ARTICLE 19 AS AMENDED

RELATING TO MEDICAL ASSISTANCE

SECTION 1. Sections 40-8-13.4, 40-8-17 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 ~~department~~ 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 ~~department~~ executive office of health and human services shall:

(1) (A) With respect to inpatient services for persons in fee for service Medicaid, which is non-managed care, implement a new payment methodology for inpatient services utilizing the Diagnosis Related Groups (DRG) method of payment, which is, a patient classification method which provides a means of relating payment to the hospitals to the type of patients cared for by the hospitals. It is understood that a payment method based on Diagnosis Related Groups may include cost outlier payments and other specific exceptions. The ~~department~~ 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 (12) month period beginning July 1, 2013 the Medicaid managed care payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient

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

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

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

(d) The ~~director~~ secretary of the ~~department~~ executive office of health and human

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

(e) The ~~department~~ 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 ~~department~~ 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 ~~department~~ executive office shall withhold financial cycle payments due by any state agency with respect to this hospital by not more than ten percent (10%) until said report is submitted. For hospital fiscal year 2010 and all subsequent fiscal years, hospitals will not be required to submit year-end settlement reports on payments for outpatient services. For hospital fiscal year 2011 and all subsequent fiscal years, hospitals will not be required to submit year-end settlement reports on claims for hospital inpatient services. Further, for hospital fiscal year 2010, hospital inpatient claims subject to settlement shall include only those claims received between October 1, 2009 and June 30, 2010.

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

~~(h) The director of the Department of Human Services shall establish an independent study commission comprised of representatives of the hospital network, representatives from the communities the hospitals serve, state and local policy makers and any other stakeholders or consumers interested in improving the access and affordability of hospital care.~~

~~The study commission shall assist the director in identifying: issues of concern and priorities in the community hospital system, the delivery of services and rate structures, including graduate medical education and training programs; and opportunities for building sustainable and effective pubic private partnerships that support the missions of the department and the state's~~

~~community hospitals.~~

~~The director of the Department of Human Services shall report to the chairpersons of the House and Senate Finance Committees the findings and recommendations of the study commission by December 31, 2010.~~

40-8-17. Waiver request. -- (a) Formation. - The ~~department of human services, in conjunction with the~~ executive office of health and human services, is directed and authorized 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, including, but not limited to, ~~a~~ an extension of the section 1115(a) ~~global~~ demonstration waiver ~~that provides program flexibility in exchange for federal budgetary certainty and under which Rhode Island will operate all facets of the state's Medicaid program, except as may be explicitly exempted under any applicable public or general laws.~~ amended, as appropriate, and renamed to reflect the state's effort to coordinate all publicly financed healthcare. The secretary of the office shall ensure that the state's health and human services departments and the people and communities they serve in the Medicaid program shall have the opportunity to contribute to and collaborate in the formulation of any request for a new waiver, waiver extension and/or state plan amendment(s). Any such actions shall: (1) continue efforts to re-balance the system of long-term services and supports by assisting people in obtaining care in the most appropriate and least restrictive setting; (2) pursue further utilization of care management models that promote preventive care, offer a health home, and provide an integrated system of services; (3) use smart payments and purchasing to finance and support Medicaid initiatives that fill gaps in the integrated system of care; and (4) recognize and assure access to non-medical services and supports, such as peer navigation and employment and housing stabilization services, that are essential for optimizing a person's health, wellness and safety and that reduce or delay the need for long-term services and supports.

(b) Effective July 1, 2009, any provision presently in effect in the Rhode Island General Laws where ~~the department of human services, in conjunction with~~ the executive office of health and human services, is authorized to apply for and obtain any necessary waiver(s), waiver amendment(s) and/or state plan amendment(s) for the purpose of providing medical assistance to recipients, shall authorize ~~the department of human services, in conjunction with~~ the executive office of health and human services, to proceed with appropriate category changes in accordance with the special terms and conditions of the Rhode Island Global Consumer Choice Compact section 1115(a) Demonstration Waiver~~, which became effective January 16, 2009.~~ or any extension thereof, as amended and/or renamed under the authority provided in this section.

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

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

(i) A direct care rate adjusted for resident acuity;

(ii) An indirect care rate comprised of a base per diem for all facilities;

(iii) A rearray of costs for all facilities every three (3) years beginning October, 2015, which may or may not result in automatic per diem revisions;

(iv) Application of a fair rental value system;

(v) Application of a pass-through system; and

(vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013, but will resume on October 1, 2014. Said inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.

