ARTICLE 9

RELATING TO MEDICAL ASSISTANCE AND UNCOMPENSATED CARE

Preamble: Building on the foundation of the Reinventing Medicaid Act of 2015, Rhode Island is seeking to leverage funds from all available sources to ensure access to coordinated health care services and promote higher-quality care through payment incentives and reform. Accordingly, the Executive Office of Health and Human Services is taking the opportunity to maximize and repurpose funds derived from redesigning certain financing mechanisms and health care delivery systems and to implement innovative care models and payment systems that encourage and reward quality, efficiency and healthy outcomes.

SECTION 1. Section 27-18-64 of the General Laws in Chapter 27-18 entitled “Accident and Sickness Insurance Policies” is hereby amended to read as follows:

§ 27-18-64. Coverage for early intervention services. – (a) Every individual or group hospital or medical expense insurance policy or contract providing coverage for dependent children, delivered or renewed in this state on or after July 1, 2004, shall include coverage of early intervention services which coverage shall take effect no later than January 1, 2005. Such coverage shall not be subject to deductibles and coinsurance factors. Any amount paid by an insurer under this section for a dependent child shall not be applied to any annual or lifetime maximum benefit contained in the policy or contract. For the purpose of this section, "early intervention services" means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for dependents from birth to age three (3) who are certified by the executive office of health and human services as eligible for services under part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

(b) Insurers shall reimburse certified early intervention providers, who are designated as such by the executive office of health and human services, for early intervention services as defined in this section at rates of reimbursement equal to or greater than the prevailing integrated state Medicaid rate for early intervention services as established by the executive office of health and human services.

(c) This section shall not apply to insurance coverage providing benefits for: (1) hospital

confinement indemnity; (2) disability income; (3) accident only; (4) long-term care; (5) Medicare supplement; (6) limited benefit health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both; and (9) other limited benefit policies.

SECTION 2. Sections 40-8-13.4 and 40-8-19 of the General Laws in Chapter 40-8 entitled "Medical Assistance" are hereby amended to read as follows:

§ 40-8-13.4. Rate methodology for payment for in state and out of state hospital services. – (a) The executive office of health and human services ("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 ~~of health and human services~~ 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 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~~ 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 Center for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index. For the twelve (12) month 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.

(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. 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; (B) provided, however, for the twenty-four (24) 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 and for the twelve (12) month 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) negotiated increases in inpatient hospital payments for each annual twelve (12) month period beginning July 1, 2016 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; (D) The ~~Rhode Island~~ 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; (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 (12) month 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. 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~~ increases in the outpatient hospital payments for each annual twelve (12) month period beginning July 1, 2016 many not exceed the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index for the applicable period. 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)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)~~ (iii) provided, however, for the twenty-four (24) 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 and for the twelve (12) month 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; ~~(iii)~~ (iv) negotiated increases in outpatient hospital payments for each annual twelve (12) month period beginning July 1, 2016 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.

(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 § 23-17.14 (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 the §§ 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 (12) month 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 ~~Diagnosis Related Groups~~ 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 ~~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~~ DRG 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 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 ~~amendments and~~ new payment methodology set forth ~~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.

§ 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 ~~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 or October 1, 2015, but will occur on April 1, 2015. The adjustment will also not occur on October 1, 2016. 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 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. 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 and October 1, 2016, 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 3. 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, ~~2014~~ 2015, the period from October 1, ~~2012~~ 2013 through September 30, ~~2013~~ 2014, and for any fiscal year ending after September 30, ~~2015~~ 2016, the period from October 1, ~~2014~~ 2015 through September 30, ~~2014~~ 2015.

(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 § 23-17.14 (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 for the §§ 40-8-13.4(b)(1)(B)(iii) and 40-8-13.4(b)(2), respectively, shall thereafter apply to negotiated increases for each annual twelve (12) month 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, ~~and~~ September 30, 2015, ~~and~~ September 30, 2016, and September 30, 2017 shall be deemed to be five and thirty hundredths percent (5.30%).

