Senate File 2221 - Introduced

SENATE FILE 2221
BY CHELGREN

A BILL FOR

An Act relating to Medicaid managed care policies and procedures.

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

Section 1. MEDICAID MANAGED CARE —— POLICIES AND PROCEDURES. The department of human services shall adopt rules pursuant to chapter 17A and shall amend all Medicaid managed care contracts, to require all of the following:

1. If a managed care organization fails to pay, contest, deny, or settle a clean claim in full within the time frame established by the managed care contract, the managed care organization shall pay the claimant interest in an amount equal to eighteen percent per annum on the total amount of the claim ultimately authorized, as calculated from fifteen days after the date the claim was submitted.

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

3. A managed care organization shall provide written notice to all affected individuals at least thirty days prior to a change in administrative processes or 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 upon which an affected individual relies under Medicaid managed care.

4. A managed care organization shall pay, contest, deny, or settle a claim, in whole or in part, within forty-five business days after receipt of the claim. If a claim is contested or denied, the managed care organization shall, with as much specificity as possible, identify the claim or portion of the claim affected, provide an explanation and the reasons for contesting or denying the claim, and provide the claimant with instructions for appealing the contested or denied claim.

5. A managed care organization shall complete the internal

review process for any claim submitted within ninety business days of receipt of the request for internal review. If the first level of review is not completed within the ninety-day period, the claim shall be subject to contested case review pursuant to chapter 17A, notwithstanding the fact that the claimant has not exhausted the managed care organization's internal review process and received a final written determination from the managed care organization.

EXPLANATION

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

This bill requires the department of human services (DHS) to adopt administrative rules and amend all Medicaid managed care contracts to require compliance with various policies and procedures.

The bill provides that if a managed care organization (MCO) fails to pay, contest, deny, or settle a clean claim in full within the time frame established by the managed care contract, the MCO is required to pay the claimant interest equal to 18 percent per annum on the total amount of the claim ultimately authorized as calculated from 15 days after the date the claim was submitted. For claims ultimately found to be incorrectly denied or underpaid through an appeals process or audit, an MCO is required to pay, in addition to the amount determined to be owed, interest of 18 percent per annum on the total amount of the claim authorized.

The bill requires an MCO to provide written notice to all affected individuals at least 30 days prior to a change in any term of a managed care contract or agreement upon which an affected individual has relied under the Medicaid managed care program.

The bill requires an MCO to pay, contest, or deny a claim, in whole or in part, within 45 business days after receipt of the claim. If a claim is contested or denied, the managed care organization shall, with as much specificity as possible,

identify the claim or portion of the claim affected, provide an explanation and the reasons for contesting or denying the claim, and provide the claimant with instruction for appeal of the claim.

The bill requires an MCO to complete the internal review process for any claim submitted within 90 business days of receipt of the request for internal review. If the internal review is not completed within the 90-day period, the claim is subject to contested case review pursuant to Code chapter 17A, notwithstanding the fact that the claimant has not exhausted the managed care organization's internal review process and received a final written determination from the MCO.