House File 2462

H-8220

Amend House File 2462 as follows:

1. By striking page 2, line 35, through page 3, line 3, and inserting:

<Sec. ___. MEDICAID PROGRAM ADMINISTRATION.

1. PROVIDER PROCESSES AND PROCEDURES.

a. When all of the required documents and other information necessary to process a claim have been received by a managed care organization, the managed care organization shall either provide payment to the claimant within the timelines specified in the managed care contract or, if the managed care organization is denying the claim in whole or in part, shall provide notice to the claimant including the reasons for such denial consistent with national industry best practice guidelines.

b. If a managed care organization discovers that a claims payment barrier is the result of a managed care organization's identified system configuration error, the managed care organization shall correct such error within ninety days of the discovery of the error and shall fully and accurately reprocess the claims affected by the error within thirty days of such discovery. For the purposes of this paragraph, "configuration error" means an error in provider data, an incorrect fee schedule, or an incorrect claims edit.

c. The department of human services shall provide for the development and require the use of standardized Medicaid provider enrollment forms to be used by the department and uniform Medicaid provider credentialing standards to be used by managed care organizations. The credentialing process is deemed to begin when the managed care organization has received all necessary credentialing materials from the provider and is deemed to have ended when written communication is mailed or faxed to the provider notifying the provider of the managed care organization's decision.

2. MEMBER SERVICES AND PROCESSES.

a. If a Medicaid member prevails in a review by a managed

care organization or on appeal regarding the provision of services, the services subject to the review or appeal shall be extended for a period of time determined by the director of human services. However, services shall not be extended if there is a change in the member's condition that warrants a change in services as determined by the member's interdisciplinary team, there is a change in the member's eligibility status as determined by the department of human services, or the member voluntarily withdraws from services.

b. If a Medicaid member is receiving court-ordered services or treatment, such services or treatment shall be provided and reimbursed for an initial period of five days before a managed care organization may apply medical necessity criteria to determine the most appropriate services, treatment, or placement for the Medicaid member.

c. The department of human services shall review and have approval authority for a Medicaid member's level of care reassessment that indicates a decrease in the level of care. A managed care organization shall comply with the findings of the departmental review and approval of such level of care reassessment. If a level of care reassessment indicates there is no change in a Medicaid member's level of care needs, the Medicaid member's existing level of care shall be continued. A managed care organization shall maintain and make available to the department of human services all documentation relating to a Medicaid member's level of care assessment.

d. The department of human services shall maintain and update Medicaid member eligibility files in a timely manner consistent with national industry best practices.

3. MEDICAID PROGRAM REVIEW AND OVERSIGHT.

a. (1) The department of human services shall facilitate a workgroup, in collaboration with representatives of the managed care organizations and health home providers, to review the health home programs. The review shall include all of the following:

(a) An analysis of the state plan amendments applicable to health homes.

(b) An analysis of the current health home system, including the rationale for any recommended changes.

(c) The development of a clear and consistent delivery model linked to program-determined outcomes and data reporting requirements.

(d) A work plan to be used in communicating with stakeholders regarding the administration and operation of the health home programs.

(2) The department of human services shall submit a report of the workgroup's findings and recommendations by December 15, 2018, to the governor and to the Eighty-eighth General Assembly, 2019 session, for consideration.

b. The department of human services, in collaboration with Medicaid providers and managed care organizations, shall initiate a review process to determine the effectiveness of prior authorizations used by the managed care organizations with the goal of making adjustments based on relevant service costs and member outcomes data utilizing existing industry-accepted standards. Prior authorization policies shall comply with existing rules, guidelines, and procedures developed by the centers for Medicare and Medicaid services of the United States department of health and human services.

c. The department of human services shall enter into a contract with an independent auditor to perform an audit of small dollar claims paid to or denied Medicaid long-term services and supports providers. The department may take any action specified in the managed care contract relative to any claim the auditor determines to be incorrectly paid or denied, subject to appeal by the managed care organization to the director of human services. For the purposes of this paragraph, "small dollar claims" means those claims less than or equal to two thousand five hundred dollars.>

2. By renumbering as necessary.

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HEATON of Henry

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FRY of Clarke