§ 40-8.3-3. Implementation. ~~(a) For federal fiscal year 2014, commencing on October 1, 2013 and ending September 30, 2014, 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 state plan for disproportionate share hospital payments (DSH Plan) to provide:~~

~~(1) That the disproportionate share hospital payments to all participating hospitals, not to exceed an aggregate limit of $136.8 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 disproportionate share payments shall be made on or before July 14, 2014 and are expressly conditioned upon approval on or before July 7, 2014 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 2014 for the disproportionate share payments.~~

~~(b)~~(a) For federal fiscal year 2015, commencing on October 1, 2014 and ending September 30, 2015, 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 state plan for disproportionate share hospital payments (DSH Plan) to provide:

(1) That the ~~disproportionate share hospital payments~~ DSH Plan to all participating hospitals, not to exceed an aggregate limit of $140.0 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 ~~disproportionate share~~ DSH Plan payments shall be made on or before July 13, 2015 and are expressly conditioned upon approval on or before July 6, 2015 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 2015 for the disproportionate share payments.

~~(c)~~(b) 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 ~~state plan for disproportionate share hospital payments (~~DSH Plan~~)~~ to provide:

(1) That the disproportionate share hospital payments to all participating hospitals, not to exceed an aggregate limit of $~~138.2~~ 125.0 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 ~~disproportionate share payments~~ 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 disproportionate share payments.

federal financial participation in federal fiscal year 2016 for the ~~disproportionate share payments~~ DSH Plan.

(c) 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 $125.0 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 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.

(d) 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) 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) 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 4. Section 40-8.3-10 of the General Laws in Chapter 40-8.3 entitled "Uncompensated Care" is hereby repealed.

§ 40-8.3-10. Hospital adjustment payments. – ~~Effective July 1, 2012 and for each subsequent year, the executive office of health and human services is hereby authorized and directed to amend its regulations for reimbursement to hospitals for inpatient and outpatient services as follows:~~

~~(a) Each hospital in the state of Rhode Island, as defined in subdivision 23-17-38.19(b)(1), shall receive a quarterly outpatient adjustment payment each state fiscal year of an amount determined as follows:~~

~~(1) Determine the percent of the state's total Medicaid outpatient and emergency department services (exclusive of physician services) provided by each hospital during each hospital's prior fiscal year;~~

~~(2) Determine the sum of all Medicaid payments to hospitals made for outpatient and emergency department services (exclusive of physician services) provided during each hospital's prior fiscal year;~~

~~(3) Multiply the sum of all Medicaid payments as determined in subdivision (2) by a percentage defined as the total identified upper payment limit for all hospitals divided by the sum of all Medicaid payments as determined in subdivision (2); and then multiply that result by each hospital's percentage of the state's total Medicaid outpatient and emergency department services as determined in subdivision (1) to obtain the total outpatient adjustment for each hospital to be paid each year;~~

~~(4) Pay each hospital on or before July 20, October 20, January 20, and April 20 one quarter (1/4) of its total outpatient adjustment as determined in subdivision (3) above.~~

~~(b) Each hospital in the state of Rhode Island, as defined in subdivision 3-17-38.19(b)(1), shall receive a quarterly inpatient adjustment payment each state fiscal year of an amount determined as follows:~~

~~(1) Determine the percent of the state's total Medicaid inpatient services (exclusive of physician services) provided by each hospital during each hospital's prior fiscal year;~~

~~(2) Determine the sum of all Medicaid payments to hospitals made for inpatient services (exclusive of physician services) provided during each hospital's prior fiscal year;~~

~~(3) Multiply the sum of all Medicaid payments as determined in subdivision (2) by a percentage defined as the total identified upper payment limit for all hospitals divided by the sum of all Medicaid payments as determined in subdivision (2); and then multiply that result by each hospital's percentage of the state's total Medicaid inpatient services as determined in subdivision (1) to obtain the total inpatient adjustment for each hospital to be paid each year;~~

~~(4) Pay each hospital on or before July 20, October 20, January 20, and April 20 one quarter (1/4) of its total inpatient adjustment as determined in subdivision (3) above.~~

