

**Department of State Health Services
Council Agenda Memo for State Health Services Council
September 9-10, 2015**

Agenda Item Title: Amendments to rules, repeal of a rule, and a new rule concerning the Kidney Health Care Program

Agenda Number: 4.a

Recommended Council Action:

For Discussion Only

For Discussion and Action by the Council

Background:

The Kidney Health Care (KHC) Program is located within the Family and Community Health Services Division, Specialized Health Services Section, Purchased Health Services Unit. The program serves Texas residents with an end-stage renal disease (ESRD) diagnosis, who are not Medicaid eligible, and have a gross income of less than \$60,000 annually.

The KHC Program is a safety net for clients with an ESRD diagnosis who may otherwise not have access to or afford ongoing care for their condition. The program provides Medicare Part D premium payment, deductible, and coinsurance benefits; limited drug benefits; travel reimbursement for ESRD-related travel up to 13 round trips monthly; and allowable dialysis and access surgery benefits to 20,005 clients of all ages. The program contracts with providers to deliver covered services.

In fiscal year 2014, 517 clients received a medical benefit, 6,706 clients received a prescription benefit, and 16,415 clients received a transportation benefit. The program's budget for fiscal year 2015 is \$18,587,191 and is supported by general revenue.

Summary:

The purpose of the amendments, repeal, and new rule is to strengthen and clarify understanding of the program; and improve the flow, accuracy, and clarity of the rules. The updated rules will reflect program information accurately for better interpretation of the rules by the public. The rules affect KHC applicants, clients, and providers.

An amendment to Section 61.3 updates the program requirement to align with eligibility requirements of the Social Security Administration. Section 61.6 was moved into new 1 TAC Section 392.605, concerning Kidney Health Care Provider Enrollment Requirements and Effective Dates, to comply with the consolidation of contract and procurement rules under the Health and Human Services Commission. Additionally, new Section 61.11 clarifies the right to appeal for applicants, clients, and providers by outlining the circumstances for which administrative reviews may be requested. The new section aligns the appeal guidelines with other programs located in the Purchased Health Services Unit.

The amendments, repeal, and new rule comply with the four-year review of rules required by Government Code, Section 2001.039.

Key Health Measures:

The program reports the number of clients served and the average monthly cost per KHC client as a required state performance measure.

Data for KHC Program for FY 2015			
	1 st Quarter	2 nd Quarter	Year To Date Unduplicated
Number of Clients Served	17,067	16,556	17,720
Average Cost per Client	\$239	\$295	\$505

The rule changes do not change current program operations, so no changes to program outcomes are anticipated. The rule changes will not increase or decrease the number of clients served or the average cost per client. DSHS will routinely review program data, including application and claim denials, to ensure that the rule changes do not have any unintended consequences on service delivery. DSHS will also review and consider all feedback received from clients, stakeholders, and providers.

Summary of Input from Stakeholder Groups:

The draft rules were solicited via the program website and electronic mail to 4,634 KHC providers and clients, including advocacy groups. The groups solicited include the American Association of Kidney Patients; American Diabetes Association; Coastal Bend Kidney Foundation, Inc.; End-Stage Renal Disease Network of Texas; Juvenile Diabetes Research Foundation, Houston Gulf Coast Chapter; National Association of Social Workers, Texas Chapter; National Kidney Foundation, Serving Texas – Division Office; Texas Diabetes Council; and Texas Renal Coalition.

The program received one recommendation from the End-Stage Renal Disease Network of Texas. The stakeholder suggested that the program’s requirement for clients to re-apply for low-income subsidies annually be revised to align with the requirement set by the Social Security Administration. This recommendation was adapted into the proposed rules.

Upon completion of the draft rules, the program announced an opportunity for stakeholders to review and comment on the proposed rules via the program website and electronic mail. The program did not receive any comments from stakeholders or advocacy groups regarding the proposed rules.

Proposed Motion:

Motion to recommend HHSC approval for publication of rules contained in agenda item #4.a.

