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STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Administration  
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**Memorandum**

**To:** The Honorable Raymond Gallison  
Chairman, House Finance Committee

The Honorable Daniel DaPonte  
Chairman, Senate Finance Committee

**From:** Thomas A. Mullaney *Thomas A. Mullaney*  
Executive Director/State Budget Officer

**Date:** April 3, 2014

**Subject:** Amendments to the FY 2015 Appropriations Act (13-H-7133)

The Governor requests that Article 25 – Relating to Medical Assistance and Section 3 of Article 27 – Relating to Medical Assistance Recoveries be replaced with the attached versions. The specific statutory purpose(s) and policy rationales underlying these amendments are set forth below.

Article 25 – Relating to Medical Assistance

The Governor requests that Section 1 of Article 25, Relating to Medical Assistance, be withdrawn in its entirety. This section proposes new language within RIGL 40-5.2-21 that conditions all Transitional Medical Assistance (TMA) coverage on the availability of federal financial participation pursuant to Title XIX of the Social Security Act, thereby safeguarding the State in the event that the TMA program is not reauthorized by Congress. Subsequent to the submission of the Governor's FY 2015 Appropriations Act, however, the Executive Office of Health and Human Services determined that Section 1 is more appropriately placed within a series of (forthcoming) recommended revisions to the statutes governing both the Executive Office and the Medical Assistance program. These recommendations are outside the scope of the budget process.

In addition, in Section 3, The Rhode Island Medicaid Reform Act of 2008, on page 236, Line 19, the Governor requests that "2014" be replaced with "2015" to correct a typographical oversight.

Article 27 – Relating to Medical Assistance Recoveries

The Governor requests that the entirety of Section 3 of Article 27, Relating to Medical Assistance Recoveries, be replaced with the attached version. As submitted, Section 3 adds a new section to the General Laws, RIGL 40-8-3.1, providing that as a condition of eligibility for Medical Assistance, every applicant or recipient who owns a Life Estate with Powers in property, with retained rights to revoke, amend or re-designate the remainderman, must exercise those rights by conveying the property back to himself or herself. Effectively, this provision bars any individual owning a Life Estate with Powers Deed (a “Lady Bird Deed”) from accessing services under the Medical Assistance program.

Following recent deliberations with various stakeholders, the Executive Office of Health and Human Services proposes a somewhat less restrictive policy designed to achieve the original objectives of Article 27. In the attached replacement section, eligibility for Medical Assistance is not fully precluded due to the applicant’s ownership of a Life Estate with Powers Deed. Instead, it requires that a Medical Assistance applicant or recipient owning such a deed must convey all outstanding remainder interest in the real property (in this case, the primary residence) back to himself or herself in order for the property to be treated as an excluded resource for purposes of eligibility determination.

Please also note that the legal term “remainderman” has been replaced with the (synonymous) term “holder(s) of the remainder interest”, which is more prevalent throughout the General Laws.

If you have any questions regarding these amendments, please feel free to call me or my staff at 222-6300.

TAM:14-Amend-25/27

Attachments

cc: Sharon Reynolds Ferland, House Fiscal Advisor  
Stephen Whitney, Senate Fiscal Advisor  
Steve Hartford, Director of Policy  
Richard Licht, Director of Administration  
Peter Marino, Director, Office of Management and Budget  
Daniel Orgel, Principal Budget Analyst

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ARTICLE 25

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~~ twenty-four (24) month period beginning July 1, 2013 the Medicaid managed care payment rates between

1 each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013; (iii)  
2 negotiated increases in inpatient hospital payments for each annual twelve (12) month period beginning  
3 July 1, ~~2014~~ 2015 may not exceed the Centers for Medicare and Medicaid Services national CMS  
4 Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the  
5 applicable period; (iv) The Rhode Island executive office of health and human services will develop an  
6 audit methodology and process to assure that savings associated with the payment reductions will accrue  
7 directly to the Rhode Island Medicaid program through reduced managed care plan payments and shall  
8 not be retained by the managed care plans; (v) All hospitals licensed in Rhode Island shall accept such  
9 payment rates as payment in full; and (vi) for all such hospitals, compliance with the provisions of this  
10 section shall be a condition of participation in the Rhode Island Medicaid program.

11 (2) With respect to outpatient services and notwithstanding any provisions of the law to the  
12 contrary, for persons enrolled in fee for service Medicaid, the executive office will reimburse hospitals for  
13 outpatient services using a rate methodology determined by the executive office and in accordance with  
14 federal regulations. Fee-for-service outpatient rates shall align with Medicare payments for similar  
15 services. Notwithstanding the above, there shall be no increase in the Medicaid fee-for-service outpatient  
16 rates effective on July 1, 2013 or July 1, 2014. Thereafter, changes to outpatient rates will be  
17 implemented on July 1 each year and shall align with Medicare payments for similar services from the  
18 prior federal fiscal year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until  
19 December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan  
20 shall not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated  
21 increases in hospital outpatient payments for each annual twelve (12) month period beginning January 1,  
22 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient  
23 Prospective Payment System (OPPS) hospital price index for the applicable period; (ii) provided,  
24 however, for the ~~twelve (12)~~ twenty-four (24) month period beginning July 1, 2013 the Medicaid  
25 managed care outpatient payment rates between each hospital and health plan shall not exceed the  
26 payment rates in effect as of January 1, 2013; (iii) negotiated increases in outpatient hospital payments for

1 each annual twelve (12) month period beginning July 1, ~~2014~~ 2015 may not exceed the Centers for  
2 Medicare and Medicaid Services national CMS Outpatient Prospective Payment System (OPPS) Hospital  
3 Input Price Index, less Productivity Adjustment, for the applicable period.

