ARTICLE 5

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)(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 and for the twelve (12) month period beginning July 1, 2015, the Medicaid managed care payment rates between each hospital and
health plan shall not exceed ninety-five percent (95.0%) of 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, or July 1,
2015. For the twelve (12) month period beginning July 1, 2015, Medicaid fee-for-service
outpatient rates shall not exceed ninety-five percent (95.0%) of the rates in effect as of 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 and for the twelve (12) month period beginning July 1, 2015, the
Medicaid managed care outpatient payment rates between each hospital and health plan shall not
exceed ninety-five percent (95.0%) of 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.

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 or October 1, 2015, but will resume on 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.
(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning July 1, 2015, payment rates established pursuant to this section shall not exceed ninety-seven percent (97.0%) of the rates in effect as of April 1, 2015.

SECTION 2. Section 40-8.13-5 of the General Laws in Chapter 40-8.13 entitled “Long-Term Managed Care Arrangements” is hereby amended to read as follows:

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.

(3) Notwithstanding any law to the contrary, for the twelve (12) month period beginning July 1, 2015, payment rates between each nursing facility and managed care organization shall not exceed ninety-seven percent (97.0%) of the payment rates in effect during state fiscal year 2015.

SECTION 3. Section 5 of Article 18 of Chapter 145 of the Public Laws of 2014 is hereby repealed.

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 4. Pursuant to § 42-12.4-7 of the General Laws, the Secretary of Health and Human Services is hereby authorized by the General Assembly to undertake those programmatic changes requiring 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, or any category II change or category III change as defined in the demonstration, that are integral to the appropriations for the medical assistance program contained in Article 1 of this Act and detailed in official budgetary documents supplemental thereto.

SECTION 5. This article shall take effect as of July 1, 2014.