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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2017

A N A C T

RELATING TO HUMAN SERVICES - MEDICAL ASSISTANCE – LONG-TERM CARE SERVICE AND FINANCE REFORM

Introduced By: Representatives Serpa, and Fellela

Date Introduced: March 01, 2017

Referred To: House Finance

It is enacted by the General Assembly as follows:

SECTION 1. Section 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical Assistance - Long-Term Care Service and Finance Reform" is hereby amended to read as follows:

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

(a) Notwithstanding any other provision of state law, the executive office of health and human services is authorized and directed to apply for, and obtain, any necessary waiver(s), waiver amendment(s) and/or state-plan amendments from the secretary of the United States department of health and human services, and to promulgate rules necessary to adopt an affirmative plan of program design and implementation that addresses the goal of allocating a minimum of fifty percent (50%) of Medicaid long-term-care funding for persons aged sixty-five (65) and over and adults with disabilities, in addition to services for persons with developmental disabilities, to home- and community-based care; provided, further, the executive office shall report annually as part of its budget submission, the percentage distribution between institutional care and home- and community-based care by population and shall report current and projected waiting lists for long-term care and home- and community-based care services. The executive office is further authorized and directed to prioritize investments in home- and community-based care and to maintain the integrity and financial viability of all current long-term-care services while pursuing this goal.

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

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

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

~~(a)~~(i) 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)~~(ii) 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 [42 U.S.C. § 1396n] into a single system of home- and community-based services that include options for consumer direction and shared living. The resulting single-home and community-based services system shall replace and supersede all § 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 chapter 17.24 of title 23) that establish for each, an acuity-based, tiered service and payment methodology tied to: licensure authority; level of beneficiary needs; the scope of services and supports provided; and specific quality and outcome measures.

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

(3) 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 through to personal-care attendants and home health aides in their salaries or wages less any attendant costs incurred by the provider for additional payroll taxes, insurance contributions, and other costs required by federal or state law, regulation, or policy and directly attributable to the wage pass-through program established in this section. 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 an assurance by the provider 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.

(4) By October 1, 2017, institute a prospective base adjustment effective of twenty-eight and one-half percent (28.5%) of the current base rate for home care providers, home nursing care providers, and hospice providers contracted with the executive office of health and human services, its subordinate agencies, and contractors to deliver Medicaid services.

(5) On the first of October in each year beginning on October 1, 2018, the executive office of health and human services shall initiate an annual inflation increase to the base rate by a percentage amount equal to the change in cost inflation by the rate as determined by the United States Department of Labor Consumer Price Index Card Rate for Medical Care in New England and for compliance with all federal and state laws, regulations, and rules, and all national accreditation on program requirements.

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

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

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

have the resources to continue living in their own homes or rental units or other home-based settings.

(j) The executive office shall implement, no later than January 1, 2016, the following home- and community-based service and payment reforms:

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

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

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

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

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HUMAN SERVICES - MEDICAL ASSISTANCE – LONG-TERM CARE SERVICE AND FINANCE REFORM

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This act would provide for a Medicaid home care base rate adjustment in parity with Medicaid base rates in neighboring states. This act would help Medicaid-contracted home care providers compete with neighboring states in hiring and retaining direct care workers.

This act would take effect upon passage.

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