ARTICLE 13

RELATING TO MEDICAL ASSISTANCE

SECTION 1. Sections 40-8-13.4, 40-8-15 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 ("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. For the twelve (12) month period beginning July 1, 2018, there will be no increase in the DRG base rate for Medicaid fee-for-service inpatient hospital rates. For the period beginning July 1, 2019, any rates adjusted for the Centers for Medicare and Medicaid Services National CMS Prospective Payment System Hospital Input Price Index will be applied to the payments made for FY 2019.

(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) For the twelve (12) month period beginning July 1, 2018, the Medicaid managed care inpatient payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2018. For the period beginning July 1, 2019, any rates adjusted for the Centers for Medicare and Medicaid Services National CMS Prospective Payment System Hospital Input Price Index will be applied to the payments made for FY 2019.

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; (E) All hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and (F) 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. 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. For the twelve (12) month period beginning July 1, 2018, the Medicaid managed care outpatient payment rates between each hospital and health plan shall not exceed the payments rates in effect as of January 1, 2018. For the period beginning July 1, 2019, any rates adjusted for the Centers for Medicare and Medicaid Services National CMS Prospective Payment System Hospital Input Price Index will be applied to the payments made for FY 2019.

(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 subdivisions (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, 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 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.

40-8-15. Lien on deceased recipient's estate for assistance.

(a)(1) Upon the death of a recipient of ~~medical assistance~~ Medicaid under Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et seq., (42 U.S.C. § 1396 et seq. and referred to hereinafter as the "Act"), the total sum ~~of medical assistance~~ for Medicaid benefits so paid on behalf of a ~~recipient~~ beneficiary who was fifty-five (55) years of age or older at the time of receipt ~~of the assistance~~ shall be and constitute a lien upon the estate, as defined in subdivision (a)(2) below, of the ~~recipient~~ beneficiary in favor of the executive office of health and human services ("executive

office"). The lien shall not be effective and shall not attach as against the estate of a ~~recipient~~ beneficiary who is survived by a spouse, or a child who is under the age of twenty-one (21), or a child who is blind or permanently and totally disabled as defined in Title XVI of the federal Social Security Act, 42 U.S.C. § 1381 et seq. The lien shall attach against property of a ~~recipient~~ beneficiary, which is included or includible in the decedent's probate estate, regardless of whether or not a probate proceeding has been commenced in the probate court by the executive office ~~of health and human services~~ or by any other party. Provided, however, that such lien shall only attach and shall only be effective against the ~~recipient's~~ beneficiary's real property included or includible in the ~~recipient's~~ beneficiary's probate estate if such lien is recorded in the land evidence records and is in accordance with subsection 40-8-15(f). Decedents who have received ~~medical assistance~~ Medicaid benefits are subject to the assignment and subrogation provisions of §§ 40-6-9 and 40-6-10.

(2) For purposes of this section, the term "estate" with respect to a deceased individual shall include all real and personal property and other assets included or includable within the individual's probate estate.

(b) The executive office ~~of health and human services~~ is authorized to promulgate regulations to implement the terms, intent, and purpose of this section and to require the legal representative(s) and/or the heirs-at-law of the decedent to provide reasonable written notice to the executive office ~~of health and human services~~ of the death of a ~~recipient~~ beneficiary of ~~medical assistance~~ Medicaid benefits who was fifty-five (55) years of age or older at the date of death, and to provide a statement identifying the decedent's property and the names and addresses of all persons entitled to take any share or interest of the estate as legatees or distributes thereof.

(c) The amount of ~~medical assistance~~ reimbursement for Medicaid benefits imposed under this section shall also become a debt to the state from the person or entity liable for the payment thereof.

(d) Upon payment of the amount of reimbursement for ~~medical assistance~~ Medicaid benefits imposed by this section, the secretary of the executive office ~~of health and human services~~, or his or her designee, shall issue a written discharge of lien.

(e) Provided, however, that no lien created under this section shall attach nor become effective upon any real property unless and until a statement of claim is recorded naming the debtor/owner of record of the property as of the date and time of recording of the statement of claim, and describing the real property by a description containing all of the following: (1) tax assessor's plat and lot; and (2) street address. The statement of claim shall be recorded in the records of land evidence in the town or city where the real property is situated. Notice of said lien shall be

sent to the duly appointed executor or administrator, the decedent's legal representative, if known, or to the decedent's next of kin or heirs at law as stated in the decedent's last application for ~~medical assistance~~ Medicaid benefits.

(f) The executive office ~~of health and human services~~ shall establish procedures, in accordance with the standards specified by the secretary, U.S. Department of Health and Human Services, under which the executive office ~~of health and human services~~ shall waive, in whole or in part, the lien and reimbursement established by this section if such lien and reimbursement would ~~work~~ cause an undue hardship, as determined by the executive office ~~of health and human services~~, on the basis of the criteria established by the secretary in accordance with 42 U.S.C. § 1396p(b)(3).

(g) Upon the filing of a petition for admission to probate of a decedent's will or for administration of a decedent's estate, when the decedent was fifty-five (55) years or older at the time of death, a copy of said petition and a copy of the death certificate shall be sent to the executive office ~~of health and human services~~. Within thirty (30) days of a request by the executive office ~~of health and human services~~, an executor or administrator shall complete and send to the executive office ~~of health and human services~~ a form prescribed by that office and shall provide such additional information as the office may require. In the event a petitioner fails to send a copy of the petition and a copy of the death certificate to the executive office ~~of health and human services~~ and a decedent has received ~~medical assistance~~ Medicaid benefits for which the executive office of ~~health and human services~~ is authorized to recover, no distribution and/or payments, including administration fees, shall be disbursed. Any person and /or entity that receive a distribution of assets from the decedent's estate shall be liable to the executive office ~~of health and human services~~ to the extent of such distribution.

(h) Compliance with the provisions of this section shall be consistent with the requirements set forth in § 33-11-5 and the requirements of the affidavit of notice set forth in § 33-11-5.2. Nothing in these sections shall limit the executive office ~~of health and human services~~ from recovery, to the extent of the distribution, in accordance with all state and federal laws.

