20-77-1708. Medical necessity.

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

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

17
18 SECTION 6. Arkansas Code § 20-77-1715 is amended to read as follows:
19 20-77-1715. Federal law.

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

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

29
30 SECTION 7. Arkansas Code Title 20, Chapter 77, Subchapter 17, is
31 amended to add two additional sections to read as follows:

32 20-77-1717. Timelines for audits.

33 (a) If a Medicaid provider audit by the Medicaid Integrity Program or
34 Audit Medicaid Integrity Contractors is conducted, the Department of Human
35 Services or the contractor shall provide the audit report to the provider
36 within one hundred twenty (120) days after the completion of the audit field

1 work.

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

6 (c) If there is a failure to meet the timelines specified in this
7 section, no adverse decision based on the noncompliant audit shall be
8 enforced against the provider unless the department shows good cause for the
9 failure to meet the timelines.

10
11 20-77-1718. Termination – Appeals.

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

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

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

29
30 SECTION 8. EMERGENCY CLAUSE. It is found and determined by the
31 General Assembly of the State of Arkansas that clarifications and changes in
32 state law are needed for Medicaid providers to have a fair appeals process
33 and to interact with the Medicaid program as envisioned under the Medicaid
34 Fairness Act. It is further found and determined that Medicaid providers are
35 entitled to a fair and impartial hearing with a neutral decision maker, that
36 the most effective and efficient way to accomplish this is to utilize

1 administrative law judges hired through the Department of Health to hear all
2 provider appeals under the act, and that subdivision 20-77-1704(b)(1)(C)
3 becomes effective on July 1, 2013. Therefore, an emergency is declared to
4 exist, and this act being immediately necessary for the preservation of the
5 public peace, health, and safety shall become effective on:

6 (1) The date of its approval by the Governor;

7 (2) If the bill is neither approved nor vetoed by the Governor,
8 the expiration of the period of time during which the Governor may veto the
9 bill; or

10 (3) If the bill is vetoed by the Governor and the veto is
11 overridden, the date the last house overrides the veto.

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13 */s/Irvin*
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