STATEMENT OF CONSIDERATION RELATING TO
907 KAR 17:015

Department for Medicaid Services
Not Amended After Comments

(1) A public hearing regarding 907 KAR 17:015 was not requested and; therefore, not held.

(2) The following individuals submitted written comments regarding 907 KAR 17:015:

Name and Title	Organization/Agency/Other Entity
Kathy Adams, Director of Public Policy	The Children's Alliance; Frankfort, KY
Nancy C. Galvagni, Senior Vice President	Kentucky Hospital Association; Louisville, KY

(3) The following individuals from the promulgating agency responded to comments received regarding 907 KAR 17:015:

Name and Title	Organization/Agency/Other Entity
Christina Heavrin, General Counsel	Cabinet for Health and Family Services
Stuart Owen, Regulation Coordinator	Department for Medicaid Services

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Section 1: Provider Network

(a) Comment: Kathy Adams, Director of Public Policy of The Children's Alliance, stated the following:

"The Children's Alliance is in favor of the provisions that clarify that the Department for Medicaid Services (DMS) has authority to determine if an MCO's provider network is inadequate and adding a proximity requirement (mileage and time) for enrollee's access to providers, which previously had no proximity requirement (pharmacies, dentists, general vision, laboratory and radiological services) [*ensures recipients have reasonable access to those provider types*]. However, the Children's Alliance requests that timeframes be added to Section 1 to indicate how long the MCO has to meet/fulfill the Section 1 requirements, especially Subsection (4) and (5). Additionally, the Children's Alliance requests that provisions to provide oversight and address non-compliance be added to the regulation. What are the repercussions for non-compliance

with these regulatory requirements (the entire regulation, not just Section 1)? Children's Alliance members continue to experience inadequate access to services, especially specialty services like oral surgeons, and often have to drive long distances to access these services for their clients."

(b) Response: The Department for Medicaid Services (DMS) has the authority to determine inadequate access. DMS has a contract with each managed care organization (MCO) and among the terms and conditions of the contracts are requirements regarding provider network adequacy and DMS's remedies for addressing MCO failure to comply with contractual requirements. The contracts possess the necessary authority for DMS to police this issue.

(c) Comment: Nancy Galvagni, Senior Vice President of the Kentucky Hospital Association stated the following:

"Section 1 of this rule sets out requirements for providers that the MCO shall attempt to enroll in their network. KHA and hospitals recommend that this section be amended to add that the MCOs shall be required to enroll hospitals which are 340B providers. This would make this rule consistent with the Health Benefit Exchange which recognizes 340B providers as essential providers which also must be in the networks for qualified health plans."

(d) Response: The health benefit exchange is an "open market" for health insurance plans while Medicaid managed care is a benefit program. Network flexibility is a necessary tool for managed care organizations to manage costs.

(2) Subject: Section 2: Network Adequacy Standards

(a) Comment: Nancy Galvagni, Senior Vice President of the Kentucky Hospital Association stated the following:

"Section 2 of this rule sets out specific network adequacy standards. KHA and its members are **strongly opposed** to the proposed rule which weakens the network adequacy standards for access to rural hospitals and to behavioral health and rehabilitation providers. Specifically, this rule would change the existing network adequacy standard for these types of hospitals by increasing the travel time for rural residents and enrollees needing acute care, behavioral and physical rehabilitation services to 60 miles, not just 60 minutes which is the current standard. Federal Medicaid regulations require that MCO network adequacy be assessed on the basis of the mode of transportation normally used by Medicaid enrollees, which is road miles. In a rural area, most roads have low speed limits. Therefore, it will take most rural enrollees more than 60 minutes to drive 60 miles. In fact, by including the 60 mile standard, rural residents could be forced to travel 90 minutes or more to access hospital services, yet still be considered to have access to an adequate hospital network. Increasing the travel time through the inclusion of a 60 mile standard will allow MCOs to

have fewer acute care hospitals, behavioral health, and physical rehabilitation service providers in their networks and still meet network adequacy."

(b) Response: The actual standard approved by the Centers for Medicare and Medicaid Services (CMS) was the sixty mile standard. This amendment clarifies that the standard is sixty miles or sixty minutes.

(c) Comment: Nancy Galvagni, Senior Vice President of the Kentucky Hospital Association stated the following:

"The network adequacy standards under private managed care are 30 miles or 30 minutes statewide for hospital care. Not only does the existing Medicaid MCO network adequacy standard increase the travel time two-fold, but this newest addition of 60 miles will exacerbate the double standard for Medicaid patients by requiring them to potentially have to travel up to three times longer than a privately insured patient for the receipt of hospital care as well as behavioral health and physical rehab services. We believe this is in conflict with federal rules which govern Medicaid managed care which require that MCO provider networks be comparable to the access which is available to commercially insured patients."

