ARTICLE 5 AS AMENDED

THE REINVENTING MEDICAID ACT OF 2015

Preamble: The following Act shall be known as "The Reinventing Medicaid Act of 2015", which achieves significant Medicaid savings while improving quality, controlling costs and putting Rhode Island on a path toward closing a $190 million structural deficit.

The Rhode Island Medicaid program is an integral component of the State's health care system. Medicaid provides services and supports to as many as one out of four Rhode Islanders, including low-income children and families, developmentally-disabled residents, elders and individuals with severe and persistent mental illness.

Rhode Island currently spends more than 30 cents of every state revenue dollar on Medicaid, much of it on fee-for-service payments to hospitals and nursing homes. As the program's reach expands, the costs of Medicaid have continued to rise, the delivery of care has become more fragmented and uncoordinated and funding for Medicaid has crowded out investments for important economic development priorities like education, skills training and infrastructure.

Given the crucial role of the Medicaid program to the state, it is of compelling importance that the state conduct a fundamental restructuring of its Medicaid program that achieves measurable improvement in health outcomes for the people of Rhode Island and transforms the health care system to one that pays for outcomes and quality at a sustainable, predictable and affordable cost for Rhode Island taxpayers and employers.

Rhode Island cannot build a foundation for economic growth unless the state addresses its structural deficit. Nor can it tackle the structural deficit without reforming Medicaid. Rhode Island needs a strong Medicaid system that functions as a safety net for the most vulnerable Rhode Islanders, but it also needs a sustainable model that works for patients, providers, and taxpayers.

The Reinventing Medicaid Act of 2015 makes a number of statutory changes to the state Medicaid program, including the creation of incentive models that reward better hospitals and nursing homes for better quality and better coordination, a pilot coordinated care program that establishes person-centered care and payment methods, targeted community-based programs for individuals who need intensive services and managed care for Rhode Islanders with severe and

persistent mental illness.

This Act shall be known as the "Reinventing Medicaid Act of 2015."

SECTION 1. Chapter 15-10 of the General Laws entitled "Support of Parents" is hereby amended by adding thereto the following section:

15-10-8. Support for certain patients of nursing facilities. -- The uncompensated costs of care provided by a licensed nursing facility to any person may be recovered by the nursing facility from any child of that person who is above the age of eighteen (18) years, to the extent that the child previously received a transfer of any interests or assets from the person receiving such care, which transfer resulted in a period of Medicaid ineligibility imposed pursuant to 42 USC 1396p(c), as amended from time to time, on a person whose assets have been transferred for less than fair market value.

Recourse hereunder shall be limited to the fair market value of the interests or assets transferred at the time of transfer. For the purposes of this section "the costs of care" shall mean the costs of providing care, including nursing care, personal care, meals, transportation and any other costs, charges, and expenses incurred by the facility. Costs of care shall not exceed the customary rate the nursing facility charges to a patient who pays for his or her care directly rather than through a governmental or other third party payor. Nothing contained in this section shall prohibit or otherwise diminish any other causes of action possessed by any such nursing facility. The death of the person receiving nursing facility care shall not nullify or otherwise affect the liability of the person or persons charged with the costs of care hereunder.

SECTION 2. Section 23-17-38.1 of the General Laws in Chapter 23-17 entitled "Licensing of Health Care Facilities" is hereby amended to read as follows:

23-17-38.1 Hospitals - Licensing fee. -- ~~(a) There is imposed a hospital licensing fee at the rate of five and four hundred eighteen thousandths percent (5.418%) upon the net patient services revenue of every hospital for the hospital's first fiscal year ending on or after January 1, 2012, except that the license fee for all hospitals located in Washington County, Rhode Island, shall be discounted by thirty-seven percent (37%). The discount for Washington County hospitals is subject to approval by the Secretary of the US Department of Health and Human Services of a state plan amendment submitted by the executive office of health and human services for the purpose of pursuing a waiver of the uniformity requirement for the hospital license fee. This licensing fee shall be administered and collected by the tax administrator, division of taxation within the department of revenue, and all the administration, collection, and other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before July 14, 2014, and payments shall be made by electronic transfer of~~

~~monies to the general treasurer and deposited to the general fund. Every hospital shall, on or before June 16, 2014, make a return to the tax administrator containing the correct computation of net patient services revenue for the hospital fiscal year ending September 30, 2012, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.~~

~~(b)~~(a) There is ~~also~~ imposed a hospital licensing fee at the rate of five and seven hundred ~~three~~ forty-five thousandths percent ~~(5.703%)~~ (5.745%) upon the net patient services revenue of every hospital for the hospital's first fiscal year ending on or after January 1, 2013, except that the license fee for all hospitals located in Washington County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for Washington County hospitals is subject to approval by the Secretary of the US Department of Health and Human Services of a state plan amendment submitted by the executive office of health and human services for the purpose of pursuing a waiver of the uniformity requirement for the hospital license fee. This licensing fee shall be administered and collected by the tax administrator, division of taxation within the department of revenue, and all the administration, collection and other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before July 13, 2015 and payments shall be made by electronic transfer of monies to the general treasurer and deposited to the general fund. Every hospital shall, on or before June 15, 2015, make a return to the tax administrator containing the correct computation of net patient services revenue for the hospital fiscal year ending September 30, 2013, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.

(b) There is also imposed a hospital licensing fee at the rate of five and eight hundred sixty-two thousandths percent (5.862%) upon the net patient services revenue of every hospital for the hospital's first fiscal year ending on or after January 1, 2014, except that the license fee for all hospitals located in Washington County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for Washington County hospitals is subject to approval by the Secretary of the US Department of Health and Human Services of a state plan amendment submitted by the executive office of health and human services for the purpose of pursuing a waiver of the uniformity requirement for the hospital license fee. This licensing fee shall be administered and collected by the tax administrator, division of taxation within the department of revenue, and all the administration, collection and other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before July 11, 2016 and payments shall be made by electronic transfer of monies to the general treasurer and

deposited to the general fund. Every hospital shall, on or before June 13, 2016, make a return to the tax administrator containing the correct computation of net patient services revenue for the hospital fiscal year ending September 30, 2014, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.

(c) For purposes of this section the following words and phrases have the following meanings:

(1) "Hospital" means ~~a person or governmental unit duly licensed in accordance with this chapter to establish, maintain, and operate a hospital, except a hospital whose primary service and primary bed inventory are psychiatric.~~ 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.

(2) "Gross patient services revenue" means the gross revenue related to patient care services.

(3) "Net patient services revenue" means the charges related to patient care services less (i) charges attributable to charity care; (ii) bad debt expenses; and (iii) contractual allowances.

(d) The tax administrator shall make and promulgate any rules, regulations, and procedures not inconsistent with state law and fiscal procedures that he or she deems necessary for the proper administration of this section and to carry out the provisions, policy, and purposes of this section.

(e) The licensing fee imposed by this section shall apply to hospitals as defined herein

that are duly licensed on July 1, ~~2014~~ 2015, and shall be in addition to the inspection fee imposed by § 23-17-38 and to any licensing fees previously imposed in accordance with § 23-17-38.1.

SECTION 3. Section 23-17.5-17 of the General Laws in Chapter 23-17.5 entitled "Rights of Nursing Home Patients" is hereby amended to read as follows:

23-17.5-17. Transfer to another facility. -- (a) Before transferring a patient to another facility or level of care within a facility, the patient shall be informed of the need for the transfer and of any alternatives to the transfer.

(b) A patient shall be transferred or discharged only for medical reasons, or for the patient's welfare or that of other patients or for nonpayment of the patient's stay. A facility seeking to discharge a patient for nonpayment of the patient's stay must, if the patient has been a patient of the facility for thirty (30) days or longer, provide the patient and, if known, a family member or legal representative of the patient, with written notice of the proposed discharge thirty (30) days in advance of the discharge.

(c) The patient may file an appeal of the proposed discharge with the state agency designated for hearing such appeals, and if the appeal is received by that agency within ten days after the date of written notice, the patient may remain in the facility until the decision of the hearing officer. For appeals where the patient remains in the facility:

(i) Any hearing on the appeal shall be scheduled no later than thirty (30) days after the receipt by the state agency of the request for appeal;

(ii) No more than one request for continuance by the patient shall be permitted and, if granted, the hearing on the appeal must be rescheduled for a date and time no later than forty (40) days after the receipt by the state agency of the request for appeal; and

(iii) The decision of the hearing officer shall be rendered as soon as possible, but in any event within five (5) days after the date of the hearing.

