

House File 2292 - Introduced

HOUSE FILE 2292

BY HEATON

A BILL FOR

1 An Act relating to Medicaid managed care, including process and
2 contract requirements, and oversight.

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

1 Section 1. MEDICAID MANAGED CARE — PROCESS AND CONTRACT
2 REQUIREMENTS — OVERSIGHT. The department of human services
3 shall adopt rules pursuant to chapter 17A and shall amend all
4 Medicaid managed care contracts to provide for all of the
5 following relative to managed care organizations under contract
6 with the state:

7 1. Upon request by a Medicaid provider, the department
8 shall provide accurate and uniform patient encounter data to
9 a Medicaid provider, under contract with the managed care
10 organization, within sixty calendar days of the request. The
11 provision of the patient encounter data shall comply with the
12 federal Health Insurance Portability and Accountability Act
13 and any other applicable federal and state laws and regulatory
14 requirements and shall include but not be limited to the
15 managed care organization's claim number, the Medicaid member
16 identification number, the Medicaid member's name, the type of
17 claim, the amount billed by revenue code and procedure code,
18 the managed care organization's paid amount and payment date,
19 and the hospital patient account number, as applicable. The
20 department may charge a reasonable fee for the actual cost of
21 providing the patient encounter data to a Medicaid provider.

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

1 by rule of the department. A managed care organization shall
2 offer quarterly in-person training on claim adjustment reason
3 codes and remark codes required by the department and utilized
4 by the managed care organization.

5 3. A managed care organization shall offer quarterly
6 in-person education regarding billing guidelines, reimbursement
7 requirements, and program policies and procedures utilizing a
8 format approved by the department and incorporating information
9 collected through surveys of Medicaid providers.

10 4. The department shall develop and require utilization of
11 uniform standards by all managed care organizations applicable
12 to all of the following:

13 a. A standardized enrollment form and a uniform process for
14 credentialing and recredentialing Medicaid providers.

15 b. Procedures, requirements, and periodic reviews
16 and reporting of reductions in and limitations for prior
17 authorization relative to services and prescriptions.

18 c. Retrospective utilization review of hospital
19 readmissions that complies with any applicable federal law
20 or regulatory requirements, prohibiting such reviews for a
21 Medicaid member who is readmitted with a related medical
22 condition as an inpatient to a hospital more than fifteen
23 calendar days after the Medicaid member's discharge from the
24 hospital.

25 d. A requirement that a managed care organization, within
26 sixty calendar days of receiving an appeal request, provides
27 notice and resolves one hundred percent of provider appeals,
28 subject to remedies, including but not limited to liquidated
29 damages, if such appeals are not resolved within the required
30 time frame.

31 5. The department shall enter into a contract with an
32 independent auditor for the purpose of reviewing, at least once
33 each calendar year, a random sample of all claims paid and
34 denied by each managed care organization and each managed care
35 organization's subcontractors. Each managed care organization

1 and each managed care organization's subcontractors shall
2 pay any claim that the independent auditor determines to be
3 incorrectly denied, any applicable liquidated damages, and any
4 costs attributable to the annual audit.

5 6. A managed care organization shall pay one hundred percent
6 of the state-established per diem rate to nursing facilities
7 for those nursing facility residents enrolled in Medicaid
8 during any recredentialing process caused by a change in
9 ownership of the nursing facility.

10 7. A managed care organization shall not discriminate
11 against any licensed pharmacy or pharmacist located within the
12 geographic coverage area of the managed care organization that
13 is willing to meet the conditions for participating established
14 by the department and to accept reasonable contract terms
15 offered by the managed care organization.

16 Sec. 2. MEDICAID MANAGED CARE ORGANIZATION APPEALS PROCESS
17 — EXTERNAL REVIEW.

18 1. a. A Medicaid managed care organization under contract
19 with the state shall include in any written response to
20 a Medicaid provider under contract with the managed care
21 organization that reflects a final adverse determination of the
22 managed care organization's internal appeal process relative to
23 an appeal filed by the Medicaid provider, all of the following:

24 (1) A statement that the Medicaid provider's internal
25 appeal rights within the managed care organization have been
26 exhausted.

27 (2) A statement that the Medicaid provider is entitled to
28 an external independent third-party review pursuant to this
29 section.