(i) To assure the financial integrity of the Medicaid eligibility determination, benefit renewal, and estate recovery processes in this and related sections, the secretary of health and human services is authorized and directed to, by no later than August 1, 2018: (1), implement an automated asset verification system, as mandated by § 1940 of the of Act that uses electronic data sources to verify the ownership and value of countable resources held in financial institutions and any real property for applicants and beneficiaries subject to resource and asset tests pursuant in the Act in § 1902(e)(14)(D); (2) Apply the provisions required under §§ 1902(a)(18) and 1917(c) of the Act pertaining to the disposition of assets for less than fair market value by applicants and

beneficiaries for Medicaid long-term services and supports and their spouses, without regard to whether they are subject to or exempted from resources and asset tests as mandated by federal guidance; and (3) Pursue any state plan or waiver amendments from the U.S. Centers for Medicare and Medicaid Services and promulgate such rules, regulations, and procedures he or she deems necessary to carry out the requirements set forth herein and ensure the state plan and Medicaid policy conform and comply with applicable provisions Title XIX.

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 ("executive office") 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 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 occur on April 1, 2015. Beginning July 1, 2018, the rates paid to nursing facilities will be reduced by eight and one-half percent (8.5%) from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2017 for nine (9) months until March 2019, at which time the rates will revert to the

October 1, 2017 level and be increased by one percent (1%). Said inflation index shall be applied without regard for the transition ~~factor~~ factors in ~~subsection~~ subsections (b)(1) and (b)(2) below. For purposes of October 1, 2016, adjustment only, any rate increase that results from application of the inflation index to subparagraphs (a)(2)(i) and (a)(2)(ii) shall be dedicated to increase compensation for direct-care workers in the following manner: Not less than 85% of this aggregate amount shall be expended to fund an increase in wages, benefits, or related employer costs of direct-care staff of nursing homes. For purposes of this section, direct-care staff shall include registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), certified medical technicians, housekeeping staff, laundry staff, dietary staff, or other similar employees providing direct care services; provided, however, that this definition of direct-care staff shall not include: (i) RNs and LPNs who are classified as "exempt employees" under the Federal Fair Labor Standards Act (29 U.S.C. § 201 et seq.); or (ii) CNAs, certified medical technicians, RNs, or LPNs who are contracted, or subcontracted, through a third-party vendor or staffing agency. By July 31, 2017, nursing facilities shall submit to the secretary, or designee, a certification that they have complied with the provisions of this subparagraph (a)(2)(vi) with respect to the inflation index applied on October 1, 2016. Any facility that does not comply with terms of such certification shall be subjected to a clawback, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification.

(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; for the year beginning October 1, 2017, the reimbursement for direct-care costs under this provision will be phased out in twenty-five-percent (25%) increments each year until October 1, 2021, when the reimbursement will no longer be in effect. ~~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. An adjustment to the per diem loss or gain may be phased out by twenty-five percent (25%) each year; except, however, for the years beginning October 1, 2015, there shall be no adjustment to the per diem gain or loss, but the phase out shall resume thereafter; 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, Medicaid payment rates for nursing facilities established pursuant to this section shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.

SECTION 2. Sections 40-8.3-2 and 40-8.3-3 of the General Laws in Chapter 40-8.3 entitled "Uncompensated Care" are hereby amended to read as follows:

40-8.3-2. Definitions.

As used in this chapter:

(1) "Base year" means, for the purpose of calculating a disproportionate share payment for any fiscal year ending after September 30, ~~2016~~ 2017, the period from October 1, ~~2014~~ 2015, through September 30, ~~2015~~ 2016, and for any fiscal year ending after September 30, ~~2017~~ 2018, the period from October 1, ~~2015~~ 2016, through September 30, ~~2016~~ 2017.

(2) "Medicaid inpatient utilization rate for a hospital" means a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days during the base year attributable to patients who were eligible for medical assistance during the base year and the denominator of which is the total number of the hospital's inpatient days in the base year.

(3) "Participating hospital" means any nongovernment and nonpsychiatric hospital that:

(i) Was licensed as a hospital in accordance with chapter 17 of title 23 during the base year and 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 negotiated 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 newly negotiated 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 newly negotiated rate. The rate-setting methodology for inpatient hospital payments and outpatient hospital payments set forth in §§ 40-8-13.4(b)(1)(ii)(C) and 40-8-13.4(b)(2), respectively, shall thereafter apply to negotiated 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.

(ii) Achieved a medical assistance inpatient utilization rate of at least one percent (1%) during the base year; and

(iii) Continues to be licensed as a hospital in accordance with chapter 17 of title 23 during the payment year.

(4) "Uncompensated-care costs" means, as to any hospital, the sum of: (i) The cost incurred by such hospital during the base year for inpatient or outpatient services attributable to charity care (free care and bad debts) for which the patient has no health insurance or other third-party coverage less payments, if any, received directly from such patients; and (ii) The cost incurred by such hospital during the base year for inpatient or out-patient services attributable to Medicaid beneficiaries less any Medicaid reimbursement received therefor; multiplied by the uncompensated care index.

(5) "Uncompensated-care index" means the annual percentage increase for hospitals established pursuant to § 27-19-14 for each year after the base year, up to and including the payment year; provided, however, that the uncompensated-care index for the payment year ending September 30, 2007, shall be deemed to be five and thirty-eight hundredths percent (5.38%), and that the uncompensated-care index for the payment year ending September 30, 2008, shall be deemed to be five and forty-seven hundredths percent (5.47%), and that the uncompensated-care index for the payment year ending September 30, 2009, shall be deemed to be five and thirty-eight hundredths percent (5.38%), and that the uncompensated-care index for the payment years ending September 30, 2010, September 30, 2011, September 30, 2012, September 30, 2013, September 30, 2014, September 30, 2015, September 30, 2016, September 30, 2017, and September 30, 2018, shall be deemed to be five and thirty hundredths percent (5.30%).

