

Senate File 2280 - Introduced

SENATE FILE 2280
BY MATHIS and BROWN

A BILL FOR

1 An Act relating to reimbursement of hospitals for days awaiting
2 placement through private insurance and the Medicaid
3 program.

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

1 Section 1. NEW SECTION. 514C.2A Days awaiting placement
2 in a hospital — reimbursement.

3 1. For the purposes of this section:

4 a. "*Days awaiting placement*" means the days during which
5 a covered individual no longer meets acute care criteria for
6 stay in a hospital, has been verified to require placement in a
7 lower-level facility which may not be immediately located, and
8 is awaiting placement at the lower-level facility.

9 b. "*Lower-level facility*" means a facility that is able
10 to provide adequate, available, and accessible services and
11 supports, including but not limited to mental health services
12 and supports, to meet the covered individual's needs as
13 specified in the covered individual's discharge plan.

14 2. Notwithstanding the uniformity of treatment requirements
15 of section 514C.6, a policy, contract, or plan providing
16 for third-party payment or prepayment of health or medical
17 expenses that provides hospital benefits shall not deny
18 reimbursement for the continuation of all higher-level
19 services, including but not limited to inpatient care, provided
20 to a covered individual during a days awaiting placement
21 period. Reimbursement shall be provided to a hospital for each
22 day a covered individual remains in the care of the hospital
23 while awaiting placement in a lower-level facility.

24 3. For a hospital to receive days awaiting placement
25 reimbursement under this section, all of the following criteria
26 must be met:

27 a. The covered individual has a diagnosed condition that
28 required an acute inpatient level of care.

29 b. The covered individual no longer meets continued
30 stay criteria for the acute inpatient level of care and
31 requires placement in a lower-level facility, but barriers to
32 implementation of the discharge plan exist that are beyond the
33 control of the hospital.

34 c. The carrier as defined in section 513B.2 has authorized
35 placement in the lower-level facility sought under the

1 discharge plan.

2 *d.* The hospital is making every reasonable effort to
3 continue to actively work to identify resources to implement
4 the discharge plan in a timely manner and documents the
5 reasonable efforts taken.

6 4. This section applies to the following classes of
7 third-party payment provider policies, contracts, or plans
8 delivered, issued for delivery, continued, or renewed in this
9 state on or after January 1, 2021:

10 *a.* Individual or group accident and sickness insurance
11 providing coverage on an expense-incurred basis.

12 *b.* An individual or group hospital or medical service
13 contract issued pursuant to chapter 509, 514, or 514A.

14 *c.* An individual or group health maintenance organization
15 contract regulated under chapter 514B.

16 *d.* A plan established pursuant to chapter 509A for public
17 employees.

18 5. This section shall not apply to accident-only, specified
19 disease, short-term hospital or medical, hospital confinement
20 indemnity, credit, dental, vision, Medicare supplement,
21 long-term care, basic hospital and medical-surgical expense
22 coverage as defined by the commissioner of insurance,
23 disability income insurance coverage, coverage issued as a
24 supplement to liability insurance, workers' compensation or
25 similar insurance, or automobile medical payment insurance.

26 6. This section shall not apply to the medical assistance
27 program pursuant to chapter 249A, including to a managed care
28 organization acting pursuant to a contract with the department
29 of human services to provide coverage to medical assistance
30 program members, or to the hawk-i program pursuant to chapter
31 514I.

32 7. The commissioner of insurance may adopt rules pursuant to
33 chapter 17A as necessary to administer this section.

34 **Sec. 2. DAYS AWAITING PLACEMENT — MEDICAID REIMBURSEMENT.**

35 1. Under both fee-for-service and managed care

1 administration of the Medicaid program, a hospital shall not
2 be denied reimbursement based on failure to meet medical
3 necessity for the continuation of all higher-level services,
4 including but not limited to inpatient care, provided to a
5 Medicaid-eligible member during a days awaiting placement
6 period. Reimbursement shall be provided to a hospital for
7 each day a Medicaid-eligible member remains in the care of the
8 hospital while awaiting placement in a lower-level facility.

9 2. For a hospital to receive days awaiting placement
10 reimbursement under this section, all of the following criteria
11 must be met:

12 a. The Medicaid-eligible member has a diagnosed condition
13 that required an acute inpatient level of care.

14 b. The Medicaid-eligible member no longer meets continued
15 stay criteria for the acute inpatient level of care and
16 requires placement in a lower-level facility, but barriers to
17 implementation of the discharge plan exist that are beyond the
18 control of the hospital.

19 c. The department of human services or managed care
20 organization has authorized placement in the lower-level
21 facility sought under the discharge plan.

22 d. The hospital is making every reasonable effort to
23 continue to actively work to identify resources to implement
24 the discharge plan in a timely manner and documents the
25 reasonable efforts taken. However, if the Medicaid-eligible
26 member is covered through a managed care organization, the
27 managed care organization, rather than the hospital, shall
28 be responsible for identifying and obtaining the lower-level
29 facility placement.

30 3. For the purposes of this section:

31 a. "Days awaiting placement" means the days during which a
32 Medicaid-eligible member no longer meets acute care criteria
33 for stay in a hospital, has been verified to require placement
34 in a lower-level facility which may not be immediately located,
35 and is awaiting placement at the lower-level facility.

1 b. "Lower-level facility" means a facility that is able
2 to provide adequate, available, and accessible services and
3 supports, including but not limited to mental health services
4 and supports, to meet the Medicaid-eligible member's needs as
5 specified in the member's discharge plan.

6 4. The department of human services shall adopt rules
7 pursuant to chapter 17A to administer this section.

8 EXPLANATION

9 The inclusion of this explanation does not constitute agreement with
10 the explanation's substance by the members of the general assembly.

11 This bill relates to reimbursement for services provided by
12 a hospital during a days awaiting placement period.

13 The bill provides that under private insurance and
14 fee-for-service and managed care administration of Medicaid, a
15 hospital shall not be denied reimbursement for the continuation
16 of all higher-level services, including but not limited
17 to inpatient care, provided to a covered individual or
18 Medicaid-eligible member, respectively, during a days awaiting
19 placement period. Reimbursement shall be provided to a
20 hospital for each day a covered individual or Medicaid-eligible
21 member remains in the care of the hospital while awaiting
22 placement in a lower-level facility.

23 The bill defines "days awaiting placement" as the days
24 during which a covered individual or Medicaid-eligible member
25 no longer meets acute care criteria for stay in a hospital, has
26 been verified to require placement in a lower-level facility
27 which may not be immediately located, and is awaiting placement
28 at the lower-level facility. "Lower-level facility" is defined
29 as a facility that is able to provide adequate, available, and
30 accessible services and supports, including but not limited
31 to mental health services and supports, to meet a covered
32 individual's or Medicaid-eligible member's needs as specified
33 in the covered individual's or Medicaid-eligible member's
34 discharge plan.

35 The bill provides the criteria that must be met by a hospital

S.F. 2280

1 to receive reimbursement and requires the department of human
2 services and the commissioner of insurance, respectively, to
3 adopt administrative rules to administer the bill.