Senate File 2083 - Introduced

SENATE FILE 2083
BY JOCHUM, PETERSEN, TRONE
GARRIOTT, DONAHUE, WAHLS,
DOTZLER, T. TAYLOR, WEINER,
WINCKLER, GIDDENS, CELSI,
BISIGNANO, BOULTON, KNOX,
BENNETT, and QUIRMBACH

A BILL FOR

1 An Act relating to Medicaid program improvements, making an
2 appropriation, and providing penalties.
3 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 health and human services shall adopt rules
7 pursuant to chapter 17A to ensure that services are provided
8 under the Medicaid program to members of the long-term
9 services and supports population in a conflict-free manner.
10 Specifically, case management services shall be provided by
11 independent providers and supports intensity scale assessments
12 shall be performed by independent assessors.
13 DIVISION II
14 LONG-TERM SERVICES AND SUPPORTS POPULATION MEMBERS — OPTION
15 FOR FEE-FOR-SERVICE PROGRAM ADMINISTRATION
16 Sec. 2. LONG-TERM SERVICES AND SUPPORTS POPULATION MEMBERS
17 — OPTION FOR FEE-FOR-SERVICE PROGRAM ADMINISTRATION. The
18 department of health and human services shall require each
19 Medicaid managed care organization with whom the department
20 executes a contract to administer the Iowa high quality
21 health care initiative as established by the department,
22 to provide the option to Medicaid long-term services and
23 supports population members to enroll in or transition to
24 fee-for-service Medicaid program administration rather than
25 managed care administration. The department shall amend any
26 contract, request any Medicaid state plan amendment, and adopt
27 rules pursuant to chapter 17A, as necessary, to administer this
28 section. The rules shall include the process for transitioning
29 a current Medicaid long-term services and supports population
30 member to fee-for-service program administration.
31 DIVISION III
32 MEDICAID WORKFORCE PROGRAM
33 Sec. 3. WORKFORCE RECRUITMENT, RETENTION, AND TRAINING
34 PROGRAMS. The department of health and human services shall
35 contractually require any managed care organization with whom

1 the department executes a contract under the Medicaid program
2 to collaborate with the department and stakeholders to develop
3 and administer a workforce recruitment, retention, and training
4 program to provide adequate access to appropriate services,
5 including but not limited to services to older Iowans.
6 The department shall ensure that any program developed is
7 administered in a coordinated and collaborative manner across
8 all contracting managed care organizations and shall require
9 the managed care organizations to submit quarterly progress and
10 outcomes reports to the department.
11 DIVISION IV
12 PROVIDER APPEALS PROCESS —— EXTERNAL REVIEW
13 Sec. 4. MEDICAID MANAGED CARE ORGANIZATION APPEALS PROCESS
14 —— EXTERNAL REVIEW —— PENALTY.
15 1. a. A Medicaid managed care organization under contract
16 with the department of health and human services shall include
17 in any written response to a Medicaid provider under contract
18 with the managed care organization that reflects a final
19 adverse determination of the managed care organization's
20 internal appeal process relative to an appeal filed by the
21 Medicaid provider, all of the following:
22 (1) A statement that the Medicaid provider's internal
23 appeal rights within the managed care organization have been
24 exhausted.
25 (2) A statement that the Medicaid provider is entitled to
26 an external independent third-party review pursuant to this
27 section.
28 (3) The requirements for requesting an external independent
29 third-party review.
30 b. If a managed care organization's written response does
31 not comply with the requirements of paragraph "a", the managed
32 care organization shall pay to the affected Medicaid provider a
33 penalty not to exceed one thousand dollars.
34 2. a. A Medicaid provider who has been denied the provision
35 of a service to a Medicaid member or a claim for reimbursement

1 for a service rendered to a Medicaid member, and who has
2 exhausted the internal appeal process of a managed care
3 organization, shall be entitled to an external independent
4 third-party review of the managed care organization's final
5 adverse determination.
6 b. To request an external independent third-party review of
7 a final adverse determination by a managed care organization,
8 an aggrieved Medicaid provider shall submit a written request
9 for such review to the managed care organization within sixty
10 calendar days of receiving the final adverse determination.
11 c. A Medicaid provider's request for an external
12 independent third-party review shall include all of the
13 following:
14 (1) Identification of each specific issue and dispute
15 directly related to the final adverse determination issued by
16 the managed care organization.
17 (2) A statement of the basis upon which the Medicaid
18 provider believes the managed care organization's determination
19 to be erroneous.
20 (3) The Medicaid provider's designated contact information,
21 including name, mailing address, phone number, fax number, and
22 email address.
23 3. a. Within five business days of receiving a Medicaid
24 provider's request for an external independent third-party
25 review pursuant to this subsection, the managed care
26 organization shall do all of the following:
27 (1) Confirm to the Medicaid provider's designated contact,
28 in writing, that the managed care organization has received the
29 request for review.
30 (2) Notify the department of health and human services of
31 the Medicaid provider's request for review.
32 (3) Notify the affected Medicaid member of the Medicaid
33 provider's request for review, if the review is related to the
34 denial of a service.
35 b. If the managed care organization fails to satisfy the