30 (3) The requirements for requesting an external independent
31 third-party review.

32 b. If a managed care organization's written response does
33 not comply with the requirements of paragraph "a", the managed
34 care organization shall pay to the affected Medicaid provider a
35 penalty not to exceed one thousand dollars.

1 2. a. A Medicaid provider who has been denied the provision
2 of a service to a Medicaid member or a claim for reimbursement
3 for a service rendered to a Medicaid member, and who has
4 exhausted the internal appeals process of a managed care
5 organization, shall be entitled to an external independent
6 third-party review of the managed care organization's final
7 adverse determination.

8 b. To request an external independent third-party review of
9 a final adverse determination by a managed care organization,
10 an aggrieved Medicaid provider shall submit a written request
11 for such review to the managed care organization within sixty
12 calendar days of receiving the final adverse determination.

13 c. A Medicaid provider's request for such review shall
14 include all of the following:

15 (1) Identification of each specific issue and dispute
16 directly related to the final adverse determination issued by
17 the managed care organization.

18 (2) A statement of the basis upon which the Medicaid
19 provider believes the managed care organization's determination
20 to be erroneous.

21 (3) The Medicaid provider's designated contact information,
22 including name, mailing address, phone number, fax number, and
23 email address.

24 3. a. Within five business days of receiving a Medicaid
25 provider's request for review pursuant to this subsection, the
26 managed care organization shall do all of the following:

27 (1) Confirm to the Medicaid provider's designated contact,
28 in writing, that the managed care organization has received the
29 request for review.

30 (2) Notify the department of the Medicaid provider's
31 request for review.

32 (3) Notify the affected Medicaid member of the Medicaid
33 provider's request for review, if the review is related to the
34 denial of a service.

35 b. If the managed care organization fails to satisfy the

1 requirements of this subsection 3, the Medicaid provider shall
2 automatically prevail in the review.

3 4. a. Within fifteen calendar days of receiving a Medicaid
4 provider's request for external independent third-party review,
5 the managed care organization shall do all of the following:

6 (1) Submit to the department all documentation submitted
7 by the Medicaid provider in the course of the managed care
8 organization's internal appeal process.

9 (2) Provide the managed care organization's designated
10 contact information, including name, mailing address, phone
11 number, fax number, and email address.

12 b. If a managed care organization fails to satisfy the
13 requirements of this subsection 4, the Medicaid provider shall
14 automatically prevail in the review.

15 5. An external independent third-party review shall
16 automatically extend the deadline to file an appeal for a
17 contested case hearing under chapter 17A, pending the outcome
18 of the external independent third-party review, until thirty
19 calendar days following receipt of the review decision by the
20 Medicaid provider.

21 6. Upon receiving notification of a request for external
22 independent third-party review, the department shall do all of
23 the following:

24 a. Assign the review to an external independent third-party
25 reviewer.

26 b. Notify the managed care organization of the identity of
27 the external independent third-party reviewer.

28 c. Notify the Medicaid provider's designated contact of the
29 identity of the external independent third-party reviewer.

30 7. The department shall deny a request for an external
31 independent third-party review if the requesting Medicaid
32 provider fails to exhaust the managed care organization's
33 internal appeals process or fails to submit a timely request
34 for an external independent third-party review pursuant to this
35 subsection.

1 8. a. Multiple appeals through the external independent
2 third-party review process regarding the same Medicaid
3 member, a common question of fact, or interpretation of common
4 applicable regulations or reimbursement requirements may
5 be combined and determined in one action upon request of a
6 party in accordance with rules and regulations adopted by the
7 department.

8 b. The Medicaid provider that initiated a request for
9 an external independent third-party review, or one or more
10 other Medicaid providers, may add claims to such an existing
11 external independent third-party review following exhaustion
12 of any applicable managed care organization internal appeals
13 process, if the claims involve a common question of fact
14 or interpretation of common applicable regulations or
15 reimbursement requirements.

16 9. Documentation reviewed by the external independent
17 third-party reviewer shall be limited to documentation
18 submitted pursuant to subsection 4.

19 10. An external independent third-party reviewer shall do
20 all of the following:

21 a. Conduct an external independent third-party review
22 of any claim submitted to the reviewer pursuant to this
23 subsection.

