



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

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BUDGET OFFICE

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Memorandum

To: The Honorable Helio Melo
Chairman, House Finance Committee

The Honorable Daniel DaPonte
Chairman, Senate Finance Committee

From: Thomas A. Mullaney *Thomas A. Mullaney*
Executive Director/State Budget Officer

Date: May 3, 2013

Subject: Amendments to FY 2014 Appropriations Act (13-H-5127)

The Governor requests that Article 19 – Relating to Medical Assistance and Article 20 – Relating to Medicaid Reform Act of 2008 be replaced with the attached versions. Within each new article, all changes from the articles as originally submitted are denoted by grey shading. The specific statutory purpose(s) and policy rationales underlying these amendments are set forth below.

Article 19 – Relating to Medical Assistance

This amendment, consisting of statutory revisions to RIGL 40-8-17, authorizes the Executive Office of Health and Human Services (EOHHS) to seek an extension of the Medicaid, Title XIX, Section 1115 demonstration waiver, now known as the Global Consumer Choice Waiver. Additionally, the amendment authorizes EOHHS to rename the waiver to reflect changes in policy priorities and the waiver's federal financing arrangement, and to request from the Centers for Medicare and Medicaid Services (CMS) the authorities required to pursue programs that will further the goals of Medicaid reform.

This amendment further directs EOHHS to request authority to further ongoing Section 1115 demonstration initiatives, such as rebalancing of the long term care system and the promotion of integrated care management systems and smart purchasing strategies. In conjunction with these efforts, EOHHS will be required to pursue new authorities that enable the state to obtain federal matching funds for other services necessary to support these initiatives (e.g., housing stabilization, work supports, alternative therapies, etc.). Lastly, the amendment mandates public participation in the waiver extension process, which is required under CMS regulations.

ARTICLE 19

RELATING TO MEDICAL ASSISTANCE

SECTION 1. Sections 40-8-13.4, 40-8-17 and 40-8-19 of the General Laws in Chapter 40-8 entitled "Medical Assistance" are hereby amended to read as follows:

§ 40-8-13.4. Rate methodology for payment for in state and out of state hospital services. (a) The ~~department~~ executive office of health and human services shall implement a new methodology for payment for in state and out of state hospital services in order to ensure access to and the provision of high quality and cost-effective hospital care to its eligible recipients.

(b) In order to improve efficiency and cost effectiveness, the ~~department~~ executive office of health and human services shall:

(1) With respect to inpatient services for persons in fee for service Medicaid, which is non-managed care, implement a new payment methodology for inpatient services utilizing the Diagnosis Related Groups (DRG) method of payment, which is, a patient classification method which provides a means of relating payment to the hospitals to the type of patients cared for by the hospitals. It is understood that a payment method based on Diagnosis Related Groups may include cost outlier payments and other specific exceptions. The ~~department~~ executive office will review the DRG payment method and the DRG base price annually, making adjustments as appropriate in consideration of such elements as trends in hospital input costs, patterns in hospital coding, beneficiary access to care, and the Center for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index.

(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June 30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid

Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the applicable period; (ii) provided, however, for the twelve (12) month period beginning July 1, 2013 the Medicaid managed care payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital payments for each annual twelve (12) month period beginning July 1, 2014 may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (iv) The Rhode Island ~~department~~ executive office of health and human services will develop an audit methodology and process to assure that savings associated with the payment reductions will accrue directly to the Rhode Island Medicaid program through reduced managed care plan payments and shall not be retained by the managed care plans; ~~(iii)~~ (v) All hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and ~~(iv)~~ (vi) for all such hospitals, compliance with the provisions of this section shall be a condition of participation in the Rhode Island Medicaid program.

(2) With respect to outpatient services and notwithstanding any provisions of the law to the contrary, for persons enrolled in fee for service Medicaid, the ~~department~~ executive office will reimburse hospitals for outpatient services using a rate methodology determined by the ~~department~~ executive office and in accordance with federal regulations. Fee-for-service outpatient rates shall align with Medicare payments for similar services. ~~Changes~~ Notwithstanding the above, there shall be no increase in the Medicaid fee-for-service outpatient rates effective July 1, 2013. Thereafter, changes to outpatient rates will be implemented on July 1 each year and shall align with Medicare payments for similar services from the prior federal fiscal year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated increases in hospital outpatient payments for each annual twelve (12) month period beginning January 1, 2012 may

not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period: ;(ii) provided, however, for the twelve (12) month period beginning July 1, 2013 the Medicaid managed care outpatient payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital payments for each annual twelve (12) month period beginning July 1, 2014 may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period.

(c) It is intended that payment utilizing the Diagnosis Related Groups method shall reward hospitals for providing the most efficient care, and provide the ~~department~~ executive office the opportunity to conduct value based purchasing of inpatient care.

