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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. 2015

A N A C T

RELATING TO HUMAN SERVICES - MEDICAL ASSISTANCE

Introduced By: Representatives Phillips, Casey, Morin, Newberry, and MacBeth

Date Introduced: February 11, 2015

Referred To: House Finance

It is enacted by the General Assembly as follows:

SECTION 1. Sections 40-8-2 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is hereby amended to read as follows:

40-8-2. Definitions. -- As used in this chapter, unless the context shall otherwise require:

(1) "Dental service" means and includes emergency care, X-rays for diagnoses, extractions, palliative treatment, and the refitting and relining of existing dentures and prosthesis.

(2) "Department" means the department of human services.

(3) "Director" means the director of human services.

(4) "Distressed hospital purchaser" means a person or governmental entity that acquires the assets of a hospital through receivership or special mastership proceedings and is licensed after January 1, 2013, pursuant to the hospital conversion process set forth in chapter 17.14 of title 23, to establish, maintain and operate a hospital.

~~(4)~~(5) "Drug" means and includes only such drugs and biologicals prescribed by a licensed dentist or physician as are either included in the United States pharmacopoeia, national formulary, or are new and nonofficial drugs and remedies.

(6) "Hospital" means a person or governmental entity licensed in accordance with chapter 17 of title 23 to establish, maintain and operate a hospital, including a rehabilitation hospital and persons for profit and not-for-profit.

~~(5)~~(7) "Inpatient" means a person admitted to and under treatment or care of a physician or surgeon in a hospital or nursing facility which meets standards of and complies with rules and

regulations promulgated by the director.

~~(6)~~(8) "Inpatient hospital services" means the following items and services furnished to an inpatient in a hospital other than a hospital, institution or facility for tuberculosis or mental diseases:

(i) Bed and board;

(ii) Such nursing services and other related services as are customarily furnished by the hospital for the care and treatment of inpatients and such drugs, biologicals, supplies, appliances, and equipment for use in the hospital, as are customarily furnished by the hospital for the care and treatment of patients;

(iii) (A) Such other diagnostic or therapeutic items or services, including, but not limited to, pathology, radiology, and anesthesiology furnished by the hospital or by others under arrangements made by the hospital, as are customarily furnished to inpatients either by the hospital or by others under such arrangements, and services as are customarily provided to inpatients in the hospital by an intern or resident-in-training under a teaching program having the approval of the Council on Medical Education and Hospitals of the American Medical Association or of any other recognized medical society approved by the director.

(B) The term "inpatient hospital services" shall be taken to include medical and surgical services provided by the inpatient's physician, but shall not include the services of a private duty nurse or services in a hospital, institution, or facility maintained primarily for the treatment and care of patients with tuberculosis or mental diseases. Provided, further, it shall be taken to include only the following organ transplant operations: kidney, liver, cornea, pancreas, bone marrow, lung, heart, and heart/lung, and such other organ transplant operations as may be designated by the director after consultation with medical advisory staff or medical consultants; and provided that any such transplant operation is determined by the director or his or her designee to be medically necessary. Prior written approval of the director or his or her designee shall be required for all covered organ transplant operations.

(C) In determining medical necessity for organ transplant procedures, the state plan shall adopt a case-by-case approach and shall focus on the medical indications and contra-indications in each instance, the progressive nature of the disease, the existence of any alternative therapies, the life threatening nature of the disease, the general state of health of the patient apart from the particular organ disease, and any other relevant facts and circumstances related to the applicant and the particular transplant procedure.

~~(7)~~(9) "Nursing services" means the following items and services furnished to an inpatient in a nursing facility:

(i) Bed and board;

(ii) Such nursing care and other related services as are customarily furnished to inpatients admitted to the nursing facility, and such drugs, biologicals, supplies, appliances, and equipment for use in the facility, as are customarily furnished in the facility for the care and treatment of patients;

(iii) Such other diagnostic or therapeutic items or services, legally furnished by the facility or by others under arrangements made by the facility, as are customarily furnished to inpatients either by the facility or by others under such arrangement;

(iv) Medical services provided in the facility by the inpatient's physician, or by an intern or resident-in-training of a hospital with which the facility is affiliated or which is under the same control, under a teaching program of the hospital approved as provided in subsection ~~(6)~~(8) of this section; and

(v) A personal needs allowance of fifty dollars ($50.00) per month.

(10) "Person" means any individual, trust or estate, partnership, corporation (including associations, joint stock companies and insurance companies), limited liability company, state or political subdivision or instrumentality of the state.

~~(8)~~(11)"Relative with whom such dependent child is living" means and includes the father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece of any dependent child who maintains a home for the dependent child.

~~(9)~~(12) "Visiting nurse service" means part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse other than in a hospital or nursing home.

SECTION 2. Section 40-8-13.4 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is 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) (A) 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 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, 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 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, 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.

(h)(1) Except as set forth in § 40-8-13.4(h)(3), § 40-8-13.4(b) shall not apply to distressed hospital purchasers.

(2) If a distressed hospital purchaser does not have a negotiated Medical managed care contract with the health plan on or after the effective date of § 40-8-13.4(h), the negotiated Medicaid managed care payment rates for distressed hospital purchasers shall be based upon the rates negotiated between the distressed hospital purchaser and the health plan following the effective date of § 40-8-13.4(h), and such rates shall be effective as of the latter of the effective date of this section or the date the distressed hospital purchaser and the health plan execute an agreement containing the negotiated rate.

(3) The rate-setting methodology for inpatient hospital payments and outpatient hospital payments set forth in §§ 40-8-13.4(b)(1)(B)(iii) and 40-8-13.4(b)(2), respectively, shall apply to negotiated increases for each annual twelve (12) month period as of the July 1 following the completion of the first full year of a distressed hospital purchaser's initial Medicaid managed care contract.

(4) There shall be no right of recoupment or set-off against any amounts paid to or received by a distressed hospital purchaser prior to the effective date of the negotiated rates.

SECTION 3. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO HUMAN SERVICES - MEDICAL ASSISTANCE

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This act would establish a baseline for Medicaid managed care payment rates for certain distressed hospital purchasers.

This act would take effect upon passage.

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