

Health and Human Services Committee
LB 835
February 23, 2018

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Division of Medicaid & Long-Term Care
Department of Health and Human Services

Good afternoon, Chairman Riepe, and members of the Health and Human Services Committee. My name is Thomas Rocky Thompson (T-H-O-M-A-S R-O-C-K-Y T-H-O-M-P-S-O-N), and I am the Interim Director of the Division of Medicaid and Long-Term Care (MLTC) in the Department of Health and Human Services (DHHS). I am here to testify in opposition of LB 835.

LB 835 would provide an additional level of grievance and appeal rights to providers, mandate the utilization of an external independent third-party reviewer (EITPR) for provider's disputes, and create a streamlined standardized enrollment and credentialing process for providers that participate in managed care.

First, the process of an external independent third-party reviewer appears to conflict with federal law. After an internal appeal with the managed care organization is exhausted, federal law provides that any further appeal is taken through the state fair hearing process. This federal requirement requires the hearing be held before the Medicaid agency. Also, the recent federal managed care rule requires that our members are only subject to one level of appeal at the managed care level and then access the state fair hearing process. As a part of the state fair hearing process, individuals also have the opportunity to a hearing in district court under judicial review if they are not satisfied with the result from the administrative hearing before the department.

The managed care organizations as well as the Department have written processes and procedures in place for all appeals. These process are based on the federal requirements regarding appeal rights. Providers are given this information as they enroll and can access it anytime from the managed care organizations or the department. Under this bill, it is unclear how an external review process would work in conjunction with the state's administrative appeals process. In your handout we have included flow charts with the several different possibilities of where this new process would fit in. Also, due to the current low utilization of the existing state fair hearing process by our providers, it is unknown how many providers would take advantage of this new process.

There are additional concerns this bill could interfere with the department's program integrity functions. Our program integrity team works together with Medicaid fraud and patient abuse unit in the attorney general's office to investigate provider fraud and abuse. There are legal concerns where payment is made to a provider if resolution to a claims dispute is not made within a certain number of days. It is unclear what effect this may have if the provider is later taken to court under the false claims act. This requirement could lead to federal disallowance or payment using only state general funds if the provider legitimately should not have received payment.

LB 835 also requires the Department to streamline the enrollment and credentialing process. I do agree that this is a good idea and would be a process improvement. However, the state does not currently have systems in place to do both enrollment and credentialing together and adding this would come at a cost which is reflected in the fiscal note.

Current Appeal Process

MCO Appeal Process

A provider, on behalf of an enrollee, files an appeal with an MCO of the MCO's "adverse benefit determination", which includes a "denial, in whole or in part, of payment for a service". The appeal must be filed with the MCO within 60 days of the MCO's "adverse benefit determination". See 42 CFR 438.400 and 438.402



The MCO must resolve the appeal no later than 30 days after the MCO received the appeal, although this timeframe may be expedited or extended. See 42 CFR 438.408.



State Fair Hearing

Provider may request a state fair hearing if the MCO upholds the adverse benefit determination. The state fair hearing must be "before the Medicaid agency" See 42 CFR 431.205



