MISSISSIPPI LEGISLATURE REGULAR SESSION 2020

By: Representative Currie To: Medicaid

HOUSE BILL NO. 1518

AN ACT TO BE KNOWN AS THE MISSISSIPPI MEDICAID BENEFICIARIES AND PROVIDERS OVER PAPERWORK ACT OF 2020; TO REQUIRE THAT ALL CONTRACTS ENTERED INTO OR REAUTHORIZED BY THE DIVISION OF MEDICAID RELATING TO THE IMPLEMENTATION OF ANY MANAGED CARE PROGRAM BY THE DIVISION OF MEDICAID HAVE CERTAIN SPECIFIC PROVISIONS RELATING TO STANDARDIZED CLAIMS PROCESSING AND PAYMENT, TRANSPARENCY IN PRIOR AUTHORIZATIONS, PEER-TO-PEER REVIEW, CREDENTIALING, RECREDENTIALING AND CLEAN CLAIMS; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. This act shall be known as the "Mississippi Medicaid Beneficiaries and Providers Over Paperwork Act of 2020."

SECTION 2. The purposes of this act are to:

(a) Recognize that providers are an essential part of the Medicaid process and that administrative burdens jeopardize the health care of Mississippi's Medicaid beneficiaries;

(b) Set forth requirements that are fundamental in achieving the goals of the Mississippi Coordinated Access Network. The Mississippi Coordinated Access Network was designed to (i) improve beneficiary access to needed medical services, (ii) improve the quality of care, and (iii) improve program efficiencies as well as cost-effectiveness; and

(c) Provide solutions for issues to relieve unnecessary administrative burdens that hinder quality care provided to beneficiaries while maintaining a cost-effective but efficient and effective way of providing quality health care.

SECTION 3. All contracts entered into or reauthorized by the Division of Medicaid relating to the implementation of any program listed in Section 43-13-117(H) shall require the following provisions at a minimum:

(a) Standardized claims processing and payment:

(i) All first-time claims must be submitted within one hundred eighty (180) days of the date of service;

(ii) When the Mississippi Coordinated Access Network payer is the secondary payer, the provider has three hundred sixty-five (365) days after the final determination of the primary payer to submit a claim;

(iii) The payer has twenty-five (25) days from the date of electronic receipt or thirty-five (35) days from the date of paper receipt to submit payment for a clean claim;

(iv) The payer has thirty (30) days to notify the provider of a claims issue that will not result in payment;

(v) All requests for correction, reconsideration, retroactive eligibility, or adjustment must be received within ninety (90) days from the date of notification of denial;

(vi) Claim appeals must be filed within thirty (30) days of receiving the adverse benefit determination; and

(vii) The payer has twenty-five (25) days to submit payment after correction or appeal of a denied claim that is eligible for payment.

(b) Transparency in prior authorizations:

(i) A Mississippi Coordinated Access Network entity or subcontractor vendor shall make any current prior authorization requirements and restrictions readily accessible on the Division of Medicaid's website to providers;

(ii) Requirements for a prior authorization shall be described in detail but also understandable language;

(iii) If a Mississippi Coordinated Access Network entity or subcontractor vendor intends to either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the entity or subcontractor vendor shall ensure that the new or amended requirement is not implemented unless the Division of Medicaid's website has been updated to reflect the new or amended requirement or restriction;

(iv) If a Mississippi Coordinated Access Network entity or subcontractor vendor intends to either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the entity or subcontractor vendor shall provide contracted providers notice of the new or amended requirement or amendment no less than sixty (60) days before the requirement or restriction is implemented through posting on the Division of Medicaid's website;

(v) A Mississippi Coordinated Access Network entity or subcontractor vendor must ensure that all prior authorization adverse determinations are made by a physician who possesses a current and valid nonrestricted license to practice medicine in Mississippi, is of the same specialty as the physician who typically manages the medical condition or disease or provides the healthcare service involved in the request, and has experience treating patients with the medical condition or disease for which the health care service is being requested, and if an adverse determination is made, the physician must do so under the clinical direction of one of the Mississippi Coordinated Access Network's medical directors who is responsible for the providing of health care services provided to the beneficiaries of the Mississippi Medicaid Program. All such medical directors must be physicians licensed in Mississippi.