~~(c)~~(d) Reasonable advance notice of transfers to health care facilities other than hospitals shall be given to ensure orderly transfer or discharge and those actions shall be documented in the medical record.

~~(d)~~(e) In the event that a facility seeks a variance from the required thirty (30) day notice of closure of the facility, reasonable advance notice of the hearing for the variance shall be given by the facility to the patient, his or her guardian, or relative so appointed or elected to be his or her decision-maker, and an opportunity to be present at the hearing shall be granted to the designated person.

~~(e)~~(f) In the event of the voluntary closure of a facility, which closure is the result of a variance from the required thirty (30) day notice of closure, granted by the director of the

department of health, reasonable advance notice of the closure shall be given by the facility to the patient, his or her guardian, or relative so appointed or elected to be his or her decision-maker.

(g) Nothing herein shall be construed to relieve a patient from any obligation to pay for the patient's stay in a facility.

SECTION 4. 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 be limited to a benefit of five thousand dollars ($5,000) per dependent child per policy or calendar year and~~ 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 ~~department of human services~~ 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) ~~Subject to the annual limits provided in this section, insurers~~ Insurers shall reimburse certified early intervention providers, who are designated as such by the ~~Department of Human Services~~ executive office, 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 Department of 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 5. Section 27-20.11-3 of the General Laws in Chapter 27-20.11 entitled "Autism Spectrum Disorders" is hereby amended to read as follows:

27-20.11-3. Scope of coverage. -- (a) Benefits under this section shall include coverage for pharmaceuticals, applied behavior analysis, physical therapy, speech therapy, psychology, psychiatric and occupational therapy services for the treatment of Autism spectrum disorders, as

defined in the most recent edition of the DSM. Provided, however:

(1) Coverage for physical therapy, speech therapy and occupational therapy and psychology, psychiatry and pharmaceutical services shall be, to the extent such services are a covered benefit for other diseases and conditions under such policy ; and

(2) Applied behavior analysis ~~.shall be limited to thirty-two thousand dollars ($32,000) per person per year~~.

(b) Benefits under this section shall continue until the covered individual reaches age fifteen (15).

(c) The health care benefits outlined in this chapter apply only to services delivered within the State of Rhode Island; provided, that all health insurance carriers shall be required to provide coverage for those benefits mandated by this chapter outside of the State of Rhode Island where it can be established through a pre-authorization process that the required services are not available in the State of Rhode Island from a provider in the health insurance carrier's network.

SECTION 6: Section 35-17-1 of the General Laws in Chapter 35-17 entitled "Medical Assistance and Public Assistance Caseload Estimating Conferences" is hereby amended to read as follows:

35-17-1. Purpose and membership. -- (a) In order to provide for a more stable and accurate method of financial planning and budgeting, it is hereby declared the intention of the legislature that there be a procedure for the determination of official estimates of anticipated medical assistance expenditures and public assistance caseloads, upon which the executive budget shall be based and for which appropriations by the general assembly shall be made.

(b) The state budget officer, the house fiscal advisor, and the senate fiscal advisor shall meet in regularly scheduled caseload estimating conferences (C.E.C.). These conferences shall be open public meetings.

(c) The chairpersonship of each regularly scheduled C.E.C. will rotate among the state budget officer, the house fiscal advisor, and the senate fiscal advisor, hereinafter referred to as principals. The schedule shall be arranged so that no chairperson shall preside over two (2) successive regularly scheduled conferences on the same subject.

(d) Representatives of all state agencies are to participate in all conferences for which their input is germane.

(e) The department of human services shall provide monthly data to the members of the caseload estimating conference by the fifteenth day of the following month. Monthly data shall include, but is not limited to, actual caseloads and expenditures for the following case assistance programs: Rhode Island Works, SSI state program, general public assistance, and child care. The

executive office of health and human services shall report relevant caseload information and expenditures for the following medical assistance categories: hospitals, long-term care, managed care, pharmacy, and other medical services. In the category of managed care, caseload information and expenditures for the following populations shall be separately identified and reported: children with disabilities, children in foster care, and children receiving adoption assistance. The information shall include the number of Medicaid recipients whose estate may be subject to a recovery and the anticipated amount to be collected from those subject to recovery ~~estate~~, ~~and~~ the total recoveries collected each month and number of estates attached to the collections and each month, the number of open cases and the number of cases that have been open longer than three months.

SECTION 7. Section 40-5-13 of the General Laws in Chapter 40-5 entitled "Support of the Needy" is hereby amended to read as follows:

40-5-13. Obligation of kindred for support. – (a) The kindred of any poor person, if any he or she shall have in the line or degree of father or grandfather, mother or grandmother, children or grandchildren, by consanguinity, or children by adoption, living within this state and of sufficient ability, shall be holden to support the pauper in proportion to their ability.

(b) The uncompensated costs of care provided by a licensed nursing facility to any person may be recovered by the nursing facility from any person who is obligated to provide support to that patient under subsection (a) hereof, to the extent that the individual so obligated received a transfer of any interests or assets from the patient receiving such care, which transfer resulted in a period of Medicaid ineligibility imposed pursuant to 42 USC 1396p(c), as amended from time to time, on a person whose assets have been transferred for less than fair market value.

Recourse hereunder shall be limited to the fair market value of the interests or assets transferred at the time of transfer. For the purposes of this section "the costs of care" shall mean the costs of providing care, including nursing care, personal care, meals, transportation and any other costs, charges, and expenses incurred by the facility. Costs of care shall not exceed the customary rate the nursing facility charges to a patient who pays for his or her care directly rather than through a governmental or other third party payor. Nothing contained in this section shall prohibit or otherwise diminish any other causes of action possessed by any such nursing facility. The death of the person receiving nursing facility care shall not nullify or otherwise affect the liability of the person or persons charged with the costs of care hereunder.

SECTION 8. Sections 40-6-27 and 40-6-27.2 of the General Laws in Chapter 40-6 entitled General Public Assistance are hereby amended to read as follows:

40-6-27. Supplemental security income. -- (a)(1) The director of the department is

hereby authorized to enter into agreements on behalf of the state with the secretary of the U.S. Department of Health and Human Services or other appropriate federal officials, under the supplementary and security income (SSI) program established by title XVI of the Social Security Act, 42 U.S.C. § 1381 et seq., concerning the administration and determination of eligibility for SSI benefits for residents of this state, except as otherwise provided in this section. The state's monthly share of supplementary assistance to the supplementary security income program shall be as follows:

(i) Individual living alone: $39.92

(ii) Individual living with others: $51.92

(iii) Couple living alone: $79.38

(iv) Couple living with others: $97.30

(v) Individual living in state licensed assisted living residence: $332.00

(vi) Individual eligible to receive Medicaid-funded long-term services and supports and living in a Medicaid certified state licensed assisted living residence or adult supportive ~~housing~~ care residence, as defined in §23-17.24, participating in the program authorized under § 40-8.13-2.~~1~~:

(a) with countable income above one hundred and twenty (120) percent of poverty: up to $465.00;

(b) with countable income at or below one hundred and twenty (120) percent of poverty: up to the total amount established in (v) and $465: $797

~~(vi)~~(vii) Individual living in state licensed supportive residential care settings that, depending on the population served, meet the standards set by the department of human services in conjunction with the department(s) of children, youth and families, elderly affairs and/or behavioral healthcare, developmental disabilities and hospitals: $300.00.

Provided, however, that the department of human services shall by regulation reduce, effective January 1, 2009, the state's monthly share of supplementary assistance to the supplementary security income program for each of the above listed payment levels, by the same value as the annual federal cost of living adjustment to be published by the federal social security administration in October 2008 and becoming effective on January 1, 2009, as determined under the provisions of title XVI of the federal social security act [42 U.S.C. § 1381 et seq.]; and provided further, that it is the intent of the general assembly that the January 1, 2009 reduction in the state's monthly share shall not cause a reduction in the combined federal and state payment level for each category of recipients in effect in the month of December 2008; provided further, that the department of human services is authorized and directed to provide for payments to

recipients in accordance with the above directives.

