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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. 2021

A N A C T

RELATING TO HUMAN SERVICES -- MEDICAL ASSISTANCE

Introduced By: Senators DiPalma, Miller, Valverde, Lawson, and Murray

Date Introduced: May 07, 2021

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

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

40-8-13.6. Review of provider rates - advisory committee - recommendations.

(a) Except for care for behavioral health, on or before January 1, 2022, the executive office of health and human services (EOHHS) shall establish a schedule for an annual review of selected provider rates paid pursuant to the provisions of chapter 8 of this title and for any provider that is providing services pursuant to a contract with the state or any subdivision or agency to include, but not limited to, the department of children, youth and families (DCYF) and the department of behavioral healthcare, developmental disabilities, and hospitals (BHDDH), in order that each provider rate is reviewed at least once every five (5) years. With respect to care for behavioral health, which includes mental health and substance use disorder services and treatments, provider reimbursement rates paid by a medical assistance program pursuant to the provisions of chapter 8 of this title and its contracted managed care entities shall be reviewed on or before February 1, 2022, and annually for the following four (4) years and biennially thereafter. EOHHS shall provide the schedule and the results of the review upon completion to the speaker of the house, president of the senate and the governor. If the EOHHS receives any petitions or proposals for provider rates to be reviewed or adjusted at any time other than the scheduled review, the EOHHS shall forward a copy of the petition or proposal to the advisory committee, established pursuant to the provisions of subsection (c) of this section.

(1) The EOHHS shall review each of the provider rates scheduled for review pursuant to the process described in this section. Additionally, the advisory committee established pursuant to subsection (c) of this section, by a majority vote, may recommend that the EOHHS conduct a review of a provider rate that is not scheduled for review during that year. The advisory committee shall notify the EOHHS by December 1 of the year prior to the year in which the out-of-cycle review is recommended to take place of its request for an out-of-cycle review.

(2)(i) The EOHHS may exclude a rate review from the schedule established pursuant to this subsection, if those rates are adjusted on a periodic basis as a result of other state statute, federal law, or regulation. The EOHHS shall include the proposed list of exclusions with the schedule established pursuant to this subsection.

(ii) The advisory committee established pursuant to subsection (c) of this section, may by a majority vote recommend to the EOHHS to include any rate that the EOHHS has selected to exclude from the schedule pursuant to this subsection.

(b)(1) In the first phase of the review process, the EOHHS shall conduct an analysis of the access, service, quality, and utilization of each service subject to a provider rate review. The EOHHS shall compare the rates paid with available benchmarks, including medicare rates and usual and customary rates paid by private pay parties, and use qualitative tools to assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services. On or before May 1, 2022, and each May 1 thereafter, the EOHHS shall provide a report on the analysis required by this section to the advisory committee, and any stakeholder groups identified by the EOHHS whose rates are reviewed, and to the speaker of the house, the president of the senate and the governor.

(2) Following the report required by this subsection, the EOHHS shall work with the advisory committee, established pursuant to the provisions of subsection (c) of this section, and any stakeholders identified by the EOHHS to review the report and develop strategies for responding to the findings, including any nonfiscal approaches or rebalancing of rates.

(3) Following the review required by this subsection, the EOHHS shall work with the governor or designee to determine achievable goals and executive branch priorities within the statewide budget.

(4) On or before November 1, 2022, and each November 1 thereafter, the EOHHS shall submit a written report to the speaker of the house, the president of the senate, the governor and the advisory committee containing its determinations on all of the provider rates reviewed pursuant to this section and all of the data relied upon by the EOHHS in making its determinations.

(c)(1) There is hereby established the "medical assistance provider rate review advisory

committee", referred to in this section as the "advisory committee", to assist the EOHHS in the review of the provider rate reimbursements pursuant to the provisions of chapter 8 of this title. The advisory committee shall:

(i) Review the schedule for annual review of provider rates established by the EOHHS pursuant to subsection (a) of this section, and recommend any changes to the schedule;

(ii) Review the reports prepared by the EOHHS on its analysis of provider rates pursuant to the provisions of this section and provide comments and feedback to the EOHHS on the reports;

(iii) With the EOHHS, conduct public meetings to allow providers, recipients, and other interested parties an opportunity to comment on the report required by the provisions of this section;

(iv) Review petitions or proposals for provider rates to be reviewed or adjusted that are received by the advisory committee from EOHHS pursuant to the provisions of subsection (a) of this section;

(v) Determine whether any provider rates not scheduled for review during the next calendar year should be recommended for review during that calendar year;

(vi) Recommend to the EOHHS and to the speaker of the house, president of the senate and the governor any changes to the process of reviewing provider rates, including measures to increase access to the process such as by providing for electronic comments by providers and the public; and

(vii) Provide other assistance to the EOHHS as requested by the EOHHS.

(2) The advisory committee shall consist of the following twenty-four (24) members:

(i) The following members appointed by the president of the senate:

(A) A recipient with a disability or a representative of recipients with disabilities;

(B) A representative of hospitals providing services to recipients;

(C) A representative of providers of transportation;

(D) A representative of health centers or clinics;

(E) A representative of home health providers; and

(F) A representative of providers of durable medical equipment;

(ii) The following members appointed by the minority leader of the senate:

(A) A representative of providers of behavioral health care services;

(B) A representative of primary care physicians who provide services to recipients;

(C) A representative of dentists providing services to recipients;

(D) A representative of federally qualified health centers;

(E) A representative of nonmedical home- and community-based service providers; and

(F) A representative of providers serving recipients with intellectual and developmental

disabilities;

(iii) The following members appointed by the speaker of the house of representatives:

(A) A representative of child recipients with disabilities;

(B) A representative of specialty care physicians not employed by a hospital who provide services to recipients;

(C) A representative of providers of alternative care facilities;

(D) A representative of home health care agencies;

(E) A representative of ambulatory surgical centers;

(F) A representative of hospice providers; and

(iv) The following members appointed by the minority leader of the house of representatives:

(A) A representative of substance use disorder providers;

(B) A representative of facility-based physicians who provide services to recipients. "Facility-based physicians" include anesthesiologists, emergency room physicians, neonatologists, pathologists, and radiologists;

(C) A representative of pharmacists providing services to recipients;

(D) A representative of managed care health plans;

(E) A representative of advanced practice nurses; and

(F) A representative of physical therapists or occupational therapists.