24 b. Within thirty calendar days from receiving the request
25 for review from the department and the documentation submitted
26 pursuant to subsection 4, issue the reviewer's final decision
27 to the Medicaid provider's designated contact, the managed
28 care organization's designated contact, the department, and
29 the affected Medicaid member if the decision involves a denial
30 of service. The reviewer may extend the time to issue a final
31 decision by fourteen calendar days upon agreement of all
32 parties to the review.

33 11. The department shall enter into a contract with
34 an independent review organization that does not have a
35 conflict of interest with the department or any managed care

1 organization to conduct the independent third-party reviews
2 under this section.

3 a. A party, including the affected Medicaid member or
4 Medicaid provider, may appeal a final decision of the external
5 independent third-party reviewer in a contested case proceeding
6 in accordance with chapter 17A within thirty calendar days from
7 receiving the final decision. A final decision in a contested
8 case proceeding is subject to judicial review.

9 b. The final decision of any external independent
10 third-party review conducted pursuant to this subsection shall
11 also direct the nonprevailing party to pay an amount equal to
12 the costs of the review to the external independent third-party
13 reviewer. Any payment ordered pursuant to this subsection
14 shall be stayed pending any appeal of the review. If the
15 final outcome of any appeal is to reverse the decision of the
16 external independent third-party review, the nonprevailing
17 party shall pay the costs of the review to the external
18 independent third-party reviewer within forty-five calendar
19 days of entry of the final order.

20 EXPLANATION

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

23 This bill relates to Medicaid managed care including process
24 and contract requirements, and oversight.

25 The bill requires the department of human services (DHS) to
26 adopt administrative rules and amend all Medicaid managed care
27 contracts to administer the provisions of the bill.

28 The bill requires that, upon request by a Medicaid provider,
29 DHS shall provide accurate and uniform patient encounter data
30 to a Medicaid provider, under contract with a managed care
31 organization (MCO), within 60 calendar days of the request.
32 DHS may charge a reasonable fee for the actual cost of
33 providing the patient encounter data to a Medicaid provider.

34 The bill requires an MCO to provide documentation to a
35 Medicaid provider claimant when the MCO contests or denies

1 a claim, in whole or in part, within 15 calendar days after
2 receipt of the claim. The bill specifies the information to be
3 included in the documentation, requires the MCO to utilize the
4 standard coding and format of responses, established uniformly
5 across all MCOs by DHS, and requires MCOs to offer quarterly
6 in-person training on claim adjustment reason codes and remark
7 codes.

8 The bill requires MCOs to offer quarterly in-person
9 education regarding billing guidelines, reimbursement
10 requirements, and program policies and procedures utilizing a
11 format approved by DHS and incorporating information collected
12 through surveys of Medicaid providers.

13 The bill requires DHS to develop uniform standards and
14 require utilization of such uniform standards by all MCOs
15 regarding a standardized enrollment form and a uniform process
16 for credentialing and recredentialing Medicaid providers;
17 procedures, requirements, and periodic reviews and reporting of
18 reductions in and limitations for prior authorization relative
19 to services and prescriptions; retrospective utilization review
20 of hospital readmissions; a grievance, appeal, external review,
21 and state fair hearing process; and resolution of all appeals
22 within a 60-day time frame.

23 The bill requires DHS to enter into a contract with an
24 independent auditor to, at least annually, review a random
25 sample of all claims paid and denied by each MCO and each MCO's
26 subcontractors, and provides for payment by an MCO of any claim
27 that the independent auditor determines to be incorrectly
28 denied, any applicable liquidated damages, and any costs
29 attributable to the annual audit.

30 The bill requires an MCO to pay 100 percent of the
31 state-established per diem rate to nursing facilities for those
32 nursing facility residents enrolled in Medicaid during any
33 recredentialing process caused by a change in ownership of the
34 nursing facility.

35 The bill prohibits MCOs from discriminating against any

1 licensed pharmacy or pharmacist located within the geographic
2 coverage area of the MCO that is willing to meet the conditions
3 for participating established by DHS and to accept reasonable
4 contract terms offered by the MCO.

5 The bill also establishes an external review process for the
6 review of final adverse determinations of the MCOs' internal
7 appeal processes. The bill provides that a final decision
8 of an external reviewer may be reviewed in a contested case
9 proceeding pursuant to Code chapter 17A, and ultimately is
10 subject to judicial review.