Approved by Assistant Commissioner/Director: Evelyn Delgado **Date:** 5/14/2015

Presenter: Carol Labaj **Program:** Purchased Health Services Unit **Phone No.:** 512-776-3104

Approved by CPEA: Carolyn Bivens **Date:** 5/14/2015

Title 25. Health Services
Part 1. Department of State Health Services
Chapter 61. Chronic Diseases
Subchapter A. Kidney Health Care
Amendments §§61.1 - 61.5 and 61.7 - 61.10
Repeal §61.11
New §61.11

Proposed Preamble

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes the amendments to §§61.1 - 61.5 and 61.7 - 61.10, repeal of §61.11, and new §61.11 concerning the Kidney Health Care (KHC) Program (program).

BACKGROUND AND PURPOSE

The KHC Program serves Texas residents with an end-stage renal disease (ESRD) diagnosis, who are not Medicaid eligible, and have a gross income of less than \$60,000 annually. The program provides Medicare Part D premium payment, deductible and coinsurance benefits; limited drug benefits; travel reimbursement for ESRD related travel up to 13 round trips monthly; and allowable dialysis and access surgery benefits.

The KHC rules implement Texas Health and Safety Code, Chapter 42, Kidney Health Care, and set guidelines necessary for the administration of the program. The proposed amendments to §§61.1 - 61.5 and 61.7 - 61.10, repeal of §61.11, and new §61.11 are necessary to strengthen and clarify understanding of the program, and improve flow, accuracy, and clarity of the rules.

Government Code, §2001.039, requires that each state agency review and consider for re-adoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 61.1 - 61.11 have been reviewed, and the department has determined that reasons for adopting the sections continue to exist because rules on this subject are needed to administer the program effectively.

SECTION-BY-SECTION SUMMARY

Proposed amendments to §61.1 update existing language for accuracy and clarity by adding the term "authorized entities" and replacing the acronym "KHC" with the word "program."

Proposed amendments to §61.2 revise existing definitions, remove unnecessary definitions, and add new definitions. New terms used in this subchapter include authorized entity; enrolled provider; incomplete claim; resubmitted claim; and veteran's programs.

Proposed amendments to §61.3 update the program requirement to align with eligibility requirements of the Social Security Administration and replace the acronym "KHC" with the word "program."

Proposed amendments to §61.4 add language which stipulates that applications must be submitted by an authorized entity. The notary requirement was removed to streamline the application process.

Proposed amendments to §61.5 replace the term "drug products" with "supplies" to accurately reflect program benefits; add language that better describes benefit limitations; and replace the acronym "KHC" with the word "program."

Section 61.6 was moved into new 1 TAC §392.605, concerning Kidney Health Care Provider Enrollment Requirements and Effective Dates, to comply with the consolidation of contract and procurement rules under the Health and Human Services Commission. Section 392.605 defines some words and terms used in Subchapter G (relating to Contracting with Providers for Certain DSHS Programs), and establishes certain requirements for providers to qualify as providers for the Kidney Health Care Program. This section also establishes effective dates for all enrolled provider agreements and pharmacy agreements.

Proposed amendments to §61.7 add language that specifies who may file claims; remove reference to the Automated System for Kidney Information Tracking to allow for an updated software application; and replace the acronym "KHC" with the word "program." Amendments in this section also add new language that the program will not pay claims for medical benefits until the provider has entered into a fully executed provider agreement.

Proposed amendments to §61.8 clarify existing language by explaining that claims that do not meet the filing deadlines will be denied; and replacing the term "approved" provider with "enrolled" provider for consistency throughout the subchapter.

Proposed amendments to §61.9 clarify existing language related to client and provider rights and responsibilities; add new language to outline responsibilities for authorized entities; and replace the acronym "KHC" with the word "program."

Proposed amendments to §61.10 clarify existing language by specifying that clients must reapply for benefits when program eligibility is terminated, and by replacing the acronym "KHC" with the word "program."

Proposed new §61.11 clarifies the rights of appeal for applicants, clients, and providers by outlining the circumstances for which an administrative review may be requested.

FISCAL NOTE

Sam Cooper, LMSW-IPR, Director, Specialized Health Services Section, has determined that for each year of the first five years that the sections will be in effect, there will be no fiscal implications to state or local governments as a result of enforcing and administering the sections as proposed.