40-8.3-3. Implementation.

~~(a) For federal fiscal year 2016, commencing on October 1, 2015, and ending September 30, 2016, the executive office of health and human services shall submit to the Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:~~

~~(1) That the disproportionate share hospital payments to all participating hospitals, not to exceed an aggregate limit of $138.2 million, shall be allocated by the executive office of health and human services to the Pool A, Pool C, and Pool D components of the DSH Plan; and,~~

~~(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual, participating hospital's uncompensated care costs for the base year,~~

~~inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by uncompensated-care index for all participating hospitals. The DSH Plan shall be made on or before July 11, 2016, and are expressly conditioned upon approval on or before July 5, 2016, by the Secretary of the U.S. Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2016 for the DSH Plan.~~

~~(b)~~(a) For federal fiscal year 2017, commencing on October 1, 2016, and ending September 30, 2017, the executive office of health and human services shall submit to the Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $139.7 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and,

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual, participating hospital's uncompensated-care costs for the base year, inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by uncompensated-care index for all participating hospitals. The disproportionate-share payments shall be made on or before July 11, 2017, and are expressly conditioned upon approval on or before July 5, 2017, by the Secretary of the U.S. Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2017 for the disproportionate share payments.

(c) for federal fiscal year 2019, commencing on October 1, 2018 and ending September 30, 2019, the executive office of health and human services shall submit to the Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $139.7 million, shall be allocated by the executive office of health and human services to Pool D component of the DSH Plan; and

(2) That the Pool D allotment shall be distributed among the participating hospitals in director proportion to the individual participating hospital's uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year inflated by uncompensated care index for all participating hospitals. The disproportionate share payments shall be made on or before July 10, 2019 and are expressly conditioned upon

approval on or before July 5, 2019 by the Secretary of U.S. Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2018 for the disproportionate share payments.

~~(c)~~(d) For federal fiscal year 2018, commencing on October 1, 2017, and ending September 30, 2018, the executive office of health and human services shall submit to the Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $138.6 million, shall be allocated by the executive office of health and human services to Pool D component of the DSH Plan; and,

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year inflated by uncompensated care index for all participating hospitals. The disproportionate share payments shall be made on or before July 10, 2018, and are expressly conditioned upon approval on or before July 5, 2018, by the Secretary of the U.S. Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2018 for the disproportionate share payments.

~~(d)~~(e) No provision is made pursuant to this chapter for disproportionate-share hospital payments to participating hospitals for uncompensated-care costs related to graduate medical education programs.

~~(e)~~(f) The executive office of health and human services is directed, on at least a monthly basis, to collect patient-level uninsured information, including, but not limited to, demographics, services rendered, and reason for uninsured status from all hospitals licensed in Rhode Island.

~~(f)~~(g) Beginning with federal FY 2016, Pool D DSH payments will be recalculated by the state based on actual hospital experience. The final Pool D payments will be based on the data from the final DSH audit for each federal fiscal year. Pool D DSH payments will be redistributed among the qualifying hospitals in direct proportion to the individual, qualifying hospital's uncompensated-care to the total uncompensated-care costs for all qualifying hospitals as determined by the DSH audit. No hospital will receive an allocation that would incur funds received in excess of audited uncompensated-care costs.

SECTION 3. Section 40-8.4-12 of the General Laws in Chapter 40-8.4 entitled “Health

Care for Families" is hereby amended to read as follows:

40-8.4-12. RIte Share Health Insurance Premium Assistance Program.

(a) Basic RIte Share Health Insurance Premium Assistance Program. ~~The office of health and human services is authorized and directed to amend the medical assistance Title XIX state plan to implement the provisions of section 1906 of Title XIX of the Social Security Act, 42 U.S.C. section 1396e, and establish the Rhode Island health insurance premium assistance program for RIte Care eligible families with incomes up to two hundred fifty percent (250%) of the federal poverty level who have access to employer-based health insurance. The state plan amendment shall require eligible families with access to employer-based health insurance to enroll themselves and/or their family in the employer-based health insurance plan as a condition of participation in the RIte Share program under this chapter and as a condition of retaining eligibility for medical assistance under chapters 5.1 and 8.4 of this title and/or chapter 12.3 of title 42 and/or premium assistance under this chapter, provided that doing so meets the criteria established in section 1906 of Title XIX for obtaining federal matching funds and the department has determined that the person's and/or the family's enrollment in the employer-based health insurance plan is cost-effective and the department has determined that the employer-based health insurance plan meets the criteria set forth in subsection (d). The department shall provide premium assistance by paying all or a portion of the employee's cost for covering the eligible person or his or her family under the employer-based health insurance plan, subject to the cost-sharing provisions in subsection (b), and provided that the premium assistance is cost-effective in accordance with Title XIX, 42 U.S.C. section 1396 et seq.~~ Under the terms of Section 1906 of Title XIX of the U.S. Social Security Act, states are permitted to pay a Medicaid eligible person's share of the costs for enrolling in employer-sponsored health insurance (ESI) coverage if it is cost effective to do so. Pursuant to general assembly's direction in Rhode Island Health Reform Act of 2000, the Medicaid agency requested and obtained federal approval under § 1916 to establish the RIte Share premium assistance program to subsidize the costs of enrolling Medicaid eligible persons and families in employer sponsored health insurance plans that have been approved as meeting certain cost and coverage requirements. The Medicaid agency also obtained, at the general assembly's direction, federal authority to require any such persons with access to ESI coverage to enroll as a condition of retaining eligibility providing that doing so meets the criteria established in Title XIX for obtaining federal matching funds.