(2) As of July 1, 2010, state supplement payments shall not be federally administered and shall be paid directly by the department of human services to the recipient.

(3) Individuals living in institutions shall receive a twenty dollar ($20.00) per month personal needs allowance from the state which shall be in addition to the personal needs allowance allowed by the Social Security Act, 42 U.S.C. § 301 et seq.

(4) Individuals living in state licensed supportive residential care settings and assisted living residences who are receiving SSI supplemental payments under this section who are participating in the program under §40-8.13-2.~~1~~ or otherwise shall be allowed to retain a minimum personal needs allowance of fifty-five dollars ($55.00) per month from their SSI monthly benefit prior to payment of any monthly fees in addition to any amounts established in an administrative rule promulgated by the secretary of the executive office of health and human services for persons eligible to receive Medicaid-funded long-term services and supports in the settings identified in subsection (a)(1)(v) and (a)(1)(vi).

(5) Except as authorized for the program authorized under §40-8.13-2.~~1, To~~ to ensure that supportive residential care or an assisted living residence is a safe and appropriate service setting, the department is authorized and directed to make a determination of the medical need and whether a setting provides the appropriate services for those persons who:

(i) Have applied for or are receiving SSI, and who apply for admission to supportive residential care setting and assisted living residences on or after October 1, 1998; or

(ii) Who are residing in supportive residential care settings and assisted living residences, and who apply for or begin to receive SSI on or after October 1, 1998.

(6) The process for determining medical need required by subsection ~~(4)~~ (5) of this section shall be developed by the office of health and human services in collaboration with the departments of that office and shall be implemented in a manner that furthers the goals of establishing a statewide coordinated long-term care entry system as required pursuant to the ~~Global Consumer Choice Compact Waiver~~ Medicaid section 1115 waiver demonstration.

(7) To assure access to high quality coordinated services, the ~~department~~ executive office of health and human services is further authorized and directed to establish ~~rules specifying the payment~~ certification or contract standards that must be met by those state licensed supportive residential care settings, including adult supportive care homes and assisted living residences admitting or serving any persons eligible for state-funded supplementary assistance under this section or the program established under §40-8.13-2.~~1~~. Such ~~payment~~ certification or contract standards shall define:

(i) The scope and frequency of resident assessments, the development and implementation of individualized service plans, staffing levels and qualifications, resident monitoring, service coordination, safety risk management and disclosure, and any other related areas;

(ii) The procedures for determining whether the ~~payment~~ certifications or contract standards have been met; and

(iii) The criteria and process for granting a one time, short-term good cause exemption from the ~~payment~~ certification or contract standards to a licensed supportive residential care setting or assisted living residence that provides documented evidence indicating that meeting or failing to meet said standards poses an undue hardship on any person eligible under this section who is a prospective or current resident.

(8) The ~~payment~~ certification or contract standards required by this section or § 40-8.13-2.~~1~~ shall be developed in collaboration by the departments, under the direction of the executive office of health and human services, so as to ensure that they comply with applicable licensure regulations either in effect or in development.

(b) The department is authorized and directed to provide additional assistance to individuals eligible for SSI benefits for:

(1) Moving costs or other expenses as a result of an emergency of a catastrophic nature which is defined as a fire or natural disaster; and

(2) Lost or stolen SSI benefit checks or proceeds of them; and

(3) Assistance payments to SSI eligible individuals in need because of the application of federal SSI regulations regarding estranged spouses; and the department shall provide such assistance in a form and an amount in which the department shall by regulation determine.

40-6-27.2. Supplementary cash assistance payment for certain supplemental security income recipients. -- There is hereby established a $206 monthly payment for disabled and elderly individuals who, on or after July 1, 2012, receive the state supplementary assistance payment for an individual in state licensed assisted living residence under § 40-6-27 and further reside in an assisted living facility that is not eligible to receive funding under Title XIX of the Social Security Act, 42 U.S.C. § 1381 et seq~~., including through the program authorized under §40-8.13-2.1~~ or reside in any assisted living facility financed by the Rhode Island housing and mortgage finance corporation prior to January 1, 2006, and receive a payment under § 40-6-27. Such a monthly payment shall not be made on behalf of persons participating in the program authorized under §40-8.13-2.

SECTION 9. Sections 40-8-4 and 40-8-13.4 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. -- (a) The department shall furnish medical care benefits to eligible beneficiaries through a direct vendor payment plan. 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:

(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) With respect to medical care benefits furnished to eligible individuals under this chapter or Title XIX of the federal Social Security Act, the department 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

(ii) Co-payments for prescription drugs in the amount of one dollar ($1.00) for generic drug prescriptions and three dollars ($3.00) for brand name drug prescriptions in accordance with the provisions of 42 U.S.C. § 1396, et seq.

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

(e) No state agency shall pay a vendor for medical benefits provided to a recipient of assistance 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, 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.

SECTION 10. Chapter 40-8 of the General Laws entitled "Medical Assistance" is hereby amended by adding thereto the following section:

40-8-6.1. Nursing facility care during pendency of application. -- (a) Definitions. or purposes of this section, the following terms shall have the meanings indicated:

"Applied Income" – The amount of income a Medicaid beneficiary is required to contribute to the cost of his or her care.

"Authorized Representative" – An individual who signs an application for Medicaid benefits on behalf of a Medicaid Applicant

"Complete Application" – An application for Medicaid benefits filed by or on behalf of an individual receiving care and services from a nursing facility, including attachments and supplemental information as necessary, which provides sufficient information for the director or designee to determine the applicant's eligibility for coverage. An application shall not be disqualified from status as a complete application hereunder except for failure on the part of the Medicaid applicant, or his or her authorized representative, to provide necessary information or documentation, or to take any other action necessary to make the application a complete application.

"Medicaid Applicant" – An individual who is receiving care in a nursing facility during the pendency of an application for Medicaid benefits.

"Nursing Facility" – A nursing facility licensed under Chapter 17 of Title 23, which is a participating provider in the Rhode Island Medicaid program.

"Uncompensated Care" – Care and services provided by a nursing facility to a Medicaid applicant without receiving compensation therefore from Medicaid, Medicare, the Medicaid applicant, or other source. The acceptance of any payment representing actual or estimated applied income shall not disqualify the care and services provided from qualifying as uncompensated care.

(b) Uncompensated Care During Pendency of an Application for Benefits. A nursing facility may not discharge a Medicaid applicant for non-payment of the facility's bill during the pendency of a complete application; nor may a nursing facility charge a Medicaid applicant for care provided during the pendency of a complete application, except for an amount representing the estimated applied income. A nursing facility may discharge a Medicaid applicant for non-payment of the facility's bill during the pendency of an application for Medicaid coverage that is not a complete application, but only if the nursing facility has provided the patient (and his or her authorized representative, if known) with thirty (30) days' written notice of its intention to do so, and the application remains incomplete during that thirty (30) day period.

(c) Notice Of Application Status. When a nursing facility is providing uncompensated care to a Medicaid applicant, then the nursing facility may inform the director or designee of its status, and the director or designee shall thereafter inform the nursing facility of any decision on the application at the time the decision is rendered and, if coverage is approved, of the date that coverage will begin. In addition, a nursing facility providing uncompensated care to a Medicaid applicant may inquire of the director or designee as to the status of that individual's application, and the director or designee shall respond within five business days as follows:

(i) Without Release – If the nursing facility has not obtained a signed release authorizing disclosure of information to the facility, the director or designee must provide the following information only, in writing: (a) whether or not the application has been approved; (b) the identity of any authorized representative; and (c) if the application has not yet been decided, whether or not the application is a complete application.

(ii) With Release – If the nursing facility has obtained a signed release, the director or designee must additionally provide any further information requested by the nursing facility, to the extent that the release permits its disclosure.

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 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)(A) With respect to inpatient services for persons in fee for service Medicaid, which is non-managed care, implement a new payment methodology for inpatient services utilizing the Diagnosis Related Groups (DRG) method of payment, which is, a patient classification method which provides a means of relating payment to the hospitals to the type of patients cared for by the hospitals. It is understood that a payment method based on Diagnosis Related Groups may include cost outlier payments and other specific exceptions. The 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.

