House File 2244 - Introduced

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A BILL FOR

An Act relating to the Medicaid program, including long-term services and supports, integrated health homes, capitation and reimbursement rates, and oversight, and including effective date provisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. TERMINATION OF MEDICAID MANAGED CARE CONTRACTS RELATIVE TO LONG-TERM SERVICES AND SUPPORTS POPULATION —— TRANSITION TO FEE-FOR-SERVICE. The department of human services shall, upon the effective date of this Act, provide written notice in accordance with the termination provisions of the contract, to each managed care organization with whom the department executed a contract to administer the Iowa high quality health care initiative as established by the department, to terminate such contracts as applicable to the Medicaid long-term services and supports population, following a sixty-day transition period. The department shall transfer the long-term services and supports population to fee-for-service program administration. The transition shall be based on a transition plan developed by the department and submitted to the council on human services and the medical assistance advisory council for review.

Sec. 2. INTEGRATED HEALTH HOME FOR PERSONS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI INTEGRATED HEALTH HOME). The department of human services shall adopt rules pursuant to chapter 17A and shall amend existing Medicaid managed care contracts to carve out SPMI integrated health homes services as specified in the Medicaid state plan amendment, IA-16-013, from Medicaid managed care contracts and instead provide SPMI integrated health home services through the fee-for-service payment and delivery system.

Sec. 3. RECALCULATION OF CERTAIN CAPITATION RATES UNDER MEDICAID MANAGED CARE. For the fiscal year beginning July 1, 2018, the department of human services shall utilize Medicaid program claims paid data for the period beginning April 1, 2015, and ending March 31, 2016, as base data to develop and certify capitation rates for providers of home and community-based intellectual disability waiver services under Medicaid managed care.

Sec. 4. MEDICAID MANAGED CARE OVERSIGHT. The department of human services shall amend the Medicaid managed care contracts

and adopt rules pursuant to chapter 17A to provide that beginning July 1, 2018, all of the following shall apply:

1. MEMBER STATUS CHANGES.

a. A Medicaid managed care organization shall provide prior notice, in writing, to a member and to any affected provider, of any change in the status of the member at least thirty days prior to the effective date of the change in status. If notification is not received by the provider and the member continues to receive services from the provider, the Medicaid managed care organization shall reimburse the provider for services rendered.

b. If a member transfers from one managed care organization to another, the managed care organization from which the member is transferring shall forward the member's records to the managed care organization assuming the member's coverage at least thirty days prior to the managed care organization assuming such coverage.

c. If a provider provides services to a member for which the member is eligible while awaiting any necessary authorization, and the authorization is subsequently approved, the provider shall be reimbursed at the contracted rate for any services provided prior to receipt of the authorization.

2. DATA. Managed care organizations shall report to the department of human services not only the percentage of medical and pharmacy clean claims paid or denied within a certain time frame, but shall also report all of the following on a quarterly basis:

a. The total number of original medical and pharmacy claims submitted to the managed care organization.

b. The total number of original medical and pharmacy claims deemed rejected and the reason for rejection.

c. The total number of original medical and pharmacy claims deemed suspended, the reason for suspension, and the number of days from suspension to submission for processing.

d. The total number of original medical and pharmacy

claims initially deemed either rejected or suspended that are subsequently deemed clean claims and paid, and the average number of days from initial submission to payment of the clean claim.

e. The total number of medical and pharmacy claims that are outstanding for thirty, sixty, ninety, one hundred eighty, or more than one hundred eighty days, and the total amount attributable to these outstanding claims if paid as submitted.

f. The total amount requested as payment for all original medical or pharmacy claims versus the total amount actually paid as clean claims and the total amount of payment denied.

g. The total number of original medical and pharmacy claims received, the number of such claims for which one hundred percent of the requested amount was paid, the number of such claims for which less than one hundred percent of the requested amount was paid and the percentage actually paid, and the total dollar amount of payments denied.

3. REIMBURSEMENT. For the fiscal year beginning July 1, 2018, Medicaid providers or services shall be reimbursed as follows:

a. For fee-for-service claims, reimbursement shall be calculated based on the methodology in effect on June 30, 2018, for the respective provider or service.

b. For claims subject to a managed care contract:

(1) Reimbursement shall be based on the methodology established by the managed care contract. However, any reimbursement established under such contract shall not be lower than the rate floor established by the department of human services as the managed care organization provider or service reimbursement rate floor for the respective provider or service in effect on June 30, 2018.

(2) For any provider or service to which a reimbursement increase is applicable for the fiscal year under state law, upon the effective date of the reimbursement increase, the department of human services shall modify the rate floor in

effect on June 30, 2018, to reflect the increase specified. Any reimbursement established under the managed care contract shall not be lower than the rate floor as modified by the department of human services to reflect the provider rate increase specified.

