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STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

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Memorandum

To: The Honorable Steven M. Costantino
Chairman, House Finance Committee

The Honorable Daniel DaPonte
Chairman, Senate Finance Committee

From: Rosemary Booth Gallogly *RBS Gallogly*
Executive Director/State Budget Officer

Date: February 24, 2010

Subject: Amendments to Article 20 of FY 2011 Appropriations Act (10-H-7397)

The Governor requests that Article 20 of the FY 2011 Appropriations Act entitled "Relating to Medical Assistance" be replaced with the attached version. The new version makes several revisions to the amending language included within the original Article 20. This revised language is indicated by shading.

Article 20 sets forth statutory changes that will facilitate the procurement of contracts for Medicaid managed care services in FY 2011. The success of this initiative is dependent upon the full participation of hospitals since hospital payments represent more than half of capitation-based expenditures. This requires that specific, binding contractual language relating to the hospitals be included in the associated legislation. Also necessary is a change to the present "lesser of" language related to the Medicaid managed care payment rates to replace CMS national trends with the CMS Prospective Payment System Hospital Input Price Index in order to limit the scope of potential influences on rate determination.

The reasons for modifying the current language are as follows:

(1) To achieve the intended effect, it has been determined that this legislation must include specific language stipulating that acceptance of the managed care payments on the part of the hospitals shall be considered payment in full.

(2) The language must also include implications if a hospital refuses to accept a Medicaid managed care payment as payment in full. The proposed amendment mandates that acceptance of payment in full be a condition of a hospital's participation in the Medicaid program.

(3) Previously, the legislation required that the Medicaid managed care payments not exceed national Medicaid hospital care expenditure trend(s), as measured annually by CMS. The Department proposes amending this requirement to be based upon the annual CMS Prospective Payment System (IPPS) Hospital Input Price Index (HIPI). It is the Department's opinion, that it is more appropriate to use the HIPI rather than the national trends. The national trends are influenced by three factors: Medicaid caseload, utilization, and price. In order to limit influence solely to price, use of the HIPI is more appropriate.

If you have any questions regarding the amendments to Article 20, please feel free to call me at 222-6300, or Kevin Madigan of the Office of Health and Human Services at 462-0732.

RBG:sm 10-16
Attachment

cc: Representative Robert A. Watson
Senator Dennis L. Algiere
Sharon Reynolds Ferland
Peter Marino
Tim Costa
Michael Cronan
Daniel Ogel
Kevin Madigan
Gregory Stack

ARTICLE 20 (Revised 2/24/10)

RELATING TO MEDICAL ASSISTANCE

SECTION 1. Sections 40-8-13.4 and 40-8-29 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 of 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 of human services shall:

(1)(A) With respect to inpatient services: ~~Implement 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.

(B) With respect to inpatient services for persons enrolled in Medicaid managed care plans, it is required effective July 1, 2010 that (i) Medicaid managed care payment rates to any hospital, in aggregate on a case mix adjusted basis (adjusting payment for a beneficiary's condition and needs), shall not exceed that hospital's Medicaid payment rates; and (ii) Medicaid managed care payment rates between each hospital and health plan shall not exceed contracted payment rates between the hospital and the health plan that were in effect during calendar year 2009 as adjusted by the Center for Medicare and Medicaid Services National CMS Prospective Payment System (IPPS) Hospital Input Price Index and using calendar year 2009 as a base year; (iii) payments made for Medicaid services pursuant to this section shall be deemed as payment in

full; and (iv) for all such hospitals, compliance with the provisions of this section shall be a condition of participation in the Rhode Island Medicaid program.

(2)(A) With respect to outpatient services: ~~Notwithstanding~~ and notwithstanding any provisions of the law to the contrary, for persons enrolled in fee for service Medicaid, the department will reimburse hospitals for outpatient services using a rate methodology determined by the department and in accordance with federal regulations.