SMALL AND MICRO-BUSINESSES IMPACT ANALYSIS

Mr. Cooper has also determined that there will be no adverse effect on small businesses or micro-businesses required to comply with the sections as proposed because small businesses and micro-businesses will not be required to alter their business practices in order to comply with the sections.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

Mr. Cooper has determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of the sections. The anticipated benefits include improved consistency and interpretation of the rules for clients and providers, as well as efficiencies in program operations and functions regarding eligibility, enrollment, and administrative reviews.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed amendments, repeal and new rule do not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted by mail to Laura Ethridge, Purchased Health Services Unit, Mail Code 1938, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347; by telephone at (512) 776-3664; or by email to laura.ethridge@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The proposed amendments, repeal, and new section are authorized by Health and Safety Code, §42.003(c), which authorizes the Executive Commissioner of the Health and Human Services Commission to adopt rules necessary to carry out Chapter 42 and to provide adequate kidney care and treatment for citizens of this state; and by Government Code, §531.0055(e), and the Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001.

The proposed amendments, repeal, and new section affect Government Code, Chapter 531; and Health and Safety Code, Chapters 42 and 1001. Review of the sections implements Government Code, §2001.039.

Section for Repeal.

§61.11. Right to Appeal.

Legend: (Proposed Amendment(s))

Single Underline = Proposed new language

[Bold, Print, and Brackets] = Current language proposed for deletion

Regular Print = Current language

(No change.) = No changes are being considered for the designated subdivision

§61.1. General.

(a) (No change.)

(b) Confidentiality of Information.

(1) All information submitted, as required by this subchapter, may be verified at the discretion of the Department of State Health Services (department) with or without notice to applicants, clients, authorized entities, or providers of program [KHC] benefits or services. This information is confidential to the extent authorized by law.

(2) (No change.)

(c) Forms. The program provides approved forms to applicants, clients, authorized entities, and providers.

§61.2. Definitions.

The following words and terms when used in this subchapter **[shall]** have the following meanings, unless the context clearly indicates otherwise.

(1) (No change.)

(2) Action--A suspension, modification, denial, or termination of program [KHC] eligibility, benefits, or participation.

(3) - (4) (No change.)

(5) Applicant--A person [An individual] who has submitted an application for program [KHC] benefits and has not received a final determination of eligibility.

(6) Authorized entity--Any individual or organization approved by the program to submit applications for benefits or travel verification reports on behalf of an applicant or client.

(7) [(6)] Claim--A request for payment or reimbursement of services.

(8) [7] Client--A person who has applied for program services and who meets all program [KHC] eligibility requirements and is determined to be eligible for program services.

(9) [(8)] CMS--The Centers for Medicare and Medicaid Services.

(10) [(9)] Co-insurance--A cost-sharing arrangement in which a covered person is responsible for paying a specified percentage of the charge for a covered service or product.

(11) [(10)] Commissioner--The commissioner of the Department of State Health Services.

(12) [(11)] Co-pay/Co-payment--A cost-sharing arrangement in which a covered person is responsible for paying a specified or fixed charge for a covered service or product.

(13) [(12)] CRNA--Certified registered nurse anesthetist.

(14) [(13)] Date of service (DOS)--The date a service is rendered.

(15) [(14)] Denial--An action by the program that disallows program eligibility, benefits, or provider enrollment **[administrative review requests]**.

(16) [(15)] Department--The Department of State Health Services.

(17) [(16)] Effective date--The **[initial]** date a program client or enrolled provider is approved to receive program benefits or reimbursements **[of eligibility for a KHC client or provider]**.

(18) [(17)] End-Stage Renal Disease (ESRD)--The final stage of renal failure [impairment] that requires dialysis or [and/or] kidney transplant to reduce uremic symptoms and [and/or] prevent the death of the patient.

(19) Enrolled provider--Any individual or entity who has completed all the requirements located in the Texas Health and Human Services Commission rule at 1 TAC, §392.605, Kidney Health Care Provider Enrollment Requirements and Effective Dates and is deemed enrolled by the program to furnish covered services to program clients including:

(A) outpatient dialysis facilities;

(B) out-of-state outpatient dialysis facilities;

(C) hospitals and ambulatory surgical centers (ASCs) located in Texas and operating in compliance with applicable law;

(D) out-of-state hospitals and ASCs;

(E) military or Veterans Administration hospitals located in Texas which have a renal unit;

(F) pharmacies approved as Texas Medicaid providers and licensed to operate within the United States and its territories, including mail order pharmacies;

(G) physicians and certified registered nurse anesthetists (CRNAs) licensed in Texas;

(H) out-of-state physicians and CRNAs; and

(I) Medicare Prescription Drug Plan (PDP) providers.