1 requirements of this subsection, the Medicaid provider shall
2 automatically prevail in the review.
3 4. a. Within fifteen calendar days of receiving a Medicaid
4 provider's request for an external independent third-party
5 review, the managed care organization shall do all of the
6 following:
7 (1) Submit to the department of health and human services
8 all documentation submitted by the Medicaid provider in the
9 course of the managed care organization's internal appeal
10 process.
11 (2) Provide the managed care organization's designated
12 contact information, including name, mailing address, phone
13 number, fax number, and email address.
14 b. If a managed care organization fails to satisfy the
15 requirements of this subsection, the Medicaid provider shall
16 automatically prevail in the review.
17 5. A request for an external independent third-party review
18 shall automatically extend the deadline to file an appeal for a
19 contested case hearing under chapter 17A, pending the outcome
20 of the external independent third-party review, until thirty
21 calendar days following receipt of the review decision by the
22 Medicaid provider.
23 6. Upon receiving notification of a request for an external
24 independent third-party review, the department of health and
25 human services shall do all of the following:
26 a. Assign the review to an external independent third-party
27 reviewer.
28 b. Notify the managed care organization of the identity of
29 the external independent third-party reviewer.
30 c. Notify the Medicaid provider's designated contact of the
31 identity of the external independent third-party reviewer.
32 7. The department of health and human services shall deny a
33 request for an external independent third-party review if the
34 requesting Medicaid provider fails to exhaust the managed care
35 organization's internal appeal process or fails to submit a

1 timely request for an external independent third-party review
2 pursuant to this section.
3 8. a. Multiple appeals through the external independent
4 third-party review process regarding the same Medicaid member,
5 a common question of fact, or the interpretation of common
6 applicable regulations or reimbursement requirements may
7 be combined and determined in one action upon request of a
8 party in accordance with rules and regulations adopted by the
9 department of health and human services.
10 b. The Medicaid provider that initiated a request for
11 an external independent third-party review, or one or more
12 other Medicaid providers, may add claims to such an existing
13 external independent third-party review request following the
14 exhaustion of any applicable managed care organization internal
15 appeal process, if the claims involve a common question of
16 fact or interpretation of common applicable regulations or
17 reimbursement requirements.
18 9. Documentation reviewed by the external independent
19 third-party reviewer shall be limited to documentation
20 submitted pursuant to subsection 4.
21 10. An external independent third-party reviewer shall do
22 all of the following:
23 a. Conduct an external independent third-party review
24 of any claim submitted to the reviewer pursuant to this
25 subsection.
26 b. Within thirty calendar days from receiving the request
27 for an external independent third-party review from the
28 department of health and human services and the documentation
29 submitted pursuant to subsection 4, issue the reviewer's final
30 decision to the Medicaid provider's designated contact, the
31 managed care organization's designated contact, the department
32 of health and human services, and the affected Medicaid member
33 if the decision involves a denial of service. The reviewer may
34 extend the time to issue a final decision by up to fourteen
35 calendar days upon agreement of all parties to the review.

1 11. The department of health and human services shall
2 enter into a contract with an external independent review
3 organization that does not have a conflict of interest with the
4 department of health and human services or any managed care
5 organization to conduct the external independent third-party
6 reviews under this section.
7 a. A party, including the affected Medicaid member or
8 Medicaid provider, may appeal a final decision of the external
9 independent third-party reviewer in a contested case proceeding
10 in accordance with chapter 17A within thirty calendar days from
11 receiving the final decision. A final decision in a contested
12 case proceeding is subject to judicial review.
13 b. The final decision of an external independent
14 third-party reviewer conducted pursuant to this section shall
15 also direct the nonprevailing party to pay an amount equal to
16 the costs of the review to the external independent third-party
17 reviewer. Any payment ordered pursuant to this subsection
18 shall be stayed pending any appeal of the review. If the
19 final outcome of any appeal is to reverse the decision of the
20 external independent third-party reviewer, the nonprevailing
21 party on appeal shall pay the costs of the review to the
22 external independent third-party reviewer within forty-five
23 calendar days of entry of the final order.
24 DIVISION V
25 MEMBER DISENROLLMENT FOR GOOD CAUSE
26 Sec. 5. MEMBER DISENROLLMENT FOR GOOD CAUSE. The department
27 of health and human services shall contractually require all
28 Medicaid managed care organizations to issue a decision in
29 response to a member's request for disenrollment for good cause
30 within ten days of the date the member submits the request to
31 the Medicaid managed care organization utilizing the Medicaid
32 managed care organization's grievance process. The department
33 shall adopt rules pursuant to chapter 17A to administer this
34 division.
35 DIVISION VI