(3) The appointing authorities shall make their initial appointments to the advisory committee no later than August 1, 2021. In making appointments to the advisory committee, the appointing authorities shall make a concerted effort to include members of diverse political, racial, cultural, income, and ability groups.

(4) Each member of the advisory committee shall serve at the pleasure of the official who appointed the member. Each member of the advisory committee shall serve a four (4) year term and may be reappointed.

(5) The members of the advisory committee shall serve without compensation and without reimbursement for expenses.

(6) At the first meeting of the advisory committee, to be held on or after September 13, 2021, the members shall elect a chair and vice-chair from among the members.

(7) The advisory committee shall meet at least once every quarter. The chair may call such additional meetings as may be necessary for the advisory committee to complete its duties.

(8) The advisory committee shall develop bylaws and procedures to govern its operations.

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 ("executive office") 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 shall:

(1)(i) 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 that 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 DRG 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 Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index. For the twelve-month (12) period beginning July 1, 2015, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of July 1, 2014. Beginning July 1, 2019, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall be 107.2% of the payment rates in effect as of July 1, 2018. Increases in the Medicaid fee-for-service DRG hospital payments for the twelve-month (12) period beginning July 1, 2020, shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national Prospective Payment System (IPPS) Hospital Input Price Index.

(ii) With respect to inpatient services, (A) 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. Increases in inpatient hospital payments for each annual twelve-month (12) 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; (B) Provided, however, for the twenty-four-month (24) 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-month (12) period beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each hospital and health plan

shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (C) Increases in inpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2017, shall be the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1; (D) Beginning July 1, 2019, the Medicaid managed care payment inpatient rates between each hospital and health plan shall be 107.2% of the payment rates in effect as of January 1, 2019, and shall be paid to each hospital retroactively to July 1; (E) Increases in inpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2020, shall be based on the payment rates in effect as of January 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1; the executive office 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; (F) All hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and (G) 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, July 1, 2014, or July 1, 2015. For the twelve-month (12) period beginning July 1, 2015, Medicaid fee-for-service outpatient rates shall not exceed ninety-seven and one-half percent (97.5%) of the rates in effect as of July 1, 2014. Increases in the outpatient hospital payments for the twelve-month (12) period beginning July 1, 2016, may not exceed the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. Beginning July 1, 2019, the Medicaid fee-for-service outpatient rates shall be 107.2% of the payment rates in effect as of July 1, 2018. Increases in the outpatient hospital payments for the twelve-month (12) period beginning July 1, 2020, shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. 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; (ii) Increases in hospital outpatient payments for each annual twelve-month (12) period beginning January 1, 2012, until July 1, 2017, may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment System OPPS hospital price index for the applicable period; (iii) Provided, however, for the twenty-four-month (24) 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-month (12) period beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (iv) Increases in outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2017, shall be the Centers for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1; (v) Beginning July 1, 2019, the Medicaid managed care outpatient payment rates between each hospital and health plan shall be one hundred seven and two-tenths percent (107.2%) of the payment rates in effect as of January 1, 2019 and shall be paid to each hospital retroactively to July 1; (vi) Increases in outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2020, shall be based on the payment rates in effect as of January 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1.

(3) "Hospital," as used in this section, shall mean the actual facilities and buildings in existence in Rhode Island, licensed pursuant to § 23-17-1 et seq. on June 30, 2010, and thereafter any premises included on that license, regardless of changes in licensure status pursuant to chapter 17.14 of title 23 (hospital conversions) and § 23-17-6(b) (change in effective control), that provides short-term, acute inpatient and/or outpatient care to persons who require definitive diagnosis and treatment for injury, illness, disabilities, or pregnancy. Notwithstanding the preceding language, the Medicaid managed care payment rates for a court-approved purchaser that acquires a hospital through receivership, special mastership or other similar state insolvency proceedings (which court-approved purchaser is issued a hospital license after January 1, 2013), shall be based upon the new rates between the court-approved purchaser and the health plan, and such rates shall be effective as of the date that the court-approved purchaser and the health plan execute the initial agreement containing the new rates. The rate-setting methodology for inpatient-hospital payments and outpatient-hospital payments set forth in subsections (b)(1)(ii)(C) and (b)(2), respectively, shall

thereafter apply to increases for each annual twelve-month (12) period as of July 1 following the completion of the first full year of the court-approved purchaser's initial Medicaid managed care contract.

(c) It is intended that payment utilizing the DRG 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 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 DRG-payment methodology. Furthermore, amendment of the Rhode Island state plan for Medicaid, pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et seq., 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 the 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 new payment methodology set forth in 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) Notwithstanding any provision in this section to the contrary, the payment for medical services for eligible recipients shall be subject to the provisions of § 40-8-13.6.

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 provide for a medical assistance rate review process. The act would further provide for a twenty-four (24) member advisory committee. Pursuant to the act, each provider rate would be reviewed at least once every five (5) years.

This act would take effect upon passage.

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