~~(c) The amounts determined in subsections (a) and (b) are in addition to Medicaid inpatient and outpatient payments and emergency services payments (exclusive of physician services) paid to hospitals in accordance with current state regulation and the Rhode Island Plan for Medicaid Assistance pursuant to Title XIX of the Social Security Act and are not subject to recoupment or settlement.~~

SECTION 5. Sections 40-8.4-3 and 40-8.4-12 of the General Laws in Chapter 40-8.4

entitled “Health Care for Families” are hereby amended to read as follows:

§ 40-8.4-3. Definitions. – (a) ~~Family" means a minor child or children and the parent(s) or relative as defined in § 40-5.1-3, with whom they reside including two parent families in which one parent is working more than one hundred (100) hours per month.~~ “Cost-effective” means that the portion of the ESI that the state would subsidize, as well as costs for wrap-around services and coverage, that would on average cost less to the State than enrolling that same individual/family in a managed care delivery system.

(b) “Cost sharing” means any co-payments, deductibles or co-insurance associated with ESI.

(c) “Employee premium” means the monthly premium share an individual or family is required to pay to the employer to obtain and maintain ESI coverage.

(d) “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).

(e) "Minor child" means a child under the age of eighteen (18) or who is eighteen (18) and a full-time student in a secondary school or in the equivalent level of vocational or technical training.

(f) “Policy holder” means the person in the household with access to ESI, typically the employee.

(g) “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.

(h) “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 150% the FPL.

(i) **“**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 and, in instances in which it is cost-effective to do so, the cost of the ineligible policy holder. This allows the State to share the cost of the health insurance coverage with the employer.

(j) **“**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.

(k) "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.

(l) "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.

§ 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 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.~~ - Under the terms of Section 1906 of Title XIX of the U.S. Social Security Act, states are permitted to pay a Medicaid eligible individual'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 individuals 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 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 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 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~~. *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 42-12.3 and adults under age 65 eligible under chapters 40-8.5 and 40-8.12 as follows:

(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 150% of FPL -- Individuals and families determined to have household income at or below 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 150% FPL -- 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.

(c) RIte Share Enrollment as a Condition of Eligibility. For Medicaid beneficiaries over the age of nineteen (19) enrollment in RIte Share is 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. Medicaid-eligible children and young adults shall remain eligible for Medicaid and shall be enrolled in a RIte Care plan if the person with access to RIte Share-approved ESI does not enroll as required.

(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 § 40-5.2.

(d)Approval of health insurance plans for premium assistance. The executive 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 to 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 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.

(e) Premium Assistance – EOHHS Payment. The executive office 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 such a RIte Share-approved ESI plan subject to the buy-in provisions in this section.

(f) Buy-in – Beneficiary Costs. The executive office is authorized and directed to apply for and obtain any necessary waivers from the secretary of the U.S. DHHS to require that families 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 individual'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)~~*(g) 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)~~*(h) 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 6. Section 40-8.5-1.1 of the General Laws in Chapter 40-8.5 entitled "Health Care for Elderly and Disabled Residents Act" is hereby amended to read as follows:

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

(b) "Managed care" is defined as systems that: integrate an efficient financing mechanism

with quality service delivery; provides a "medical home" to assure appropriate care and deter unnecessary services; and place emphasis on preventive and primary care. For purposes of ~~Medical Assistance~~ this section, managed care systems ~~are also~~ may also be defined to include a primary care case management model ~~in which ancillary services are provided under the direction of a physician in a practice~~, community health teams, and/or other such arrangements that ~~meets~~ meet standards established by the ~~department of human services~~ executive office and serve the purposes of this section. Managed care systems may also include services and supports that optimize the health and independence of ~~recipients~~ beneficiaries who are determined to need Medicaid funded long-term care under chapter 40-8.10 or to be at risk for such care under applicable federal state plan or waiver authorities and the rules and regulations promulgated by the ~~department. Any medical assistance recipients~~ executive office. Any Medicaid beneficiaries who have third-party medical coverage or insurance may be provided such services through an entity certified by or in a contractual arrangement with the ~~department~~ executive office or, as deemed appropriate, exempt from mandatory managed care in accordance with rules and regulations promulgated by the ~~department of human services~~ executive office of health and human services.

