HOUSE FILE 2291
BY HEATON

A BILL FOR

An Act relating to Medicaid managed care oversight and improvement.

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

Section 1. MEDICAID MANAGED CARE OVERSIGHT AND IMPROVEMENT. The department of human services shall adopt rules pursuant to chapter 17A and shall amend all Medicaid managed care contracts to provide for all of the following:

1. TIMELY PAYMENT AND CORRECTION OF CLAIMS PROCESSING ERRORS.

a. A managed care organization shall provide documentation to a Medicaid provider claimant when the managed care organization contests or denies a claim, in whole or in part, within fifteen calendar days after receipt of the claim. The documentation shall, with as much specificity as possible, identify the claim or portion of the claim affected, and shall provide an explanation including the reasons for contesting or denying the claim utilizing the federal Health Insurance Portability and Accountability Act standard claim adjustment reason codes and remittance advice remark codes, or other standard adjustment reasons and remark codes approved by rule of the department. A managed care organization shall utilize the standard coding and format of responses, established uniformly across all managed care organizations, as required by rule of the department.

b. When a Medicaid provider, a managed care organization, or another affected entity identifies a systemic programming or processing error in a managed care organization's programming or processing system that results in systemic incorrect results, including those related to Medicaid provider payment or authorizations, the managed care organization shall correct the programming or processing error within thirty calendar days of the discovery of the error and shall reprocess any affected payments or authorizations with sixty calendar days of the discovery of such error.

c. A managed care organization that fails to pay, deny, or settle a clean claim in full within the time frame established by the managed care contract shall pay the Medicaid provider claimant interest equal to twelve percent per annum on the

total amount of the claim ultimately authorized.

d. For claims ultimately found to be incorrectly denied or underpaid through an appeals process or audit, a managed care organization shall pay a Medicaid provider claimant, in addition to the amount determined to be owed, interest of twenty percent per annum on the total amount of the claim as calculated from fifteen calendar days after the date the claim was submitted.

e. If a managed care organization disputes a portion of a claim, any undisputed portion of the claim is deemed a clean claim and shall be paid within the time frame for the payment of clean claims established by the managed care contract such that ninety percent of clean claims are paid or denied within fourteen calendar days of receipt, ninety-nine and one-half percent of clean claims are paid or denied within twenty-one calendar days of receipt, and one hundred percent of clean claims are paid or denied within ninety calendar days of receipt.

2. SUPPLEMENTAL PAYMENTS AND RATE CHANGES.

a. A managed care organization shall pay interest of twelve percent per annum on any physician supplemental payment or graduated medical education payment paid after the fifteenth day of the month in which the payment is due.

b. Retroactive rate decreases such as rebasing delays, update delays, cost containment, or other payment changes and delays shall not be retroactively applicable to a date that is more than three months from the date of the final rate decision.

3. APPEALS, EXTERNAL REVIEW, AND AUDIT PROCESSES.

a. (1) The department shall establish an appeals and external review process for Medicaid members and Medicaid providers for review of adverse determinations issued by a managed care organization.

(2) The process shall require that an internal appeal to a managed care organization of an adverse determination resulting

from a first-level review be completed and a notice of the decision issued by a managed care organization within fifteen calendar days of a request by a Medicaid member or Medicaid provider for an internal appeal or within three calendar days if the appeal is considered expedited based on urgent medical need.

(3) If an internal appeal results in a final adverse determination, the Medicaid member or Medicaid provider may either appeal the decision as a contested case pursuant to chapter 17A, or may request an external review.

(4) The department shall establish an external review and an expedited external review process, consistent with chapter 514J, to the extent applicable. The process shall allow a Medicaid member or a Medicaid provider to submit a request for external review or expedited external review to the department following receipt of notice of a final adverse determination from a managed care organization. If an external review or expedited external review is approved by the department, the review shall be completed and a decision shall be issued by the independent review organization within forty-five calendar days of receipt of the request for external review and within seventy-two hours of receipt of the request for an expedited external review. The process shall provide that the decision of the independent review organization is subject to judicial review.

(5) The department shall enter into a contract with an independent review organization that does not have a conflict of interest with the department or any managed care organization to conduct the external reviews.

b. A managed care organization shall allow a Medicaid provider to consolidate complaints or appeals of multiple claims that involve the same or a similar payment or coverage issue, regardless of the number of individual Medicaid members or payment claims affected, in a request for an internal managed care organization review or appeal.

c. The department shall enter into a contract with an independent auditor for the purpose of reviewing, at least once each calendar year, a random sample of all claims paid and denied by a managed care organization. Each managed care organization and each managed care organization's subcontractor shall pay any claim that the independent auditor determines to be incorrectly denied, any applicable liquidated damages, and any costs attributable to the annual audit. The independent auditor shall also review payment patterns to determine any unfair payment patterns and shall review any request for such investigation based on submission of evidence by a Medicaid provider of an unfair payment practice in accordance with standards developed by the department.

d. If a claim submitted to a managed care organization is not deemed a clean claim and remains in dispute for longer than six months from the date initially submitted, the claim shall automatically be subject to the appeals and external review process established by the department.

