Fiscal Note

Fiscal Services Division

HF 2483 – Human Services Department Programs and Services (LSB6226HV)
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Fiscal Note Version – As amended and passed by the House

Description

House File 2483 as amended makes various changes to the administration and oversight of the Medicaid Program. The changes and the fiscal impacts are listed below by division.

Division I

Description

Division I requires the Department of Human Services (DHS) to suspend the eligibility of individuals for medical assistance following the first 30 days of the individuals' commitment to an institution. The Bill also requires public institutions to provide a monthly report of the inmates who are committed and of those who are discharged to the DHS and to the Social Security Administration.

Assumptions

- The changes in Division I are estimated to require 380 staff contract hours at $105 per hour to update the income maintenance system.
- The federal match rate for the income maintenance system is 85.79% federal and 14.21% State.
- The DHS does not believe the Department will be able to implement Division I in FY 2019; therefore, the fiscal impact will begin with FY 2020.

Fiscal Impact

Division I of the Bill as amended is estimated to increase General Fund expenditures by $5,670 in FY 2019.

Division II

Description

Provider Processes and Procedures

- Specifies that when all of the required documents and other information necessary to process a claim have been received by a managed care organization (MCO), the MCO is required to provide payment to the claimant within the timeline specified if the claim is approved. If the MCO is denying the claim in whole or in part, the MCO is required to provide notice to the claimant, including the reasons for the denial, in a manner consistent with national industry best practice guidelines.
- Requires an MCO to correct any errors it finds due to system configuration and fully reprocess the claims affected by the error within 30 days of the discovery.
- Requires the DHS to develop and use standardized Medicaid provider enrollment forms.
- Requires the DHS to develop and implement uniform Medicaid provider credentialing standards to be used by the MCOs. The credentialing process is deemed to begin when the MCO 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 MCO's decision.
- Requires an MCO to provide written notice at least 60 days prior to a significant change in administrative procedures relating to the scope or coverage of benefits, billings and collections provisions, provider network provisions, member or provider services, prior authorization requirements, or any other terms of a managed care contract or agreement as determined by the DHS.
- Requires the DHS to engage dedicated provider relations staff to assist Medicaid providers in resolving billing conflicts with MCOs, including conflicts involving denied claims, technical omissions, or incomplete information.
- Requires the DHS to adopt rules to require the inclusion of advanced registered nurse practitioners and physician assistants as primary care providers by MCOs.

Members Services and Processes
- Specifies that if a Medicaid member prevails on appeal regarding the provision of services, the services subject to the review or appeal are required to be extended for a period of time determined by the Director of the DHS. However, services are not required to 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 DHS, or the member voluntarily withdraws from services.
- Specifies that if a Medicaid member is receiving court-ordered services or treatment for a substance-related disorder pursuant to Iowa Code chapter 125 or for a mental illness pursuant to Iowa Code chapter 229, the services or treatment are required to be provided and reimbursed for an initial period of three days before an MCO may apply medical necessity criteria to determine the most appropriate services, treatment, or placement for the Medicaid member.
- Specifies the DHS is to review and have approval authority for a Medicaid long-term services and supports (LTSS) member's level of care reassessment that indicates a decrease in the level of care. Managed care organizations are required to comply with the findings of the DHS review. 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 will be continued.
- Requires the DHS to maintain and update Medicaid member eligibility files in a timely manner consistent with national industry best practices.

Medicaid Program Review and Oversight
- Requires the DHS to facilitate a workgroup, in collaboration with representatives of the MCOs and health home providers, to review the health home programs. The Bill requires the DHS to submit a report of the workgroup's findings and recommendations by December 15, 2018, to the Governor and the General Assembly.
- Requires the DHS, in collaboration with Medicaid providers and MCOs, to initiate a review process to determine the effectiveness of prior authorizations used by the MCOs, with the goal of making adjustments based on relevant service costs and member outcomes data.
- Requires the DHS to enter into a contract with an independent auditor to perform an audit of a random sample of small dollar claims paid to or denied Medicaid long-term services and supports providers during the first quarter of calendar year 2018. The Bill specifies that the DHS may take any action specified in the MCO contract relative to any claim the auditor determines to be incorrectly paid or denied, subject to appeal by the MCO to the Director of the DHS.

Assumptions

Provider Processes and Procedures

- The provisions in subsection 1 (a) - (f) are either current practice or are not estimated to have any additional impact to the State.