(20) [(18)] Explanation of benefits (EOB) [EOB]--A form, in paper or electronic format, which provides an explanation of benefits. It is used to explain a payment or denial of a claim.

(21) [(19)] Fair hearing--The informal hearing process the department follows under §§1.51 - 1.55 of this title (relating to Fair Hearing Procedures).

(22) [(20)] Filing deadline--The last date that a claim may be received by the program and still be considered eligible for benefit.

(23) [(21)] Final decision--A decision that is made by a decision maker after conducting a fair hearing under §§1.51 - 1.55 of this title.

(24) Incomplete claim--A claim that is submitted to the program without the required information to enable determination of program liability or payment.

[(22) Interim approval--The status given by the program to an outpatient dialysis facility, free-standing or hospital-based, which has applied for participation as a KHC provider but has not executed an agreement with the program.]

(25) [(23)] KHC--Kidney Health Care.

(26) [(24)] KHC formulary--A list of general therapeutic categories of drugs, over-the-counter products, and limited diabetic supplies that are covered for reimbursement by the program.

(27) [(25)] Low Income Subsidy (LIS)--The subsidy provided under the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 for Medicare Part D plan premiums and related costs, at varying levels, for some low-income Medicare beneficiaries.

(28) [(26)] Medical benefit--Any medical treatment or procedure approved by the program as a covered service.

(29) [(27)] Medicare Advantage Plan--A Medicare health plan that is similar to a health maintenance organization, participating provider organization, or other Medicare health plan, and includes medical, drug coverage and other benefits.

(30) [(28)] Medicare Part A--Hospital insurance for people age 65 or older, or under age 65 with certain disabilities, that helps cover inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

(31) [(29)] Medicare Part B--Health insurance for people age 65 or older, or under age 65 with certain disabilities, and any age with ESRD, that helps cover medically necessary services, such as doctors' services and outpatient care, and some preventive services.

(32) [(30)] Medicare Part D--Established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), it provides members with prescription drug coverage, expanded health plan options, improved health care access for rural Americans, and preventive care services.

(33) [(31)] Medicare Part D out-of-pocket expenses--Include premiums, deductibles, co-payments, or **[and]** co-insurance amounts.

(34) [(32)] Medicare Part D Premium--The amount paid monthly under a Medicare Part D contract to insure coverage.

(35) [(33)] Medicare Prescription Drug Plan (PDP)--A stand-alone drug plan offered by insurers and other private companies to individuals eligible for Medicare Part D.

(36) [(34)] Medigap plan--A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Medicare coverage.

(37) [(35)] Modification--A change made to a client or provider account **[client's record]** that can affect **[affects a]** program benefits, **[benefit or]** eligibility, or **[status]** enrollment.

(38) [(36)] Program--Kidney Health Care **[Program]**.

(39) [(37)] Provider--Any individual or entity who furnishes benefits or **[approved by the program to furnish covered]** services to program **[KHC]** clients, **[including:]**

[(A) outpatient dialysis facilities;]

[(B) out-of-state outpatient dialysis facilities;]

[(C) hospitals and ambulatory surgical centers (ASCs) located in Texas and operating in compliance with applicable law;]

[(D) out-of-state hospitals and ASCs;]

[(E) military or Veterans Administration hospitals located in Texas which have a renal unit [approved by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association];

[(F) pharmacies approved as Texas Medicaid providers and licensed to operate within the United States and its territories, including mail order pharmacies;]

[(G) physicians and certified registered nurse anesthetists (CRNAs) licensed in Texas;]

[(H) out-of-state physicians and CRNAs; and]

[(I) Medicare Prescription Drug Plan (PDP) [and Medicare Advantage Plan (MA-PD)] providers.]

(40) [(38) Qualified Individual (QI) Program--A Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must be entitled to [have] Medicare Part A, and have limited income and resources as calculated using federal and state guidelines, and not be otherwise eligible for Medicaid. For those who qualify, the Medicaid program pays full Medicare Part B premiums only.