1 UNIFORM, SINGLE CREDENTIALING
2 Sec. 6. MEDICAID PROGRAM —— USE OF UNIFORM AUTHORIZATION
3 CRITERIA AND SINGLE CREDENTIALING VERIFICATION
4 ORGANIZATION. The department of health and human services
5 shall develop uniform authorization criteria for, and
6 shall utilize a request for proposals process to procure,
7 a single credentialing verification organization to be
8 utilized in credentialing and recredentialing providers for
9 both the Medicaid managed care and fee-for-service payment
10 and delivery systems. The department or health and human
11 services shall contractually require all Medicaid managed care
12 organizations to apply the uniform authorization criteria and
13 to accept verified information from the single credentialing
14 verification organization procured by the department, and shall
15 contractually prohibit Medicaid managed care organizations
16 from requiring additional credentialing information from a
17 provider in order to participate in the Medicaid managed care
18 organization´s provider network.
19 DIVISION VII
20 MEDICAID MANAGED CARE OMBUDSMAN PROGRAM —— APPROPRIATION
21 Sec. 7. OFFICE OF LONG-TERM CARE OMBUDSMAN —— MEDICAID
22 MANAGED CARE OMBUDSMAN.
23 1. There is appropriated from the general fund of the
24 state to the department of health and human services office of
25 long-term care ombudsman for the fiscal year beginning July
26 1, 2024, and ending June 30, 2025, in addition to any other
27 funds appropriated from the general fund of the state to,
28 and in addition to any other full-time equivalent positions
29 authorized for, the office of long-term care ombudsman for the
30 same purpose, the following amount, or so much thereof as is
31 necessary, to be used for the purposes designated:
32 For the purposes of the Medicaid managed care ombudsman
33 program including for salaries, support, administration,
34 maintenance, and miscellaneous purposes, and for not more than
35 the following full-time equivalent positions:

1 .... $ 300,000
2 .... FTEs 2.50
3 2. The funding appropriated and the full-time equivalent
4 positions authorized under this section are in addition to any
5 other funds appropriated from the general fund of the state and
6 actually expended, and any other full-time equivalent positions
7 authorized and actually filled as of July 1, 2024, for the
8 Medicaid managed care ombudsman program.
9 3. Any funds appropriated to and any full-time equivalent
10 positions authorized for the office of long-term care ombudsman
11 for the Medicaid managed care ombudsman program for the fiscal
12 year beginning July 1, 2024, and ending June 30, 2025, shall
13 be used exclusively for the Medicaid managed care ombudsman
14 program.
15 4. The additional full-time equivalent positions authorized
16 in this section for the Medicaid managed care ombudsman program
17 shall be filled no later than September 1, 2024.
18 5. The office of long-term care ombudsman shall include
19 in the Medicaid managed care ombudsman program report, on a
20 quarterly basis, the disposition of resources for the Medicaid
21 managed care ombudsman program including actual expenditures
22 and a full-time equivalent positions summary for the prior
23 quarter.
24 DIVISION VIII
25 HEALTH POLICY OVERSIGHT COMMITTEE MEETINGS
26 Sec. 8. Section 2.45, subsection 5, Code 2024, is amended
27 to read as follows:
28 5. The legislative health policy oversight committee,
29 which shall be composed of ten members of the general
30 assembly, consisting of five members from each house, to
31 be appointed by the legislative council. The legislative
32 health policy oversight committee ~~may~~ shall meet at least two
33 times, annually, during the legislative interim to provide
34 continuing oversight for Medicaid managed care, and to ensure
35 effective and efficient administration of the program, address

