

House File 2244 - Introduced

HOUSE FILE 2244

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A BILL FOR

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

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

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

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

26 Sec. 3. RECALCULATION OF CERTAIN CAPITATION RATES UNDER
27 MEDICAID MANAGED CARE. For the fiscal year beginning July
28 1, 2018, the department of human services shall utilize
29 Medicaid program claims paid data for the period beginning
30 April 1, 2015, and ending March 31, 2016, as base data to
31 develop and certify capitation rates for providers of home and
32 community-based intellectual disability waiver services under
33 Medicaid managed care.

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

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

3 1. MEMBER STATUS CHANGES.

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

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

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

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

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

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

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

35 d. The total number of original medical and pharmacy

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

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

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

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

18 3. REIMBURSEMENT. For the fiscal year beginning July 1,
19 2018, Medicaid providers or services shall be reimbursed as
20 follows:

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

24 b. For claims subject to a managed care contract:

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

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

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

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

13 4. PRIOR AUTHORIZATION.

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

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

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

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

31 EXPLANATION

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

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

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

12 The bill requires DHS to adopt rules pursuant to Code chapter
13 17A and to amend existing Medicaid managed care contracts to
14 carve out SPMI integrated health homes services as specified
15 in the Medicaid state plan amendment, IA-16-013, from Medicaid
16 managed care contracts and instead provide SPMI integrated
17 health home services through the fee-for-service payment and
18 delivery system.

19 The bill requires DHS to use Medicaid program claims paid
20 data for the period beginning April 1, 2015, and ending March
21 31, 2016, as base data to develop and certify capitation
22 rates for providers of home and community-based intellectual
23 disability waiver services under Medicaid managed care for the
24 fiscal year beginning July 1, 2018.

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

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

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

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

15 With regard to reimbursement, the bill requires
16 reimbursement beginning July 1, 2018, for Medicaid providers
17 and services, to be calculated based on the methodology
18 in effect on June 30, 2018, for the respective provider or
19 service for fee-for-service claims and for claims subject to
20 a managed care contract, reimbursement shall be based on the
21 methodology established by the managed care contract. However,
22 any reimbursement established under such contract shall not be
23 lower than the rate floor established by DHS as a rate floor
24 for the respective provider or service in effect on June 30,
25 2018. Additionally, for any provider or service to which a
26 reimbursement increase is applicable for the fiscal year under
27 state law beginning July 1, 2018, upon the effective date of
28 the reimbursement increase, DHS shall modify the rate floor in
29 effect on June 30, 2018, to reflect the increase specified and
30 any reimbursement established under the managed care contract
31 shall not be lower than the rate floor as modified. Any
32 reimbursement established between the managed care organization
33 and the provider shall be in effect for at least 12 months from
34 the date established, unless the reimbursement is increased. A
35 reimbursement rate negotiated and established above the rate

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

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

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

13 The bill takes effect upon enactment.