(41) [(39) Qualified Medicare Beneficiary (QMB) Program--A Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must be entitled to [have] Medicare Part A, and have limited income and resources as calculated using federal and state guidelines. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.

(42) [(40) Reimbursement--Payment of a claim for covered benefits or services [allowable services or transportation].

(43) [(41) Reimbursement rate--The program [KHC] payment rate for covered benefits or services [allowable products, services, and transportation determined annually for the following fiscal year].

(44) Resubmitted claim--A claim that is submitted to the program more than once to correct errors.

(45) [(42) Specified Low Income Medicare Beneficiary (SLMB) Program--A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources as calculated using federal and state guidelines.

(46) [(43) Suspension--An action by the program, [Eligibility for benefits] which holds client benefits or reimbursement to enrolled providers [is held without final action] pending satisfaction of a program request or requirement.

(47) [(44)] Termination--A final action by the program, which ends client or enrolled provider participation in the [KHC] program.

(48) Veterans programs--Health care programs authorized and administered by the United States Department of Veterans Affairs and the United States Department of Defense.

§61.3. Client Eligibility Requirements.

(a) A person must [shall] meet all of the following requirements to be eligible for program [KHC] benefits:

(1) - (5) (No change.)

(b) - (c) (No change.)

(d) Maintenance of Benefits Eligibility.

(1) A client must meet the following requirements within the first 3 months of program [KHC] eligibility:

(A) - (D) (No change.)

(2) A client must meet the following requirements to continue benefit eligibility:

(A) continue premium payments to [on] health insurance plans under Medicare, individual or group health insurance plans, and prepaid medical plans, where enrollment was effective prior to program [KHC] eligibility;

(B) re-apply for LIS as required by the Social Security Administration [annually];

(C) (No change.)

(D) (No change.)

(E) notify the program within 30 days of changes in the following:

(i) - (ii) (No change.)

(iii) coverage under Medicaid, Medicare, individual or group insurance, Veterans programs, or any other health benefits coverage; [insurance coverage; and]

(iv) location of treatment; and [.]

(v) income.

§61.4. Applications.

Persons meeting the eligibility requirements set forth in §61.3(a) - (c) of this title (relating to Client Eligibility Requirements) must submit an [make a complete] application packet for benefits.

(1) A complete application packet must be submitted by an authorized entity and include all of the following:

(A) a completed, signed and dated program application [complete]and notarized Application for Benefits, with the applicant's, or the applicant's representative's, original signature or "mark;"];

(B) a copy of the completed, signed and dated Centers for Medicare and Medicaid Services (CMS) End-Stage Renal Disease Medical Evidence Report or, with program approval, the Kidney Health Care Physician Assessment Form;

(C) documentation of Texas residency as required by §61.3 of this title;

(D) a copy of the applicant's social security card issued by the Social Security Administration (SSA), or an allowable substitute, as follows:

(i) (No change.)

(ii) a copy of a valid Medicare card, if the Medicare account is established in the applicant's own social security number and the social security number is printed on the Medicare card; and [.]

(E) applicant's financial data. The applicant or the person(s) legally obligated to support the applicant must verify income by providing one of the following:

(i) a copy of the first page of the federal individual income tax return for the most recent tax year, if self-employed; or

(ii) a statement of estimated or declared income for the current tax year, and supporting documentation[, **if requested**].

(2) (No change.)

(3) **[Eligibility date for KHC benefits.]** The program [KHC] eligibility date is the date the program receives a complete application packet, if approved, the client receives an effective date.

(4) If program [KHC] benefits are terminated, the eligibility date for any subsequent benefit period is the date the program receives a subsequent complete application packet for program [KHC] benefits.

(5) (No change.)

§61.5. Benefits and Limitations.

(a) Benefits.

(1) Outpatient drugs and supplies [**drug products**] listed on the current KHC formulary.

(2) - (4) (No change.)

(5) Medicare Part B immunosuppressive drug co-insurance amounts. To qualify for this benefit, clients must:

(A) be eligible for program [KHC] drug benefits;

(B) - (F) (No change.)

(6) Limited Medicare Part D out-of-pocket expenses. To qualify for this benefit, clients must:

(A) be eligible for program [KHC] drug benefits;

(B) - (E) (No change.)