(B) With respect to inpatient services, (i) it is required as of January 1, 2011 until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June 30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the applicable period; (ii) provided, however, for the 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; (iii) negotiated increases in inpatient hospital payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 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; (iv) 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; (v) All hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and (vi) for all such hospitals, compliance with the provisions of this section shall be a condition of participation in the Rhode Island Medicaid program.

(2) With respect to outpatient services and notwithstanding any provisions of the law to the contrary, for persons enrolled in fee for service Medicaid, the 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 ~~or,~~ 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. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall

not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated increases in hospital outpatient payments for each annual twelve (12) month period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment System (OPPS) hospital price index for the applicable period; (ii) provided, however, for the 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) negotiated increases in outpatient hospital payments for each annual twelve (12) month period beginning July 1, ~~2015~~ 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 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.

(c) It is intended that payment utilizing the Diagnosis Related Groups 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 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 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.

40-8-13.5. Hospital Incentive Program (HIP). -- The secretary of the executive office of health and human services is authorized to seek the federal authorities required to implement a hospital incentive program (HIP). The HIP shall provide the participating licensed hospitals the ability to obtain certain payments for achieving performance goals established by the secretary. HIP payments shall commence no earlier than July 1, 2016.

SECTION 11. Section 40-8-19 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is hereby amended to read as follows:

40-8-19. Rates of payment to nursing facilities. -- (a) Rate reform. (1) The rates to be paid by the state to nursing facilities licensed pursuant to chapter 17 of title 23, and certified to participate in the Title XIX Medicaid program for services rendered to Medicaid-eligible

residents, shall be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in accordance with 42 U.S.C. § 1396a(a)(13). The executive office of health and human services shall promulgate or modify the principles of reimbursement for nursing facilities in effect as of July 1, 2011 to be consistent with the provisions of this section and Title XIX, 42 U.S.C. § 1396 et seq., of the Social Security Act.

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

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

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

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

(iv) Application of a fair rental value system;

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

(vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013 or October 1, 2015 but will ~~resume~~ occur on April 1, 2015. 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. ~~The~~ An adjustment to the per diem loss or gain may be phased out by twenty-five percent (25%) each year; except, however, for the year beginning October 1, 2015, there shall be no adjustment to the per diem gain or loss, ~~gain during state fiscal year 2016~~, but ~~it may resume~~ 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.

40-8-19.2. Nursing Facility Incentive Program (NFIP). -- The secretary of the executive office of health and human services is authorized to seek the federal authority required to implement a nursing facility incentive program (NFIP). The NFIP shall provide the participating licensed nursing facilities the ability to obtain certain payments for achieving performance goals established by the secretary. NFIP payments shall commence no earlier than July 1, 2016.

SECTION 12. Sections 40-8.2-2 to 40-8.2-4, 40-8.2-10 to 40-8.2-12, and 40-8.2-14 to 40-8.2-22 of the General Laws in Chapter 40-8.2 entitled "Medical Assistance Fraud " are hereby amended to read as follows:

40-8.2-1. Short title. -- This chapter shall be known as the "Rhode Island Medical Assistance Fraud Law".

40-8.2-2. Definitions. -- Whenever used in this chapter:

(1) "Benefit" means pecuniary benefit as defined herein.

(2) "Claim" means any request for payment, electronic or otherwise, and shall also include any data commonly known as encounter data, which is used or is to be used for the development of a capitation fee payable to a provider of managed health care goods, merchandise or services.

(3) ~~"Department" means the Rhode Island department of human services~~ "Executive Office" means the executive office of health and human services, the agency designated by state law and the Medicaid state plan as the Medicaid single state agency.

(4) "Fee schedule" means a list of goods or services to be recognized as properly compensable under the Rhode Island Medicaid program and applicable rates of reimbursement.

(5) "Kickback" means a return in any form by any individual of a part of an expenditure made by a provider:

(i) To the same provider;

(ii) To an entity controlled by the provider; or

(iii) To an entity, which the provider intends to benefit whenever the expenditure is reimbursed, or reimbursable, or claimed by a provider as being reimbursable by the Rhode Island

Medicaid program and when the sum or value returned is not credited to the benefit of the Rhode Island Medicaid program.

(6) "Medicaid fraud control unit" means a duly certified Medicaid fraud control unit under federal regulation authorized to perform those functions as described by § 1903(q) of the Social Security Act, 42 U.S.C. § 1396b(q).

(7) "Medically unnecessary services or merchandise" means services or merchandise provided to recipients intentionally without any expectation that the services or merchandise will alleviate or aid the recipient's medical condition.

(8) "Office of Program Integrity or OPI" means the ~~unit~~ division within the executive office of health and human services authorized pursuant to §42-7.2-18 to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud; to develop cooperative strategies to investigate and eliminate Medicaid and public assistance fraud and to recover state and federal funds; and to represent the executive office and act on the secretary's behalf in any matters related to the prevention, detection , and prosecution of Medicaid fraud under this chapter.

~~(8)~~(9) "Pecuniary benefit" means benefit in the form of money, property, commercial interests, or anything else the primary significance of which is economic gain.

~~(9)~~(10) "Person" means any person or individual, natural or otherwise and includes those person(s) or entities defined by the term "provider".

~~(10)~~(11) "Provider" means any individual, individual medical vendor, firm, corporation, professional association, partnership, organization, or other legal entity that provides goods or services under the Rhode Island Medicaid program or the employee of any person or entity who, on his or her own behalf or on the behalf of his or her employer, knowingly performs any act or is knowingly responsible for an omission prohibited by this chapter.

~~(11)~~(12) "Recipient" means any person receiving medical assistance under the Rhode Island Medicaid program.

~~(12)~~(13) "Records" means all documents developed by a provider and related to the provision of services reimbursed or claimed as reimbursable by the Rhode Island Medicaid program.

~~(13)~~(14) "Rhode Island Medicaid program" means a state administered, medical assistance health care program which is funded by the state and federal governments under Title XIX and Title XXI of the U.S., Social Security Act~~, 42 U.S.C. § 1396 et seq~~ and any general or public laws and administered by the executive office of health and human services.

40-8.2-3. Prohibited acts. -- (a) It shall be unlawful for any person intentionally to:

(1) Present or cause to be presented for preauthorization or payment to the Rhode Island Medicaid program:

(i) Any materially false or fraudulent claim or cost report for the furnishing of services or merchandise; or

(ii) Present or cause to be presented for preauthorization or payment, any claim or cost report for medically unnecessary services or merchandise; or

(iii) To submit or cause to be submitted materially false or fraudulent information, for the intentional purpose(s) of obtaining greater compensation than that to which the provider is legally entitled for the furnishing of services or merchandise; or

(iv) Submit or cause to be submitted materially false information for the purpose of obtaining authorization for furnishing services or merchandise; or

(v) Submit or cause to be submitted any claim or cost report or other document which fails to make full disclosure of material information.

(2) (i) Solicit, receive, offer, or pay any remuneration, including any kickback, bribe, or rebate, directly or indirectly, in cash or in kind, to induce referrals from or to any person in return for furnishing of services or merchandise or in return for referring an individual to a person for the furnishing of any services or merchandise for which payment may be made, in whole or in part, under the Rhode Island Medicaid program.

(ii) Provided, however, that in any prosecution under this subsection, it shall not be necessary for the state to prove that the remuneration returned was taken from any particular expenditure made by a person.

(3) Submit or cause to be submitted a duplicate claim for services, supplies, or merchandise to the Rhode Island Medicaid program for which the provider has already received or claimed reimbursement from any source, unless the duplicate claim is filed

(i) For payment of more than one type of service or merchandise furnished or rendered to a recipient for which the use of more than one type of claim is necessary; or

(ii) Because of a lack of a response from or a request by the Rhode Island Medicaid program; provided, however, in such instance a duplicate claim will clearly be identified as such, in writing, by the provider; or

(iii) Simultaneous with a claim submission to another source of payment when the provider has knowledge that the other payor will not pay the claim.

(4) Submit or cause to be submitted to the Rhode Island Medicaid program a claim for service or merchandise which was not rendered to a recipient.

(5) Submit or cause to be submitted to the Rhode Island Medicaid program a claim for services or merchandise which includes costs or charges not related to the provision or rendering of services or merchandise to the recipient.