(d) The ~~director~~ secretary of the ~~department~~ executive office of health and human services and/or the ~~secretary of executive office of health and human services~~ is hereby authorized to promulgate such rules and regulations consistent with this chapter, and to establish fiscal procedures he or she deems necessary for the proper implementation and administration of this chapter in order to provide payment to hospitals using the Diagnosis Related Group payment methodology. Furthermore, amendment of the Rhode Island state plan for medical assistance (Medicaid) pursuant to Title XIX of the federal Social Security Act is hereby authorized to provide for payment to hospitals for services provided to eligible recipients in accordance with this chapter.

(e) The ~~department~~ executive office shall comply with all public notice requirements necessary to implement these rate changes.

(f) As a condition of participation in the DRG methodology for payment of hospital services, every hospital shall submit year-end settlement reports to the ~~department~~ executive office within one year from the close of a hospital's fiscal year. Should a participating hospital fail to timely submit a year-end settlement report as required by this section, the ~~department~~

executive office shall withhold financial cycle payments due by any state agency with respect to this hospital by not more than ten percent (10%) until said report is submitted. For hospital fiscal year 2010 and all subsequent fiscal years, hospitals will not be required to submit year-end settlement reports on payments for outpatient services. For hospital fiscal year 2011 and all subsequent fiscal years, hospitals will not be required to submit year-end settlement reports on claims for hospital inpatient services. Further, for hospital fiscal year 2010, hospital inpatient claims subject to settlement shall include only those claims received between October 1, 2009 and June 30, 2010.

(g) The provisions of this section shall be effective upon implementation of the amendments and new payment methodology pursuant to this section and § 40-8-13.3, which shall in any event be no later than March 30, 2010, at which time the provisions of §§ 40-8-13.2, 27-19-14, 27-19-15, and 27-19-16 shall be repealed in their entirety.

~~(h) The director of the Department of Human Services shall establish an independent study commission comprised of representatives of the hospital network, representatives from the communities the hospitals serve, state and local policy makers and any other stakeholders or consumers interested in improving the access and affordability of hospital care.~~

~~The study commission shall assist the director in identifying: issues of concern and priorities in the community hospital system, the delivery of services and rate structures, including graduate medical education and training programs; and opportunities for building sustainable and effective public-private partnerships that support the missions of the department and the state's community hospitals.~~

~~The director of the Department of Human Services shall report to the chairpersons of the House and Senate Finance Committees the findings and recommendations of the study commission by December 31, 2010.~~

§ 40-8-17. Waiver request. – (a) *Formation.* The department of human services, in conjunction with the executive office of health and human services, is directed and authorized to

apply for and obtain any necessary waiver(s), waiver amendment(s) and/or state plan amendments from the secretary of the United States department of health and human services, including, but not limited to, a an extension of the § 1115(a) global demonstration waiver that provides program flexibility in exchange for federal budgetary certainty and under which Rhode Island will operate all facets of the state's Medicaid program, except as may be explicitly exempted under any applicable public or general laws amended, as appropriate, and renamed to reflect the state's effort to coordinate all publicly financed health care. The secretary of the office shall ensure that the state's health and human services departments and the people and communities they serve in the Medicaid program shall have the opportunity to contribute to and collaborate in the formulation of any request for a new waiver, waiver extension and/or state plan amendment(s). Any such actions shall: (1) continue efforts to re-balance the system of long term services and supports by assisting people in obtaining care in the most appropriate and least restrictive setting; (2) pursue further utilization of care management models that promote preventive care, offer a health home, and provide an integrated system of services; (3) use smart payments and purchasing to finance and support Medicaid initiatives that fill gaps in the integrated system of care; and (4) recognize and assure access to non-medical services and supports, such as peer navigation and employment and housing stabilization services, that are essential for optimizing a person's health, wellness and safety and that reduce or delay the need for long term services and supports.

(b) Effective July 1, 2009, any provision presently in effect in the Rhode Island General Laws where the department of human services, in conjunction with the executive office of health and human services is authorized to apply for and obtain any necessary waiver(s), waiver amendment(s) and/or state plan amendment(s) for the purpose of providing medical assistance to recipients, shall authorize the department of human services, in conjunction with the executive office of health and human services, to proceed with appropriate category changes in accordance with the special terms and conditions of the Rhode Island Global Consumer Choice Compact

section 1115(a) Demonstration Waiver, which became effective January 16, 2009, or any extension thereof, as amended and/or renamed under the authority provided in this section.

§ 40-8-19. Rates of payment to nursing facilities. - (a) Rate reform. (1) The rates to be paid by the state to nursing facilities licensed pursuant to chapter 17 of title 23, and certified to participate in the Title XIX Medicaid program for services rendered to Medicaid-eligible residents, shall be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in accordance with 42 U.S.C. § 1396a(a)(13). The executive office of health and human services shall promulgate or modify the principles of reimbursement for nursing facilities in effect as of July 1, 2011 to be consistent with the provisions of this section and Title XIX, 42 U.S.C. § 1396 et seq., of the Social Security Act.