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

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

exchanged in accordance with all applicable state and federal medical record confidentiality laws and regulations.

SECTION 7. Sections 40-8.9-3, 40-8.9-4, 40-8.9-6, 40-8.9-7, 40-8.9-8 and 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical Assistance - Long-Term Care Service and Finance Reform " are hereby amended to read as follows:

§ 40-8.9-3. Least restrictive setting requirement.- ~~Beginning on July 1, 2007, the department of human services~~ The executive office of health and human services (executive office) is directed to recommend the allocation of existing Medicaid resources as needed to ensure that those in need of long-term care and support services receive them in the least restrictive setting appropriate to their needs and preferences. The ~~department~~ executive office is hereby authorized to utilize screening criteria, to avoid unnecessary institutionalization of persons during the full eligibility determination process for Medicaid community based care.

§ 40-8.9-4. Unified long-term care budget.- Beginning on July 1, 2007, a unified long-term care budget shall combine in a single line-item appropriation within the ~~department of human services budget~~ executive office of health and human services (executive office), annual ~~department of human services~~ executive office Medicaid appropriations for nursing facility and community-based long-term care services for elderly sixty-five (65) years and older and younger persons at risk of nursing home admissions (including adult day care, home health, pace, and personal care in assisted living settings). Beginning on July 1, 2007, the total system savings attributable to the value of the reduction in nursing home days including hospice nursing home days paid for by Medicaid shall be allocated in the budget enacted by the general assembly for the ensuing fiscal year for the express purpose of promoting and strengthening community-based alternatives; provided, further, beginning July 1, 2009, said savings shall be allocated within the budgets of the executive office and, as appropriate, the department of human services, ~~and the department~~ division of elderly affairs. The allocation shall include, but not be limited to, funds to support an on-going statewide community education and outreach program to provide the public with information on home and community services and the establishment of presumptive eligibility criteria for the purposes of accessing home and community care. The home and community care service presumptive eligibility criteria shall be developed through rule or regulation on or before September 30, 2007. The allocation may also be used to fund home and community services provided by the ~~department~~ division of elderly affairs for persons eligible for Medicaid long-term care, and the co-pay program administered pursuant to section 42-66.3. Any monies in the allocation that remain unexpended in a fiscal year shall be carried forward to the next fiscal year for the express purpose of strengthening community-based alternatives.

The caseload estimating conference pursuant to § 35-17-1 shall determine the amount of general revenues to be added to the current service estimate of community based long-term care services for elderly sixty-five (65) and older and younger persons at risk of nursing home admissions for the ensuing budget year by multiplying the combined cost per day of nursing home and hospice nursing home days estimated at the caseload conference for that year by the reduction in nursing home and hospice nursing home days from those in the second fiscal year prior to the current fiscal year to those in the first fiscal year prior to the current fiscal year.

§ 40-8.9-6. Reporting.- Annual reports showing progress in long-term care system reform and rebalancing shall be submitted by April 1st of each year by the ~~department~~ executive office of health and human services to the Joint Legislative Committee on Health Care Oversight as well as the finance committees of both the senate and the house of representatives and shall include: the number of persons aged sixty-five (65) years and over and adults with disabilities served in nursing facilities, the number of persons transitioned from nursing homes to Medicaid supported home and community based care, the number of persons aged sixty-five (65) years and over and adults with disabilities served in home and community care to include home care, adult day services, assisted living and shared living, the dollar amounts and percent of expenditures spent on nursing facility care and home and community-based care, and estimates of the continued investments necessary to provide stability to the existing system and establish the infrastructure and programs required to achieve system-wide reform and the targeted goal of spending fifty percent (50%) of Medicaid long-term care dollars on nursing facility care and fifty percent (50%) on home and community-based services.

§ 40-8.9-7. Rate reform.- ~~By January 2008 the department of human services~~ The executive office of health and human services shall design and require to be submitted by all service providers cost reports for all community-based long-term services.

§ 40-8.9-8. System screening.- ~~By January 2008 the department of human services~~ The executive office of health and human services shall develop and implement a screening strategy for the purpose of identifying entrants to the publicly financed long-term care system prior to application for eligibility as well as defining their potential service needs.

