Senate File 2259 - Introduced

SENATE FILE 2259
BY PETERSEN

A BILL FOR

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

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

Section 1. MEDICAID MANAGED CARE —— PROCESS AND CONTRACT REQUIREMENTS —— OVERSIGHT. 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 relative to managed care organizations under contract with the state:

1. Upon request by a Medicaid provider, the department shall provide accurate and uniform patient encounter data to a Medicaid provider, under contract with the 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 a Medicaid provider.

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

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

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

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

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

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

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

5. 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 each managed care organization and each managed care organization's subcontractors. Each managed care organization

and each managed care organization's subcontractors 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. If the managed care organization fails to satisfy the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. 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 independent third-party reviews under this section.

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

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

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 including process and contract requirements, and oversight.

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

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

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

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

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

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

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

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

The bill prohibits MCOs from discriminating against any

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

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