Senate File 156 - Introduced

SENATE FILE 156
BY MATHIS and RAGAN

A BILL FOR

An Act relating to Medicaid program improvements, and including effective date provisions.

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

TLSB 1590ST (11) 88
pf/rh

DIVISION I

MEDICAID MANAGED CARE TO FEE-FOR-SERVICE TRANSITION —— LONG-TERM SERVICES AND SUPPORTS

Section 1. TERMINATION OF MEDICAID MANAGED CARE CONTRACTS RELATIVE TO LONG-TERM SERVICES AND SUPPORTS POPULATION —— TRANSITION TO FEE-FOR-SERVICE. The department of human services shall, upon the effective date of this division of this Act, provide written notice in accordance with the termination provisions of the contract, to each managed care organization with whom the department executed a contract to administer the Iowa high quality health care initiative as established by the department, to terminate such contracts as applicable to the Medicaid long-term services and supports population, following a sixty-day transition period. The department shall transfer the long-term services and supports population to the Medicaid fee-for-service payment and delivery system. The transition shall be based on a transition plan developed by the department and submitted to the council on human services and the medical assistance advisory council for review. The department of human services shall seek any Medicaid state plan or waiver amendments necessary to complete the transition.

Sec. 2. EFFECTIVE DATE. This division of this Act, being deemed of immediate importance, takes effect upon enactment.

DIVISION II

MEDICAID LONG-TERM SERVICES AND SUPPORTS POPULATION MEMBERS —— PROVISION OF CONFLICT-FREE SERVICES

Sec. 3. MEDICAID LONG-TERM SERVICES AND SUPPORTS POPULATION MEMBERS —— PROVISION OF CONFLICT-FREE SERVICES. The department of human services shall adopt rules pursuant to chapter 17A to ensure that services are provided under the Medicaid program to members of the long-term services and supports population in a conflict-free manner. Specifically, case management services shall be provided by independent providers and supports intensity scale assessments shall be performed by independent

assessors.

DIVISION III

MEDICATION-ASSISTED TREATMENT

Sec. 4. MEDICATION-ASSISTED TREATMENT —— PRIOR AUTHORIZATION PROHIBITED. The department of human services shall adopt rules pursuant to chapter 17A that prohibit prior authorization for medication-assisted treatment under both Medicaid fee-for-service and managed care payment and delivery systems. The department of human services shall also include this prohibition in any contract entered into with a Medicaid managed care organization. For the purposes of this section, "medication-assisted treatment" means the medically monitored use of certain substance use disorder medications in combination with other treatment services.

DIVISION IV

MEDICAID WORKFORCE PROGRAM

Sec. 5. WORKFORCE RECRUITMENT, RETENTION, AND TRAINING PROGRAMS. The department of human services shall contractually require any managed care organization with whom the department contracts under the Medicaid program to collaborate with the department and stakeholders to develop and administer a workforce recruitment, retention, and training program to provide adequate access to appropriate services, including but not limited to services to older Iowans. The department shall ensure that any program developed is administered in a coordinated and collaborative manner across all contracting managed care organizations and shall require the managed care organizations to submit quarterly progress and outcomes reports to the department.

DIVISION V

PROVIDER APPEALS PROCESS —— EXTERNAL REVIEW

Sec. 6. 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.

DIVISION VI

MEMBER DISENROLLMENT FOR GOOD CAUSE

Sec. 7. MEMBER DISENROLLMENT FOR GOOD CAUSE. The department of human services shall adopt rules pursuant to chapter 17A and shall contractually require all Medicaid managed care organizations to issue a decision in response to a member's request for disenrollment for good cause within ten days of the date the member submits the request to the Medicaid managed care organization utilizing the Medicaid managed care organization's grievance process.

DIVISION VII

OMBUDSMAN —— MEDICAID PROGRAM ASSISTANCE AND ADVOCACY

Sec. 8. NEW SECTION. **2C.6A Assistant for Medicaid program.**

1. The ombudsman shall appoint an assistant who shall be primarily responsible for investigating complaints relating to the Medicaid program, including both Medicaid fee-for-service and managed care payment and delivery systems, and all Medicaid populations including the long-term services and supports population.

