Senate File 2177 - Introduced

SENATE FILE 2177
BY MATHIS and RAGAN

A BILL FOR

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

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

TLSB 6020XS (8) 88
pf/rh

DIVISION I

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

Section 1. 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 II

MEDICAID WORKFORCE PROGRAM

Sec. 2. 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 III

PROVIDER APPEALS PROCESS —— EXTERNAL REVIEW

Sec. 3. 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.

ll. 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 IV

MEMBER DISENROLLMENT FOR GOOD CAUSE

Sec. 4. 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 V

UNIFORM, SINGLE CREDENTIALING

Sec. 5. MEDICAID PROGRAM —— USE OF UNIFORM AUTHORIZATION CRITERIA AND SINGLE CREDENTIALING VERIFICATION ORGANIZATION. The department of human services shall develop uniform authorization criteria for, and shall utilize a request for proposals process to procure a single credentialing verification organization to be utilized by the state in credentialing and recredentialing providers for both the Medicaid managed care and fee-for-service payment and delivery systems. The department shall contractually require all Medicaid managed care organizations to apply the uniform authorization criteria and to accept verified information from the single credentialing verification organization procured by the state, and shall contractually prohibit Medicaid managed care organizations from requiring additional credentialing information from a provider in order to participate in the Medicaid managed care organization's provider network.

DIVISION VI

MEDICAID MANAGED CARE OMBUDSMAN PROGRAM —— APPROPRIATION

Sec. 6. OFFICE OF LONG-TERM CARE OMBUDSMAN —— MEDICAID MANAGED CARE OMBUDSMAN.

1. There is appropriated from the general fund of the state to the office of long-term care ombudsman for the fiscal year beginning July 1, 2020, and ending June 30, 2021, in addition to any other funds appropriated from the general fund of the state to, and in addition to any other full-time

equivalent positions authorized for, the office of long-term care ombudsman for the same purpose, the following amount, or so much thereof as is necessary, to be used for the purposes designated:

For the purposes of the Medicaid managed care ombudsman program including for salaries, support, administration, maintenance, and miscellaneous purposes, and for not more than the following full-time equivalent positions:

..... $ 300,000

..... FTEs 2.50

2. The funding appropriated and the full-time equivalent positions authorized under this section are in addition to any other funds appropriated from the general fund of the state and actually expended, and any other full-time equivalent positions authorized and actually filled as of July 1, 2020, for the Medicaid managed care ombudsman program.

3. Any funds appropriated to and any full-time equivalent positions authorized for the office of long-term care ombudsman for the Medicaid managed care ombudsman program for the fiscal year beginning July 1, 2020, and ending June 30, 2021, shall be used exclusively for the Medicaid managed care ombudsman program.

4. The additional full-time equivalent positions authorized in this section for the Medicaid managed care ombudsman program shall be filled no later than September 1, 2020.

5. The office of long-term care ombudsman shall include in the Medicaid managed care ombudsman program report, on a quarterly basis, the disposition of resources for the Medicaid managed care ombudsman program including actual expenditures and a full-time equivalent positions summary for the prior quarter.

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 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 II of the bill requires DHS to contractually require any Medicaid managed care organization (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 III 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 IV 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 V of the bill requires the DHS to develop

uniform authorization criteria for, and to utilize a request for proposals process to procure a single credentialing verification organization to be utilized in credentialing and recredentialing providers for the Medicaid managed care and fee-for-service payment and delivery systems. The bill requires DHS to contractually require all Medicaid managed care organizations (MCOs) to apply the uniform authorization criteria and to accept verified information from the single credentialing verification organization procured by the state, and to contractually prohibit the MCOs from requiring additional credentialing information from a provider in order to participate in the Medicaid managed care organization's provider network.

Division VI of the bill relates to the office of long-term care ombudsman (OLTCO) and the Medicaid managed care ombudsman program (MCOP).

For fiscal year 2020-2021, the bill appropriates $300,000 from the general fund of the state, in addition to any other funds appropriated from the general fund of the state to, and authorizes 2.50 FTEs in addition to any other full-time equivalent (FTE) positions authorized for, the OLTCO for the purposes of the MCOP. The funding appropriated and the FTE positions authorized under the bill are in addition to any other funds appropriated from the general fund of the state and actually expended, and any other FTE positions authorized and actually filled as of July 1, 2020, for the MCOP. For fiscal year 2019-2020, the expenditures budgeted for MCOP were $171,536 and the FTE positions filled totaled 1.50.

The bill requires that any funds appropriated to and any full-time equivalent positions authorized for the OLTCO for the MCOP for fiscal year 2020-2021 shall be used exclusively for the MCOP. The additional FTE positions authorized in the bill for the MCOP shall be filled no later than September 1, 2020.

The bill requires the OLTCO to include in the MCOP report, on a quarterly basis, the disposition of resources for the MCOP

including expenditures and a full-time equivalent positions summary for the prior quarter.