Members Services and Processes

- For subsection 2(a), it is estimated there will be 4,000 reviews that the Director of the DHS will be required to evaluate to determine the period of time in which a service may be received if a Medicaid member prevails in a review or appeal, and it is estimated that each review will cost $40 in staff time.
- For subsection 2(b), it is estimated that 20.0% of cases (600 cases) will result in court-ordered services that are not medically necessary. It is assumed that the court order will be lifted, or the Medicaid Program will not be responsible for payment on day three when services are not medically necessary. The total estimated cost per case is $4,020.
- For subsection 2(c), giving the DHS the authority to review and have approval authority for a Medicaid member's level of care reassessment that indicates a decrease in the level of care is not expected to have an impact on current MCO capitation rates because current Program experience is built into the capitation rates. On average, the DHS is currently overruling half of the LTSS level of care determinations the Department reviews. Given this, the provision may impact possible savings to future MCO capitation rates due to a lower level of care being provided to LTSS and Home and Community-Based Services (HCBS) waiver populations.
- The Federal Medical Assistance Percentage (FMAP) rate for FY 2019 and FY 2020 is 59.57% federal and 40.43% State.

Medicaid Program Review and Oversight

- Subsection 3(a), requiring the DHS to facilitate a workgroup to review the health home programs, will have no fiscal impact because current MCO capitation rates include the cost of health homes.
- Subsection 3(b), requiring the DHS to initiate a review process to determine the effectiveness of prior authorizations used by the MCOs, may have a fiscal impact, but any potential impact will depend on the results of the review.
- For subsection 3(c), there are approximately 7,000,000 approved claims and 4,000,000 denied claims paid annually. The subsection requires an audit of a random sample of claims during the first quarter of calendar year 2018.
- The administrative match rate is 50.0% federal and 50.0% State.

Fiscal Impact

Division II of the Bill as amended is estimated to increase General Fund expenditures by $1.6 million in FY 2019 and $1.1 million in FY 2020. In addition, the provision giving the DHS the authority to review and have approval authority for a Medicaid member's level of care reassessment may impact future Medicaid Program savings. The provisions with a fiscal impact are listed in **Table 1** below.

Table 1 — Division II Estimated Fiscal Impact

Activities – Division II	Total Cost	State Cost
Director Review – Length of Services	$ 160,000	$ 64,688
Non-Medically Necessary Court-Ordered Services	2,412,000	975,172
Small Dollar Claims Audit	1,000,000	500,000
Total Activities – Division II	$ 3,572,000	$ 1,539,860

Divisions III, IV, and V

Description

Division III eliminates the various copayments for a covered prescription drug under the Medicaid Program and instead provides that a recipient of Medicaid is required to pay a copayment of $1 on each prescription filled or refilled for a covered prescription drug.

Division IV directs the Executive Committee of the Medical Assistance Advisory Council (MAAC) to review data collected and analyzed in periodic reports to the General Assembly to determine which data points should be included and analyzed to more accurately identify trends and issues with, and promote the effective and efficient administration of, Medicaid managed care for all stakeholders. The Executive Committee is required to report its findings and recommendations to the MAAC for review and comment by October 1, 2018, and to submit a final report to the Governor and the General Assembly by December 31, 2018.

Division V amends the reimbursement provision for targeted case management (TCM) services under the Medicaid Program, which is currently established as cost-based reimbursement for 100.0% of the reasonable costs for provision of the services. Under the Bill, effective July 1, 2018, TCM services will instead be reimbursed based on a statewide fee schedule amount developed by rule of the DHS in accordance with Iowa Code chapter 17A. The Division also amends the reimbursement provisions for psychiatric medical institutions for children (PMICs) to provide that inpatient psychiatric services for individuals under 21 years of age that are provided by non-State-owned providers are required to be reimbursed according to a fee schedule without reconciliation, and services provided by State-owned providers are required to be reimbursed at 100.0% of the actual and allowable cost of providing the service.

Assumptions

- The changes to the Medicaid copayments in Division III have been in place since December 2015 due to federal requirements. The conforming State changes will have no fiscal impact to the State.
- The rate changes for TCM services and PMICs will be developed so that they are budget neutral and will have no fiscal impact to the State.

Fiscal Impact

Divisions III through V of the Bill have no fiscal impact.

Summary of Fiscal Impacts

House File 2483 as amended is estimated to increase General Fund expenditures by $1.5 million in FY 2019 and $1.1 million in FY 2020. **Table 2** below lists the estimated fiscal impact by Division.

Table 2 — Summary of Estimated General Fund Fiscal Impacts FY 2019 and FY 2020

Fiscal Impact by Division	FY 2019	FY 2020
Division I	5,670	0
Division II	1,539,860	1,039,860
Division III	0	0
Division IV	0	0
Division V	0	0
Total	$ 1,545,530	$ 1,039,860

Sources

Department of Human Services
LSA analysis

/s/ Holly M. Lyons

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The fiscal note for this Bill was prepared pursuant to Joint Rule 17 and the Iowa Code. Data used in developing this fiscal note is available from the Fiscal Services Division of the Legislative Services Agency upon request.
