## ARTICLE 14

## RELATING TO MEDICAL ASSISTANCE

SECTION 1. Section 40-8-4 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is hereby amended to read as follows:

**40-8-4. ~~Direct vendor payment plan.~~ Medicaid vendor payment and beneficiary copayment.**

(a) The ~~department~~ executive office of health and human services ("executive office") shall furnish medical care benefits to eligible beneficiaries through ~~a~~ direct vendor payment ~~plan~~ and/or other methodologies and plans authorized in this chapter. ~~The plan shall include, but need not be limited to, any or all of the following benefits, which benefits shall be contracted for by the director~~ Such plans and methodologies shall cover the services and supports approved as eligible for federal financial participation identified in the Medicaid state plan and any active waivers.~~:~~

~~(1) Inpatient hospital services, other than services in a hospital, institution, or facility for tuberculosis or mental diseases;~~

~~(2) Nursing services for such period of time as the director shall authorize;~~

~~(3) Visiting nurse service;~~

~~(4) Drugs for consumption either by inpatients or by other persons for whom they are prescribed by a licensed physician;~~

~~(5) Dental services; and~~

~~(6) Hospice care up to a maximum of two hundred and ten (210) days as a lifetime benefit.~~

~~(b) For purposes of this chapter, the payment of federal Medicare premiums or other health insurance premiums by the department on behalf of eligible beneficiaries in accordance with the provisions of Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et seq., shall be deemed to be a direct vendor payment.~~

~~(c)~~ (b) With respect to medical care benefits furnished ~~to eligible individuals~~ under this chapter, ~~or~~ Title XIX, or Title XXI of the federal Social Security Act, the ~~department~~ executive office is authorized and directed to impose~~:~~

(i) Nominal co-payments or similar charges upon ~~eligible individuals for non-emergency services provided in a hospital emergency room; and~~ adults over the age of nineteen (19) who are not living with a disability or receiving care and treatment in a facility or eligible for Medicaid pursuant to §-40-8.5-1,-or pregnant women, the total of which is not to exceed five (5) percent of annual countable income in a year eligibility period, as follows:

(1) Co-payments in the amount of three dollars ($3.00) for each inpatient hospitalization; and

~~(ii)~~ (2) Co-payments for prescription drugs in the amount of one dollar ($1.00) for ~~generic~~ selected drug prescriptions for the treatment of diabetes, high blood pressure, and high cholesterol and three dollars and sixty-five cents ($3.~~00~~65) for ~~brand name~~ all other drug prescriptions in accordance with the provisions of 42 U.S.C. § 1396, et seq. Family planning prescription drugs are exempt from co-payment requirements.

~~(d)~~ (c) The ~~department~~ executive office is authorized and directed to promulgate rules and regulations to impose such co-payments or charges and to provide that, with respect to subdivisions ~~(ii)~~ (i) above, those regulations shall be effective upon filing.

~~(e)~~ (d) No state agency shall pay a vendor for medical benefits provided to a ~~recipient of assistance~~ beneficiary under this chapter until and unless the vendor has submitted a claim for payment to a commercial insurance plan, Medicare, and/or a Medicaid managed care plan, if applicable for that ~~recipient~~ beneficiary, in that order. This includes payments for skilled nursing and therapy services specifically outlined in Chapter 7, 8 and 15 of the Medicare Benefit Policy Manual.

(e) Medicaid covered services will not be withheld due to the beneficiary's inability to pay a co-payment.

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 shall:

(1)(i) With respect to inpatient services for persons in fee-for-service Medicaid, which is non-managed care, implement a new payment methodology for inpatient services utilizing the Diagnosis Related Groups (DRG) method of payment, which is, a patient-classification method that provides a means of relating payment to the hospitals to the type of patients cared for by the hospitals. It is understood that a payment method based on DRG may include cost outlier payments and other specific exceptions. The executive office will review the DRG-payment method and the DRG base price annually, making adjustments as appropriate in consideration of such elements as trends in hospital input costs; patterns in hospital coding; beneficiary access to care; and the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index. For the twelve-month (12) period beginning July 1, 2015, the DRG base rate for

Medicaid fee-for-service inpatient hospital services shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of July 1, 2014. Beginning July 1, 2019, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall be 107.2% of the payment rates in effect as of July 1, 2018. For the twelve (12) month period beginning July 1, 2020, there shall be no increase in the DRG base rate for Medicaid fee-for-service inpatient hospital services. Increases in the Medicaid fee-for-service DRG hospital payments for the twelve-month (12) period beginning ~~July 1, 2020~~ July 1, 2021 shall be based on the payment rates in effect as of July 1 of the preceding fiscal year and shall be inflated by the Centers for Medicare and Medicaid Services national Prospective Payment System (IPPS) Hospital Input Price Index.

