

House File 555 - Introduced

HOUSE FILE 555

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A BILL FOR

1 An Act relating to Medicaid managed care including the
2 provision of certain services and payment for services.
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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

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

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

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

1 a Medicaid managed care organization shall pay a Medicaid
2 provider claimant, in addition to the amount determined to be
3 owed, interest of twenty percent per annum on the total amount
4 of the claim ultimately authorized as calculated from fifteen
5 calendar days after the date the claim was submitted.

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

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

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

1 discharge planning and relocation processes.

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

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

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