§ 40-8.9-9. Long-term care re-balancing 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 re-balancing 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 of the general laws, 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 § 1915(c) of title XIX of the United States Code

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 §1915(c) 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 § 23-17.24) 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) By October 1, 2016, institute an increase in the base payment rates for home care service providers, in an amount to be determined through the appropriations process, for the purpose of implementing a wage pass-through program for personal care attendants and home health aides assisting long-term care beneficiaries. On or before September 1, 2016, Medicaid-funded home health providers seeking to participate in the program shall submit to the secretary for his or her approval a written plan describing and attesting to the manner in which the increased payment rates shall be passed fully through to personal care attendants and home health

aides. Any such providers contracting with a Medicaid managed care organization shall develop the plan for the wage pass-through program in conjunction with the managed care entity and shall include assurances by both parties that the base-rate increase is implemented in accordance with the goal of raising the wages of the health workers targeted in this subsection. Participating providers who do not comply with the terms of their wage pass-through plan shall be subject to a clawback, paid by the provider to the state, for any portion of the rate increase administered under this section that the secretary deems appropriate.

(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, 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 § 40-8.13-2.1;

(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 8. Section 40-8.13-2 of the General Laws in Chapter 40-8.13 entitled "Long-Term Managed Care Arrangements" is hereby amended to read as follows:

§ 40-8.13-2. Beneficiary choice options and informed choice .- The executive office of health and human services must assure that any beneficiaries enrolling in a ~~Any~~ managed long-term care arrangement ~~shall offer beneficiaries the option to decline participation and remain in traditional Medicaid and, if a duals demonstration project, traditional Medicare. Beneficiaries must be~~ are provided with options counseling, as required under §40-8.9-9, in the person-centered care planning process that includes sufficient information to ~~make~~ assist them in making an informed choice ~~regarding enrollment, including~~ about the delivery of their care.

~~(1) Any changes in the beneficiary's payment or other financial obligations with respect to long-term care services and supports as a result of enrollment;~~

~~(2) Any changes in the nature of the long-term care services and supports available to the beneficiary as a result of enrollment, including specific descriptions of new services that will be available or existing services that will be curtailed or terminated;~~

~~(3) A contact person who can assist the beneficiary in making decisions about enrollment;~~

~~(4) Individualized information regarding whether the managed care organization's network includes the health care providers with whom beneficiaries have established provider relationships. Directing beneficiaries to a website identifying the plan's provider network shall not be sufficient to satisfy this requirement; and~~

~~(5) The deadline by which the beneficiary must make a choice regarding enrollment, and the length of time a beneficiary must remain enrolled in a managed care organization before being permitted to change plans or opt out of the arrangement.~~

SECTION 9. Section 42-7.2-5 of the General Laws in Chapter 42-7.2 entitled "Office of

Health and Human Services" is hereby amended to read as follows:

§ 42-7.2-5 Duties of the secretary. – The secretary shall be subject to the direction and supervision of the governor for the oversight, coordination and cohesive direction of state administered health and human services and in ensuring the laws are faithfully executed, notwithstanding any law to the contrary. In this capacity, the Secretary of Health and Human Services shall be authorized to:

(1) Coordinate the administration and financing of health care benefits, human services and programs including those authorized by the state's Medicaid section 1115 demonstration waiver and, as applicable, the Medicaid State Plan under Title XIX of the US Social Security Act. However, nothing in this section shall be construed as transferring to the secretary the powers, duties or functions conferred upon the departments by Rhode Island public and general laws for the administration of federal/state programs financed in whole or in part with Medicaid funds or the administrative responsibility for the preparation and submission of any state plans, state plan amendments, or authorized federal waiver applications, once approved by the secretary.

(2) Serve as the governor's chief advisor and liaison to federal policymakers on Medicaid reform issues as well as the principal point of contact in the state on any such related matters.