(d) Response: Actually, the private realm managed care standards (pursuant to KRS 304.17A-515) are thirty miles or thirty minutes "to the extent that services are available." If an insurer cannot reach agreement with a given provider, then the provider is not available.

(e) Comment: Nancy Galvagni, Senior Vice President of the Kentucky Hospital Association stated the following:

"The Medicaid program has historically struggled to have robust provider participation, and has sought to enroll as many providers as possible to increase Medicaid patient access to care. This rule moves in the opposite direction because it allows MCOs from the outset to have fewer providers and allows patients to have to travel further for care. Given the intent of Medicaid managed care is to improve the health of Medicaid patients, weaker network adequacy standards will only work against that goal. For these reasons, KHA strongly urges that the Department adopt the same network adequacy standards for hospital services that apply to all other managed care plans in the state. At a minimum, the new reference to inclusion of a 60 mile standard should be removed from the rule."

(f) Response: One of the goals of managed care is to employ a primary care physician as the main health care provider for a managed care enrollee. While this may limit an enrollee's choices, the continuity of care and the management of disease will improve health outcomes for the enrollee.

(g) Comment: Kathy Adams, Director of Public Policy of The Children's Alliance, stated the following:

“A behavioral health service appointment following a discharge from an acute psychiatric hospital shall occur within fourteen (14) days of discharge. Children’s Alliance members report that this requirement is not being met. Often children are de-certified from the psychiatric hospital without adequate discharge plans in place. Obtaining a behavioral health service appointment via Medicaid in some areas of the state is not possible within fourteen (14) days of a child’s discharge. The Children’s Alliance requests that provisions to provide oversight and address non-compliance be added to the regulation.”

(h) Response: The Department for Medicaid Services (DMS) monitors this requirement and would appreciate any detailed or specific information so that DMS can investigate the specific cases.

Regarding the regulation, DMS has a contract with each managed care organization (MCO) and among the terms and conditions of the contracts are requirements regarding timely access to services as well as DMS’s remedies for addressing MCO failure to comply with contractual requirements. The contracts possess the necessary authority for DMS to police this issue.

(3) Subject: Section 4: Provider Credentialing

(a) Comment: Nancy Galvagni, Senior Vice President of the Kentucky Hospital Association stated the following:

“Section 4 of this rule addresses provider credentialing. KHA and its members request that the rule require MCOs to reimburse a provider back to the date that they make application to participate with the MCO, and not after the provider's credentials have been approved. This has been the longstanding policy of the Department for the good reason that this affords physicians the opportunity to begin treating patients as soon as possible in order to improve access to care.”

(b) Response: This requirement was not established in the request for proposal (RFP) that the Cabinet for Health and Family Services published in soliciting bids from managed care organizations, nor is it established in the contracts between DMS and the managed care organizations. Consequently, DMS is not going to impose it on MCOs in administrative regulation.

(4) Subject: Section 11: Provider Grievances and Appeals

(a) Comment: Nancy Galvagni, Senior Vice President of the Kentucky Hospital Association stated the following:

“Section 11 of this rule sets out requirements for provider grievances and appeals. However, the regulation only gives providers the right to have an appeal back to the same MCO that issued the original denial of care, and no further appeal to the state to

challenge egregious MCO denials which are upheld by the MCO. Federal rules which govern Medicaid managed care permit states to give providers the right to obtain a state fair hearing to challenge MCO denials of coverage and payment. KHA and hospitals strongly urge the Department to include the right of a provider to obtain a state fair hearing. Providers have the ability to access an outside appeal mechanism under private insurance when they continue to disagree with a managed care organization's denial of services or payment. Providers have the right to file an appeal of a coverage denial with the Department of Insurance and to obtain independent external review of a medical necessity denial. The lack of such an appeal mechanism for Medicaid managed care is a deprivation of due process. Without a mechanism to challenge denials, MCOs have an incentive to issue more denials than may be appropriate and the state lacks the ability to obtain knowledge of this occurrence in their monitoring of MCO actions. For these reasons, KHA strongly requests that Section 11 be amended to permit providers to request and obtain a state fair hearing of MCO denials of coverage or payment for services after exhausting the MCO's internal appeals process."

(b) Response: A provider who participates in a given managed care organization's network does so via a contract negotiated by the provider and the given managed care organization. The contract states the specific terms and conditions of participation. Provider appeals' requirements and conditions are under the domain of the provider's contract with the managed care organization.

SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments it received regarding 907 KAR 17:015 and is not amending the administrative regulation.