1 stakeholder concerns, monitor program costs and expenditures,
2 and make recommendations.
3 EXPLANATION
4 The inclusion of this explanation does not constitute agreement with
5 the explanation's substance by the members of the general assembly.
6 This bill relates to the Medicaid program.
7 Division I of the bill requires the department of health
8 and human services (HHS) to adopt administrative rules to
9 ensure that services are provided to the Medicaid long-term
10 services and supports population in a conflict-free manner.
11 Specifically, the bill requires that case management services
12 shall be provided by independent providers and that the
13 supports intensity scale assessments are performed by
14 independent assessors.
15 Division II of the bill directs HHS to require each Medicaid
16 managed care organization (MCO) with whom HHS executes
17 a contract, to provide the option to Medicaid long-term
18 services and supports population members to enroll in or
19 transition to fee-for-service Medicaid program administration
20 rather than managed care administration. The department
21 shall amend any contract, request any Medicaid state plan
22 amendment, and adopt administrative rules, as necessary,
23 to administer this provision. The rules shall include the
24 process for transitioning a current Medicaid long-term services
25 and supports population member to fee-for-service program
26 administration.
27 Division III of the bill requires HHS to contractually
28 require any Medicaid MCO to collaborate with HHS and
29 stakeholders to develop and administer a workforce recruitment,
30 retention, and training program to provide adequate access to
31 appropriate services, including but not limited to services
32 to older Iowans. The department shall ensure that any such
33 program developed is administered in a coordinated and
34 collaborative manner across all contracting MCOs and shall
35 require the MCOs to submit quarterly progress and outcomes

1 reports to HHS.
2 Division IV of the bill establishes an external independent
3 third-party review process for Medicaid providers for the
4 review of final adverse determinations of the MCOs' internal
5 appeals processes. The division provides that a final
6 decision of an external independent third-party reviewer may
7 be reviewed in a contested case proceeding pursuant to Code
8 chapter 17A, and ultimately is subject to judicial review. The
9 bill provides a civil penalty for an MCO that does not comply
10 with the written response requirements relating to an adverse
11 determination.
12 Division V of the bill relates to member disenrollment
13 for good cause during the 12 months of closed enrollment
14 between open enrollment periods. The bill requires HHS to
15 contractually require all Medicaid MCOs to issue a decision
16 in response to a member's request for disenrollment for good
17 cause within 10 days of the date the member submits the request
18 to the MCO utilizing the MCO's grievance process and to adopt
19 administrative rules to administer the division.
20 Division VI of the bill requires the HHS to develop
21 uniform authorization criteria for, and to utilize a request
22 for proposals process to procure, a single credentialing
23 verification organization to be utilized in credentialing
24 and recredentialing providers for the Medicaid managed care
25 and fee-for-service payment and delivery systems. The bill
26 requires HHS to contractually require all Medicaid MCOs to
27 apply the uniform authorization criteria, to accept verified
28 information from the single credentialing verification
29 organization procured by HHS, and to contractually prohibit the
30 MCOs from requiring additional credentialing information from a
31 provider in order to participate in the Medicaid MCO's provider
32 network.
33 Division VII of the bill relates to the office of long-term
34 care ombudsman (OLTCO) and the Medicaid managed care ombudsman
35 program (MCOP).

1 For fiscal year 2024-2025, the bill appropriates $300,000
2 from the general fund of the state, in addition to any other
3 funds appropriated from the general fund of the state to,
4 and authorizes 2.50 FTEs in addition to any other full-time
5 equivalent (FTE) positions authorized for, HHS for the OLTCO
6 for the purposes of the MCOP. The funding appropriated and the
7 FTE positions authorized under the bill are in addition to any
8 other funds appropriated from the general fund of the state and
9 actually expended, and any other FTE positions authorized and
10 actually filled as of July 1, 2024, for the MCOP.
11 The bill requires that any funds appropriated to and any
12 full-time equivalent positions authorized for the OLTCO for the
13 MCOP for fiscal year 2024-2025 shall be used exclusively for
14 the MCOP. The additional FTE positions authorized in the bill
15 for the MCOP shall be filled no later than September 1, 2024.
16 The bill requires the OLTCO to include in the MCOP report, on
17 a quarterly basis, the disposition of resources for the MCOP
18 including expenditures and an FTE positions summary for the
19 prior quarter.
20 Division VIII amends the provision regarding the meetings of
21 the health policy oversight committee (HPOC) of the legislative
22 council. Current law provides that HPOC may meet annually.
23 The bill provides that HPOC shall meet, and further requires
24 that HPOC meet at least two times, annually, during the
25 legislative interim. The bill reflects the law related to the
26 meeting of HPOC in effect prior to that law being amended in
27 2023.