(ii) With respect to inpatient services, (A) It is required as of January 1, 2011, until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June 30, 2010. Increases in inpatient hospital payments for each annual twelve-month (12) period beginning January 1, 2012, may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the applicable period; (B) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the Medicaid managed care payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (C) Increases in inpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2017, shall be the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1; (D) Beginning July 1, 2019, the Medicaid managed care payment inpatient rates between each hospital and health plan shall be 107.2% of the payment rates in effect as of January 1, 2019 and shall be paid to each hospital retroactively to July 1; (E) For the twelve (12) month period beginning July 1, 2020, the Medicaid managed care payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2020. (F) Increases in inpatient hospital payments for each annual twelve-month (12) period beginning ~~July 1, 2020~~July 1, 2021, shall be based on the payment rates in effect as of January 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1. The executive office will develop an audit methodology and process to

assure that savings associated with the payment reductions will accrue directly to the Rhode Island Medicaid program through reduced managed care plan payments and shall not be retained by the managed care plans; (~~F~~G) All hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and (~~G~~H) For all such hospitals, compliance with the provisions of this section shall be a condition of participation in the Rhode Island Medicaid program.

(2) With respect to outpatient services and notwithstanding any provisions of the law to the contrary, for persons enrolled in fee-for-service Medicaid, the executive office will reimburse hospitals for outpatient services using a rate methodology determined by the executive office and in accordance with federal regulations. Fee-for-service outpatient rates shall align with Medicare payments for similar services. Notwithstanding the above, there shall be no increase in the Medicaid fee-for-service outpatient rates effective on July 1, 2013, July 1, 2014, or July 1, 2015. For the twelve-month (12) period beginning July 1, 2015, Medicaid fee-for-service outpatient rates shall not exceed ninety-seven and one-half percent (97.5%) of the rates in effect as of July 1, 2014. Increases in the outpatient hospital payments for the twelve-month (12) period beginning July 1, 2016, may not exceed the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. Beginning July 1, 2019, the Medicaid fee-for-service outpatient rates shall be 107.2% of the payment rates in effect as of July 1, 2018. For the twelve-month (12) period beginning July 1, 2020, Medicaid fee-for-service outpatient rates shall not exceed the rates in effect as of July 1, 2019. Increases in the outpatient hospital payments for the twelve-month (12) period beginning ~~July 1, 2020~~ July 1, 2021 shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. With respect to the outpatient rate, (i) It is required as of January 1, 2011, until December 31, 2011, that the Medicaid managed-care payment rates between each hospital and health plan shall not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010; (ii) Increases in hospital outpatient payments for each annual twelve-month (12) period beginning January 1, 2012, until July 1, 2017, may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment System OPPS hospital price index for the applicable period; (iii) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the Medicaid managed care outpatient payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (iv) Increases in outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2017, shall be the Centers

for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1. Beginning July 1, 2019, the Medicaid managed care outpatient payment rates between each hospital and health plan shall be one hundred seven and two-tenths percent (107.2%) of the payment rates in effect as of January 1, 2019 and shall be paid to each hospital retroactively to July 1~~;~~. For the twelve (12) month period beginning July 1, 2020, 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, 2020. (vi) Increases in outpatient hospital payments for each annual twelve-month (12) period beginning ~~July 1, 2020~~July 1, 2021, shall be based on the payment rates in effect as of January 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1.

(3) "Hospital", as used in this section, shall mean the actual facilities and buildings in existence in Rhode Island, licensed pursuant to § 23-17-1 et seq. on June 30, 2010, and thereafter any premises included on that license, regardless of changes in licensure status pursuant to chapter 17.14 of title 23 (hospital conversions) and § 23-17-6(b) (change in effective control), that provides short-term, acute inpatient and/or outpatient care to persons who require definitive diagnosis and treatment for injury, illness, disabilities, or pregnancy. Notwithstanding the preceding language, the Medicaid managed care payment rates for a court-approved purchaser that acquires a hospital through receivership, special mastership or other similar state insolvency proceedings (which court-approved purchaser is issued a hospital license after January 1, 2013) shall be based upon the new rates between the court-approved purchaser and the health plan, and such rates shall be effective as of the date that the court-approved purchaser and the health plan execute the initial agreement containing the new rates. The rate-setting methodology for inpatient-hospital payments and outpatient-hospital payments set forth in subdivisions (b)(1)(ii)(C) and (b)(2), respectively, shall thereafter apply to increases for each annual twelve-month (12) period as of July 1 following the completion of the first full year of the court-approved purchaser's initial Medicaid managed care contract.

