2014 -- H 7880

========
LC004831
========

S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2014

A N A C T

RELATING TO HUMAN SERVICES -- MEDICAL ASSISTANCE

Introduced By: Representatives Lima, and Shekarchi

Date Introduced: March 06, 2014

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. Title 40 of the General Laws entitled "HUMAN SERVICES" is hereby amended by adding thereto the following chapter:

CHAPTER 8.13

LONG-TERM MANAGED CARE ARRANGEMENTS

40-8.13-1. Definitions. -- For purposes of this section the following terms shall have the meanings indicated:

(1) "Beneficiary" means an individual who is eligible for medical assistance under the Rhode Island Medicaid state plan established in accordance with 42 U.S.C. 1396, and includes individuals who are additionally eligible for benefits under the Medicare program (42 U.S.C. 1395 et seq.) or other health plan.

(2) "Duals Demonstration Project" means a demonstration project established pursuant to the financial alignment demonstration established under section 2602 of the Patient Protection and Affordable Care Act (Pub. L. 111-148), involving a three-way contract between Rhode Island, the Federal Centers for Medicare and Medicaid Services ("CMS") and qualified health plans, and covering health care services provided to beneficiaries.

(3) "EOHHS" means the Rhode Island executive office of health and human services.

(4) "EOHHS level of care tool" refers to a set of criteria established by EOHHS and used in January, 2014 to determine the long-term care needs of a beneficiary as well as the appropriate setting for delivery of that care.

(5) Long-term care services and supports" means a spectrum of services covered by the Rhode Island Medicaid program and/or the Medicare program, that are required by individuals with functional impairments and/or chronic illness, and includes skilled or custodial nursing facility care, as well as various home and community-based services.

(6) "Managed long-term care arrangement" means any arrangement under which a managed care organization is granted some or all of the responsibility for providing and/or paying for long-term care services and supports that would otherwise be provided or paid under the Rhode Island Medicaid program. The term includes, but is not limited to, a duals demonstration project, and/or phase I and phase II of the integrated care initiative established by the executive office of health and human services.

(7) "Managed care organization" means any health plan, health maintenance organization, managed care plan, or other person or entity that enters into a contract with the state under which it is granted the authority to arrange for the provision of, and/or payment for, long-term care supports and services to eligible beneficiaries under a managed long-term care arrangement.

(8) "Plan of care" means a care plan established by a nursing facility in accordance with state and federal regulations, and which identifies specific care and services provided to a beneficiary.

40-8.13-2. Beneficiary choice. -- Any managed long-term care arrangement shall offer beneficiaries the option to decline participation and remain in traditional Medicaid and, if a duals demonstration project, traditional Medicare. Beneficiaries must be provided with sufficient information to make an informed choice regarding enrollment, including:

(1) Any changes in the beneficiary's payment or other financial obligations with respect to long-term care services and supports as a result of enrollment;

(2) Any changes in the nature of the long-term care services and supports available to the beneficiary as a result of enrollment, including specific descriptions of new services that will be available or existing services that will be curtailed or terminated;

(3) A contact person who can assist the beneficiary in making decisions about enrollment;

(4) Individualized information regarding whether the managed care organization's network includes the health care providers with whom beneficiaries have established provider relationships. Directing beneficiaries to a website identifying the plan's provider network shall not be sufficient to satisfy this requirement; and

(5) The deadline by which the beneficiary must make a choice regarding enrollment, and

the length of time a beneficiary must remain enrolled in a managed care organization before being permitted to change plans or opt out of the arrangement.

40-8.13-3. Ombudsman process. -- EOHHS shall designate an ombudsperson to advocate for beneficiaries enrolled in a managed long-term care arrangement. The ombudsperson shall advocate for beneficiaries through complaint and appeal processes and ensure that necessary health care services are provided. At the time of enrollment, a managed care organization must inform enrollees of the availability of the ombudsperson, including contact information.

40-8.13-4. Provider/plan liaison. -- EOHHS shall designate an individual, not employed by or otherwise under contract with a participating managed care organization, who shall act as liaison between health care providers and managed care organizations, for the purpose of facilitating communications and assuring that issues and concerns are promptly addressed.

