House File 2483 - Reprinted

HOUSE FILE 2483
BY COMMITTEE ON APPROPRIATIONS

(SUCCESSOR TO HSB 680)

(As Amended and Passed by the House April 23, 2018)

A BILL FOR

An Act relating to programs and activities under the purview of the department of human services.

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

DIVISION I

SHARING OF INCARCERATION DATA

Section 1. Section 249A.38, Code 2018, is amended to read as follows:

249A.38 Inmates of public institutions —— suspension or termination of medical assistance.

1. ~~The following conditions shall apply to~~ Following the first thirty days of commitment, the department shall suspend the eligibility of an individual who is an inmate of a public institution as defined in 42 C.F.R. §435.1010, who is enrolled in the medical assistance program at the time of commitment to the public institution, and who remains eligible for medical assistance as an individual except for the individual's institutional status~~:~~

~~*a. The department shall suspend the individual's eligibility for up to the initial twelve months of the period of commitment. The department shall delay the suspension of eligibility for a period of up to the first thirty days of commitment if such delay is approved by the centers for Medicare and Medicaid services of the United States department of health and human services. If such delay is not approved, the department shall suspend eligibility during the entirety of the initial twelve months of the period of commitment. Claims submitted on behalf of the individual under the medical assistance program for covered services provided during the delay period shall only be reimbursed if federal financial participation is applicable to such claims.*~~

~~*b. The department shall terminate an individual's eligibility following a twelve-month period of suspension of the individual's eligibility under paragraph "a"*~~, during the period of the individual's commitment to the public institution.

2. *a.* A public institution shall provide the department and the social security administration with a monthly report of the individuals who are committed to the public institution and of

the individuals who are discharged from the public institution. The monthly report to the department shall include the date of commitment or the date of discharge, as applicable, of each individual committed to or discharged from the public institution during the reporting period. The monthly report shall be made through the reporting system created by the department for public, nonmedical institutions to report inmate populations. Any medical assistance expenditures, including but not limited to monthly managed care capitation payments, provided on behalf of an individual who is an inmate of a public institution but is not reported to the department in accordance with this subsection, shall be the financial responsibility of the respective public institution.

b. The department shall provide a public institution with the forms necessary to be used by the individual in expediting restoration of the individual's medical assistance benefits upon discharge from the public institution.

~~3. This section applies to individuals as specified in subsection 1 on or after January 1, 2012.~~

~~4.~~ 3. The department may adopt rules pursuant to chapter 17A to implement this section.

DIVISION II

MEDICAID PROGRAM ADMINISTRATION

Sec. 2. MEDICAID PROGRAM ADMINISTRATION.

1. PROVIDER PROCESSES AND PROCEDURES.

a. When all of the required documents and other information necessary to process a claim have been received by a managed care organization, the managed care organization shall either provide payment to the claimant within the timelines specified in the managed care contract or, if the managed care organization is denying the claim in whole or in part, shall provide notice to the claimant including the reasons for such denial consistent with national industry best practice guidelines.

b. If a managed care organization discovers that a claims

payment barrier is the result of a managed care organization's identified system configuration error, the managed care organization shall correct such error and shall fully and accurately reprocess the claims affected by the error within thirty days of such discovery or within a time frame approved by the department. For the purposes of this paragraph, "configuration error" means an error in provider data, an incorrect fee schedule, or an incorrect claims edit.

c. The department of human services shall provide for the development and require the use of standardized Medicaid provider enrollment forms to be used by the department and uniform Medicaid provider credentialing standards to be used by managed care organizations. The credentialing process is deemed to begin when the managed care organization has received all necessary credentialing materials from the provider and is deemed to have ended when written communication is mailed or faxed to the provider notifying the provider of the managed care organization's decision.

d. A managed care organization shall provide written notice to all affected individuals at least sixty days prior to a significant change in administrative procedures relating to the scope or coverage of benefits, billings and collections provisions, provider network provisions, member or provider services, prior authorization requirements, or any other terms of a managed care contract or agreement as determined by the department of human services. A managed care organization may comply with the requirement of providing written notice under this paragraph by posting such written notice on the managed care organization's internet site.

e. The department of human services shall engage dedicated provider relations staff to assist Medicaid providers in resolving billing conflicts with managed care organizations including those involving denied claims, technical omissions, or incomplete information. If the provider relations staff observe trends evidencing fraudulent claims or improper

reimbursement, the staff shall forward such evidence to the department of human services for further review.

f. The department of human services shall adopt rules pursuant to chapter 17A to require the inclusion by a managed care organization of advanced registered nurse practitioners and physician assistants as primary care providers for the purposes of population health management.

2. MEMBER SERVICES AND PROCESSES.

a. If a Medicaid member prevails on appeal regarding the provision of services, the services subject to the appeal shall be extended for a period of time determined by the director of human services. However, services shall not be extended if there is a change in the member's condition that warrants a change in services as determined by the member's interdisciplinary team, there is a change in the member's eligibility status as determined by the department of human services, or the member voluntarily withdraws from services.

b. If a Medicaid member is receiving court-ordered services or treatment for a substance-related disorder pursuant to chapter 125 or for a mental illness pursuant to chapter 229, such services or treatment shall be provided and reimbursed for an initial period of three days before a managed care organization may apply medical necessity criteria to determine the most appropriate services, treatment, or placement for the Medicaid member.

c. The department of human services shall review and have approval authority for level of care reassessments for Medicaid long-term services and supports (LTSS) population members that indicate a decrease in the level of care. A managed care organization shall comply with the findings of the departmental review and approval of such level of care reassessments. If a level of care reassessment indicates there is no change in a Medicaid LTSS population member's level of care needs, the Medicaid LTSS population member's existing level of care shall be continued. A managed care organization shall maintain

and make available to the department of human services all documentation relating to a Medicaid LTSS population member's level of care assessment.

d. The department of human services shall maintain and update Medicaid member eligibility files in a timely manner consistent with national industry best practices.