(vi) If a Mississippi Coordinated Access Network entity or subcontractor vendor is questioning the medical necessity of a healthcare service, the entity or subcontractor vendor must notify the provider that the medical necessity is being questioned within twenty-four (24) hours of receiving the request of a nonurgent circumstance or within five (5) hours in urgent healthcare situations unless life-threatening situations. Before issuing an adverse determination for a prior authorization, the provider must have the opportunity to discuss the medical necessity of the health care service on the telephone with the

physician who will be responsible for determining authorization of the healthcare service under review;

(viii) A Mississippi Coordinated Access Network entity or subcontractor vendor cannot require a prior authorization for pre-hospital transportation for the provision of emergency health care services;

(ix) A Mississippi Coordinated Access Network entity or subcontractor vendor shall allow a provider a minimum of twenty-four (24) hours following an emergency admission or provision of emergency healthcare services for the provider to notify the Mississippi Coordinated Access Network entity or subcontractor vendor of the admission or provision of health care services. If the admission or health care service occurs on a holiday or weekend, a Mississippi Coordinated Access Network entity or subcontractor vendor cannot require notification until the next business day after the admission or provision of the healthcare services;

(x) A Mississippi Coordinated Access Network entity or subcontractor vendor shall cover emergency health care services necessary to screen and stabilize a beneficiary. If a health care provider certifies in writing to a Mississippi Coordinated Access Network entity or subcontractor vendor within forty-eight (48) hours of a enrollee's admission that the enrollee's condition required emergency health care services, that certification will create a presumption that the emergency

healthcare services were medically necessary and such presumption may be rebutted only if the utilization review entity can establish, with clear and convincing evidence, that the emergency healthcare services were not medically necessary;

(xi) If a beneficiary receives an emergency health care service that requires immediate post-evaluation or post-stabilization services, a utilization review entity shall make an authorization determination within sixty (60) minutes of receiving a request; if the authorization determination is not made within sixty (60) minutes, such services shall be deemed approved;

(xii) A Mississippi Coordinated Access Network entity or subcontractor vendor may not require a prior authorization for the provision of medication-assisted treatment for the treatment of opioid use disorder;

(xiii) A Mississippi Coordinated Access Network entity or subcontractor vendor may not revoke, limit, condition, or restrict a prior authorization if care is provided within forty-five (45) working days from the date the health care provider received the prior authorization;

(xiv) A prior authorization shall be valid for one year from the date the healthcare provider receives the prior authorization;

(xv) A prior authorization that is required for a chronic or long-term illness shall remain valid for the length of

the treatment and the Mississippi Coordinated Access Network entity or subcontractor vendor may not require another prior authorization for the continuation of treatment; and

(xvi) A Mississippi Coordinated Access Network entity must evaluate prior authorizations data to eliminate "low-value prior authorizations" and stop applying it to services with high approval rates, and consider selectively applying the prior authorization process only to "outliers" instead of broadly across providers.

(c) Peer-to-peer review:

(i) Upon denial of a prior authorization and upon a peer-to-peer appeal review, the Mississippi Coordinated Access Network entity or subcontractor vendor must ensure that all appeals are reviewed by a physician who possesses a current and valid nonrestricted license to practice medicine in Mississippi, currently be in active practice in the same or similar specialty as physician who typically manages the medical condition or disease for at least five (5) years, be knowledgeable of, and have experience providing the health care services under appeal, not have been directly involved in making the adverse determination, not have a financial interest in the outcome of the appeal, and consider all known clinical aspects of the health care service under review, including but not limited to a review of all pertinent medical records provided to the Mississippi Coordinated Access Network entity or subcontractor vendor by the provider, any

relevant records provided by a health care facility, and any medical literature provided to the Mississippi Coordinated Access Network entity or subcontractor vendor by the provider.

(d) Credentialing:

(i) The credentialing and loading process must conclude within ninety (90) days after a Mississippi Coordinated Access Network entity receives a complete application;

(ii) A Mississippi Coordinated Access Network must provide the applicant an acknowledgment within seven (7) days of receiving an application if the health insurer has determined that the application is incomplete. This must include a detailed list of items required to complete the application and allow for supplemental information requests;

(iii) The application is deemed complete if the health insurer does not send a notice within the specified timeframe;

(iv) Following a completed application, a proposed contract must be sent;

(v) A Mississippi Coordinated Access Network must provide notice of an application approval or denial to the Division of Medicaid and the provider within seven (7) days after the conclusion of the credentialing process;

(vi) Allow for a Mississippi Coordinated Access Network to enter into a detailed credentialing agreement with a

licensed health care facility with equivalent or higher standards; and

(vii) Prohibit Mississippi Coordinated Access Network entities from requiring credentialing with subcontractor vendor for dental, vision, durable medical equipment, rental equipment, and other provider services.

(e) Recredentialing:

(i) Allows a Mississippi Coordinated Access Network entity to recredential a participating provider at least once every thirty-six (36) months.

(f) Clean Claim Definition:

(i) For the purposes of this act only, a "clean claim" means a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the insurer;

(ii) A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision;

(iii) A clean claim includes resubmitted claims with previously identified deficiencies corrected;

(iv) A clean claim does not include any of the following:

1. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;

2. Claims that are submitted fraudulently or that are based upon material misrepresentations; or

3. Claims submitted by a provider more than sixty (60) days after the date of service; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than sixty (60) days after the date of billing by the provider to the insured.

SECTION 4. It is the intention of the Legislature that any corrective action plan given by the Division of Medicaid to a contracted party be followed and completed.

SECTION 5. This act shall take effect and be in force from and after its passage.