Senate Study Bill 1234 - Introduced

SENATE FILE _____
BY (PROPOSED COMMITTEE
ON COMMERCE BILL BY
CHAIRPERSON CHAPMAN)

A BILL FOR

An Act relating to Medicaid processes, procedures, and oversight.

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

DIVISION I

MEDICAID STREAMLINED PROCESSES AND OVERSIGHT

Section 1. MEDICAID STREAMLINED PROCESSES AND OVERSIGHT. The department of human services shall provide for the streamlining of and consistency in Medicaid program processes and procedures as follows:

1. That for both fee-for-service and managed care administration, prior authorization requirements shall be based on those established by the Iowa Medicaid enterprise and that resources shall be available twenty-four hours per day, three hundred sixty-five days per year to evaluate prior authorization requests and avoid delays in the provision of medically necessary care and services.

2. That all Medicaid managed care organizations under contract with the state utilize uniform payment authorization criteria and comply with contract provisions related to timely payment.

3. That all Medicaid managed care organizations contracting with the state post a complete and accurate roster of the managed care organization's participating providers and update the roster in a timely manner to ensure an accurate roster of in-network providers to facilitate service and care referrals and appropriate discharge of members.

4. That all Medicaid managed care organizations contracting with the state provide the Medicaid managed care organization's participating providers with the functionality to submit and track all claims, claim disputes, claim reconsiderations, and appeals on the Medicaid managed care organization's website to facilitate participation in an open and shared provider record.

5. That all Medicaid managed care organizations contracting with the state provide uniform benefits to eliminate disparities and provide consistent coverage to Medicaid members across all Medicaid managed care organizations.

DIVISION II

MEDICAID CREDENTIALING PROVISIONS

Sec. 2. 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, to accept verified information from the single credentialing verification organization procured by the state, and to approve or deny a provider's credentials within sixty days of receipt of the request for approval, 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 III

MEDICAID MANAGED CARE APPEALS —— INTERNAL AND EXTERNAL REVIEW

Sec. 3. MEDICAID MANAGED CARE APPEALS —— INTERNAL APPEAL PROCESS AND EXTERNAL REVIEW.

1. A Medicaid managed care organization contracting with the state shall provide an internal appeal process for a Medicaid provider who has been denied a claim for the provision of a service to a Medicaid member or a claim for reimbursement for a service rendered to a Medicaid member. All forms, processes, and communications involved in the internal appeal process shall be uniform across all Medicaid managed care organizations. The internal appeal process shall provide for all of the following:

a. The Medicaid provider's written request for an internal appeal shall include identification of the Medicaid payment policy in support of the provider's claim, each specific issue and dispute directly related to the claim, and a statement of

the basis upon which the Medicaid provider believes the managed care organization's determination to be erroneous.

b. Within fifteen days of receipt of a written request from a Medicaid provider for an internal appeal of a Medicaid managed care organization's decision, an independent third party shall hold a hearing on the claim in accordance with Medicaid program rules and written policies and the Medicaid state plan. The independent third party shall render a decision within fifteen days of completion of the hearing. The department of human services shall provide guidance to the Medicaid provider and the Medicaid managed care organization regarding any ambiguity in the rules, written policies, or Medicaid state plan to facilitate the appeal process.

c. If the internal appeal process results in a final adverse determination for the Medicaid provider, the Medicaid provider may request an external independent third-party review as provided in this section.

2. 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:

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

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

c. The requirements for requesting an external independent third-party review.

3. 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.

4. 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 4, the Medicaid provider shall automatically prevail in the review.

5. 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 5, the Medicaid provider shall automatically prevail in the review.

6. 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.

7. 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.

8. 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.

9. 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.

10. Documentation reviewed by the external independent third-party reviewer shall be limited to documentation submitted pursuant to subsection 5.

11. 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 forty-five calendar days from receiving the request for review from the department and the documentation submitted pursuant to subsection 5, 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.

12. 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 processes, procedures, and oversight.

Division I of the bill provides for streamlined processes and oversight under the Medicaid program. The bill requires the department of human services (DHS) to provide for the streamlining of and consistency in Medicaid program processes and procedures relating to prior authorization requirements; utilization of uniform payment authorization criteria and compliance with contract provisions related to timely payment; the posting and updating of a complete and accurate roster of a Medicaid managed care organization's participating providers; the submission and tracking of claims, claims disputes, claims reconsiderations, and appeals on the Medicaid managed care organization's website; and the provision of uniform benefits across all Medicaid managed care organizations.

Division II of the bill requires 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 division requires DHS to contractually require all Medicaid managed care organizations to apply the uniform authorization criteria, to accept verified information from the single credentialing verification organization procured by the state, to approve or deny a provider's application for credentialing within 60 days of submission for approval, and to contractually prohibit the 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 III of the bill establishes internal and external review processes for Medicaid providers for the review of initial and 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.