(2) The executive office of health and human services (“Executive Office”) shall review the current methodology for providing Medicaid payments to nursing facilities, including other long-term care services providers, and is authorized to modify the principles of reimbursement to replace the current cost based methodology rates with rates based on a price based methodology to be paid to all facilities with recognition of the acuity of patients and the relative Medicaid occupancy, and to include the following elements to be developed by the executive office:

- (i) A direct care rate adjusted for resident acuity;
- (ii) An indirect care rate comprised of a base per diem for all facilities;
- (iii) A rearray of costs for all facilities every three (3) years beginning October, 2015, which may or may not result in automatic per diem revisions;
- (iv) Application of a fair rental value system;
- (v) Application of a pass-through system; and
- (vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013, but will resume on October 1, 2014. Said inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.

(b) Transition to full implementation of rate reform. For no less than four (4) years after the initial application of the price-based methodology described in subdivision (a)(2) to payment rates, the ~~department~~ executive office of health and human services shall implement a transition plan to moderate the impact of the rate reform on individual nursing facilities. Said transition shall include the following components:

(1) No nursing facility shall receive reimbursement for direct care costs that is less than the rate of reimbursement for direct care costs received under the methodology in effect at the time of passage of this act; and

(2) No facility shall lose or gain more than five dollars (\$5.00) in its total per diem rate the first year of the transition. The adjustment to the per diem loss or gain may be phased out by twenty-five percent (25%) each year; and

(3) The transition plan and/or period may be modified upon full implementation of facility per diem rate increases for quality of care related measures. Said modifications shall be submitted in a report to the general assembly at least six (6) months prior to implementation.

SECTION 2. Title 40 of the General Laws entitled "Human Services" is hereby amended by adding thereto the following chapter:

CHAPTER 40-8.11

HEALTH CARE FOR ADULTS

§ 40-8.11-1 Purpose. — Pursuant to § 42-12.3-2, it is the intent of the general assembly to create access to comprehensive health care for uninsured Rhode Islanders. The Rhode Island Medicaid program has become an important source of insurance coverage for low income pregnant women, families with children, elders, and persons with disabilities who might not be able otherwise to obtain or afford health care. Under the U.S. Patient Protection and Affordable Care Act (ACA) of 2010, all Americans will be required to have health insurance, with some exceptions, beginning in 2014. Federal funding is available with ACA implementation to help pay for health insurance for low income adults, age 19 to 64, who do not qualify for Medicaid

eligibility under RI general and public laws. It is the intent of the general assembly, therefore, to implement the Medicaid expansion for childless adults authorized by the ACA, to extend health insurance coverage to these Rhode Islanders and further the goal established in § 42-12.3-2 in 1993.

§ 40-8.11-2 Eligibility– (a) Medicaid coverage for non-pregnant adults without children.

There is hereby established, effective January 1, 2014, a category of Medicaid eligibility pursuant to Title XIX of the Social Security Act, as amended by the U.S. Patient Protection and Affordable Care Act (ACA) of 2010, 42 U.S.C. § 1396u-1, for adults ages 19 to 64 who do not have children and do not qualify for Medicaid under RI general laws applying to families with children and adults who are blind, aged or living with a disability. The executive office of health and human services is directed to make any amendments to the Medicaid state plan and waiver authorities established under Title XIX necessary to implement this expansion in eligibility and assure the maximum federal contribution for health insurance coverage provided pursuant to this chapter. (b) Income. The secretary of the executive office of health and human services is authorized and directed to amend the Medicaid Title XIX state plan and, as deemed necessary, any waiver authority to effectuate this expansion of coverage to any Rhode Islander who qualifies for Medicaid eligibility under this chapter with income at or below one hundred and thirty eight percent (138%) the federal poverty level, based on modified adjusted gross income. (c) Delivery system. The executive office of health and human services is authorized and directed to apply for and obtain any waiver authorities necessary to provide persons eligible under this chapter with managed, coordinated health care coverage consistent with the principles set forth in § 42-12.4, pertaining to a health care home.

SECTION 3. Section 42-12.4-8 of the General Laws in Chapter 42-12.4 entitled “The Rhode Island Medicaid Reform Act of 2008” is hereby amended to read as follows:

§ 42-12.4-8 Demonstration termination. Demonstration expiration or termination.-

In the event the demonstration is suspended or terminated for any reason, or in the event that the

demonstration expires, ~~the department of human services, in conjunction with the executive office~~ of health and human services, is directed and authorized to apply for ~~and obtain all waivers~~ an extension or renewal of the Section 1115 Research and Demonstration Waiver or any new waiver(s) that, at a minimum, ensure continuation of the waiver authorities in existence prior to the acceptance of the demonstration. The office shall ensure that any such actions are conducted in accordance with applicable federal guidelines pertaining to Section 1115 demonstration waiver renewals, extensions, suspensions or terminations. ~~The department of human services and the executive office of health and human services to the extent possible shall ensure that said waivers~~ waiver authorities are reinstated prior to any suspension, termination, or expiration of the demonstration.

SECTION 4. This article shall take effect upon passage.