(b) ~~Individuals who can afford it shall share in the cost. The office of health and human services is authorized and directed to apply for and obtain any necessary waivers from the secretary of the United States Department of Health and Human Services, including, but not limited to, a waiver of the appropriate sections of Title XIX, 42 U.S.C. section 1396 et seq., to require that~~

~~families eligible for RIte Care under this chapter or chapter 12.3 of title 42 with incomes equal to or greater than one hundred fifty percent (150%) of the federal poverty level pay a share of the costs of health insurance based on the person's ability to pay, provided that the cost sharing shall not exceed five percent (5%) of the person's annual income. The department of human services shall implement the cost sharing by regulation, and shall consider co-payments, premium shares or other reasonable means to do so.~~ Definitions. For the purposes of this subsection, the following definitions apply:

(1) "Cost-effective" means that the portion of the ESI that the state would subsidize, as well as wrap-around costs, would on average cost less to the State than enrolling that same person/family in a managed care delivery system.

(2) "Cost sharing" means any co-payments, deductibles or co-insurance associated with ESI.

(3) "Employee premium" means the monthly premium share a person or family is required to pay to the employer to obtain and maintain ESI coverage.

(4) "Employer-Sponsored Insurance or ESI" means health insurance or a group health plan offered to employees by an employer. This includes plans purchased by small employers through the State health insurance marketplace, Healthsource, RI (HSRI).

(5) "Policy holder" means the person in the household with access to ESI, typically the employee.

(6) "RIte Share-approved employer-sponsored insurance (ESI)" means an employer-sponsored health insurance plan that meets the coverage and cost-effectiveness criteria for RIte Share.

(7) "RIte Share buy-in" means the monthly amount an Medicaid-ineligible policy holder must pay toward RIte Share-approved ESI that covers the Medicaid-eligible children, young adults or spouses with access to the ESI. The buy-in only applies in instances when household income is above one hundred fifty percent (150%) the FPL.

(8) "RIte Share premium assistance program" means the Rhode Island Medicaid premium assistance program in which the State pays the eligible Medicaid member's share of the cost of enrolling in a RIte Share-approved ESI plan. This allows the State to share the cost of the health insurance coverage with the employer.

(9) "RIte Share Unit" means the entity within EOHHS responsible for assessing the cost-effectiveness of ESI, contacting employers about ESI as appropriate, initiating the RIte Share enrollment and disenrollment process, handling member communications, and managing the overall operations of the RIte Share program.

(10) "Third-Party Liability (TPL)" means other health insurance coverage. This insurance is in addition to Medicaid and is usually provided through an employer. Since Medicaid is always the payer of last resort, the TPL is always the primary coverage.

(11) "Wrap-around services or coverage" means any health care services not included in the ESI plan that would have been covered had the Medicaid member been enrolled in a RIte Care or Rhody Health Partners plan. Coverage of deductibles and co-insurance is included in the wrap. Co-payments to providers are not covered as part of the wrap-around coverage.

(c) ~~Current RIte Care enrollees with access to employer-based health insurance. The office of health and human services shall require any family who receives RIte Care or whose family receives RIte Care on the effective date of the applicable regulations adopted in accordance with subsection (f) to enroll in an employer-based health insurance plan at the person's eligibility redetermination date or at an earlier date determined by the department, provided that doing so meets the criteria established in the applicable sections of Title XIX, 42 U.S.C. section 1396 et seq., for obtaining federal matching funds and the department has determined that the person's and/or the family's enrollment in the employer-based health insurance plan is cost-effective and has determined that the health insurance plan meets the criteria in subsection (d). The insurer shall accept the enrollment of the person and/or the family in the employer-based health insurance plan without regard to any enrollment season restrictions.~~ RIte Share Populations. Medicaid beneficiaries subject to RIte Share include: children, families, parent and caretakers eligible for Medicaid or the Children's Health Insurance Program under this chapter or chapter 12.3 of title 42; and adults between the ages of nineteen (19) and sixty-four (64) who are eligible under chapter 8.12 of title 40, not receiving or eligible to receive Medicare, and are enrolled in managed care delivery systems. The following conditions apply:

(1) The income of Medicaid beneficiaries shall affect whether and in what manner they must participate in RIte Share as follows:

(i) Income at or below one hundred fifty percent (150%) of FPL -- Persons and families determined to have household income at or below one hundred fifty percent (150%) of the Federal Poverty Level (FPL) guidelines based on the modified adjusted gross income (MAGI) standard or other standard approved by the secretary are required to participate in RIte Share if a Medicaid-eligible adult or parent/caretaker has access to cost-effective ESI. Enrolling in ESI through RIte Share shall be a condition of maintaining Medicaid health coverage for any eligible adult with access to such coverage.

(ii) Income above one hundred fifty percent (150%) FPL and policy holder is not Medicaid-eligible -- Premium assistance is available when the household includes Medicaid-eligible

members, but the ESI policy holder (typically a parent/ caretaker or spouse) is not eligible for Medicaid. Premium assistance for parents/caretakers and other household members who are not Medicaid-eligible may be provided in circumstances when enrollment of the Medicaid-eligible family members in the approved ESI plan is contingent upon enrollment of the ineligible policy holder and the executive office of health and human services (executive office) determines, based on a methodology adopted for such purposes, that it is cost-effective to provide premium assistance for family or spousal coverage.

(d) RIte Share Enrollment as a Condition of Eligibility. For Medicaid beneficiaries over the age of nineteen (19) enrollment in RIte Share shall be a condition of eligibility except as exempted below and by regulations promulgated by the executive office.

(1) Medicaid-eligible children and young adults up to age nineteen (19) shall not be required to enroll in a parent/caretaker relative's ESI as a condition of maintaining Medicaid eligibility if the person with access to RIte Share-approved ESI does not enroll as required. These Medicaid-eligible children and young adults shall remain eligible for Medicaid and shall be enrolled in a RIte Care plan

(2) There shall be a limited six (6) month exemption from the mandatory enrollment requirement for persons participating in the RI Works program pursuant to chapter 5.2 of title 40.