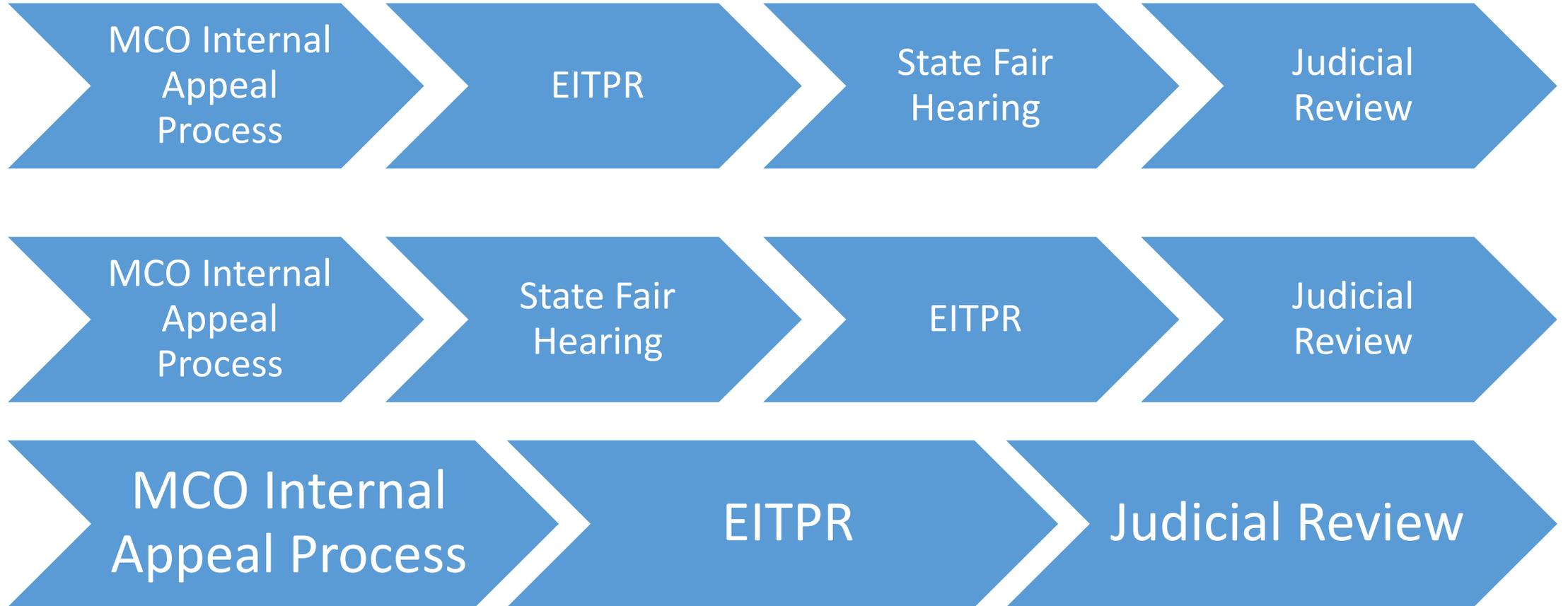
Judicial Review

If the Medicaid agency upholds the MCO's adverse benefit determination, the provider may file a petition in district court under the Nebraska Administrative Procedure Act, NRS 84-917



Further appeal may be taken to the Nebraska Court of Appeals. NRS 84-918

Potential processes with EITPR



MCO Internal Appeals Process

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graph TD; A[MCO Internal Appeals Process] --> B[State Fair Hearing]; A --> C[EITPR]; B --> D[Judicial Review]; C --> E[Judicial Review]
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The diagram is a hierarchical flowchart. At the top is a blue box with the text 'MCO Internal Appeals Process'. A vertical line descends from this box and splits into two horizontal lines. From the left horizontal line, a vertical line goes down to a blue box containing 'State Fair Hearing'. From the right horizontal line, a vertical line goes down to a blue box containing 'EITPR'. From the bottom-left corner of the 'State Fair Hearing' box, a diagonal line goes down to a blue box containing 'Judicial Review'. From the bottom-left corner of the 'EITPR' box, a diagonal line goes down to a blue box containing 'Judicial Review'.

State Fair
Hearing

EITPR

Judicial Review

Judicial Review

Behavioral Health Appeals

In the first three (3) quarters of 2017 there were over fourteen thousand (14,000) enrolled behavioral health providers. During that time three hundred eighty five (385) behavioral health appeals were filed with the managed care organizations and one (1) went to the state fair hearing. This shows the current process for appeals in place works. Providers are able to appeal directly to the managed care organization and come to a decision. If providers were not satisfied with the managed care appeal they would be filing additional appeals through the state fair hearing process. A third party appeal process is an added step, outside the scope of federal law, and there is no evidence to show the current processes do not work.