2. The ombudsman shall provide assistance and advocacy services to Medicaid recipients and the families or legal representatives of Medicaid recipients. Such assistance and advocacy shall include but is not limited to all of the following:

a. Assisting recipients in understanding the services, coverage, and access provisions and their rights under the Medicaid program.

b. Developing procedures for the tracking and reporting of the outcomes of individual requests for assistance, the procedures available for obtaining services, and other aspects of the services provided to Medicaid recipients.

c. Providing advice and assistance relating to the preparation and filing of complaints, grievances, and appeals of complaints or grievances, including through processes available under managed care plans and the state appeals

process under the Medicaid program.

3. The ombudsman shall adopt rules to administer this section.

4. The ombudsman shall publish special reports and investigative reports as deemed necessary and shall include findings and recommendations related to the assistance and advocacy provided under this section in the ombudsman's annual report.

Sec. 9. REPEAL. Section 231.44, Code 2019, is repealed.

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 the Medicaid program.

Division I of the bill requires the department of human services (DHS) to terminate existing contracts with Medicaid managed care organizations (MCOs) as the contracts apply to the Medicaid long-term services and supports population and transfer this population from the Medicaid managed care to the Medicaid fee-for-service payment and delivery system. The transition is to be based on a transition plan developed by DHS and submitted to the council on human services and the medical assistance advisory council for review. DHS is required to seek any Medicaid state plan or waiver amendments as necessary to complete the transition. The division takes effect upon enactment.

Division II of the bill requires DHS to adopt administrative rules to ensure that services are provided to the Medicaid long-term services and supports population in a conflict-free manner. Specifically, the bill requires that case management services shall be provided by independent providers and that the supports intensity scale assessments are performed by independent assessors.

Division III of the bill relates to medication-assisted treatment. The bill requires DHS to adopt administrative rules to prohibit prior authorization for the provision

of medication-assisted treatment under both the Medicaid fee-for-service and managed care payment and delivery systems. The division also requires DHS to include this prohibition in any contract entered into with a Medicaid MCO. Under the division, "medication-assisted treatment" means the medically monitored use of certain substance use disorder medications in combination with other treatment services.

Division IV of the bill requires DHS to contractually require any Medicaid MCO to collaborate with the department and stakeholders to develop and administer a workforce recruitment, retention, and training program to provide adequate access to appropriate services, including but not limited to services to older Iowans. The department shall ensure that any such program developed is administered in a coordinated and collaborative manner across all contracting MCOs and shall require the MCOs to submit quarterly progress and outcomes reports to the department.

Division V of the bill establishes an external review process for Medicaid providers for the review of final adverse determinations of the MCOs' internal appeal processes. The division 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.

Division VI of the bill relates to member disenrollment for good cause during the 12 months of closed enrollment between open enrollment periods. Currently, a member may request disenrollment for good cause initially through their MCO's grievance process, which may take up to 30 to 45 days to process. The bill requires DHS to adopt administrative rules and contractually require all Medicaid MCOs to issue a decision in response to a member's request for disenrollment for good cause within 10 days of the date the member submits the request to the MCO utilizing the MCO's grievance process.

Division VII of the bill directs the ombudsman to appoint an assistant who shall be primarily responsible for investigating

complaints relating to the Medicaid program, including both the Medicaid managed care and fee-for-service payment and delivery systems, and all Medicaid populations including the long-term services and supports population. The division specifies the minimum areas of assistance and advocacy to be provided, directs the ombudsman to adopt administrative rules for administration of this division of the bill, and directs the ombudsman to publish special reports and investigative reports as deemed necessary, and to include findings and recommendations related to the Medicaid program assistance and advocacy provided under the bill in the ombudsman's annual report.

The division also repeals the section of the Code that directs the office of long-term care ombudsman to provide assistance and advocacy services to members of the Medicaid long-term services and supports population since under the bill, the ombudsman will provide assistance and advocacy for both Medicaid managed care and fee-for-service payment and delivery systems and for all populations including the long-term services and supports population.