House File 555 - Introduced

HOUSE FILE 555
BY HEDDENS, STAED, FORBES, HUNTER, GASKILL, KRESSIG, JACOBY, and WINCKLER

A BILL FOR

An Act relating to Medicaid managed care including the provision of certain services and payment for services.

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

Section 1. MEDICAID MANAGED CARE —— DISCHARGE PLANNING AND PLACEMENT —— REIMBURSEMENT OF SERVICES PROVIDED IN GOOD FAITH —— INTEREST ON LATE PAYMENTS AND OTHER PAYMENTS —— SUPPORTS INTENSITY SCALE ADMINISTRATION.

1. The department of human services shall contractually require a Medicaid managed care organization and the Medicaid managed care organization's case managers, not individual providers of services, to be responsible for the discharge planning and relocation to an appropriate alternative placement of a Medicaid member transitioning from one level of care or placement to another. The Medicaid managed care organization shall have appropriate processes in place to reduce disruption to the Medicaid member during the discharge planning and relocation processes.

2. The department of human services shall contractually prohibit a Medicaid managed care organization from denying payment for services rendered by a Medicaid provider who, in good faith, provides services to a Medicaid member in accordance with a service plan and reimbursement agreement. Additionally, under such circumstances, payments shall not be recouped by the department or a Medicaid managed care organization if, subsequent to the provision of such services, the Medicaid managed care organization or the department determines that the member was not eligible for such services and if the provider of services is able to demonstrate, based on the information available to the provider, that the services were authorized at the time the services were rendered.

3. The department of human services shall contractually require that a Medicaid managed care organization that fails to pay, deny, or settle a clean claim in full within the time frame established by the contract shall pay the Medicaid provider claimant interest equal to twelve percent per annum on the total amount of the claim ultimately authorized. Additionally, if a claim is ultimately found to be incorrectly denied or underpaid through an appeals process or audit,

a Medicaid 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 ultimately authorized as calculated from fifteen calendar days after the date the claim was submitted.

4. The department of human services shall contract with an independent third party to administer a conflict-free uniform supports intensity scale assessment for persons with an intellectual disability or developmental disability. The assessment tool shall include an evaluation of the functional skills and abilities of the Medicaid member at the following three levels: without the provision of any supports and services, with the provision of the current level of supports and services, and with the provision of additional supports and services to assist the member in reaching the member's full potential. The assessment tool shall include a narrative portion to more fully reflect and identify the unique supports and service needs and concerns of the member as well as the member's family and caregivers.

EXPLANATION

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

This bill includes provisions relating to Medicaid managed care including discharge planning and relocation responsibilities, reimbursement of services provided in good faith, interest on late and other payments, and supports intensity scale assessment administration.

The bill requires the department of human services (DHS) to contractually require a Medicaid managed care organization (MCO) and the MCO's case managers, not individual providers of services, to be responsible for the discharge planning and relocation to an appropriate alternative placement of a Medicaid member transitioning from one level of care or placement to another. The MCO shall have appropriate processes in place to reduce disruption to the Medicaid member during the

discharge planning and relocation processes.

The bill requires DHS to also contractually prohibit an MCO from denying payment for services rendered by a Medicaid provider who, in good faith, provides services to a Medicaid member in accordance with a service plan and reimbursement agreement. The bill also prohibits recoupment of payments if, subsequent to the provision of such services, the MCO or DHS determines that the member was not eligible for such services and if the provider of services is able to demonstrate, based on the information available to the provider, that the services were authorized at the time the services were rendered.

The bill requires DHS to contractually require that an MCO that fails to pay, deny, or settle a clean claim in full within the time frame established by the contract to pay the Medicaid provider claimant interest equal to 12 percent per annum on the total amount of the claim ultimately authorized. Additionally, if a claim is ultimately found to be incorrectly denied or underpaid through an appeals process or audit, an MCO shall pay a Medicaid provider claimant, in addition to the amount determined to be owed, interest of 20 percent per annum on the total amount of the claim ultimately authorized as calculated from 15 calendar days after the date the claim was submitted.

The bill requires DHS to contract with an independent third party to administer a conflict-free uniform supports intensity scale assessment for persons with an intellectual disability or developmental disability. The assessment tool shall include an evaluation of the functional skills and abilities of the Medicaid member at three levels: without the provision of any supports and services, with the provision of the current level of supports and services, and with the provision of additional supports and services to assist the member in reaching the member's full potential. The assessment tool shall include a narrative portion to more fully reflect and identify the unique supports and service needs and concerns of the member as well as the member's family and caregivers.