ARTICLE 18 AS AMENDED

RELATING TO MEDICAL ASSISTANCE

SECTION 1. Sections 40-8-13.4 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 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 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 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)~~ twenty-four (24) 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~~ 2015 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 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; (v) All hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and (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 executive office will reimburse hospitals for outpatient services using a rate methodology determined by the executive office and in accordance with federal regulations. Fee-for-service outpatient rates shall align with Medicare payments for similar services. Notwithstanding the above, there shall be no increase in the Medicaid fee-for-service outpatient rates effective on July 1, 2013 or July 1, 2014. 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)~~ twenty-four (24) 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~~ 2015 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 executive office the opportunity to conduct value based purchasing of inpatient care.

(d) The secretary of the 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 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 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 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.

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~~ April 1, 2015. 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 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. Chapter 40-8 of the General Laws entitled "Medical Assistance" is hereby amended by adding thereto the following section:

40-8-31. Payments to out-of-state facilities. – Effective September 1, 2014, the office of health and human services shall require that any payment to an out-of-state provider from whom a Medicaid eligible individual receives services must be a facility that applies for and is approved to participate in the Rhode Island Medicaid program. This excludes payments to out-of-state providers that do not participate in the Rhode Island Medicaid program but that are determined to

be acceptable due to extenuating circumstances by the secretary of the office of health and human services. Furthermore, the department of children, youth and families is required to submit a bi-weekly report to the chair of the house committee on finance, the chair of the senate committee on finance, the house fiscal advisor, the senate fiscal advisor, and the office of management and budget detailing payments for placements to out-of-state facilities. The report should also indicate the entity recommending or ordering the placement, the types of services required, and reason for using an out-of-state facility. This change may require the adoption of new or amended rules, regulations and procedures.

SECTION 3. The Rhode Island Medicaid Reform Act of 2008.

WHEREAS, the General Assembly enacted Chapter 12.4 of Title 42 entitled "The Rhode Island Medicaid Reform Act of 2008"; and

WHEREAS, a Joint Resolution is required pursuant to Rhode Island General Laws § 42-12.4-1, et seq.; and

WHEREAS, Rhode Island General Law § 42-12.4-7 provides that any change that requires the implementation of a rule or regulation or modification of a rule or regulation in existence prior to the implementation of the global consumer choice section 1115 demonstration ("the demonstration") shall require prior approval of the general assembly; and further provides that any category II change or category III change as defined in the demonstration shall also require prior approval by the general assembly; and

WHEREAS, Rhode Island General Law § 42-7.2-5 provides that the Secretary of the Office of Health and Human Services is responsible for the "review and coordination of any Global Consumer Choice Compact Waiver requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or category II or III changes as described in the demonstration, with "the potential to affect the scope, amount, or duration of publicly-funded health care services, provider payments or reimbursements, or access to or the availability of benefits and services provided by Rhode Island general and public laws"; and

WHEREAS, in pursuit of a more cost-effective consumer choice system of care that is fiscally sound and sustainable, the Secretary requests general assembly approval of the following proposals to amend the demonstration:

(a) *Nursing Facility Payment Rates – Delay Rate Increase.* The Medicaid single state agency proposes to delay the projected nursing facility rate increase that would otherwise take effect on October 1, 2014 to April 1, 2015. A category II change is required to implement this proposal under the terms and conditions of the demonstration. Further, this change may also require the adoption of new or amended rules, regulations and procedures.

(b) *Medicaid Hospital Payments – Eliminate Rate Increases for Hospital Inpatient and Outpatient Payments.* The Medicaid single state agency proposes to reduce inpatient and outpatient hospital payments by eliminating the projected rate increase for both managed care and fee-for-service for state fiscal year 2015. A category II change is required to implement this proposal under the terms and conditions of the Section 1115 waiver demonstration.

(c) *Medicaid Manage Care Payments- Reduction.* The Medicaid agency seeks to reduce the projected growth in capitation payments to managed care organizations for SFY 2015. Implementation of this reduction requires a Category II change under the terms and conditions of the Medicaid demonstration to assure payment rates remain actuarially sound as is required by federal laws and regulation.