~~(d)~~ (e) Approval of health insurance plans for premium assistance. The office of health and human services shall adopt regulations providing for the approval of employer-based health insurance plans for premium assistance and shall approve employer-based health insurance plans based on these regulations. In order for an employer-based health insurance plan to gain approval, the ~~department~~ executive office must determine that the benefits offered by the employer-based health insurance plan are substantially similar in amount, scope, and duration to the benefits provided to ~~RIte Care~~ Medicaid-eligible persons ~~by the RIte Care program~~ enrolled in Medicaid managed care plan, when the plan is evaluated in conjunction with available supplemental benefits provided by the office. The office shall obtain and make available as sto persons otherwise eligible for ~~RIte Care~~ Medicaid identified in this section as supplemental benefits those benefits not reasonably available under employer-based health insurance plans which are required for ~~RIte Care eligible persons~~ Medicaid beneficiaries by state law or federal law or regulation. Once it has been determined by the Medicaid agency that the ESI offered by a particular employer is RIte Share-approved, all Medicaid members with access to that employer's plan are required participate in RIte Share. Failure to meet the mandatory enrollment requirement shall result in the termination of the Medicaid eligibility of the policy holder and other Medicaid members nineteen (19) or older in the household that could be covered under the ESI until the policy holder complies with the RIte Share

enrollment procedures established by the executive office.

(f) Premium Assistance. The executive office shall provide premium assistance by paying all or a portion of the employee's cost for covering the eligible person and/or his or her family under such a RIte Share-approved ESI plan subject to the buy-in provisions in this section.

(g) Buy-in. Persons who can afford it shall share in the cost. - The executive office is authorized and directed to apply for and obtain any necessary state plan and/or waiver amendments from the secretary of the U.S. DHHS to require that person enrolled in a RIte Share-approved employer-based health plan who have income equal to or greater than one hundred fifty percent (150%) of the FPL to buy-in to pay a share of the costs based on the ability to pay, provided that the buy-in cost shall not exceed five percent (5%) of the person's annual income. The executive office shall implement the buy-in by regulation, and shall consider co-payments, premium shares or other reasonable means to do so.

~~(e)~~ (h) Maximization of federal contribution. The office of health and human services is authorized and directed to apply for and obtain federal approvals and waivers necessary to maximize the federal contribution for provision of medical assistance coverage under this section, including the authorization to amend the Title XXI state plan and to obtain any waivers necessary to reduce barriers to provide premium assistance to recipients as provided for in Title XXI of the Social Security Act, 42 U.S.C. section 1397 et seq.

~~(f)~~ (i) Implementation by regulation. The office of health and human services is authorized and directed to adopt regulations to ensure the establishment and implementation of the premium assistance program in accordance with the intent and purpose of this section, the requirements of Title XIX, Title XXI and any approved federal waivers.

SECTION 4. Section 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical Assistance - Long-Term Care Service and Finance Reform" is hereby amended to read as follows:

40-8.9-9. Long-term care rebalancing system reform goal.

(a) Notwithstanding any other provision of state law, the executive office of health and human services is authorized and directed to apply for, and obtain, any necessary waiver(s), waiver amendment(s), and/or state-plan amendments from the secretary of the United States Department of Health and Human Services, and to promulgate rules necessary to adopt an affirmative plan of program design and implementation that addresses the goal of allocating a minimum of fifty percent (50%) of Medicaid long-term care funding for persons aged sixty-five (65) and over and adults with disabilities, in addition to services for persons with developmental disabilities, to home- and community-based care; provided, further, the executive office shall report annually as part of its budget submission, the percentage distribution between institutional care and home- and

community-based care by population and shall report current and projected waiting lists for long-term care and home- and community-based care services. The executive office is further authorized and directed to prioritize investments in home- and community-based care and to maintain the integrity and financial viability of all current long-term-care services while pursuing this goal.

(b) The reformed long-term-care system rebalancing goal is person-centered and encourages individual self-determination, family involvement, interagency collaboration, and individual choice through the provision of highly specialized and individually tailored home-based services. Additionally, individuals with severe behavioral, physical, or developmental disabilities must have the opportunity to live safe and healthful lives through access to a wide range of supportive services in an array of community-based settings, regardless of the complexity of their medical condition, the severity of their disability, or the challenges of their behavior. Delivery of services and supports in less costly and less restrictive community settings, will enable children, adolescents, and adults to be able to curtail, delay, or avoid lengthy stays in long-term care institutions, such as behavioral health residential-treatment facilities, long-term-care hospitals, intermediate-care facilities and/or skilled nursing facilities.

(c) Pursuant to federal authority procured under § 42-7.2-16, the executive office of health and human services is directed and authorized to adopt a tiered set of criteria to be used to determine eligibility for services. Such criteria shall be developed in collaboration with the state's health and human services departments and, to the extent feasible, any consumer group, advisory board, or other entity designated for such purposes, and shall encompass eligibility determinations for long-term-care services in nursing facilities, hospitals, and intermediate-care facilities for persons with intellectual disabilities, as well as home- and community-based alternatives, and shall provide a common standard of income eligibility for both institutional and home- and community-based care. The executive office is authorized to adopt clinical and/or functional criteria for admission to a nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities that are more stringent than those employed for access to home- and community-based services. The executive office is also authorized to promulgate rules that define the frequency of re-assessments for services provided for under this section. Levels of care may be applied in accordance with the following:

(1) The executive office shall continue to apply the level of care criteria in effect on June 30, 2015, for any recipient determined eligible for and receiving Medicaid-funded, long-term services in supports in a nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities on or before that date, unless:

(a) The recipient transitions to home- and community-based services because he or she

would no longer meet the level of care criteria in effect on June 30, 2015; or

(b) The recipient chooses home- and community-based services over the nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities. For the purposes of this section, a failed community placement, as defined in regulations promulgated by the executive office, shall be considered a condition of clinical eligibility for the highest level of care. The executive office shall confer with the long-term-care ombudsperson with respect to the determination of a failed placement under the ombudsperson's jurisdiction. Should any Medicaid recipient eligible for a nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities as of June 30, 2015, receive a determination of a failed community placement, the recipient shall have access to the highest level of care; furthermore, a recipient who has experienced a failed community placement shall be transitioned back into his or her former nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities whenever possible. Additionally, residents shall only be moved from a nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities in a manner consistent with applicable state and federal laws.