(7) Benefits are payable beyond the Medicare three-month qualifying period for eligible clients who have applied for and have been denied Medicare coverage based on ESRD. Clients must submit a copy of the official Social Security Administration Medicare denial notification (based on chronic renal disease) to the department.

(b) Limitations.

(1) Only [**out-of-state**] enrolled providers [**approved by the program**] may be reimbursed for [**provide**] covered services and [KHC] allowable drugs.

(2) Covered services are limited to a maximum allowable amount [**per client**] based upon:

(A) - (B) (No change.)

(C) an agreement between the department and the enrolled [**client's**] provider;

(D) - (F) (No change.)

(3) Clients eligible for drug coverage under Medicaid, Medicare Advantage Plan, individual or group insurance, Veterans programs, or any other health benefits coverage **[an individual or group health insurance plan]** are not eligible to receive program **[KHC]** drug benefits. A client that has exhausted drug coverage under Medicaid, Medicare Advantage Plan, individual or group insurance, Veterans programs, or any other health benefits coverage **[an individual or group health insurance plan]** may be eligible to receive drug benefits from the program.

(4) Access surgery benefits are payable only if the services are performed on or after the date Texas residency is established and not more than 180 days prior to the client's program **[KHC eligibility]** effective date.

(5) Program **[KHC]** medical benefits are payable during the Medicare three-month qualifying period. Benefits are payable for services received on or after the client's program **[KHC eligibility]** effective date. The three-month qualifying period is calculated from the first day of the month the client begins chronic maintenance dialysis. When a client becomes eligible for Medicare during the three-month period, program **[KHC]** medical benefits are not payable from the date of Medicare eligibility.

(6) Transportation reimbursement is available from the first day of the month following the program **[KHC eligibility]** effective date for in-center dialysis clients or from the program **[KHC]** effective date for transplant and home peritoneal dialysis clients.

(7) Clients eligible for coverage under Medicaid, Medicare, individual or group insurance, Veterans programs, or any other health benefits coverage **[hospital and medical benefits from Medicare, or other government programs]** which cover the treatment of ESRD are not eligible to receive program **[KHC]** medical benefits.

(8) (No change.)

[(9) Clients eligible for hospital and medical benefits from private/group health insurance which covers the treatment of ESRD are not eligible for KHC medical benefits.]

(9) **[(10)]** The program is the payor of last resort. All third parties must be billed prior to the program. The Commissioner may waive this requirement in individually considered cases where its enforcement will deny services to a class of ESRD patients because of conflicting state or federal laws or regulations, under the Texas Health and Safety Code, §42.009.

(10) **[(11)]** If budgetary limitations exist, the department may:

(A) restrict or categorize covered services. Categories will be prioritized based upon medical necessity, other third party eligibility and projected third party payments for

the different treatment modalities, caseloads, and demands for services. Caseloads and demands for services may be based on current or **[and/or]** projected data. In the event covered services must be reduced, they will be reduced in a manner that takes into consideration medical necessity and other third party coverage. The department may change covered services by adding or deleting specific services, entire categories or by making changes proportionally across a category or categories, or by a combination of these methods; or

(B) establish a waiting list of eligible applicants. Information will be collected from each applicant who is placed on a waiting list to facilitate contacting the applicant when benefits become available and to allow efficient enrollment of the applicant for benefits.

§61.7. Claims Submission and Payment Rates.

(a) (No change.)

(b) Medical benefit claims must be submitted to the program by the provider who rendered the service(s) to the program **[KHC]** client or by the provider's designee.

(c) Transportation benefit claims must be submitted to the program by the client or an authorized entity **[the provider performing outpatient dialysis services]**. Claims must be submitted electronically through the **[Automated System for Kidney Information Tracking (ASKIT), or any other]** current automated **[designated]** claims payment system, except when the program allows or requires paper submissions.

(d) Payments are made using the rates in effect on the date the service is rendered. **[, and not prospectively.]**

(e) Claims for medical benefits will not be considered for payment by the program until the program has a fully executed agreement with the provider.

(f)[(e)] Incomplete or incorrect claims will not be considered for payment. [Claims which are not received by the program within the deadlines established in §61.8 of this title (relating to Claim Filing Deadlines) will be denied payment.]

§61.8. Claim Filing Deadlines.

(a) The program must receive all claims **[for transportation reimbursement, hospital, out-patient dialysis, and access surgery services,]** within the claim filing deadlines established in this section.