4 (c) It is intended that payment utilizing the Diagnosis Related Groups method shall reward  
5 hospitals for providing the most efficient care, and provide the executive office the opportunity to conduct  
6 value based purchasing of inpatient care.

7 (d) The secretary of the executive office of health and human services is hereby authorized to  
8 promulgate such rules and regulations consistent with this chapter, and to establish fiscal procedures he or  
9 she deems necessary for the proper implementation and administration of this chapter in order to provide  
10 payment to hospitals using the Diagnosis Related Group payment methodology. Furthermore, amendment  
11 of the Rhode Island state plan for medical assistance (Medicaid) pursuant to Title XIX of the federal  
12 Social Security Act is hereby authorized to provide for payment to hospitals for services provided to  
13 eligible recipients in accordance with this chapter.

14 (e) The executive office shall comply with all public notice requirements necessary to implement  
15 these rate changes.

16 (f) As a condition of participation in the DRG methodology for payment of hospital services,  
17 every hospital shall submit year-end settlement reports to the executive office within one year from the  
18 close of a hospital's fiscal year. Should a participating hospital fail to timely submit a year-end settlement  
19 report as required by this section, the executive office shall withhold financial cycle payments due by any  
20 state agency with respect to this hospital by not more than ten percent (10%) until said report is  
21 submitted. For hospital fiscal year 2010 and all subsequent fiscal years, hospitals will not be required to  
22 submit year-end settlement reports on payments for outpatient services. For hospital fiscal year 2011 and  
23 all subsequent fiscal years, hospitals will not be required to submit year-end settlement reports on claims  
24 for hospital inpatient services. Further, for hospital fiscal year 2010, hospital inpatient claims subject to  
25 settlement shall include only those claims received between October 1, 2009 and June 30, 2010.

1 (g) The provisions of this section shall be effective upon implementation of the amendments and  
2 new payment methodology pursuant to this section and § 40-8-13.3, which shall in any event be no later  
3 than March 30, 2010, at which time the provisions of §§ 40-8-13.2, 27-19-14, 27-19-15, and 27-19-16  
4 shall be repealed in their entirety.

5 **§ 40-8-19 Rates of payment to nursing facilities.** – (a) Rate reform. (1) The rates to be paid by  
6 the state to nursing facilities licensed pursuant to chapter 17 of title 23, and certified to participate in the  
7 Title XIX Medicaid program for services rendered to Medicaid-eligible residents, shall be reasonable and  
8 adequate to meet the costs which must be incurred by efficiently and economically operated facilities in  
9 accordance with 42 U.S.C. § 1396a(a)(13). The executive office of health and human services shall  
10 promulgate or modify the principles of reimbursement for nursing facilities in effect as of July 1, 2011 to  
11 be consistent with the provisions of this section and Title XIX, 42 U.S.C. § 1396 et seq., of the Social  
12 Security Act.

13 (2) The executive office of health and human services ("Executive Office") shall review the  
14 current methodology for providing Medicaid payments to nursing facilities, including other long-term  
15 care services providers, and is authorized to modify the principles of reimbursement to replace the current  
16 cost based methodology rates with rates based on a price based methodology to be paid to all facilities  
17 with recognition of the acuity of patients and the relative Medicaid occupancy, and to include the  
18 following elements to be developed by the executive office:

- 19 (i) A direct care rate adjusted for resident acuity;
- 20 (ii) An indirect care rate comprised of a base per diem for all facilities;
- 21 (iii) A rearray of costs for all facilities every three (3) years beginning October, 2015, which may  
22 or may not result in automatic per diem revisions;
- 23 (iv) Application of a fair rental value system;
- 24 (v) Application of a pass-through system; and
- 25 (vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be  
26 applied on October 1st of each year, beginning October 1, 2012. This adjustment will not occur on

1 October 1, 2013 or on October 1, 2014, but will resume on October 1, ~~2014~~ 2015. Said inflation index  
2 shall be applied without regard for the transition factor in subsection (b)(2) below.