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

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

(2) No facility shall lose or gain more than five dollars ($5.00) in its total per diem rate the first year of the transition. The adjustment to the per diem loss or gain may be phased out by

twenty-five percent (25%) each year; and

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

SECTION 2. Title 40 of the General Laws entitled "HUMAN SERVICES" is hereby amended by adding thereto the following chapter:

CHAPTER 40-8.12

HEALTH CARE FOR ADULTS

40-8.12-1. Purpose. -- Pursuant to section 42-12.3-2, it is the intent of the general assembly to create access to comprehensive health care for uninsured Rhode Islanders. The Rhode Island Medicaid program has become an important source of insurance coverage for low income pregnant women, families with children, elders, and persons with disabilities who might not be able otherwise to obtain or afford health care. Under the *U.S. Patient Protection and Affordable Care Act (ACA) of 2010*, all Americans will be required to have health insurance, with some exceptions, beginning in 2014. Federal funding is available with ACA implementation to help pay for health insurance for low income adults, ages nineteen (19) to sixty-four (64), who do not qualify for Medicaid eligibility under Rhode Island general and public laws. It is the intent of the general assembly, therefore, to implement the Medicaid expansion for adults without dependent children authorized by the ACA, to extend health insurance coverage to these Rhode Islanders and further the goal established in section 42-12.3-2 in1993.

40-8.12-2. Eligibility.-- (a) *Medicaid coverage for non-pregnant adults without children.* There is hereby established, effective January 1, 2014, a category of Medicaid eligibility pursuant to Title XIX of the Social Security Act, as amended by the *U.S. Patient Protection and Affordable Care Act (ACA) of 2010, 42 U.S.C.* section 1396u-1, for adults ages nineteen (19) to sixty-four (64) who do not have dependent children and do not qualify for Medicaid under Rhode Island general laws applying to families with children and adults who are blind, aged or living with a disability. The executive office of health and human services is directed to make any amendments to the Medicaid state plan and waiver authorities established under title XIX necessary to implement this expansion in eligibility and assure the maximum federal contribution for health insurance coverage provided pursuant to this chapter.

(b) *Income.* The secretary of the executive office of health and human services is authorized and directed to amend the Medicaid Title XIX state plan and, as deemed necessary, any waiver authority to effectuate this expansion of coverage to any Rhode Islander who qualifies for Medicaid eligibility under this chapter with income at or below one hundred and thirty-three

percent (133%) the federal poverty level, based on modified adjusted gross income.

(c) *Delivery system.* The executive office of health and human services is authorized and directed to apply for and obtain any waiver authorities necessary to provide persons eligible under this chapter with managed, coordinated health care coverage consistent with the principles set forth in section 42-12.4, pertaining to a health care home.

40-8.12-3. Premium assistance program. – (a) The office of health and human services is directed to amend its rules and regulations to implement a premium assistance program for adults with dependent children, enrolled in the state's health benefits exchange, whose annual income and resources meet the guidelines established in section 40-8.4-4 in effect on December 1, 2013. The premium assistance will pay one-half of the cost of a commercial plan that a parent may incur after subtracting the cost-sharing requirement under section 40-8.4-4 as of December 31, 2013 and any applicable federal tax credits available. The office is also directed to amend the 1115 waiver demonstration extension and the medical assistance title XIX state plan for this program if it is determined that it is eligible for funding pursuant to title XIX of the social security act.

(b) The office of health and human services shall require any individual receiving benefits under a state funded healthcare assistance program to apply for any health insurance for which he or she is eligible, including health insurance available through the health benefits exchange. Nothing shall preclude the state from using funds appropriated for affordable care act transition expenses to reduce the impact on an individual who has been transitioned from a state program to a health insurance plan available through the health benefits exchange. It shall not be deemed cost effective for the state if it would result in a loss of benefits or an increase in the cost of health care services for the person above an amount deemed de minimus as determined by state regulation.