(1) - (2) (No change.)

(b) In addition to the requirements in subsection (a) of this section, the program must receive claims for out-patient dialysis and access surgery services within 60 days from the date on the agreement approval letter for newly enrolled **[approved]** providers, but no later than 180 days from the date of service.

(c) - (e) (No change.)

(f) Claims which are not received by the program within the filing deadlines will be denied payment.

§61.9. Rights and Responsibilities.

(a) An **[The]** applicant and client **[shall]** have the right to:

(1) (No change.)

(2) choose providers subject to program **[KHC]** limitations;

(3) be notified of the program's decisions relating to modifications, suspensions, denials, or terminations; and

(4) appeal the program's decisions and receive a response within the deadline as described in §61.11 of this title (relating to Rights of Appeal). **;** **and**

[(5) assurance that all information concerning his or her status as an applicant or client shall be confidential in the manner and to the extent authorized by law.]

(b) A provider has **[Providers shall have]** the right to:

(1) (No change.)

(2) appeal the program's decisions and receive a response within the deadline as described in §61.11 of this title.

[(2) assurance that all information concerning the provider's program status shall be confidential in the manner and to the extent authorized by law.]

(c) A client has **[The applicant and client shall have]** the responsibility to:

(1) provide accurate medical information to providers and notify providers of program **[KHC]** eligibility prior to delivery of services;

(2) abide by program **[KHC]** rules and policies; and

(3) (No change.)

(d) An enrolled provider has **[The provider shall have]** the responsibility to:

[(1) enroll as a KHC provider and submit a completed application to the program, including all documents requested;]

(1) [(2)] abide by [the] program rules and policies;

(2) [(3)] not discriminate against applicants or clients based on source of payment;
and

(3) [(4)] notify the program of any lawsuit(s) contemplated or filed concerning the cause of the medical condition for which the program has made payment.

(e) An authorized entity has the responsibility to:

(1) abide by program rules and policies; and

(2) not discriminate against applicants or clients.

§61.10. Modifications, Suspensions, Denials, and Terminations.

(a) (No change.)

(b) A provider's participation may be modified, suspended or denied for failing to comply with the provider responsibilities listed in 1 TAC, §392.605(a) [§61.6(a) of this title] (relating to Provider Enrollment Requirements and Effective Dates) and §61.9(d) of this title.

(c) A client's eligibility may be terminated for any of the following reasons:

(1) failing to maintain Texas residency or to furnish evidence upon demand of residency using the criteria in §61.3 of this title;

(2) failing to continue to meet the income requirements for program eligibility or to provide income data as requested by the department to determine continued program [KHC] eligibility;

(3) - (12) (No change.)

(d) (No change.)

(e) A client [An applicant] must reapply for [KHC] benefits when eligibility for program [KHC] benefits is terminated.

(f) - (g) (No change.)

(h) An enrolled [A] provider's participation may be terminated or suspended for any of the following reasons:

(1) - (4) (No change.)

(5) filing false or fraudulent information or claims for program [KHC] benefits;

(6) (No change.)

(7) failure to maintain the participation criteria contained in 1 TAC, §392.605(a) [§61.6(a) of this title].

(i) Enrolled providers [Providers] may appeal a termination or suspension under §61.11 of this title.

§61.11 Rights of Appeal.

(a) Administrative review.

(1) If the program denies eligibility to an applicant, the program will give the applicant written notice of the denial and the applicant's right to request an administrative review of the denial within 30 days of the date of the notification.

(2) If the program proposes to modify, suspend, or terminate a client's eligibility for covered benefits, the program will give the client written notice of the proposed action and the client's right to request an administrative review of the proposed action within 30 days of the date of notification.

(3) If the program denies a prior-authorization or authorization request for program services, the program will give the client and provider written notice of the denial and the right of the client or provider to request an administrative review of the denial within 30 days of the date of notification.

(4) If the program denies a client's or enrolled provider's claim for benefits or services, according to §61.7 of this title (relating to Claims Submission and Payment Rates) and §61.8 of this title (relating to Claims Filing Deadlines), the program will give the client or enrolled provider written notice of the denial. The client or enrolled provider has the right to request an administrative review of the denial within 30 days of the date of notification.