(6) Submit or cause to be submitted a claim or refer a recipient to a person for services or merchandise under the Rhode Island Medicaid program which are intentionally not documented in the provider's record and/or are medically unnecessary as that term is defined by § 40-8.2-2(7).

(7) Submit or cause to be submitted to the Rhode Island Medicaid program a claim which materially misrepresents:

(i) The description of services or merchandise rendered or provided to a recipient;

(ii) The cost of the services or merchandise rendered or provided to a recipient;

(iii) The dates that the services or merchandise were rendered or provided to a recipient;

(iv) The identity of the recipient(s) of the services or merchandise; or

(v) The identity of the attending, prescribing, or referring practitioner or the identity of the actual provider.

(8) Submit a claim for reimbursement to the Rhode Island Medicaid program for service(s) or merchandise at a fee or charge, which exceeds the provider's lowest fee or charge for the provision of the service or merchandise to the general public.

(9) Submit or cause to be submitted to the Rhode Island Medicaid program a claim for a service or merchandise which was not rendered by the provider, unless the claim is submitted on behalf of:

(i) A bona fide provider employee of such provider; or

(ii) An affiliated provider entity owned or controlled by the provider; or

(iii) Is submitted on behalf of a provider by a third party billing service under a written agreement with the provider, and the claims are submitted in a manner which does not otherwise violate the provisions of this chapter.

(10) Render or provide services or merchandise under the Rhode Island Medicaid program unless otherwise authorized by the regulations of the Rhode Island Medicaid program without a provider's written order and the recipient's consent, or submit or cause to be submitted a claim for services or merchandise, except in emergency situations or when the recipient is a minor or is incompetent to give consent. The type of consent to be required hereunder can include verbal acquiescence of the recipient and need not require a signed consent form or the recipient's signature, except where otherwise required by the regulations of the Rhode Island Medicaid program.

(11) Charge any recipient or person acting on behalf of a recipient, money or other consideration in addition to, or in excess of the rates of remuneration established under the Rhode Island Medicaid program.

(12) Enter into an agreement, combination or conspiracy with any party other than the Rhode Island Medicaid program to obtain or aid another to obtain reimbursement or payments from the Rhode Island Medicaid program to which the person, recipient, or provider seeking reimbursement or payment is not entitled.

(13) Make a material false statement in the application for enrollment as a provider under the Rhode Island Medicaid program.

(14) Refuse to provide representatives of the Medicaid fraud control unit and/or the office of program integrity upon reasonable request, access to information and data pertaining to services or merchandise rendered to eligible recipients, and/or former recipients while recipients under the Rhode Island Medicaid program.

(15) Obtain any monies by false pretenses through the use of any artifice, scheme, or design prohibited by this section.

(16) Seek or obtain employment with or as a provider after having actual or constructive knowledge of a then existing exclusion issued under the authority of 42 U.S.C. § 1320a-7.

(17) Grant or offer to grant employment in violation of a then existing exclusion issued under the authority of 42 U.S.C. § 1320a-7, having actual or constructive knowledge of the existence of such exclusion.

(18) File a false document to gain employment in a Medicaid funded facility or with a provider.

(b) (1) A provider or person who violates any provision of subsection (a), excepting subsection (a)(14), (a)(16), or (a)(18), is guilty of a felony for each violation, and upon conviction therefor, shall be sentenced to a term of imprisonment not exceeding ten (10) years, nor fined more than ten thousand dollars ($10,000), or both.

(2) A provider or person who violates the provisions of subsection (a)(14), (a)(16), or (a)(18), shall be guilty of a misdemeanor for each violation and, upon conviction, be fined not more than five hundred dollars ($500).

(3) Any provider who knowingly and willfully participates in any offense either as a principal or as an accessory, or conspirator shall be subject to the same penalty as if the provider had committed the substantive offense.

(c) The provisions of subsection (a)(2) shall not apply to:

(1) A discount or other reduction in price obtained by a person or provider of services or

merchandise under the Rhode Island Medicaid program, if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the person or provider under the Rhode Island Medicaid program.

(2) Any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the provision of covered services or merchandise furnished under the Rhode Island Medicaid program.

(3) Any amounts paid by a vendor of services or merchandise to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services or merchandise which are reimbursed by the Rhode Island Medicaid program, as long as:

(i) The purchasing agent has a written agreement with each individual or entity in the group that specifies the amount the agent will be paid by each vendor (where the sum may be a fixed sum or a fixed percentage of the value of the purchases made from the vendor by the group under the contract between the vendor and the purchasing agent); and

(ii) In the case of an entity that is a provider of services to the Rhode Island Medicaid program, the agent discloses in writing to the individual or entity in accordance with regulations to be promulgated by the ~~department~~ executive office, and to the ~~department~~ office of program integrity upon request, the amount received from each vendor with respect to purchases made by or on behalf of the entity.

40-8.2-4. Statute of limitations. -- The statute of limitations for any violation of the provisions of this chapter shall be ten (10) years.

40-8.2-5. Civil remedy. -- Any person, including the ~~Rhode Island Medicaid program~~ secretary of the executive office of health and human services or the office of program integrity acting on behalf of the secretary of the office, injured by any violation of the provisions of § 40-8.2-3 or § 40-8.2-4 may recover through a civil action from the persons inflicting the injury three (3) times the amount of the injury.

40-8.2-6. Civil actions brought by attorney general on behalf of persons injured by violations of chapter. -- (a) The attorney general may bring a civil action in superior court in the name of the state, as parens patriae on behalf of persons residing in this state, to secure monetary relief as provided in this section for injuries sustained by such persons by reason of any violation of this chapter. The court shall exclude from the amount of monetary relief awarded in an action any amount of monetary relief:

Which duplicates amounts which have been awarded for the same injury, or

Which is properly allocable to persons who have excluded their claims pursuant to subsection (c)(1) of this section.

(b) The court shall award the state as monetary relief threefold the total damage sustained as described in subsection (a) of this section and the costs of bringing suit, including reasonable attorney's fees.

(c) In any action brought under subsection (a) of this section, the attorney general shall, at such times, in such manner, and with such content as the court may direct, cause notice thereof to be given by publication.

(1) Any person on whose behalf an action is brought under subsection (a), may elect to exclude from adjudication the portion of the state claim for monetary relief attributable to him or her by filing notice of the election with the court within such time as specified in the notice given pursuant to this subsection.

(2) The final judgment in an action under subsection (a) shall be res judicata as to any claim under § 40-8.2-5 by any person on behalf of whom the action was brought and who fails to give notice within the period specified in the notice given pursuant to this subsection.

(d) An action under subsection (a) shall not be dismissed or compromised without the approval of the court, and notice of any proposed dismissal or compromise shall be given by publication at such times, in such manner, and with such content as the court may direct.

(e) In any action under subsection (a):

(1) The amount of the plaintiff's attorney's fees, if any, shall be determined by the court, and any attorney's fees awarded to the attorney general shall be deposited with the state as general revenues; and

(2) The court may, in its discretion, award a reasonable attorney's fee to a prevailing defendant upon a finding that the attorney general has acted in bad faith, vexatiously, wantonly, or for oppressive reasons.

(f) Monetary relief recovered in an action under this section shall:

(1) Be distributed in such manner as the court, in its discretion, may authorize; or

(2) Be deemed a civil penalty by the court and deposited with the state as general revenues; subject in either case to the requirement that any distribution procedure adopted afford each person a reasonable opportunity to secure his or her appropriate portion of the net monetary relief.

(g) In any action under this section the fact that a person or public body has not dealt directly with the defendant shall not bar or otherwise limit recovery. Provided, however, that the court shall exclude from the amount of monetary relief which duplicates amounts which have been awarded for the same injury.

40-8.2-10. Other civil remedies and criminal penalties. -- The penalties and remedies

under this statute are not exclusive and shall not preclude the use of any other civil remedy or the application of any other criminal penalty deemed appropriate by the attorney general in accordance with federal law or regulations governing Title XIX or Title XXI or the general or public laws of this state.