SECTION 3. Section 42-12.4-8 of the General Laws in Chapter 42-12.4 entitled "The Rhode Island Medicaid Reform Act of 2008" is hereby amended to read as follows:

42-12.4-8. ~~Demonstration termination.~~ Demonstration expiration or termination.- In the event the demonstration is suspended or terminated for any reason, or in the event that the demonstration expires, ~~the department of human services, in conjunction with~~ the executive office of health and human services, is directed and authorized to apply for ~~and obtain all waivers~~ an extension or renewal of the section 1115 research and demonstration waiver or any new waiver(s) that, at a minimum, ensure continuation of the waiver authorities in existence prior to the acceptance of the demonstration. The office shall ensure that any such actions are conducted in accordance with applicable federal guidelines pertaining to section 1115 demonstration waiver

renewals, extensions, suspensions or terminations. The ~~department of human services and the~~ executive office of health and human services to the extent possible shall ensure that said ~~waivers~~ waiver authorities are reinstated prior to any suspension, termination, or expiration of the demonstration.

SECTION 4. Section 40-8.4-4 of the General Laws in Chapter 40-8.4 entitled "Health Care For Families" is hereby amended to read as follows:

40-8.4-4. Eligibility. -- (a) Medical assistance for families. - There is hereby established a category of medical assistance eligibility pursuant to section 1931 of Title XIX of the Social Security Act, 42 U.S.C. section 1396u-1, for families whose income and resources are no greater than the standards in effect in the aid to families with dependent children program on July 16, 1996 or such increased standards as the department may determine. The ~~department~~ office of health and human services is directed to amend the medical assistance Title XIX state plan and to submit to the U.S. Department of Health and Human Services an amendment to the RIte Care waiver project to provide for medical assistance coverage to families under this chapter in the same amount, scope and duration as coverage provided to comparable groups under the waiver. The department is further authorized and directed to submit such amendments and/or requests for waivers to the Title XXI state plan as may be necessary to maximize federal contribution for provision of medical assistance coverage provided pursuant to this chapter, including providing medical coverage as a "qualified state" in accordance with Title XXI of the Social Security Act, 42 U.S.C. section 1397 et seq. Implementation of expanded coverage under this chapter shall not be delayed pending federal review of any Title XXI amendment or waiver.

(b) Income. - The ~~director~~ secretary of the ~~department~~ office of health and human services is authorized and directed to amend the medical assistance Title XIX state plan or RIte Care waiver to provide medical assistance coverage through expanded income disregards or other methodology for parents or relative caretakers whose income levels are below ~~one hundred seventy-five percent (175%)~~ one hundred thirty-three percent (133%) of the federal poverty level.

~~(c) Waiver. - The department of human services is authorized and directed to apply for and obtain appropriate waivers from the Secretary of the U.S. Department of Health and Human Services, including, but not limited to, a waiver of the appropriate provisions of Title XIX, to require that individuals with incomes equal to or greater than one hundred fifty percent (150%) of the federal poverty level pay a share of the costs of their medical assistance coverage provided through enrollment in either the RIte Care Program or under the premium assistance program under section 40-8.4-12, in a manner and at an amount consistent with comparable cost-sharing provisions under section 40-8.4-12, provided that such cost-sharing shall not exceed five percent~~

~~(5%) of annual income for those with annual income in excess of one hundred fifty percent (150%); and provided, further, that cost sharing shall not be required for pregnant women or children under age one.~~

SECTION 5. 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 ~~department~~ 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 ~~parents~~ families with incomes up to ~~one hundred seventy-five percent (175%)~~ 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 ~~individuals~~ 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 individual'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 individual 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.

(b) Individuals who can afford it shall share in the cost. - The ~~department~~ 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 ~~individuals~~ 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 individual's ability to pay, provided that the cost sharing shall not exceed five percent (5%) of the individual'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.

(c) Current RIte Care enrollees with access to employer-based health insurance. - The ~~department~~ office of health and human services shall require any ~~individual~~ 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 individual'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 individual'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 individual and/or the family in the employer-based health insurance plan without regard to any enrollment season restrictions.

(d) Approval of health insurance plans for premium assistance. - The ~~department~~ 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 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 eligible persons by the RIte Care program, when the plan is evaluated in conjunction with available supplemental benefits provided by the ~~department~~ office. The ~~department~~ office shall obtain and make available to persons otherwise eligible for RIte Care as supplemental benefits those benefits not reasonably available under employer-based health insurance plans which are required for RIte Care eligible persons by state law or federal law or regulation.

(e) Maximization of federal contribution. - The ~~department~~ 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) Implementation by regulation. - The ~~department~~ 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 ~~8~~6. Rhode Island Medicaid Reform Act of 2008.