(d) *Community First Choice (1915k) Option – Increase Federal Reimbursement for Home and Community-Based Alternatives*. The Medicaid Agency proposed to pursue the Community First Choice (CFC) Medicaid State Plan option as part of ongoing reforms to promote home and community-based alternatives to institutionally-based long-term services and supports. Implementation of the CFC option requires approval of a Medicaid State Plan Amendments and may require changes to the demonstration. New and amended rules, regulations and procedures may also be necessary related to these program changes.

(e) *Qualified Health Plan (QHP) Coverage for Medicaid-eligible Pregnant and Post-Partum Women – Promote QHP Coverage.* With the implementation of health care reform in Rhode Island, many pregnant women with income from 133 to 250 percent of the federal poverty level (FPL) will have access to coverage through a commercial plan. This initiative proposes to support enrollment/retention of coverage in these commercial plans by providing: 1) a RIte Share-like premium subsidy to assist in paying for the out-of-pocket costs in a commercial plan; and 2) wraparound coverage for services available if covered through Medicaid. Such an arrangement would result in a net savings to the Medicaid program. Implementation of this initiative requires Section 1115 waiver authority and may necessitate changes to EOHHS' rules, regulations and procedures.

(f) *Approved Authorities: Section 1115 Waiver Demonstration Extension.* The Medicaid agency proposes to implement authorities approved under the Section 1115 waiver demonstration extension request – formerly known as the Global Consumer Choice Waiver – that (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 utilization of care management models that offer a "health home", promote access to preventive care, and provide an integrated system of services; (3) use 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 the 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 reduce or delay the need for long term services and supports.

(g) *Medicaid Requirements and Opportunities under the U.S. Patient Protection and Affordable Care Act of 2010 (PPACA).* The Medicaid agency proposes to pursue any requirements and/or opportunities established under the PPACA that may warrant a Medicaid State Plan Amendment, category II or III change under the terms and conditions of Rhode Island's Section 1115 Waiver, its successor, or any extension thereof. Any such actions the Medicaid agency takes shall not have an adverse impact on beneficiaries or cause there to be an increase in expenditures beyond the amount appropriated for state fiscal year 2015; now, therefore, be it

RESOLVED, that the general assembly hereby approves proposals (a) through (g) listed above to amend the Section 1115 demonstration waiver; and be it further

RESOLVED, that the secretary of the office of health and human services is authorized to pursue and implement any waiver amendments, category II or category III changes, state plan amendments and/or changes to the applicable department's rules, regulations and procedures approved herein and as authorized by § 42-12.4-7.

SECTION 4. Katie Beckett State Plan Option. The Katie Beckett State Plan Option allows children who need an institutional level of care to obtain Medicaid coverage for the care they receive at home. Children eligible under this option typically have family income and resources that exceed Medicaid eligibility limits; though the Katie Beckett option enables these children to obtain Medicaid coverage by excluding their parents' family income and resources when determining Medicaid eligibility. At present, the families of Katie Beckett children are not required to contribute to the cost of Medicaid-funded care, irrespective of income. The office of health and human services shall collect annual tax and any other financial information it deems appropriate from the family of a child applying for, or currently receiving, services through the Katie Beckett State Plan Option. The information shall not affect a child's eligibility for the services.

SECTION 5. A pool is hereby established of up to $1.5 million to support Medicaid Graduate Education funding for Academic Medical Centers with level I Trauma Centers who provide care to the state's critically ill and indigent populations. The office of Health and Human Services shall utilize this pool to provide up to $3 million per year in additional Medicaid payments to support Graduate Medical Education programs to hospitals meeting all of the

following criteria:

(a) Hospital must have a minimum of 25,000 inpatient discharges per year for all patients regardless of coverage.

(b) Hospital must be designated as Level I Trauma Center.

(c) Hospital must provide graduate medical education training for at least 250 interns and residents per year.

The Secretary of the Executive Office of Health and Human Services shall determine the appropriate Medicaid payment mechanism to implement this program and amend any state plan documents required to implement the payments.

Payments for Graduate Medical Education programs shall be effective July 1, 2014.

SECTION 6. 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

(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 7. This article shall take effect upon passage.