State of Arkansas *As Engrossed: S3/8/13 S3/12/13 S3/19/13*
89th General Assembly **A Bill**
Regular Session, 2013 SENATE BILL 788

By: Senators Irvin, *Bledsoe*
By: Representatives Ferguson, Nickels, Wardlaw

For An Act To Be Entitled

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

Subtitle

TO AMEND THE MEDICAID FAIRNESS ACT TO STRENGTHEN DUE PROCESS FOR PROVIDERS WHO DELIVER SERVICES; AND TO DECLARE AN EMERGENCY.

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

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

(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:

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

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

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

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

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

~~(E)~~(e) Retrospective reviews;

~~(F)~~(f) Least restrictive setting;

~~(G)~~(g) Desk audits;

~~(H)~~(h) Field audits and onsite audits; and

~~(I)~~(i) Inspections *or surveys; and*

(ii) Payment amounts due to or from a particular provider resulting from gain sharing, risk sharing, incentive payments, or another reimbursement mechanism or methodology, including calculations that affect or have the potential to affect *payment.*

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

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

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

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

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

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

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

(B) "Technical deficiency" does not include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Contemporaneously created.

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

taken together establishes that the claim is payable.

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

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

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

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

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

20-77-1704. Provider administrative appeals allowed.

(a) The General Assembly finds it necessary to:

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

administrative appeals; and

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

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

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

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

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

adverse decisions under this subchapter.

(2) The provider may appear:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

reject, or modify the recommended decision.

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

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

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

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

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

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

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

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

20-77-1707. Prior authorizations — Retrospective reviews.

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

(1)~~(A)~~ The previous authorization was based upon

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

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

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

(2) The services billed were not provided; or

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

20-77-1708. Medical necessity.

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

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

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

20-77-1715. Federal law.

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

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

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

20-77-1717. Timelines for audits.

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

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

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

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

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

20-77-1718. Termination — Appeals.

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

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

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

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

and to interact with the Medicaid program as envisioned under the Medicaid Fairness Act. It is further found and determined that Medicaid providers are entitled to a fair and impartial hearing with a neutral decision maker, that the most effective and efficient way to accomplish this is to utilize administrative law judges hired through the Department of Health to hear all provider appeals under the act, and that subdivision 20-77-1704(b)(1)(C) becomes effective on July 1, 2013. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

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

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

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

/s/Irvin