3 (b) *Transition to full implementation of rate reform.* For no less than four (4) years after the initial  
4 application of the price-based methodology described in subdivision (a) (2) to payment rates, the  
5 executive office of health and human services shall implement a transition plan to moderate the impact of  
6 the rate reform on individual nursing facilities. Said transition shall include the following components:

7 (1) No nursing facility shall receive reimbursement for direct care costs that is less than the rate  
8 of reimbursement for direct care costs received under the methodology in effect at the time of passage of  
9 this act; and

10 (2) No facility shall lose or gain more than five dollars (\$5.00) in its total per diem rate the first  
11 year of the transition. The adjustment to the per diem loss or gain may be phased out by twenty-five  
12 percent (25%) each year; and

13 (3) The transition plan and/or period may be modified upon full implementation of facility per  
14 diem rate increases for quality of care related measures. Said modifications shall be submitted in a report  
15 to the general assembly at least six (6) months prior to implementation.

16 SECTION 2. *The Rhode Island Medicaid Reform Act of 2008.*

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

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

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

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

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

11           (a) *Nursing Facility Payment Rates – Eliminate Rate Increase.* The Medicaid single state agency  
12 proposes to eliminate the projected nursing facility rate increase that would otherwise take effect during  
13 the state fiscal year 2015. A category II change is required to implement this proposal under the terms and  
14 conditions of the demonstration. Further, this change may also require the adoption of new or amended  
15 rules, regulations and procedures.

16           (b) *Medicaid Hospital Payments – Eliminate Rate Increases for Hospital Inpatient and*  
17 *Outpatient Payments.* The Medicaid single state agency proposes to reduce inpatient and outpatient  
18 hospital payments by eliminating the projected rate increase for both managed care and fee-for-service for  
19 state fiscal year 2015. Also, the Medicaid single state agency proposes to eliminate the upper payment  
20 limit payment for outpatient services for this same period. A category II change is required to implement  
21 both aspects of this proposal under the terms and conditions of the Section 1115 waiver demonstration.

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



1 (d) *High Cost Care Review and Interventions – Lower Utilization and Cost.* By implementing an  
2 array of interventions providing intensive services and case management for Medicaid beneficiaries with  
3 chronic and disabling conditions and special health care needs, the Medicaid Agency proposes to reduce  
4 utilization of high cost services by certain children enrolled in RIte Care, children with special health care  
5 needs, and elders and adults with disabilities. Implementation of these interventions may require category  
6 II changes to the demonstration as well as adoption or amendment of rules, regulations and procedures.

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

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

23 (g) *Extended Family Planning Services – Enhanced federal funds.* The Medicaid agency sought  
24 Section 1115 demonstration waiver authority for any services and supports that are administered under  
25 current Rhode Island general laws to maximize Medicaid federal matching funds. This authority would  
26 provide enhanced Medicaid matching funds for family planning for uninsured and underinsured people

1 with income up to 250 percent of the federal poverty level. The adoption of new or amended rules and  
2 regulations may also be required.

3 (h) *Katie Beckett Eligibility Coverage – Cost Contribution.* Under current Medicaid rules and  
4 regulations, Medicaid beneficiaries receiving long-term services and supports are required to contribute to  
5 the cost of care based on income to the extent feasible. The Katie Beckett State Plan Option allows  
6 children who need an institutional level of care to obtain Medicaid coverage for the care they receive at  
7 home. Children eligible under this option typically have family income and resources that exceed  
8 Medicaid eligibility limits; though the Katie Beckett option enables these children to obtain Medicaid  
9 coverage by excluding their parents’ family income and resources when determining Medicaid eligibility.  
10 At present, the families of Katie Beckett children are not required to contribute to the cost of Medicaid-  
11 funded care, irrespective of income. The Medicaid agency proposes to implement an income-based, cost-  
12 sharing requirement for families with a Katie Beckett eligible child. Implementation of this requirement  
13 requires a Category II change to the Section 1115 waiver and new and amended rules, regulations and  
14 procedures.

15 (i) *Approved Authorities: Section 1115 Waiver Demonstration Extension.* The Medicaid agency  
16 proposes to implement authorities approved under the Section 1115 waiver demonstration extension  
17 request – formerly known as the Global Consumer Choice Waiver – that (1) continue efforts to re-  
18 balance the system of long term services and supports by assisting people in obtaining care in the most  
19 appropriate and least restrictive setting; (2) pursue utilization of care management models that offer a  
20 “health home”, promote access to preventive care, and provide an integrated system of services; (3) use  
21 payments and purchasing to finance and support Medicaid initiatives that fill gaps in the integrated  
22 system of care; and (4) recognize and assure access to the non-medical services and supports, such as  
23 peer navigation and employment and housing stabilization services, that are essential for optimizing a  
24 person’s health, wellness and safety and reduce or delay the need for long term services and supports.

25 (j) *Medicaid Requirements and Opportunities under the U.S. Patient Protection and Affordable*  
26 *Care Act of 2010 (PPACA).* The Medicaid agency proposes to pursue any requirements and/or

1 opportunities established under the PPACA that may warrant a Medicaid State Plan Amendment,  
2 category II or III change under the terms and conditions of Rhode Island's Section 1115 Waiver, its  
3 successor, or any extension thereof. Any such actions the Medicaid agency takes shall not have an  
4 adverse impact on beneficiaries or cause there to be an increase in expenditures beyond the amount  
5 appropriated for state fiscal year 2015; now, therefore, be it

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

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

12 SECTION 3. This article shall take effect upon passage.