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

(d) The secretary of the executive office is hereby authorized to promulgate such rules and regulations consistent with this chapter, and to establish fiscal procedures he or she deems necessary, for the proper implementation and administration of this chapter in order to provide

1 payment to hospitals using the DRG-payment methodology. Furthermore, amendment of the Rhode
2 Island state plan for Medicaid, pursuant to Title XIX of the federal Social Security Act, is hereby
3 authorized to provide for payment to hospitals for services provided to eligible recipients in
4 accordance with this chapter.

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

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

18 (g) The provisions of this section shall be effective upon implementation of the new
19 payment methodology set forth in this section and § 40-8-13.3, which shall in any event be no later
20 than March 30, 2010, at which time the provisions of §§ 40-8-13.2, 27-19-14, 27-19-15, and 27-
21 19-16 shall be repealed in their entirety.

22 SECTION 3. Section 40-8-19 of the General Laws in Chapter 40-8 entitled “Medical
23 Assistance” is hereby amended to read as follows:

24 **40-8-19. Rates of payment to nursing facilities.**

25 (a) Rate reform.

26 (1) The rates to be paid by the state to nursing facilities licensed pursuant to chapter 17 of
27 title 23, and certified to participate in Title XIX of the Social Security Act for services rendered to
28 Medicaid-eligible residents, shall be reasonable and adequate to meet the costs that must be
29 incurred by efficiently and economically operated facilities in accordance with 42 U.S.C. §
30 1396a(a)(13). The executive office of health and human services ("executive office") shall
31 promulgate or modify the principles of reimbursement for nursing facilities in effect as of July 1,
32 2011, to be consistent with the provisions of this section and Title XIX, 42 U.S.C. § 1396 et seq.,
33 of the Social Security Act.

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

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

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

(iii) A rearray of costs for all facilities every three (3) years beginning October, 2015, that 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 1 of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013, October 1, 2014, or October 1, 2015, but will occur on April 1, 2015. The adjustment of rates will also not occur on October 1, 2017, October 1, 2018, ~~and~~ October 1, 2019, and October 1, 2020. Effective July 1, 2018, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2017, both fee-for-service and managed care, will be increased by one and one-half percent (1.5%) and further increased by one percent (1%) on October 1, 2018, and further increased by one percent (1%) on October 1, 2019. Effective October 1, 2020, Medicaid payment rates for nursing facilities established pursuant to this section shall be increased by one percent (1%). Consistent with the other provisions of this chapter, nothing in this provision shall require the executive office to restore the rates to those in effect on October 1, 2019, at the end of this twelve-month (12) period. Additionally, the full value of the rate increase effective October 1, 2020 will be directed to the Direct Nursing Care component of the rate and nursing facilities must use this additional funding to increase wages paid to direct care staff. The inflation index shall be applied without regard for the transition factors in subsections (b)(1) and (b)(2). For purposes of October 1, 2016, adjustment only, any rate increase that results from application of the inflation index to subsections (a)(2)(i) and (a)(2)(ii) shall be dedicated to increase compensation for direct-care workers in the following manner: Not less than 85% of this aggregate amount shall be expended to fund an increase in wages, benefits, or related employer costs of direct-care staff of nursing homes. For purposes of this section, direct-care staff shall include registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), certified medical technicians, housekeeping staff, laundry staff,

dietary staff, or other similar employees providing direct-care services; provided, however, that this definition of direct-care staff shall not include: (i) RNs and LPNs who are classified as "exempt employees" under the Federal Fair Labor Standards Act (29 U.S.C. § 201 et seq.); or (ii) CNAs, certified medical technicians, RNs, or LPNs who are contracted, or subcontracted, through a third-party vendor or staffing agency. By July 31, 2017, nursing facilities shall submit to the secretary, or designee, a certification that they have complied with the provisions of this subsection (a)(2)(vi) with respect to the inflation index applied on October 1, 2016. Any facility that does not comply with terms of such certification shall be subjected to a clawback, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification.

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

(1) No nursing facility shall receive reimbursement for direct-care costs that is less than the rate of reimbursement for direct-care costs received under the methodology in effect at the time of passage of this act; for the year beginning October 1, 2017, the reimbursement for direct-care costs under this provision will be phased out in twenty-five-percent (25%) increments each year until October 1, 2021, when the reimbursement will no longer be in effect; and

(2) No facility shall lose or gain more than five dollars ($5.00) in its total, per diem rate the first year of the transition. An adjustment to the per diem loss or gain may be phased out by twenty-five percent (25%) each year; except, however, for the years beginning October 1, 2015, there shall be no adjustment to the per diem gain or loss, but the phase out shall resume thereafter; and

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

(4) Notwithstanding any law to the contrary, for the twelve-month (12) 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. Consistent with the other provisions of this chapter, nothing in this provision shall require the executive office to restore the rates to those in effect on April 1, 2015, at the end of this twelve-month (12) period.