(3)(a) Review and ensure the coordination of the state's Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or category two (II) or three (III) changes, as described in the special terms and conditions of the state's Medicaid section 1115 demonstration waiver 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. The secretary shall consider whether any such changes are legally and fiscally sound and consistent with the state's policy and budget priorities. The secretary shall also assess whether a proposed change is capable of obtaining the necessary approvals from federal officials and achieving the expected positive consumer outcomes. Department directors shall, within the timelines specified, provide any information and resources the secretary deems necessary in order to perform the reviews authorized in this section;

(b) Direct the development and implementation of any Medicaid policies, procedures, or systems that may be required to assure successful operation of the state's health and human services integrated eligibility system and coordination with HealthSource RI, the state's health insurance marketplace.

(c) Beginning in 2015, conduct on a biennial basis a comprehensive review of the Medicaid eligibility criteria for one or more of the populations covered under the state plan or a

waiver to ensure consistency with federal and state laws and policies, coordinate and align systems, and identify areas for improving quality assurance, fair and equitable access to services, and opportunities for additional financial participation.

(d) Implement service organization and delivery reforms that facilitate service integration, increase value, and improve quality and health outcomes.

(4) Beginning in 2006, prepare and submit to the governor, the chairpersons of the house and senate finance committees, the caseload estimating conference, and to the joint legislative committee for health care oversight, by no later than March 15 of each year, a comprehensive overview of all Medicaid expenditures outcomes, and utilization rates. The overview shall include, but not be limited to, the following information:

(i) Expenditures under Titles XIX and XXI of the Social Security Act, as amended;

(ii) Expenditures, outcomes and utilization rates by population and sub-population served (e.g. families with children, persons with disabilities, children in foster care, children receiving adoption assistance, adults ages nineteen (19) to sixty-four (64), and elders);

(iii) Expenditures, outcomes and utilization rates by each state department or other municipal or public entity receiving federal reimbursement under Titles XIX and XXI of the Social Security Act, as amended; and

(iv) Expenditures, outcomes and utilization rates by type of service and/or service provider.

The directors of the departments, as well as local governments and school departments, shall assist and cooperate with the secretary in fulfilling this responsibility by providing whatever resources, information and support shall be necessary.

(5) Resolve administrative, jurisdictional, operational, program, or policy conflicts among departments and their executive staffs and make necessary recommendations to the governor.

(6) Assure continued progress toward improving the quality, the economy, the accountability and the efficiency of state-administered health and human services. In this capacity, the secretary shall:

(i) Direct implementation of reforms in the human resources practices of the executive office and the departments that streamline and upgrade services, achieve greater economies of scale and establish the coordinated system of the staff education, cross-training, and career development services necessary to recruit and retain a highly-skilled, responsive, and engaged health and human services workforce;

(ii) Encourage EOHHS-wide consumer-centered approaches to service design and

delivery that expand their capacity to respond efficiently and responsibly to the diverse and changing needs of the people and communities they serve;

(iii) Develop all opportunities to maximize resources by leveraging the state's purchasing power, centralizing fiscal service functions related to budget, finance, and procurement, centralizing communication, policy analysis and planning, and information systems and data management, pursuing alternative funding sources through grants, awards and partnerships and securing all available federal financial participation for programs and services provided EOHHS-wide;

(iv) Improve the coordination and efficiency of health and human services legal functions by centralizing adjudicative and legal services and overseeing their timely and judicious administration;

(v) Facilitate the rebalancing of the long term system by creating an assessment and coordination organization or unit for the expressed purpose of developing and implementing procedures EOHHS-wide that ensure that the appropriate publicly-funded health services are provided at the right time and in the most appropriate and least restrictive setting;

(vi) Strengthen health and human services program integrity, quality control and collections, and recovery activities by consolidating functions within the office in a single unit that ensures all affected parties pay their fair share of the cost of services and are aware of alternative financing.

(vii) Assure protective services are available to vulnerable elders and adults with developmental and other disabilities by reorganizing existing services, establishing new services where gaps exist and centralizing administrative responsibility for oversight of all related initiatives and programs.

(7) Prepare and integrate comprehensive budgets for the health and human services departments and any other functions and duties assigned to the office. The budgets shall be submitted to the state budget office by the secretary, for consideration by the governor, on behalf of the state's health and human services agencies in accordance with the provisions set forth in § 35-3-4 of the Rhode Island general laws.