(2) Any Medicaid recipient eligible for the highest level of care who voluntarily leaves a nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities shall not be subject to any wait list for home- and community-based services.

(3) No nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities shall be denied payment for services rendered to a Medicaid recipient on the grounds that the recipient does not meet level of care criteria unless and until the executive office has:

(i) Performed an individual assessment of the recipient at issue and provided written notice to the nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities that the recipient does not meet level of care criteria; and

(ii) The recipient has either appealed that level of care determination and been unsuccessful, or any appeal period available to the recipient regarding that level of care determination has expired.

(d) The executive office is further authorized to consolidate all home- and community-based services currently provided pursuant to 42 U.S.C. § 1396n into a single system of home- and community-based services that include options for consumer direction and shared living. The resulting single home- and community-based services system shall replace and supersede all 42 U.S.C. § 1396n programs when fully implemented. Notwithstanding the foregoing, the resulting single program home- and community-based services system shall include the continued funding of assisted-living services at any assisted-living facility financed by the Rhode Island housing and

mortgage finance corporation prior to January 1, 2006, and shall be in accordance with chapter 66.8 of title 42 of the general laws as long as assisted-living services are a covered Medicaid benefit.

(e) The executive office is authorized to promulgate rules that permit certain optional services including, but not limited to, homemaker services, home modifications, respite, and physical therapy evaluations to be offered to persons at risk for Medicaid-funded, long-term care subject to availability of state-appropriated funding for these purposes.

(f) To promote the expansion of home- and community-based service capacity, the executive office is authorized to pursue payment methodology reforms that increase access to homemaker, personal care (home health aide), assisted living, adult supportive-care homes, and adult day services, as follows:

(1) Development of revised or new Medicaid certification standards that increase access to service specialization and scheduling accommodations by using payment strategies designed to achieve specific quality and health outcomes.

(2) Development of Medicaid certification standards for state-authorized providers of adult-day services, excluding such providers of services authorized under § 40.1-24-1(3), assisted living, and adult supportive care (as defined under chapter 17.24 of title 23) that establish for each, an acuity-based, tiered service and payment methodology tied to: licensure authority; level of beneficiary needs; the scope of services and supports provided; and specific quality and outcome measures.

The standards for adult-day services for persons eligible for Medicaid-funded, long-term services may differ from those who do not meet the clinical/functional criteria set forth in § 40-8.10-3.

(3) As the state's Medicaid program seeks to assist more beneficiaries requiring long-term services and supports in home- and community-based settings, the demand for home care workers has increased, and wages for these workers has not kept pace with neighboring states, leading to high turnover and vacancy rates in the state's home-care industry, the executive office shall institute a one-time increase in the base-payment rates for home-care service providers to promote increased access to and an adequate supply of highly trained home health care professionals, in amount to be determined by the appropriations process, for the purpose of raising wages for personal care attendants and home health aides to be implemented by such providers.

(4) A prospective base adjustment, effective not later than July 1, 2018, of ten percent (10%) of the current base rate for home care providers, home nursing care providers, and hospice providers contracted with the executive office of health and human services and its subordinate agencies to deliver Medicaid fee-for-service personal care attendant services.

(5) A prospective base adjustment, effective not later than July l, 2018, of twenty percent (20%) of the current base rate for home care providers, home nursing care providers, and hospice providers contracted with the executive office of health and human services and its subordinate agencies to deliver Medicaid fee-for-service skilled nursing and therapeutic services and hospice care.

(6) On the first of July in each year, beginning on July l, 2019, the executive office of health and human services will initiate an annual inflation increase to the base rate by a percentage amount equal to the change in cost inflation by the rate as determined by the United States Department of Labor Consumer Price Index card rate for medical care in New England and for compliance with all federal and state laws, regulations, and rules, and all national accreditation program requirements.

(g) The executive office shall implement a long-term-care options counseling program to provide individuals, or their representatives, or both, with long-term-care consultations that shall include, at a minimum, information about: long-term-care options, sources, and methods of both public and private payment for long-term-care services and an assessment of an individual's functional capabilities and opportunities for maximizing independence. Each individual admitted to, or seeking admission to, a long-term-care facility, regardless of the payment source, shall be informed by the facility of the availability of the long-term-care options counseling program and shall be provided with long-term-care options consultation if they so request. Each individual who applies for Medicaid long-term-care services shall be provided with a long-term-care consultation.

(h) The executive office is also authorized, subject to availability of appropriation of funding, and federal, Medicaid-matching funds, to pay for certain services and supports necessary to transition or divert beneficiaries from institutional or restrictive settings and optimize their health and safety when receiving care in a home or the community. The secretary is authorized to obtain any state plan or waiver authorities required to maximize the federal funds available to support expanded access to such home- and community-transition and stabilization services; provided, however, payments shall not exceed an annual or per-person amount.

(i) To ensure persons with long-term-care needs who remain living at home have adequate resources to deal with housing maintenance and unanticipated housing-related costs, the secretary is authorized to develop higher resource eligibility limits for persons or obtain any state plan or waiver authorities necessary to change the financial eligibility criteria for long-term services and supports to enable beneficiaries receiving home and community waiver services to have the resources to continue living in their own homes or rental units or other home-based settings.

(j) The executive office shall implement, no later than January 1, 2016, the following home-

and community-based service and payment reforms:

(1) Community-based, supportive-living program established in § 40-8.13-12;

(2) Adult day services level of need criteria and acuity-based, tiered-payment methodology; and

(3) Payment reforms that encourage home- and community-based providers to provide the specialized services and accommodations beneficiaries need to avoid or delay institutional care.

(k) The secretary is authorized to seek any Medicaid section 1115 waiver or state-plan amendments and take any administrative actions necessary to ensure timely adoption of any new or amended rules, regulations, policies, or procedures and any system enhancements or changes, for which appropriations have been authorized, that are necessary to facilitate implementation of the requirements of this section by the dates established. The secretary shall reserve the discretion to exercise the authority established under §§ 42-7.2-5(6)(v) and 42-7.2-6.1, in consultation with the governor, to meet the legislative directives established herein.