40-8.2-11. Barring or suspending participation in program. -- Whenever a provider is sentenced or placed on probation for an offense under this chapter, the trial judge may, in his or her discretion, order that the provider be permanently barred from further participation in the program, that the provider's participation in the program be suspended for a definite period of time not exceeding two (2) years, or that the provider conform to applicable federal regulations. For the purposes of this section, ~~the Rhode Island Medicaid program~~ office of program integrity may submit a recommendation to the trial judge as to whether the provider should be suspended or barred from the ~~Medicaid~~ program. Nothing contained herein shall be construed to prevent the ~~Rhode Island Medicaid program~~ executive office of health and human services from imposing its own administrative sanctions.

40-8.2-17. Stays and review of revocation orders. -- An order of the ~~Rhode Island Medicaid program~~ executive office of health and human services revoking a provider's certification may, in the discretion of the program, go into immediate effect or may be stayed. Review of any order may be had in accordance with the Rhode Island administrative procedures law, §§ 42-35-1 -42-35-18. If an administrative hearing is claimed, the program may, in its discretion, stay the effect of a revocation until a hearing is ~~had~~ held and a decision is rendered, and for a period not to exceed ten (10) days after the administrative decision is rendered.

40-8.2-18. Filing and enforcement of administrative decision. -- An administrative decision, not appealed, or which has been affirmed after judicial review under the Rhode Island administrative procedures law, §§ 42-35-1 - 42-35-18, determining any amounts due to the ~~Rhode Island Medicaid program~~ executive office of health and human services or to a provider, may be filed with the clerk of the superior court for Providence County and shall be enforceable as a judgment of that court.

40-8.2-19. Certification as a provider. -- Revocation or suspension of certification.- Before any provider of medical services receives payment from the Rhode Island Medicaid program, and as a condition of receipt of payment, the provider must have in effect a valid certification of eligibility from the Rhode Island ~~department of human services~~ executive office of health and human services. This certification of eligibility will take the form of either a separate provider agreement or language as required by federal regulations imprinted on the medical assistance billing form, which must be signed by the provider. This certification may be

revoked or suspended, in accordance with administrative rules to be promulgated by the ~~department~~ executive office, if a provider fails to meet professional licensure requirements, violates any administrative regulations of the ~~Rhode Island Medicaid program~~ executive office of health and human services, does not provide proper professional services, is the subject of a suspension of payments order, is convicted of Medicaid fraud, or otherwise violates any provision of this chapter.

40-8.2-21. Suspension of payments to a provider. -- (a) The ~~Rhode Island Medicaid program~~ executive office of health and human services may issue a suspension of payments order if:

(1) The provider does not meet certification requirements of the Rhode Island Medicaid program; or

(2) The Rhode Island Medicaid program has been unable to collect (or make satisfactory arrangements for the collection of) amounts due on account of overpayments to any provider; or

(3) The ~~Rhode Island Medicaid program~~ office of program integrity and/or the Medicaid fraud control unit of the attorney general's office has been unable to obtain, from a provider, the data and information necessary to enable it to determine the existence or amount (if any) of the overpayments made to a provider; or

(4) The office of program integrity or the Medicaid fund control unit of the attorney general's office has been denied reasonable access to information by a provider which pertains to a patient or resident of a long term residential care facility or to a former patient or resident of a long term residential care facility; or

(5) The ~~Rhode Island Medicaid program~~ office of program integrity and/or the Medicaid fraud control unit of the attorney general's office has been denied reasonable access to data and information by the provider for the purpose of conducting activities as described in § 1903(g) of the Social Security Act, 42 U.S.C. § 1396b(g); or

(6) The ~~Rhode Island Medicaid program~~ office of program integrity has been presented with reliable evidence that the provider has engaged in fraud or willful misrepresentation under the Medicaid program.

(b) Any such order of the ~~Rhode Island Medicaid program~~ executive office of health and human services may cease to be effective at such time as the ~~program~~ office of program integrity is satisfied that the provider is participating in substantial negotiations which seek to remedy the conditions which gave rise to its order of suspension of payments, or that amounts are no longer due from the provider or that a satisfactory arrangement has been made for the payment of the provider or that a satisfactory arrangement has been made for the payment by the provider of any

such amounts.

40-8.2-22. Interest on overcharges. -- Any provider of services or goods contracting with the ~~department of human services~~ executive office of health and human services pursuant to Title XIX or Title XXI of the Social Security Act~~., 42 U.S.C. § 1396 et seq.~~, who, without intent to defraud, obtains payments under this chapter in excess of the amount to which the provider is entitled, thereby becomes liable for payment of the amount of the excess with payment of interest allowable by law, under § 6-26-2, as was in effect on the date payment was made to the provider. The interest period will commence on the date upon which payment was made and will extend to the date upon which repayment is made to the state of Rhode Island.

SECTION 13. Chapter 40-8 of the General Laws entitled "Medical Assistance" is hereby amended by adding thereto the following section:

40-8-32. Support for certain patients of nursing facilities. -- (a) Definitions. For purposes of this section,

"Applied Income" shall mean the amount of income a Medicaid beneficiary is required to contribute to the cost of his or her care.

"Authorized Individual" shall mean a person who has authority over the income of a patient of a Nursing Facility such as a person who has been given or has otherwise obtained authority over a patient's bank account, has been named as or has rights as a joint account holder, or is a fiduciary as defined below.

"Costs of Care" shall mean the costs of providing care to a patient of a nursing facility, including nursing care, personal care, meals, transportation and any other costs, charges, and expenses incurred by a nursing facility in providing care to a patient. Costs of care shall not exceed the customary rate the nursing facility charges to a patient who pays for his or her care directly rather than through a governmental or other third party payor.

"Fiduciary" shall mean a person to whom power or property has been formally entrusted for the benefit of another such as an attorney-in-fact, legal guardian, trustee, or representative payee.

"Nursing Facility" shall mean a nursing facility licensed under Chapter 17 of Title 23, which is a participating provider in the Rhode Island Medicaid program.

"Penalty Period" means the period of Medicaid ineligibility imposed pursuant to 42 USC 1396p(c), as amended from time to time, on a person whose assets have been transferred for less than fair market value;

"Uncompensated Care" – Care and services provided by a nursing facility to a Medicaid applicant without receiving compensation therefore from Medicaid, Medicare, the Medicaid

Applicant, or other source. The acceptance of any payment representing actual or estimated Applied Income shall not disqualify the care and services provided from qualifying as uncompensated care.

(b) Penalty Period Resulting from Transfer. Any transfer or assignment of assets resulting in the establishment or imposition of a penalty period shall create a debt that shall be due and owing to a nursing facility for the unpaid costs of care provided during the penalty period to a patient of that facility who has been subject to the penalty period. The amount of the debt established shall not exceed the fair market value of the transferred assets at the time of transfer that are the subject of the penalty period. A nursing facility may bring an action to collect a debt for the unpaid costs of care given to a patient who has been subject to a penalty period, against either the transferor or the transferee, or both. The provisions of this section shall not affect other rights or remedies of the parties.

(c) Applied Income. A nursing facility may provide written notice to a patient who is a Medicaid recipient and any authorized individual of that patient of:

(1) Of the amount of applied income due;

(2) Of the recipient's legal obligation to pay the applied income to the nursing facility; and

(3) That the recipient's failure to pay applied income due to a nursing facility not later than thirty days after receiving such notice from the Nursing Facility may result in a court action to recover the amount of applied income due.

A nursing facility that is owed applied income may, in addition to any other remedies authorized under law, bring a claim to recover the applied income against a patient and any authorized individual. If a court of competent jurisdiction determines, based upon clear and convincing evidence, that a defendant willfully failed to pay or withheld applied income due and owing to a Nursing Facility for more than thirty days after receiving notice pursuant to this subsection (d), the court may award the amount of the debt owed, court costs and reasonable attorneys' fees to the nursing facility.

(d) Effects. Nothing contained in this section shall prohibit or otherwise diminish any other causes of action possessed by any such nursing facility. The death of the person receiving nursing facility care shall not nullify or otherwise affect the liability of the person or persons charged with the costs of care rendered or the applied income amount as referenced in this section.

SECTION 14. 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, ~~2013~~ 2014, the period from October 1, ~~2011~~ 2012 through September 30, ~~2012~~ 2013, and for any fiscal year ending after September 30, ~~2014~~ 2015, the period from October 1, ~~2012~~ 2013 through September 30, ~~2013~~ 2014.

(2) "~~Medical assistance~~ 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 shall be deemed to be five and thirty hundredths percent (5.30%).