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

1 ~~**40-8.3-10. Hospital adjustment payments.**~~

2 ~~Effective July 1, 2012 and for each subsequent year, the executive office of health and~~
3 ~~human services is hereby authorized and directed to amend its regulations for reimbursement to~~
4 ~~hospitals for outpatient services as follows:~~

5 ~~(a) Each hospital in the state of Rhode Island, as defined in subdivision 23-17-38.1(e)(1),~~
6 ~~shall receive a quarterly outpatient adjustment payment each state fiscal year of an amount~~
7 ~~determined as follows:~~

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

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

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

20 ~~(4) Pay each hospital on or before July 20, October 20, January 20, and April 20 one quarter~~
21 ~~(1/4) of its total outpatient adjustment as determined in subsection (a) (3).~~

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

27 SECTION 5. Rhode Island Medicaid Reform Act of 2008 Resolution.

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

30 WHEREAS, a legislative enactment is required pursuant to Rhode Island General Laws
31 42-12.4-1, *et seq.*; and

32 WHEREAS, Rhode Island General Law 42-7.2-5(3)(a) provides that the Secretary of
33 Health and Human Services (“Secretary”), of the Executive Office of Health and Human Services
34 (“Executive Office”), is responsible for the review and coordination of any Medicaid section 1115

demonstration waiver requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or changes as described in the demonstration, "with potential to affect the scope, amount, or duration of publicly-funded health care services, provider payments or reimbursements, or access to or the availability of benefits and services provided by Rhode Island general and public laws"; and

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

(a) *Provider rates – Adjustments*. The Executive Office proposes to:

(i) eliminate the risk share arrangements with the health plans and increase the capitation rates in accordance with actuarial soundness requirements;

(ii) increase non-emergency medical transportation rates to ensure access to vital advanced life-support ambulance transport services;

(iii) maintain hospital inpatient and outpatient rates that are delivered through managed care and fee-for-service at the fiscal year 2020 levels;

(iv) increase rates to be paid to nursing facilities by one percent (1%) on October 1, 2020;

(b) *Perinatal Doula Services.* The Executive Office proposes to provide medical assistance health care for expectant mothers. The Executive Office would establish medical assistance coverage and reimbursement rates for perinatal doula services.

(c) *Implement co-payments for specific populations and services*. The Executive Office proposes to institute co-payments for adults (except those in institutions and those who are disabled) on prescription drugs and inpatient hospital stays in managed care and fee-for-service.

(d) *Implement requirements for RIte Share program*. The Executive Office proposes to require for-profit employers with fifty (50) or more employees to submit certain information to the State in order to maximize RIte Share enrollment. Implementation of adjustments may require amendments to the Rhode Island's Medicaid state plan and/or section 1115 waiver under the terms and conditions of the demonstration. Further, adoption of new or amended rules, regulations and procedures may also be required.

(e) *Increase in the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals ("BHDDH") Direct Care Service Worker Wages*. To further the long-term care system rebalancing goal of improving access to high quality services in the least restrictive setting, the Executive Office proposes to establish a targeted wage increase for certain community-based BHDDH developmental disability private providers and self-directed consumer direct care service workers to be effective January 1, 2021. Implementation of this initiative may require amendments

to the Medicaid State Plan and/or Section 1115 demonstration waiver due to changes in payment methodologies.

(f) *Federal Financing Opportunities*. The Executive Office proposes to review Medicaid requirements and opportunities under the U.S. Patient Protection and Affordable Care Act of 2010 (PPACA) and various other recently enacted federal laws and pursue any changes in the Rhode Island Medicaid program that promote service quality, access and cost-effectiveness that may warrant a Medicaid state plan amendment or amendment under the terms and conditions of Rhode Island's section 1115 waiver, its successor, or any extension thereof. Any such actions by the Executive Office shall not have an adverse impact on beneficiaries or cause there to be an increase in expenditures beyond the amount appropriated for state fiscal year 2020.

Now, therefore, be it

RESOLVED, the General Assembly hereby approves the proposals stated in (a) through (f) above; and be it further;

RESOLVED, the Secretary of the Executive Office is authorized to pursue and implement any 1115 demonstration waiver amendments, Medicaid state plan amendments, and/or changes to the applicable department's rules, regulations and procedures approved herein and as authorized by Chapter 42-12.4; and be it further;

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

SECTION 6. This article shall take effect upon passage.