

Senate File 2066 - Introduced

SENATE FILE 2066
BY RAGAN and MATHIS

A BILL FOR

1 An Act relating to Medicaid program improvements.

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

1 DIVISION I
2 MEDICAID LONG-TERM SERVICES AND SUPPORTS POPULATION MEMBERS —
3 PROVISION OF CONFLICT-FREE SERVICES

4 Section 1. MEDICAID LONG-TERM SERVICES AND SUPPORTS
5 POPULATION MEMBERS — PROVISION OF CONFLICT-FREE SERVICES. The
6 department of human services shall adopt rules pursuant to
7 chapter 17A to ensure that services are provided under the
8 Medicaid program to members of the long-term services and
9 supports population in a conflict-free manner. Specifically,
10 case management services shall be provided by independent
11 providers and supports intensity scale assessments shall be
12 performed by independent assessors.

13 DIVISION II
14 MEDICAID WORKFORCE PROGRAM

15 Sec. 2. WORKFORCE RECRUITMENT, RETENTION, AND TRAINING
16 PROGRAMS. The department of human services shall contractually
17 require any managed care organization with whom the department
18 contracts under the Medicaid program to collaborate with
19 the department and stakeholders to develop and administer a
20 workforce recruitment, retention, and training program to
21 provide adequate access to appropriate services, including
22 but not limited to services to older Iowans. The department
23 shall ensure that any program developed is administered in a
24 coordinated and collaborative manner across all contracting
25 managed care organizations and shall require the managed care
26 organizations to submit quarterly progress and outcomes reports
27 to the department.

28 DIVISION III
29 PROVIDER APPEALS PROCESS — EXTERNAL REVIEW

30 Sec. 3. MEDICAID MANAGED CARE ORGANIZATION APPEALS PROCESS
31 — EXTERNAL REVIEW.
32 1. a. A Medicaid managed care organization under contract
33 with the state shall include in any written response to
34 a Medicaid provider under contract with the managed care
35 organization that reflects a final adverse determination of the

1 managed care organization's internal appeal process relative to
2 an appeal filed by the Medicaid provider, all of the following:

3 (1) A statement that the Medicaid provider's internal
4 appeal rights within the managed care organization have been
5 exhausted.

6 (2) A statement that the Medicaid provider is entitled to
7 an external independent third-party review pursuant to this
8 section.

9 (3) The requirements for requesting an external independent
10 third-party review.

11 b. If a managed care organization's written response does
12 not comply with the requirements of paragraph "a", the managed
13 care organization shall pay to the affected Medicaid provider a
14 penalty not to exceed one thousand dollars.

15 2. a. A Medicaid provider who has been denied the provision
16 of a service to a Medicaid member or a claim for reimbursement
17 for a service rendered to a Medicaid member, and who has
18 exhausted the internal appeal process of a managed care
19 organization, shall be entitled to an external independent
20 third-party review of the managed care organization's final
21 adverse determination.

22 b. To request an external independent third-party review of
23 a final adverse determination by a managed care organization,
24 an aggrieved Medicaid provider shall submit a written request
25 for such review to the managed care organization within sixty
26 calendar days of receiving the final adverse determination.

27 c. A Medicaid provider's request for an external
28 independent third-party review shall include all of the
29 following:

30 (1) Identification of each specific issue and dispute
31 directly related to the final adverse determination issued by
32 the managed care organization.

33 (2) A statement of the basis upon which the Medicaid
34 provider believes the managed care organization's determination
35 to be erroneous.

1 (3) The Medicaid provider's designated contact information,
2 including name, mailing address, phone number, fax number, and
3 email address.

4 3. a. Within five business days of receiving a Medicaid
5 provider's request for an external independent third-party
6 review pursuant to this subsection, the managed care
7 organization shall do all of the following:

8 (1) Confirm to the Medicaid provider's designated contact,
9 in writing, that the managed care organization has received the
10 request for review.

11 (2) Notify the department of the Medicaid provider's
12 request for review.

13 (3) Notify the affected Medicaid member of the Medicaid
14 provider's request for review, if the review is related to the
15 denial of a service.

16 b. If the managed care organization fails to satisfy the
17 requirements of this subsection, the Medicaid provider shall
18 automatically prevail in the review.

19 4. a. Within fifteen calendar days of receiving a Medicaid
20 provider's request for an external independent third-party
21 review, the managed care organization shall do all of the
22 following:

23 (1) Submit to the department all documentation submitted
24 by the Medicaid provider in the course of the managed care
25 organization's internal appeal process.

26 (2) Provide the managed care organization's designated
27 contact information, including name, mailing address, phone
28 number, fax number, and email address.

29 b. If a managed care organization fails to satisfy the
30 requirements of this subsection, the Medicaid provider shall
31 automatically prevail in the review.

32 5. A request for an external independent third-party review
33 shall automatically extend the deadline to file an appeal for a
34 contested case hearing under chapter 17A, pending the outcome
35 of the external independent third-party review, until thirty

1 calendar days following receipt of the review decision by the
2 Medicaid provider.

3 6. Upon receiving notification of a request for an external
4 independent third-party review, the department shall do all of
5 the following:

6 a. Assign the review to an external independent third-party
7 reviewer.

8 b. Notify the managed care organization of the identity of
9 the external independent third-party reviewer.

10 c. Notify the Medicaid provider's designated contact of the
11 identity of the external independent third-party reviewer.