4. LOGISTICS AND DOCUMENTATION.

a. A managed care organization shall provide and maintain an internet site available to all Medicaid providers under contract with the managed care organization to request reconsiderations, submit Medicaid provider inquiries, and submit, process, edit, rebill, and adjudicate claims electronically.

b. The department shall develop and require all managed care organizations to utilize, a standardized enrollment form and a uniform process for credentialing and recredentialing Medicaid providers.

c. Upon request by a Medicaid provider, the department shall provide accurate and uniform patient encounter data to a Medicaid provider under contract with a specified managed care organization within sixty calendar days of the request. The provision of the patient encounter data shall comply with the federal Health Insurance Portability and Accountability Act

and any other applicable federal and state laws and regulatory requirements and shall include but not be limited to the managed care organization's claim number, the Medicaid member identification number, the Medicaid member's name, the type of claim, the amount billed by revenue code and procedure code, the managed care organization's paid amount and payment date, and the hospital patient account number, as applicable. The department may charge a reasonable fee for the actual cost of providing the patient encounter data to Medicaid providers.

5. PRIOR AUTHORIZATION.

a. Prior authorization shall not be required by a managed care organization for admission of a Medicaid member to an intensive care unit level of care.

b. Medicaid providers shall be provided two business days following a Medicaid member's inpatient hospital admission to submit information to a managed care organization for authorization of the admission. If authorization is denied, a Medicaid provider shall be provided two business days from the date of denial to request reconsideration of the authorization. Following a reconsideration, if the authorization is denied, the reconsideration shall be subject to peer-to-peer review.

c. The department shall establish a fee schedule, proportionate to the lost productivity of staff and resources experienced by a Medicaid provider, that results from the completion of the prior authorization process.

EXPLANATION

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

This bill relates to Medicaid managed care oversight and improvement.

The bill requires the department of human services (DHS) to adopt administrative rules and amend all Medicaid managed care contracts to address timely payment and correction of claims processing errors; supplemental payments and rate changes; appeals external review and audit processes; logistics and

documentation; and prior authorization under Medicaid managed care.

TIMELY PAYMENT AND CORRECTION OF CLAIMS PROCESSING ERRORS. The bill requires a Medicaid managed care organization (MCO) to provide specific documentation to a Medicaid provider claimant when the MCO contests or denies a claim. The bill requires that if a systemic programming or processing error in an MCO's programming or processing system is identified that results in systemic incorrect results, the MCO shall correct the programming or processing error within 30 calendar days and reprocess any affected payments or authorizations within 60 calendar days of the discovery of such error. The bill requires the payment of interest on claims that are not paid within certain time frames or that, following appeal or audit, are found to be incorrectly denied or underpaid. The bill provides that any portion of a claim which is not disputed is deemed a clean claim and is required to be paid by an MCO within the time frame for the payment of clean claims established by an MCO contract such that 90 percent of clean claims are paid or denied within 14 calendar days of receipt, 99.5 percent within 21 calendar days of receipt, and 100 percent within 90 calendar days of receipt.

SUPPLEMENTAL PAYMENTS AND RATE CHANGES. The bill requires MCOs to pay interest on any physician supplemental payment or graduated medical education payment paid after the 15th day of the month in which the payment is due, and provides that retroactive rate decreases shall not be retroactively applicable to a date that is more than three months from the date of the final rate decision.

APPEALS, EXTERNAL REVIEW, AND AUDIT PROCESSES. The bill requires DHS to establish an appeals and external review process for Medicaid members and Medicaid providers for review of adverse determinations issued by an MCO, and provides time frames for the processes. DHS is required to enter into a contract with an independent review organization that does not

have a conflict of interest with DHS or any MCO to conduct the external reviews. The bill requires an MCO to allow a Medicaid provider to consolidate complaints or appeals of multiple claims that involve the same or a similar payment or coverage issue, regardless of the number of individual Medicaid members or payment claims affected in a request for internal review or appeal. The bill requires DHS to enter into a contract with an independent auditor for the purpose of reviewing, at least once each calendar year, a random sample of all claims paid and denied. Each MCO and the subcontractors of any MCO are required to pay any claim that the independent auditor determines to be incorrectly denied, any applicable liquidated damages, and the cost of the annual audits conducted. The independent auditor is also required to review payment patterns to determine any unfair payment patterns and to review any request for such investigation based on submission of evidence by a Medicaid provider of an unfair payment practice in accordance with standards developed by DHS. The bill provides that if a claim submitted to an MCO is not deemed a clean claim and remains in dispute for longer than six months from the date initially submitted, the claim shall automatically be subject to the appeals and external review process established by DHS.

LOGISTICS AND DOCUMENTATION. An MCO is required to provide and maintain an internet site available to all Medicaid providers under contract with that MCO to request reconsiderations, submit provider inquiries, and submit, process, edit, rebill, and adjudicate claims electronically. The bill requires DHS to develop and require all MCOs to utilize a standardized enrollment form and a uniform process for credentialing and recredentialing Medicaid providers. The bill provides that upon request of a Medicaid provider, DHS shall provide accurate and uniform patient encounter data to the Medicaid provider within 60 calendar days of the request. DHS may charge a reasonable fee for the actual cost of providing the patient encounter data to providers.

PRIOR AUTHORIZATION. The bill provides that prior authorization shall not be required by an MCO for admission of a Medicaid member to an intensive care unit level of care. Additionally, Medicaid providers are allowed to request authorization for an inpatient hospital admission within certain time frames following the admission of a Medicaid member and are provided a process for review of denials of authorization relative to such admissions. DHS is required to establish a fee schedule, proportionate to the lost productivity of staff and resources experienced by a Medicaid provider, that results from the completion of the prior authorization process.