(8) Utilize objective data to evaluate health and human services policy goals, resource use and outcome evaluation and to perform short and long-term policy planning and development.

(9) Establishment of an integrated approach to interdepartmental information and data management that complements and furthers the goals of the unified health infrastructure project initiative and that will facilitate the transition to consumer-centered integrated system of state administered health and human services.

(10) At the direction of the governor or the general assembly, conduct independent reviews of state-administered health and human services programs, policies and related agency actions and activities and assist the department directors in identifying strategies to address any issues or areas of concern that may emerge thereof. The department directors shall provide any information and assistance deemed necessary by the secretary when undertaking such independent reviews.

(11) Provide regular and timely reports to the governor and make recommendations with respect to the state's health and human services agenda.

(12) Employ such personnel and contract for such consulting services as may be required to perform the powers and duties lawfully conferred upon the secretary.

(13) Assume responsibility for complying with the provisions of any general or public law or regulation related to the disclosure, confidentiality and privacy of any information or records, in the possession or under the control of the executive office or the departments assigned to the executive office, that may be developed or acquired or transferred at the direction of the governor or the secretary for purposes directly connected with the secretary's duties set forth herein.

(14) Hold the director of each health and human services department accountable for their administrative, fiscal and program actions in the conduct of the respective powers and duties of their agencies.

(15) Identify and implement fiscal controls within the overall budget of the office of health and human services, as needed, to achieve the full savings enacted in the FY 2016 appropriations act under the Reinventing Medicaid Initiative.

SECTION 10. Section 42-12-29 of the General Laws in Chapter 42-12 entitled "Department of Human Services" is hereby amended to read as follows:

§ 42-12-29. Children's health account. – (a) There is created within the general fund a restricted receipt account to be known as the "children's health account." All money in the account shall be utilized by the ~~department of human services~~ executive office of health and human services (executive office) to effectuate coverage for the following service categories: (1) home health services, which include pediatric private duty nursing and certified nursing assistant services; (2) comprehensive, evaluation, diagnosis, assessment, referral and evaluation (CEDARR) services, which include CEDARR family center services, home based therapeutic services, personal assistance services and supports (PASS) and kids connect services and (3) child and adolescent treatment services (CAITS). All money received pursuant to this section shall be deposited in the children's health account. The general treasurer is authorized and directed to

draw his or her orders on the account upon receipt of properly authenticated vouchers from the ~~department of human services~~ executive office.

(b) Beginning ~~January 1, 2016~~ July 1, 2016, a portion of the amount collected pursuant to § 42-7.4-3, up to the actual amount expended or projected to be expended by the state for the services described in § 42-12-29(a), less any amount collected in excess of the prior year's funding requirement as indicated in § 42-12-29(c), but in no event more than the limit set forth in § 42-12-29(d) (the "child health services funding requirement"), shall be deposited in the "children's health account."~~.~~ The funds shall be used solely for the purposes of the "children's health account", and no other.

(c) The~~ department of human services~~ executive office shall submit to the general assembly an annual report on the program and costs related to the program, on or before February 1 of each year. The ~~department~~ executive office shall make available to each insurer required to make a contribution pursuant to § 42-7.4-3, upon its request, detailed information regarding the children's health programs described in subsection (a) and the costs related to those programs. Any funds collected in excess of funds needed to carry out the programs shall be deducted from the subsequent year's funding requirements.

(d) The total amount required to be deposited into the children's health account shall be equivalent to the amount paid by the ~~department of human services~~ executive office for all services, as listed in subsection (a), but not to exceed ~~seven thousand five hundred dollars ($7,500)~~ twelve thousand five hundred dollars ($12,500) per child per service per year.

(e) The children's health account shall be exempt from the indirect cost recovery provisions of § 35-4-27 of the general laws.

SECTION 11. Section 15 of Article 5 of Chapter 141 of the Public Laws of 2015 is hereby repealed.

~~A pool is hereby established of up to $2.5 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 effective July 1, 2015.~~

SECTION 12. This article shall take effect upon passage, except as otherwise provided herein.