40-8.3-3. Implementation. -- ~~(a) For federal fiscal year 2013, commencing on October 1, 2012 and ending September 30, 2013, 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 $128.3 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 15, 2013 and are expressly conditioned upon approval on or before July 8, 2013 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 2013 for the disproportionate share payments.~~

~~(b)~~(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.

~~(c)~~(b) 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 to all participating hospitals, not to exceed an aggregate limit of ~~$136.8~~ $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 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) 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 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, 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.

(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 15. Section 5 of Article 18 of Chapter 145 of the Public Laws of 2014 is hereby amended to read as follows:

A pool is hereby established of up to ~~$1.5 million~~ $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 ~~$3 million~~ $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, 2014~~ made annually.

SECTION 16. 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 re-balancing system reform goal. -- (a) Notwithstanding any other provision of state law, the ~~department of human services~~ 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 ~~and mental disabilities~~, to home and community-based care ~~on or before December 31, 2013~~; provided, further, the ~~executive office of health and human services~~ 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 ~~department~~ 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 ~~department of human services~~ 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 ~~the mentally retarded~~ 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 ~~department~~ executive office is~~, subject to prior approval of the general assembly,~~ authorized to adopt clinical and/or functional criteria for admission to a nursing facility, hospital, or intermediate care facility for ~~the mentally retarded~~ persons with intellectual disabilities that are more stringent than those employed for access to home and community-based services. The ~~department~~ executive office is also authorized to promulgate rules that define the frequency of re-assessments for services provided for under this section. ~~Legislatively approved levels~~ Levels of care may be applied in accordance with the following:

(1) The ~~department~~ executive office shall continue to apply ~~pre-waiver~~ the level of care criteria in effect on June 30, 2015 for any recipient determined eligible for and receiving ~~Medicaid recipient eligible for~~ Medicaid-funded long-term services in supports in a nursing facility, hospital, or intermediate care facility for ~~the mentally retarded~~ persons with intellectual disabilities ~~as of June 30, 2009~~ on or before that date, unless: (a) the recipient transitions to home and community based services because he or she~~: (a) Improves to a level where he/she~~ would no longer meet the ~~pre-waiver~~ level of care criteria in effect on June 30, 2015; or (b) ~~The individual~~ the recipient chooses home and community based services over the nursing facility, hospital, or intermediate care facility for ~~the mentally retarded~~ persons with intellectual disabilities. For the purposes of this section, a failed community placement, as defined in regulations promulgated by

the ~~department~~ executive office, shall be considered a condition of clinical eligibility for the highest level of care. The ~~department~~ 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 ~~the mentally retarded~~ persons with intellectual disabilities as of June 30, ~~2009~~ 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 ~~the mentally retarded~~ persons with intellectual disabilities whenever possible. Additionally, residents shall only be moved from a nursing home, hospital, or intermediate care facility for ~~the mentally retarded~~ 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 ~~the mentally retarded~~ 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 ~~the mentally retarded~~ 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 ~~department of human services~~ 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 ~~the mentally retarded~~ 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 ~~department of human services~~ executive office is further authorized ~~and directed~~ 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 ~~department of human services~~ 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 ~~department of human services~~ executive office is authorized ~~and directed~~ to pursue ~~rate~~ payment methodology reforms that increase access to ~~for~~ homemaker, personal care (home health aide), assisted living, adult supportive care homes, and adult day ~~care~~ services, as follows:

~~(1) A prospective base adjustment effective, not later than July 1, 2008, across all departments and programs, of ten percent (10%) of the existing standard or average rate, contingent upon a demonstrated increase in the state funded or Medicaid caseload by June 30, 2009;~~

~~(2)~~ (1) Development, ~~not later than September 30, 2008,~~ of revised or new Medicaid certification standards ~~supporting and defining targeted rate increments to encourage~~ that increase access to service specialization and scheduling accommodations ~~including but not limited to, medication and pain management, wound management, certified Alzheimer's Syndrome treatment and support programs, and work and shift differentials for night and week end services; and~~ by using payment strategies designed to achieve specific quality and health outcomes.

~~(3) Development and submission to the governor and the general assembly, not later than December 31, 2008, of a proposed rate setting methodology for home and community based services to assure coverage of the base cost of service delivery as well as reasonable coverage of changes in cost caused by wage inflation.~~

(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.

(g) The ~~department, in collaboration with the executive office of human services,~~ 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 ~~department of human services~~ executive office is also authorized, subject to availability of appropriation of funding, and federal Medicaid-matching funds, to pay for certain ~~expenses~~ services and supports necessary to transition ~~residents back to the community~~ 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)~~(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 department of human services~~ secretary is authorized to develop higher resource eligibility limits for persons ~~on~~ 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 ~~who are~~ 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 17: Sections 40-8.10-1, 40-8.10-2, 40-8.10-3, 40-8.10-4, 40-8.10-5, and 40-8.10-6 of the General Laws in Chapter 40-8.10 entitled "Long Term Care Service Reform for Medicaid Eligible Individuals" are hereby amended to read as follows:

40-8.10-1. Purpose. -- (a) In order to ensure that all Medicaid recipients eligible for long-term care have access to the full continuum of services they need, the secretary of the executive office of health and human services, in collaboration with the ~~director of the department of human services and the directors of the departments of children youth and families, elderly affairs, health, and mental health, retardation and hospitals,~~ directors of EOHHS departments, shall offer eligible Medicaid recipients the full range of services as allowed under the terms and conditions of the Rhode Island ~~Global Consumer Choice Compact 1115a Demonstration Waiver~~ Medicaid section 1115 demonstration waiver, including institutional services and the home and community based services provided for under the previous Medicaid Section 1915(c) waivers, as well as additional services for medication management, transition services and other authorized services as defined in this chapter, in order to meet the individual needs of the Medicaid recipient.

40-8.10-2. Definitions. -- As used in this chapter,

(a) "Core services" mean homemaker services, environmental modifications (home accessibility adaptations, special medical equipment (minor assistive devices), meals on wheels (home delivered meals), personal emergency response (PERS), licensed practical nurse services, community transition services, residential supports, day supports, supported employment, supported living arrangements, private duty nursing, supports for consumer direction (supports facilitation), participant directed goods and services, case management, senior companion services, assisted living, personal care assistance services and respite.

(b) "Preventive services" mean homemaker services, minor environmental modifications, physical therapy evaluation and services and respite services.

40-8.10-3. Levels of care. -- (a) The secretary of the executive office of health and human services shall coordinate responsibilities for long-term care assessment in accordance with the provisions of this chapter ~~within the department of human services, and with the cooperation of the directors of the department of elderly affairs, the department of children, youth and families, and the department of mental health, retardation and hospitals. Assessments conducted by each department's staff shall be coordinated through the Assessment Coordination Unit (ACU). Members of each department's staff responsible for assessing level of care, developing care plans, and determining budgets will meet on a regular basis in order to ensure that services~~

~~are provided in a uniform and consistent manner~~. Importance shall be placed upon the proper and consistent determination of levels of care across the state departments for each long-term care setting, including behavioral health residential treatment facilities, long-term care hospitals, intermediate care facilities, and/or skilled nursing facilities. ~~Three (3) appropriate~~ Specialized plans of care that meet the needs of the individual Medicaid recipients shall be coordinated and consistent across all state departments. The development of care plans shall be person-centered and shall support individual self-determination, family involvement, when appropriate, individual choice and interdepartmental collaboration.

(b) Levels of care for long-term care institutions (behavioral health residential treatment facilities, long-term care hospitals, intermediate care facilities and/or skilled nursing facilities), for which alternative community-based services and supports are available, shall be established pursuant to the § 40-8.9-9. The structure of the three (3) levels of care is as follows:

(i) Highest level of care. Individuals who are determined, based on medical need, to require the institutional level of care will have the choice to receive services in a long-term care institution or in a home and community-based setting.

(ii) High level of care. Individuals who are determined, based on medical need, to benefit from home and community-based services.

(iii) Preventive level of care. Individuals who do not presently need an institutional level of care but who need services targeted at preventing admission, re-admissions or reducing lengths of stay in an institution.

(c) Determinations of levels of care and the provision of long term care health services shall be determined in accordance with this section and shall be in accordance with the applicable provisions of § 40-8.9-9.