SECTION 5. Section 40.1-21-4 of the General Laws in Chapter 40.1-21 entitled "Division of Developmental Disabilities" is hereby amended to read as follows:

40.1-21-4. Powers and duties of director of behavioral healthcare, developmental disabilities and hospitals.

(a) The director of behavioral healthcare, developmental disabilities and hospitals shall be responsible for planning and developing a complete, comprehensive, and integrated statewide program for the developmentally disabled for the implementation of the program; and for the coordination of the efforts of the department of behavioral healthcare, developmental disabilities and hospitals with those of other state departments and agencies, municipal governments as well as the federal government and private agencies concerned with and providing services for the developmentally disabled.

(b) The director shall be responsible for the administration and operation of all state operated community and residential facilities established for the diagnosis, care, and training of the developmentally disabled. The director shall be responsible for establishing standards in conformance with generally accepted professional thought and for providing technical assistance to all state supported and licensed habilitative, developmental, residential and other facilities for the developmentally disabled, and exercise the requisite surveillance and inspection to insure compliance with standards. Provided, however, that none of the foregoing shall be applicable to any of the facilities wholly within the control of any other department of state government.

(c) The director of behavioral healthcare, developmental disabilities and hospitals shall stimulate research by public and private agencies, institutions of higher learning, and hospitals, in

the interest of the elimination and amelioration of developmental disabilities, and care and training of the developmentally disabled.

(d) The director shall be responsible for the development of criteria as to the eligibility for admittance of any developmentally disabled person for residential care in any department supported and licensed residential facility or agency.

(e) The director of behavioral healthcare, developmental disabilities and hospitals may transfer retarded persons from one state residential facility to another when deemed necessary or desirable for their better care and welfare.

(f) The director of behavioral healthcare, developmental disabilities and hospitals shall make grants-in-aid and otherwise provide financial assistance to the various communities and private nonprofit agencies, in amounts which will enable all developmentally disabled adults to receive developmental and other services appropriate to their individual needs.

(g) The director shall coordinate all planning for the construction of facilities for the developmentally disabled, and the expenditure of funds appropriated or otherwise made available to the state for this purpose.

(h) To ensure individuals eligible for services under § 40.1-21-43 receive the appropriate medical benefits through the Executive Office of Health and Human Services' Medicaid program, the director, or designee, will work in coordination with the Medicaid program to determine if an individual is eligible for long-term care services and supports and that he or she has the option to enroll in the Medicaid program that offers these services. As part of the monthly reporting requirements, the Department will indicate how many individuals have declined enrollment in a managed care plan that offers these long-term care services.

SECTION 6. Title 42 of the General Laws entitled "STATE AFFAIRS AND GOVERNMENT" is hereby amended by adding thereto the following chapter:

CHAPTER 66.12

THE RHODE ISLAND AGING AND DISABILITY RESOURCE CENTER

42-66.12-1. Short title.

This chapter shall be known and may be cited as the "The Rhode Island Aging and Disability Resource Center Act".

42-66.12-2. Purpose.

To assist Rhode Islanders and their families in making informed choices and decisions about long-term service and support options and to streamline access to long-term supports and services for older adults, persons with disabilities, family caregivers and providers, a statewide aging and disability resource center shall be maintained. The Rhode Island aging and disability

resource center (ADRC) is a state multi-agency effort. It consists of a centrally operated, coordinated system of information, referral and options counseling for all persons seeking long-term supports and services in order to enhance individual choice, foster informed decision-making and minimize confusion and duplication.

42-66.12-3. Aging and disability resource center established.

The Rhode Island aging and disability resource center (ADRC) shall be established and operated by the department of human services, division of elderly affairs (DEA) in collaboration with other agencies within the executive office of health and human services. The division of elderly affairs shall build on its experience in development and implementation of the current ADRC program. The ADRC is an integral part of the Rhode Island system of long-term supports and services working to promote the state's long-term system rebalancing goals by diverting persons, when appropriate, from institutional care to home and community-based services and preventing short-term institutional stays from becoming permanent through options counseling and screening for eligibility for home and community-based services.

42-66.12-4. Aging and disability resource center service directives.

(a) The aging and disability resource center (ADRC) shall provide for the following:

(l) A statewide toll-free ADRC information number available during business hours with a messaging system to respond to after-hours calls during the next business day and language services to assist individuals with limited English language skills;

(2) A comprehensive database of information, updated on a regular basis and accessible through a dedicated website, on the full range of available public and private long-term support and service programs, service providers and resources within the state and in specific communities, including information on housing supports, transportation and the availability of integrated long-term care;

(3) Personal options counseling, including implementing provisions required in § 40-8.9-9, to assist individuals in assessing their existing or anticipated long-term care needs, and assisting them to develop and implement a plan designed to meet their specific needs and circumstances;

(4) A means to link callers to the ADRC information line to interactive long-term care screening tools and to make these tools available through the ADRC website by integrating the tools into the website;

(5) Development of partnerships, through memorandum agreements or other arrangements, with other entities serving older adults and persons with disabilities, including those working on nursing home transition and hospital discharge programs, to assist in maintaining and providing ADRC services; and

(6) Community education and outreach activities to inform persons about the ADRC services, in finding information through the Internet and in planning for future long-term care needs including housing and community service options.

SECTION 7. Section 15 of Article 5 of Chapter 141 of the Public Laws of 2015 is hereby amended to read as follows:

A pool is hereby established of up to ~~$4.0 million~~ $5.0 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 $5 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 made annually.

SECTION 8. Rhode Island Medicaid Reform Act of 2008 Resolution.