(B) With respect to outpatient services and notwithstanding any provisions of law to the contrary, for persons enrolled in Medicaid managed care plans it is required effective July 1, 2010 that (i) Medicaid managed care payment rates to any hospital, in aggregate on a case mix adjusted basis shall not exceed that hospital's Medicaid payment rates; and (ii) Medicaid managed care payment rates between each hospital and health plan shall not exceed contracted payment rates between the hospital and the health plan that were in effect during calendar year 2009 as adjusted by the Center for Medicare and Medicaid Services National CMS Prospective Payment System (IPPS) Hospital Input Price Index and using calendar year 2009 as a base year; (iii) payments made for Medicaid services pursuant to this section shall be deemed as payment in full; and (iv) for all such hospitals, compliance with the provisions of this section shall be a condition of participation in the Rhode Island Medicaid program.

(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 the opportunity to conduct value based purchasing of inpatient care.

(d) The director of the department of 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 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 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 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.

(g) The provisions of this section shall be effective upon implementation of the amendments and new payment methodology pursuant to this section and section 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.

§ 40-8-29 Selective contracting. – (a) Notwithstanding any other provision of state law, the department of human services is authorized to utilize selective contracting with prior general assembly approval for the purpose of purchasing for Medicaid recipients shared living provider services, durable medical equipment and supplies, non-emergency transportation, and any other Medicaid services, when appropriate, in order to assure that all service expenditures under this chapter have the maximum benefit of competition, and afford Rhode Islanders the overall best value, optimal quality, and the most cost-effective care possible. Beneficiaries will be limited to using the services/products of only those providers determined in a competitive bidding process to meet the standards for best quality, performance and price set by the department in accordance with applicable federal and state laws.

(b) For purposes of this section "selective contracting" shall mean the process for choosing providers to serve Medicaid beneficiaries based on their ability to deliver the best quality products or services, at the best value or price.

(c) To ensure all services allowable for Medicare reimbursement for beneficiaries who are dually eligible, selective contractors must be willing and able to accept Medicare.

SECTION 2. Section 40-8.5-1.1 of the General Laws in Chapter 40-8.5 entitled "The Health Care for Elderly and Disabled Residents Act" is hereby amended to read as follows:

§ 40-8.5-1.1 Managed health care delivery systems. – (a) To ensure that all medical assistance beneficiaries, including the elderly and all individuals with disabilities, have access to quality and affordable health care, the department of human services is authorized to implement mandatory managed care health systems.

(b) "Managed care" is defined as systems that: integrate an efficient financing mechanism with quality service delivery; provides a "medical home" to assure appropriate care and deter unnecessary services; and place emphasis on preventive and primary care. For purposes of Medical Assistance, managed care systems are also defined to include a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the department of human services. Managed care systems may also include services and supports that optimize the health and independence of recipients who are determined to need Medicaid funded long-term care under § 40-8.10 or to be at risk for such care under applicable rules and regulations promulgated by the department. These Any medical assistance recipients who have third-party medical coverage or insurance may be provided such services through an entity certified by or in a contractual arrangement with the department or, as deemed appropriate, exempt from mandatory managed care in accordance with rules and regulations promulgated by the department of human services. The department is further authorized to redesign benefit packages for medical assistance beneficiaries subject to appropriate federal approval.

(c) ~~The~~ In accordance with § 42-12.4-7, the department is authorized to obtain any approval through waiver(s), category II or III changes, and/or state plan amendments, from the secretary of the United States department of health and human services, that are necessary to implement mandatory managed health care delivery systems for all medical assistance recipients, including the primary case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the department of human services. The waiver(s), category II or III changes, and/or state plan amendments shall include the authorization to ~~exempt~~ extend managed care to cover long-term care services and supports. Such authorization shall also include, as deemed appropriate, exempting certain beneficiaries with third-party medical coverage or insurance from mandatory managed care in accordance with rules and regulations promulgated by the department of human services.

(d) To ensure the delivery of timely and appropriate services to persons who become eligible for Medicaid by virtue of their eligibility for a U.S. social security administration program, the department of human services is authorized to seek any and all data sharing agreements or other agreements with the social security administration as may be necessary to receive timely and accurate diagnostic data and clinical assessments. Such information shall be used exclusively for the purpose of service planning, and shall be held and exchanged in accordance with all applicable state and federal medical record confidentiality laws and regulations.

SECTION 3. This article shall take effect upon passage.