40-8.13-5. Financial savings under managed care. -- To the extent that financial savings are a goal under any managed long-term care arrangement, it is the intent of the legislature to achieve such savings through administrative efficiencies, care coordination, and improvements in care outcomes, rather than through reduced reimbursement rates to providers. Therefore, any managed long-term care arrangement shall include a requirement that the managed care organization reimburse providers for services in accordance with the following:

(1) For a duals demonstration project, the managed care organization:

(i) Shall not combine the rates of payment for post-acute skilled and rehabilitation care provided by a nursing facility and long-term and chronic care provided by a nursing facility in order to establish a single payment rate for dual eligible beneficiaries requiring skilled nursing services;

(ii) Shall pay nursing facilities providing post-acute skilled and rehabilitation care or long-term and chronic care rates that reflect the different level of services and intensity required to provide these services; and

(iii) For purposes of determining the appropriate rate for the type of care set forth in § 40-18.13-5, the managed care organization shall pay no less than the rates which would be paid for that care under Medicare and Rhode Island Medicaid for these service types.

(2) For a managed long-term care arrangement that is not a duals demonstration project, the managed care organization shall reimburse providers in an amount not less than the rate that would be paid for the same care by EOHHS under the Medicaid program.

40-8.13-6. Payment incentives. -- In order to encourage quality improvement and promote appropriate utilization incentives for providers in a managed long-term care arrangement, a managed care organization may use incentive or bonus payment programs that are

in addition to the rates identified in § 40-18.13-5.

40-8.13-7. Willing provider. -- A managed care organization must contract with and cover services furnished by any nursing facility licensed under chapter 17 of title 23 and certified by CMS that provides Medicaid-covered nursing facility services pursuant to a provider agreement with the state, provided that the nursing facility is not disqualified under the managed care organization's quality standards that are applicable to all nursing facilities; and the nursing facility is willing to accept the reimbursement rates described in § 40-18.13-5.

40-8.13-8. Level of care tool. -- A managed long-term care arrangement must require that all participating managed care organizations use only the EOHHS level of care tool in determining coverage of long-term care supports and services for beneficiaries. EOHHS may amend the level of care tool provided that any changes are established in consultation with beneficiaries and providers of Medicaid-covered long-term care supports and services, and are based upon reasonable medical evidence or consensus, in consideration of the specific needs of Rhode Island beneficiaries. Notwithstanding any other provisions herein, however, in the case of a duals demonstration project, a managed care organization may use a different level of care tool for determining coverage of services that would otherwise be covered by Medicare, since the criteria established by EOHHS are directed towards Medicaid-covered services; provided, that such level of care tool is based on reasonable medical evidence or consensus in consideration of the specific needs of Rhode Island beneficiaries.

40-8.13-9. Case management/plan of care. -- No managed care organization acting under a managed long-term care arrangement may require a provider to change a plan of care if the provider reasonably believes that such an action would conflict with the provider's responsibility to develop an appropriate care plan under state and federal regulations.

40-8.13-10. Care transitions. -- In the event that a beneficiary:

(1) Has been determined to meet level of care requirements for nursing facility coverage as of the date of his or her enrollment in a managed care organization; or

(2) Has been determined to meet level of care requirements for nursing facility coverage by a managed care organization after enrollment; and there is a change in condition whereby the managed care organization determines that the beneficiary no longer meets such level of care requirements, the nursing facility shall promptly arrange for an appropriate and safe discharge (with the assistance of the managed care organization if the facility requests it), and the managed care organization shall continue to pay for the beneficiary's nursing facility care at the same rate until the beneficiary is discharged.

40-8.13-11. Reporting requirements. -- EOHHS shall report to the general assembly

and shall make available to interested persons a separate accounting of state expenditures for long-term care supports and services under any managed long-term care arrangement, specifically and separately identifying expenditures for home and community-based services, assisted living services, hospice services within nursing facilities, hospice services outside of nursing facilities, and nursing facility services. Such reports shall be made twice annually, six (6) months apart, beginning six (6) months following the implementation of any managed long-term care arrangement, and shall include a detailed report of utilization of each such service. In order to facilitate such reporting, any managed long-term care arrangement shall include a requirement that a participating managed care organization make timely reports of the data necessary to compile such reports.

SECTION 2. This act shall take effect upon passage.

========
LC004831
========

EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HUMAN SERVICES -- MEDICAL ASSISTANCE

***

This act would provide a choice for beneficiaries to decline participation in any managed long-term care arrangement, and to remain in traditional Medicaid and/or traditional Medicare, designate an ombudsperson to advocate on their behalf, provide an individual to act as a liaison between health care providers and managed care organizations, and realize financial savings whenever possible without any detrimental effect on the quality of care afforded beneficiaries with reports required by the executive office of health and human services every six (6) months.

This act would take effect upon passage.

========
LC004831
========