(5) If the program denies or proposes to modify, suspend, or terminate a provider's participation in the program, the program will give the provider written notice of the proposed action and the provider's right to request an administrative review of the proposed action within 30 days of the date of notification.

(6) The department establishes the program's reimbursement rates. Clients and providers may not request an administrative review of reimbursement amounts for claims that are paid in accordance with the reimbursement rates as described in §61.5 of this title (relating to Benefits and Limitations).

(7) A client or provider may not request administrative review of the program's decision to restrict or categorize program services or reduce provider reimbursement amounts that are authorized by §61.5(b)(10) of this title.

(8) If the program receives a written request for administrative review within 30 days of the date of the notification, the program will conduct an administrative review of the circumstances surrounding the proposed action. Within 30 days following receipt of a request for administrative review, the program will send the applicant, client, or provider written notice of:

(A) the program decision, including the supporting reasons for the decision; or

(B) the need for extended time to research the circumstances, including an expected date for response to the request.

(9) If the program does not receive a written request for administrative review within 30 days of the date of the notification, the applicant, client, or provider is presumed to have waived the administrative review as well as access to a fair hearing, and the program's action is final.

(b) Fair hearing.

(1) If the applicant, client, or provider is dissatisfied with the program's decision and supporting reasons following the administrative review, the applicant, client, or provider may request a fair hearing in writing, addressed to the program, within 20 days of receipt of the administrative review decision notice.

(2) If the program receives a written request for fair hearing within 20 days of receipt of the administrative review decision notice, a fair hearing will be conducted in accordance with §§1.51 - 1.55 of this title (relating to Fair Hearing Procedures).

(A) The program may not terminate a client or enrolled provider's eligibility until a final decision is rendered under the department's fair hearings process.

(B) The program may withhold claims payment pending final decision under the department's fair hearings process.

(C) The program must release any withheld payments and reinstate participation if the final determination is in favor of the client or provider.

(D) The program must not enter into, extend, or renew an agreement with a provider until a final decision is rendered under the department's fair hearings process.

(3) If the applicant, client, or provider fails to request a fair hearing within the 20-day period, the applicant, client, or provider is presumed to have waived the request for a fair hearing, and the program may take final action.

Legend: (Proposed Repeal)

Repealed Language = Strikethrough—Repealed Text

~~§61.11. Rights of Appeal.~~

~~————(a) Administrative Review:~~

~~————(1) When the program modifies, suspends, denies, or terminates eligibility or benefits, the program shall give written notice of and the reason for the action. Applicants, clients, and providers have the right to request an administrative review of the action within 30 days of the notice date.~~

~~————(2) If the program does not receive a written request for administrative review within 30 days of the notice date, applicants, clients, and providers waive the right to the administrative review process.~~

~~————(3) If a written request for administrative review is received within 30 days of the notice date, the program conducts an administrative review of the circumstances surrounding the action. The program must give written notice of the decision including the supporting reasons, within 30 days of receiving all information required to make a determination regarding the request for an administrative review.~~

~~————(4) The department establishes the KHC reimbursement rates. Clients and providers may not request an administrative review of reimbursement amounts for claims that are paid in accordance with the reimbursement rates as described in §61.5 of this title (relating to Benefits and Limitations).~~

~~————(b) Fair Hearing:~~

~~————(1) Applicants, clients, and providers who disagree with a program administrative review decision may request a fair hearing in writing addressed to Kidney Health Care, Purchased Health Services Unit, MC 1938, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347, within 20 calendar days following the date of receipt of the administrative review decision notice.~~

~~————(2) If the fair hearing request is not received within 20 calendar days following the date of the receipt of the administrative review decision notice, the program will presume the fair hearing process has been waived, and the program may take final action.~~

~~————(3) A fair hearing shall be conducted in accordance with §§1.51—1.55 of this title (relating to Fair Hearing Procedures).~~

~~————(4) The program may not terminate KHC participation until a final decision is rendered under the department's fair hearings process.~~

~~_____ (5) The program may withhold claims payment pending final decision under the department's fair hearings process.~~

~~_____ (6) The program must release any withheld payments and reinstate participation if the final determination is in favor of the provider.~~

~~_____ (7) The program shall not enter into, extend, or renew an agreement with a provider until a final decision is rendered under the department's fair hearings process.~~