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

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

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

WHEREAS, Rhode Island General Law § 42-7.2-5 provides that the Secretary of the Office of Health and Human Services is responsible for the "review and coordination of any Global Consumer Choice Compact 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 "the 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 as 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 general assembly approval of the following proposals to amend the demonstration:

(a) *Nursing Facility Payment Rates - Eliminate Rate Increase*. The Medicaid agency proposes to eliminate the projected nursing facility rate increase and associated hospice rate increase that would otherwise become effective during state fiscal year 2014. A Category II change is required to implement this proposal under the terms and conditions of the Global Consumer Choice Compact Waiver. Further, this change may also require the adoption of new or amended rules, regulations and procedures.

(b) *Medicaid Hospital Payment Rates - Eliminate Adjustments*. The Medicaid single state agency proposes to reduce hospital payments by eliminating the projected inpatient and outpatient hospital rate increase for state fiscal year 2014. A Category II change is required to implement this proposal under the terms and conditions of the Global Consumer Choice Compact Waiver. Further, this change may also require the adoption of new or amended rules, regulations and

procedures.

(c) *Integrated Care initiative - Implementation Phase-in*. The Medicaid single state agency proposes to continue implementation of the Medicaid Integrated Care Initiative for Adults authorized under the Rhode Island Medicaid Reform Act of 2008, as amended in 2011. Moving the initiative forward may require Category II changes under the terms and conditions of the Global Consumer Choice Compact Waiver and the adoption of new or amended rules, regulations and procedures.

(d) *BHDDH System Reforms - implementation of Employment First Initiative*. As part of ongoing reforms promoting rehabilitation services that enhance a person's dignity, self-worth and connection to the community, the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals proposes to change Medicaid financing to support the Employment First initiative. The initiative uses reductions in Medicaid payments to provide incentives for service alternatives that optimize health and independence. The resulting changes in payment rates may require Category II changes under the terms and conditions of the Global Consumer Choice Compact Waiver and the adoption of new or amended rules, regulations and procedures.

(e) *Costs Not Otherwise Matchable (CNOM) Federal Funding*. Implementation of the U.S. Patient Protection and Affordable Care Act of 2010 will render it unnecessary for the Medicaid agency to continue to pursue federal CNOM funding for services to certain newly Medicaid eligible populations served by the Executive Office of Health and Human Services, the Department of Human Services and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals. Category II changes may be necessary under the terms and conditions of the Global Consumer Choice Compact Waiver to facilitate the transition of the affected people and services to full Medicaid coverage.

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

(g) *Medicaid Requirements and Opportunities under the US. Patient Protection and Affordable Care Act of 2010*. The Medicaid agency proposes to pursue any requirements and/or opportunities established under the U.S. Patient Protection and Affordable Care Act of 2010 that may warrant a Medicaid State Plan Amendment and/or a Category II or III change under the terms and conditions of the Global Consumer Choice Compact Waiver or its successor or any extension thereof. Such opportunities and requirements include, but are not limited to: (1) the continuation of coverage for youths who had been in substitute care who are at least eighteen (18) years old but are not yet twenty-six (26) years of age, and who are eligible for Medicaid coverage under the Foster Care Independence Act of 1999 (2) the maximizing of Medicaid federal matching funds for any services currently administered by the health and human services agencies that are authorized under Rhode Island general and public laws. Any such actions the Medicaid agency takes 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 2014. Now, therefore, be it

(h) *RIte Care Parents Eligibility*. The Medicaid single state agency proposes to reduce the RIte Care coverage income eligibility threshold for parents to one hundred thirty-three percent (133%) of the federal poverty level. A Category III change is required to implement this proposal under the terms and conditions of the Global Consumer Choice Compact Waiver. Further this change requires the adoption of amended rules, regulations and procedures.

(i) *Cortical Integrative Therapy*. The Medicaid single state agency shall seek to create a new service entitled Cortical Integrative Therapy. This service is designed to effectuate either neuronal excitation or inhibition through temporal and spatial summation to strengthen synaptic connections. Creating this new service may require Category II changes under the terms and conditions of the Global Consumer Choice Waiver and the adoption of new or amended rules, regulations, and procedures;

Now, therefore, be it

RESOLVED, that the general assembly hereby approves proposals (a) through ~~(f)~~(i) listed above to amend the demonstration; and be it further

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

~~SECTION 9. This article shall take effect upon passage.~~ SECTION 7. Section 4 of this article shall take effect on January 1, 2014. The remainder of this Article shall take effect upon passage.