IOWA HOUSE DEMOCRATS

AMENDMENT SUMMARY

Medicaid Efficiency HF 2462

Status of Bill: House Calendar
Committee: Human Resources (21-0)
Research Analyst: Kelsey Thien; 515-281-6972; kelsey.thien@legis.iowa.gov
Lead Democrat: Rep. Heddens
Floor Manager: Rep. Koester

Amendment Summary

H-8220 (Heaton)
This amendment strikes out the intent language in Division III of the bill and inserts the following.

Provider Processes and Procedures

- Reinforces that the Managed Care Organizations (MCOs) must pay the claimant within the time specified in the contract, and that if the MCO is denying a claim, they have to provide notice to the claimant with a reason that is consistent with national industry best practices.
- If a payment error is found due to the system configuration, the MCO has to fully and correctly reprocess the claim within 30 days and correct the system within 90 days.
- Directs the Department of Human Services (DHS) to use standardized Medicaid provider enrollment forms, and directs the MCOs to use uniform Medicaid provider credentialing standards.

Member Services and Processes

- If a member wins an appeal or a review by a MCO, the Director of DHS shall extend the services subject to the appeal or review for a period of time that they determine. These services will not be extended if there is a change in the member's condition that warrants a change, a change in the member's eligibility status or if the member voluntarily withdraws from services. This process is similar to the Exception of Policy that occurred in the fee-for-service model.
- Directs that if a member is court-ordered to receive services or treatment, these will be provided and reimbursed for an initial period of five days. After five days, the MCO may apply medical necessity criteria to determine if these services are appropriate for the member. This will help members who are in crisis, or have substance-abuse related issues to get the initial services they need without worrying if the treatment will be covered.
- If a MCO reassesses and decreases a member's level of care, DHS will have to review and has approval authority over this assessment. The MCO will have to comply with the findings and provide all documentation relating to a member's level of care assessment.
- States that DHS has to maintain and update the member eligibility files in a timely manner.

Medicaid Program Review and Oversight

- Directs DHS to create a workgroup in collaboration with MCO representatives and the health home providers to review the health home programs. DHS shall submit a report of the findings and recommendations by December 15, 2018 to the Governor and General Assembly for consideration.

- Directs DHS to initiate a review process of prior authorizations used by the MCOs and determine their effectiveness. The goal of this is to make adjustments based on relevant service costs and member outcomes utilizing existing industry-accepted standards.
- Directs DHS to enter into a contract with an independent auditor to perform an audit of small dollar claims paid to or denied to Medicaid long-term services and supports providers. Small dollar claims are claims less than or equal to $2,500. DHS may take any action specified in the managed care contract to any claim the auditor determines to be incorrectly paid or denied. This is subject to appeal by both the MCOs and the Director of DHS.

Thien, Kelsey [LEGIS]|G:\Caucus Staff\Kelsey.Thien\2018 Session\Bill Summaries\Already Printed\HF 2462-Amendment Summary.docx|March 8, 2018|7:58 AM