IOWA HOUSE DEMOCRATS

BILL & AMENDMENT SUMMARY

Medicaid Efficiency HF 2483

Status of Bill: House Calendar
Committee: Appropriations (25-0)
Lead Democrat: Rep. Heddens
Floor Manager: Rep. Heaton
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Background

This bill is very similar to HF 2462 that the House passed unanimously this session but died in the Senate. However, an amendment was added that makes changes to Division III to help reduce the fiscal impact of the bill, which was published after the House passed it.

The changes include:

- The time a MCO has to fully reprocess a claim in which an error was found changes from 90 days to 30 days.
- Clarifies that the Department of Human Services (DHS) will only extend services to a member who wins an appeal. The previous bill extended this to a member who had also prevailed in a review.
- Changes the time that a MCO has to pay for court-ordered treatment from five days to three days.
- Clarifies that DHS will only review cases in which a MCO decreases services for a long-term services and supports population member, not for all cases.
- States that DHS is still able to enforce the Medicaid state plan amendment regarding Health Homes during the time the Health Home workgroup is meeting.
- Adds "random" to the sample of small claims that the independent auditor will review. It also states these audits will occur only using data taken from the first quarter of the 2018 calendar year. Both of these changes reduce the amount of claims being audited, thereby reducing the fiscal impact.

Summary

Division I-hawk-i

Transfers capitation process and member premium collection from a third party company to the Iowa Medicaid Enterprise (IME) for the hawk-i program.

Division II-Incarceration Data

Creates a standard system for all 99 counties to share monthly incarceration data with IME. Report has to include date of commitment or discharge. The Department of Human Services (DHS) will create a reporting system for counties to update inmate populations. Federal regulations prohibit Medicaid from paying for care for inmates except for inpatient hospital claims. This data will help IME to not pay out capitation rates that they shouldn't be paying.

Division III-Medicaid Program Administration

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 and correct the system within 30 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 by a MCO, the Director of DHS shall extend the services subject to the appeal by 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 three days. After three 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 decreases a long-term services and supports (LTSS) 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. During the time the workgroup is meeting, DHS is still able to enforce the Medicaid state plan amendment for health homes.
- 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 random small dollar claims paid to or denied to Medicaid long-term services and supports providers during the first quarter of 2018. 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.

Division IV-Pharmacy Copayment

Institutes a flat copayment of $1.00 for all prescriptions. Currently, there are different copayments for drugs on the preferred list and the non-preferred list. With the implementation of a federal rule, Medicaid members will no longer receive a non-preferred drug unless it is medically necessary, so all drug copayments will be at the preferred amount of $1.00.

Division V-Medical Assistance Advisory Council (MAAC)

Directs the MAAC to review all data collected for reporting to the General Assembly. The MAAC is then to make recommendations to the Governor and General Assembly determining which data points and information should be included in future reports.

Division VI-Reimbursement for Targeted Case Management

Instead of being reimbursed at 100% of the reasonable costs, beginning July 1, 2018, targeted case management will be reimbursed based on a statewide fee schedule developed by DHS. Services by non-state-owned providers will be reimbursed according to this fee schedule without reconciliation, while state-owned providers will be reimbursed at 100% of the actual and allowable cost of providing the service.

Amendment Summary

H-8071 by Rep. Heaton of Henry

Adds oversight language to Division III-Provider Processes and Procedures, the section that deals with Managed Care Organization (MCO) payment and claim denial processes.

Requires an MCO to provide written notice (this notice can mean posting the information on the MCO website) to all affected individuals at least 60 days before there is a significant change in administrative procedures. These procedures include:

- Scope or coverage of benefits.
- Billings and collection provisions.
- Provider network provisions.
- Member or provider services.
- Prior authorization requirements.
- Any other terms of the MCO contract as determined by the Department of Human Services (DHS).

The amendment also directs DHS to have dedicated provider relations staff to assist Medicaid providers in resolving billing conflicts with the MCOs. If these staff members find trends regarding fraudulent claims or improper reimbursement, they are to forward this information to DHS for further review.

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