3. MEDICAID PROGRAM REVIEW AND OVERSIGHT.

a. (1) The department of human services shall facilitate a workgroup, in collaboration with representatives of the managed care organizations and health home providers, to review the health home programs. The review shall include all of the following:

(a) An analysis of the state plan amendments applicable to health homes.

(b) An analysis of the current health home system, including the rationale for any recommended changes.

(c) The development of a clear and consistent delivery model linked to program-determined outcomes and data reporting requirements.

(d) A work plan to be used in communicating with stakeholders regarding the administration and operation of the health home programs.

(2) The department of human services shall submit a report of the workgroup's findings and recommendations by December 15, 2018, to the governor and to the Eighty-eighth General Assembly, 2019 session, for consideration.

(3) The workgroup and the workgroup's activities shall not affect the department's authority to apply or enforce the Medicaid state plan amendment relative to health homes.

b. The department of human services, in collaboration with Medicaid providers and managed care organizations, shall initiate a review process to determine the effectiveness of prior authorizations used by the managed care organizations with the goal of making adjustments based on relevant service costs and member outcomes data utilizing existing

industry-accepted standards. Prior authorization policies shall comply with existing rules, guidelines, and procedures developed by the centers for Medicare and Medicaid services of the United States department of health and human services.

c. The department of human services shall enter into a contract with an independent auditor to perform an audit of a random sample of small dollar claims paid to or denied Medicaid long-term services and supports providers during the first quarter of the 2018 calendar year. The department of human services shall submit a report of the findings of the audit to the governor and the general assembly by December 15, 2018. The department may take any action specified in the managed care contract relative to any claim the auditor determines to be incorrectly paid or denied, subject to appeal by the managed care organization to the director of human services. For the purposes of this paragraph, "small dollar claims" means those claims less than or equal to two thousand five hundred dollars.

DIVISION III

MEDICAID PROGRAM PHARMACY COPAYMENT

Sec. 3. 2005 Iowa Acts, chapter 167, section 42, is amended to read as follows:

SEC. 42. COPAYMENTS FOR PRESCRIPTION DRUGS UNDER THE MEDICAL ASSISTANCE PROGRAM. The department of human services shall require recipients of medical assistance to pay ~~the following copayments~~ a copayment of $1 on each prescription filled for a covered prescription drug, including each refill of such prescription~~, as follows:~~

~~1. A copayment of $1 on each prescription filled for each covered nonpreferred generic prescription drug~~.

~~2. A copayment of $1 for each covered preferred brand-name or generic prescription drug.~~

~~3. A copayment of $1 for each covered nonpreferred brand-name prescription drug for which the cost to the state is up to and including $25.~~

~~4. A copayment of $2 for each covered nonpreferred~~

~~brand-name prescription drug for which the cost to the state is more than $25 and up to and including $50.~~

~~5. A copayment of $3 for each covered nonpreferred brand-name prescription drug for which the cost to the state is more than $50.~~

DIVISION IV

MEDICAL ASSISTANCE ADVISORY COUNCIL

Sec. 4. Section 249A.4B, subsection 2, paragraph a, subparagraphs (27) and (28), Code 2018, are amended by striking the subparagraphs.

Sec. 5. MEDICAL ASSISTANCE ADVISORY COUNCIL —— REVIEW OF MEDICAID MANAGED CARE REPORT DATA. The executive committee of the medical assistance advisory council shall review the data collected and analyzed for inclusion in periodic reports to the general assembly, including but not limited to the information and data specified in 2016 Iowa Acts, chapter 1139, section 93, to determine which data points and information should be included and analyzed to more accurately identify trends and issues with, and promote the effective and efficient administration of, Medicaid managed care for all stakeholders. At a minimum, the areas of focus shall include consumer protection, provider network access and safeguards, outcome achievement, and program integrity. The executive committee shall report its findings and recommendations to the medical assistance advisory council for review and comment by October 1, 2018, and shall submit a final report of findings and recommendations to the governor and the general assembly by December 31, 2018.

DIVISION V

TARGETED CASE MANAGEMENT AND INPATIENT PSYCHIATRIC SERVICES REIMBURSEMENT

Sec. 6. Section 249A.31, Code 2018, is amended to read as follows:

249A.31 Cost-based reimbursement.

1. ~~Providers of individual case management services for~~

~~persons with an intellectual disability, a developmental disability, or chronic mental illness shall receive cost-based reimbursement for one hundred percent of the reasonable costs for the provision of the services in accordance with standards adopted by the mental health and disability services commission pursuant to section 225C.6.~~ Effective July 1, 2018, targeted case management services shall be reimbursed based on a statewide fee schedule amount developed by rule of the department pursuant to chapter 17A.

2. Effective July 1, ~~2010~~ 2014, ~~the department shall apply a cost-based reimbursement methodology for reimbursement of psychiatric medical institution for children~~ providers of inpatient psychiatric services for individuals under twenty-one years of age shall be reimbursed as follows:

a. For non-state-owned providers, services shall be reimbursed according to a fee schedule without reconciliation.

b. For state-owned providers, services shall be reimbursed at one hundred percent of the actual and allowable cost of providing the service.