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

WHEREAS, a legislative enactment is required pursuant to Rhode Island General Laws 42-12.4-1, *et seq.*; and

WHEREAS, Rhode Island General Law 42-7.2-5(3)(a) provides that the Secretary of the Executive Office of Health and Human Services (“Executive Office”) is responsible for the review and coordination of any Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or category II or III changes as described in the demonstration, “with potential to affect the scope, amount, or duration of publicly-funded health care services, provider payments or reimbursements, or access to or the availability of benefits and services provided by Rhode Island general and public laws”; and

WHEREAS, in pursuit of a more cost-effective consumer choice system of care that is fiscally sound and sustainable, the Secretary requests legislative approval of the following

proposals to amend the demonstration:

(a) *Provider Rates -- Adjustments.* The Executive Office proposes to:

(i) Maintain in-patient and out-patient hospital payment rates at SFY 2018 levels.

(ii) The nursing facility rate adjustment that would otherwise take-effect on October 1, 2018 will not exceed an increase of one percent; and

(iii) Reduce the administrative component of ~~rates for~~ Medicaid managed care plan rates ~~administration~~.

(iv) Reduce the medical component of Medicaid managed care plan rates.

Implementation of adjustments may require amendments to the Rhode Island's Medicaid State Plan and/or Section 1115 waiver under the terms and conditions of the demonstration. Further, adoption of new or amended rules, regulations and procedures may also be required.

(b) *Section 1115 Demonstration Waiver – Implementation of Existing Authorities.* To achieve the objectives of the State's demonstration waiver, the Executive Office proposes to implement the following approved authorities:

(i) Expanded expedited eligibility for long-term services and supports (LTSS) applicants who are transitioning to a home or community-based setting from a health facility, including a hospital or nursing home; and

(ii) Institute the multi-tiered needs-based criteria for determining the level of care and scope of services available to applicants with developmental disabilities seeking Medicaid home and community-based services in lieu of institutional care.

(c) *Section 1115 Demonstration Waiver – Extension Request* – The Executive Office proposes to seek approval from our federal partners to extend the Section 1115 demonstration as authorized in §42-12.4. In addition to maintaining existing waiver authorities, the Executive Office proposes to seek additional federal authorities to:

(i) Further the goals of LTSS rebalancing set forth in §40-8.9, by expanding the array of health care stabilization and maintenance services eligible for federal financial participation which are available to beneficiaries residing in home and community-based settings. Such services include adaptive and home-based monitoring technologies, transition help, and peer and personal supports that assist beneficiaries in better managing and optimizing their own care. The Executive Office proposes to pursue alternative payment strategies financed through the Health System Transformation Project (HSTP) to cover the state's share of the cost for such services and to expand on-going efforts to identify and provide cost-effective preventive services to persons at-risk for LTSS and other high cost interventions.

(ii) Leverage existing resources and the flexibility of alternative payment methodologies

to provide integrated medical and behavioral services to children and youth at risk and in transition, including targeted family visiting nurses, peer supports, and specialized networks of care.

(iii) Establish authority to provide Medicaid coverage to children who require residential care who by themselves would meet the Supplemental Security Income Disability standards but could not receive the cash benefit due to family income and resource limits and who would otherwise be placed in state custody.

(d) *Financial Integrity – Asset Verification and Transfers.* To comply with federal mandates pertaining to the integrity of the determination of eligibility and estate recoveries, the Executive Office plans to adopt an automated asset verification system which uses electronic data sources to verify ownership and the value of the financial resources and real property of applicants and beneficiaries and their spouses who are subject to asset and resource limits under Title XIX. In addition, the Executive Office proposes to adopt new or amended rules, policies and procedures for LTSS applicants and beneficiaries, inclusive of those eligible pursuant to §40-8.12, that conform to federal guidelines related to the transfer of assets for less than fair market value established in Title XIX and applicable federal guidelines. State plan amendments are required to comply fully with these mandates.

(e) *Service Delivery.* To better leverage all available health care dollars and promote access and service quality, the Executive Office proposes to:

(i) Restructure delivery systems for dual Medicare and Medicaid eligible LTSS beneficiaries who have chronic or disabling conditions to provide the foundation for implementing more cost-effective and sustainable managed care LTSS arrangements. Additional state plan authorities may be required.

(ii) Expand the reach of the RIte Share premium assistance program through amendments to the Medicaid state plan to cover ~~all~~ non-disabled adults, ages 19 and older, who have access to a cost-effective Executive Office approved employer-sponsored health insurance program.

(f) *Non-Emergency Transportation Program (NEMT).* To implement cost effective delivery of services and to enhance consumer satisfaction with transportation services by:

(i) Expanding reimbursement methodologies; and

(ii) Removing transportation restrictions to align with Title XIX of Federal law.

(g) *Community First Choice (CFC).* To seek Medicaid state plan and any additional waiver authority necessary to implement the CFC option.

(h) *Alternative Payment Methodology*. To develop, in collaboration with the Department of Behavioral Healthcare, Development Disabilities and Hospitals (BHDDH), a health home for providing conflict free person-centered planning and a quality and value based alternative payment

system that advances the goal of improving service access, quality and value.

(i) *Opioid and Behavioral Health Crisis Management.* To implement in collaboration with the Department of Behavioral Healthcare, Development Disabilities and Hospitals (BHDDH), a community based alternative to emergency departments for addiction and mental health emergencies.

(j) *Federal Financing Opportunities.* The Executive Office proposes to review Medicaid requirements and opportunities under the U.S. Patient Protection and Affordable Care Act of 2010 (PPACA) and various other recently enacted federal laws and pursue any changes in the Rhode Island Medicaid program that promote service quality, access and cost-effectiveness that may warrant a Medicaid State Plan amendment or amendment under the terms and conditions of Rhode Island's Section 1115 Waiver, its successor, or any extension thereof. Any such actions by the Executive Office shall not have an adverse impact on beneficiaries or cause there to be an increase in expenditures beyond the amount appropriated for state fiscal year 2019. Now, therefore, be it

RESOLVED, the General Assembly hereby approves proposals and be it further;

RESOLVED, the Secretary of the Executive Office is authorized to pursue and implement any waiver amendments, State Plan amendments, and/or changes to the applicable department's rules, regulations and procedures approved herein and as authorized by 42-12.4; and be it further

RESOLVED, that this Joint Resolution shall take effect upon passage.

SECTION 9. This Article shall take effect upon passage.