12 7. The department shall deny a request for an external
13 independent third-party review if the requesting Medicaid
14 provider fails to exhaust the managed care organization's
15 internal appeal process or fails to submit a timely request for
16 an external independent third-party review pursuant to this
17 section.

18 8. a. Multiple appeals through the external independent
19 third-party review process regarding the same Medicaid member,
20 a common question of fact, or the interpretation of common
21 applicable regulations or reimbursement requirements may
22 be combined and determined in one action upon request of a
23 party in accordance with rules and regulations adopted by the
24 department.

25 b. The Medicaid provider that initiated a request for
26 an external independent third-party review, or one or more
27 other Medicaid providers, may add claims to such an existing
28 external independent third-party review request following the
29 exhaustion of any applicable managed care organization internal
30 appeal process, if the claims involve a common question of
31 fact or interpretation of common applicable regulations or
32 reimbursement requirements.

33 9. Documentation reviewed by the external independent
34 third-party reviewer shall be limited to documentation
35 submitted pursuant to subsection 4.

1 10. An external independent third-party reviewer shall do
2 all of the following:

3 a. Conduct an external independent third-party review
4 of any claim submitted to the reviewer pursuant to this
5 subsection.

6 b. Within thirty calendar days from receiving the
7 request for an external independent third-party review from
8 the department and the documentation submitted pursuant to
9 subsection 4, issue the reviewer's final decision to the
10 Medicaid provider's designated contact, the managed care
11 organization's designated contact, the department, and the
12 affected Medicaid member if the decision involves a denial of
13 service. The reviewer may extend the time to issue a final
14 decision by up to fourteen calendar days upon agreement of all
15 parties to the review.

16 11. The department shall enter into a contract with an
17 external independent review organization that does not have a
18 conflict of interest with the department or any managed care
19 organization to conduct the external independent third-party
20 reviews under this section.

21 a. A party, including the affected Medicaid member or
22 Medicaid provider, may appeal a final decision of the external
23 independent third-party reviewer in a contested case proceeding
24 in accordance with chapter 17A within thirty calendar days from
25 receiving the final decision. A final decision in a contested
26 case proceeding is subject to judicial review.

27 b. The final decision of an external independent
28 third-party reviewer conducted pursuant to this section shall
29 also direct the nonprevailing party to pay an amount equal to
30 the costs of the review to the external independent third-party
31 reviewer. Any payment ordered pursuant to this subsection
32 shall be stayed pending any appeal of the review. If the
33 final outcome of any appeal is to reverse the decision of the
34 external independent third-party reviewer, the nonprevailing
35 party shall pay the costs of the review to the external

1 independent third-party reviewer within forty-five calendar
2 days of entry of the final order.

3 DIVISION IV

4 UNIFORM, SINGLE CREDENTIALING

5 Sec. 4. MEDICAID PROGRAM — USE OF UNIFORM AUTHORIZATION
6 CRITERIA AND SINGLE CREDENTIALING VERIFICATION
7 ORGANIZATION. The department of human services shall
8 develop uniform authorization criteria for, and shall
9 utilize a request for proposals process to procure, a single
10 credentialing verification organization to be utilized by
11 the state in credentialing and recredentialing providers for
12 both the Medicaid managed care and fee-for-service payment and
13 delivery systems. The department shall contractually require
14 all Medicaid managed care organizations to apply the uniform
15 authorization criteria and to accept verified information from
16 the single credentialing verification organization procured by
17 the state, and shall contractually prohibit Medicaid managed
18 care organizations from requiring additional credentialing
19 information from a provider in order to participate in the
20 Medicaid managed care organization's provider network.

21 EXPLANATION

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

24 This bill relates to Medicaid program improvements.

25 Division I of the bill requires the department of human
26 services (DHS) to adopt administrative rules to ensure that
27 services are provided to the Medicaid long-term services and
28 supports population in a conflict-free manner. Specifically,
29 the bill requires that case management services shall be
30 provided by independent providers and that the supports
31 intensity scale assessments are performed by independent
32 assessors.

33 Division II of the bill requires DHS to contractually
34 require any Medicaid managed care organization (MCO) to
35 collaborate with DHS and stakeholders to develop and administer

1 a workforce recruitment, retention, and training program to
2 provide adequate access to appropriate services, including but
3 not limited to services to older Iowans. DHS shall ensure that
4 any such program developed is administered in a coordinated
5 and collaborative manner across all contracting MCOs and shall
6 require the MCOs to submit quarterly progress and outcomes
7 reports to DHS.

8 Division III of the bill establishes an external independent
9 third-party review process for Medicaid providers for the
10 review of final adverse determinations of the MCOs' internal
11 appeal processes. The bill provides that a final decision of
12 an external independent third-party reviewer may be reviewed in
13 a contested case proceeding pursuant to Code chapter 17A, and
14 ultimately is subject to judicial review.

15 Division IV of the bill requires DHS to develop uniform
16 authorization criteria for, and to utilize a request
17 for proposals process to procure, a single credentialing
18 verification organization to be utilized in credentialing
19 and recredentialing providers for the Medicaid managed care
20 and fee-for-service payment and delivery systems. The bill
21 requires DHS to contractually require all MCOs to apply
22 the uniform authorization criteria and to accept verified
23 information from the single credentialing verification
24 organization procured by the state, and to contractually
25 prohibit MCOs from requiring additional credentialing
26 information from a provider in order to participate in the
27 Medicaid managed care organization's provider network.