(3) Any reimbursement established between the managed care organization and the provider shall be in effect for at least twelve months from the date established, unless the reimbursement is increased. A reimbursement rate that is negotiated and established above the rate floor shall not be decreased from that amount for at least twelve months from the date established.

4. PRIOR AUTHORIZATION.

a. Any change by a Medicaid managed care organization in a requirement for prior authorization for a prescription drug or service shall be preceded by the provision of sixty days' prior written notice published on the managed care organization's internet site and provided in writing to all affected members and providers before the effective date of the change.

b. Each managed care organization shall post to the managed care organization's internet site prior authorization data including but not limited to statistics on approvals and denials of prior authorization requests by physician specialty, medication, test, procedure, or service, the indication offered, and if denied, the reason for denial.

Sec. 5. MEDICAID STATE PLAN OR WAIVER AMENDMENTS. The department of human services shall seek any Medicaid state plan or waiver amendments necessary to administer this Act.

Sec. 6. EFFECTIVE DATE. This Act, being deemed of immediate importance, takes effect upon enactment.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill directs the department of human services (DHS) to provide written notice in accordance with the termination

provisions of the contract, to each managed care organization (MCO) with whom DHS executed a contract to administer the Iowa high quality health care initiative as established by the department, to terminate such contracts as applicable to the long-term services and supports population, following a 60-day transition period. DHS is directed to transfer the long-term services and supports population to fee-for-service program administration. The transition is to be based on a transition plan developed by the department and submitted to the council on human services and the medical assistance advisory council for review.

The bill requires DHS to adopt rules pursuant to Code chapter 17A and to amend existing Medicaid managed care contracts to carve out SPMI integrated health homes services as specified in the Medicaid state plan amendment, IA-16-013, from Medicaid managed care contracts and instead provide SPMI integrated health home services through the fee-for-service payment and delivery system.

The bill requires DHS to use Medicaid program claims paid data for the period beginning April 1, 2015, and ending March 31, 2016, as base data to develop and certify capitation rates for providers of home and community-based intellectual disability waiver services under Medicaid managed care for the fiscal year beginning July 1, 2018.

The bill provides for Medicaid managed care oversight. The bill requires DHS to amend the Medicaid managed care contracts and adopt rules pursuant to Code chapter 17A to provide for a number of changes, beginning July 1, 2018.

The bill requires MCOs to provide prior written notice to a member and to any affected provider of any change in the status of the member that affects such provider at least 30 days prior to the effective date of the change in status. If notification is not received by the provider and the member continues to receive services from the provider, the MCO shall reimburse the provider for services rendered. If a member transfers from one

MCO to another, the MCO from which the member is transferring shall forward the member's records to the MCO assuming the member's coverage at least 30 days prior to the MCO assuming such coverage. Additionally, if a provider provides services to a member for which the member is eligible while the provider is awaiting any necessary authorization to provide the service, and the authorization is subsequently approved, the provider shall be reimbursed at the contracted rate for any services provided prior to receipt of the authorization.

With regard to data, the bill requires that MCOs, in addition to reporting to DHS the percentage of medical and pharmacy clean claims paid or denied within a certain time frame, to also report additional data regarding claims as specified in the bill on a quarterly basis.

With regard to reimbursement, the bill requires reimbursement beginning July 1, 2018, for Medicaid providers and services, to be calculated based on the methodology in effect on June 30, 2018, for the respective provider or service for fee-for-service claims and for claims subject to a managed care contract, reimbursement shall be based on the methodology established by the managed care contract. However, any reimbursement established under such contract shall not be lower than the rate floor established by DHS as a rate floor for the respective provider or service in effect on June 30, 2018. Additionally, for any provider or service to which a reimbursement increase is applicable for the fiscal year under state law beginning July 1, 2018, upon the effective date of the reimbursement increase, DHS shall modify the rate floor in effect on June 30, 2018, to reflect the increase specified and any reimbursement established under the managed care contract shall not be lower than the rate floor as modified. Any reimbursement established between the managed care organization and the provider shall be in effect for at least 12 months from the date established, unless the reimbursement is increased. A reimbursement rate negotiated and established above the rate

floor shall not be decreased from that negotiated amount for at least a 12-month period.

With regard to prior authorization, the bill requires that any change by an MCO in a requirement for prior authorization for a prescription drug or service shall be preceded by 60 days' prior written notice published on the MCO's internet site and provided in writing to all affected members and providers before the effective date of the change. The bill requires an MCO to place certain prior authorization data on the MCO's internet site.

The bill requires DHS to seek any Medicaid state plan or waiver amendments necessary to administer the bill.

The bill takes effect upon enactment.