40-8.10-4. Long-term Care Assessment and Coordination ~~**Assessment and Coordination Unit (ACU)**~~**. --** (a) ~~The department of human services, in collaboration with the~~ The executive office of health and human services~~,~~ shall implement a long-term care options counseling program to provide individuals or their representative, 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, information on caregiver support services, including respite care, 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 a long-term care options consultation, if he or she so requests. Each

individual who applies for Medicaid long-term care services shall be provided with a long-term care consultation.

(b) Core and preventative home and community based services defined and delineated in § 40-8.10-2 shall be provided only to those individuals who meet one of the levels of care provided for in this chapter. Other long term care services authorized by the federal government, such as medication management, may also be provided to Medicaid eligible recipients who have established the requisite need~~. as determined by the Assessment and Coordination Unit (ACU). Access to institutional and community based supports and services shall be through the Assessment and Coordination Unit (ACU). The provision of Medicaid-funded long-term care services and supports shall be based upon a comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social and environmental needs of each applicant for these services or programs. The assessment shall serve as the basis for the development and provision of an appropriate plan of care for the applicant~~.

(c) ~~The ACU shall assess the financial eligibility of beneficiaries to receive long-term care services and supports in accordance with the applicable provisions of § 40-8.9-9.~~

~~(d) The ACU shall be responsible for conducting assessments; determining a level of care for applicants for medical assistance; developing service plans; pricing a service budget and developing a voucher when appropriate; making referrals to appropriate settings; maintaining a component of the unit that will provide training to and will educate consumers, discharge planners and providers; tracking utilization; monitoring outcomes; and reviewing service/care plan changes. The ACU shall provide interdisciplinary high cost case reviews and choice counseling for eligible recipients.~~

~~(e)~~ The assessments for individuals conducted in accordance with this section shall serve as the basis for individual budgets for those medical assistance recipients eligible to receive services utilizing a self-directed delivery system.

~~(f)~~(d) Nothing in this section shall prohibit the secretary of the executive office of health and human services, or the directors of that office's departments from utilizing community agencies or contractors when appropriate to perform assessment functions outlined in this chapter.

40-8.10-5. Payments. -- The ~~department of human services~~ executive office of health and human services shall not make payment for a person receiving a long-term home health care program, while payments are being made for that person for inpatient care in a skilled nursing and/or intermediate care facility or hospital.

40-8.10-6. Rules and regulations. -- The secretary of the executive office of health and

human services, the directors of the department of human services, the ~~department~~ division of elderly affairs, the department of children youth and families and the department of ~~mental health retardation and hospitals~~ behavioral healthcare, development disabilities and hospitals are hereby authorized to promulgate rules and regulations necessary to implement all provisions of this chapter and to seek necessary federal approvals in accordance with the provisions of the ~~Global Compact Waiver~~ state's Medicaid section 1115 demonstration waiver.

SECTION 18. Section 40-8.13-5 of the General Laws in Chapter 40-8.13 entitled "Long-Term Managed Care Arrangements" is hereby amended to read as follows:

40-8.13-5. ~~Financial savings under managed care.~~ Financial principles under managed care. -- To the extent that financial savings are a goal under any managed long-term care arrangement, it is the intent of the legislature to achieve such savings through administrative efficiencies, care coordination, ~~and~~ improvements in care outcomes and in a way that encourages the highest quality care for patients and maximizes value for the managed care organization and the state. ~~rather than through reduced reimbursement rates to providers.~~ Therefore, any managed long-term care arrangement shall include a requirement that the managed care organization reimburse providers for services in accordance with ~~the following:~~ these principles. Notwithstanding any law to the contrary, for the twelve (12) month period beginning July 1, 2015, Medicaid managed long term care payment rates to nursing facilities established pursuant to this section shall not exceed ninety-eight percent (98.0%) of the rates in effect on April 1, 2015.

(1) For a duals demonstration project, the managed care organization:

(i) Shall not combine the rates of payment for post-acute skilled and rehabilitation care provided by a nursing facility and long-term and chronic care provided by a nursing facility in order to establish a single payment rate for dual eligible beneficiaries requiring skilled nursing services;

(ii) Shall pay nursing facilities providing post-acute skilled and rehabilitation care or long-term and chronic care rates that reflect the different level of services and intensity required to provide these services; and

(iii) For purposes of determining the appropriate rate for the type of care identified in subsection (1)(ii) of this section, the managed care organization shall pay no less than the rates which would be paid for that care under traditional Medicare and Rhode Island Medicaid for these service types. The managed care organization shall not, however, be required to use the same payment methodology as EOHHS.

The state shall not enter into any agreement with a managed care organization in

connection with a duals demonstration project unless that agreement conforms to this section, and any existing such agreement shall be amended as necessary to conform to this subsection.

(2) For a managed long-term care arrangement that is not a duals demonstration project, the managed care organization shall reimburse providers in an amount not less than the ~~rate~~ amount that would be paid for the same care by EOHHS under the Medicaid program. The managed care organization shall not, however, be required to use the same payment methodology as EOHHS.

(3) Notwithstanding any provisions of the general or public laws to the contrary, the protections of subsections (1) and (2) of this section may be waived by a nursing facility in the event it elects to accept a payment model developed jointly by the managed care organization and skilled nursing facilities, that is intended to promote quality of care and cost effectiveness, including, but not limited to, bundled payment initiatives, value-based purchasing arrangements, gainsharing, and similar models.

(b) Notwithstanding any law to the contrary, for the twelve (12) month period beginning July 1, 2015, Medicaid managed long-term care payment rates to nursing facilities established pursuant to this section shall not exceed ninety-eight percent (98.0%) of the rates in effect on April 1, 2015.

SECTION 19. Chapter 40-8.13 of the General Laws entitled "Long-Term Managed Care Arrangements" is hereby amended by adding thereto the following section:

40-8.13-12. Community-based supportive living program. -- (a) To expand the number of community-based service options, the executive office of health and human services shall establish a program for beneficiaries opting to participate in managed care long-term care arrangements under this chapter who choose to receive Medicaid-funded assisted living, adult supportive care home, or shared living long-term care services and supports. As part of the program, the executive office shall implement Medicaid certification or, as appropriate, managed care contract standards for state authorized providers of these services that establish an acuity-based, tiered service and payment system that ties reimbursements to: beneficiary's clinical/functional level of need; the scope of services and supports provided; and specific quality and outcome measures. Such standards shall set the base level of Medicaid state plan and waiver services that each type of provider must deliver, the range of acuity-based service enhancements that must be made available to beneficiaries with more intensive care needs, and the minimum state licensure and/or certification requirements a provider must meet to participate in the pilot at each service/payment level. The standards shall also establish any additional requirements, terms or conditions a provider must meet to ensure beneficiaries have access to high quality, cost

effective care.

(b) Room and board. The executive office shall raise the cap on the amount Medicaid certified assisted living and adult supportive home care providers are permitted to charge participating beneficiaries for room and board. In the first year of the program, the monthly charges for a beneficiary living in a single room who has income at or below three hundred percent (300%) of the Supplemental Security Income (SSI) level shall not exceed the total of both the maximum monthly federal SSI payment and the monthly state supplement authorized for persons requiring long-term services under § 40-6-27.2(a)(1)(vi), less the specified personal need allowance. For a beneficiary living in a double room, the room and board cap shall be set at eighty-five percent (85%) of the monthly charge allowed for a beneficiary living in a single room.

(c) Program Cost-effectiveness. The total cost to the state for providing the state supplement and Medicaid-funded services and supports to beneficiaries participating in the program in the initial year of implementation shall not exceed the cost for providing Medicaid-funded services to the same number of beneficiaries with similar acuity needs in an institutional setting in the initial year of the operations. The program shall be terminated if the executive office determines to that the program has not met this target.

SECTION 20. Sections 42-7.2-2, 42-7.2-5, 42-7.2-6.1, 42-7.2-16, 42-7.2-18 of the General Laws in Chapter 42-7.2 entitled " Executive Office of Health and Human Services" are hereby amended to read as follows:

42-7.2-2. Executive office of health and human services. -- There is hereby established within the executive branch of state government an executive office of health and human services to serve as the principal agency of the executive branch of state government for managing the departments of children, youth and families, health, human services, and behavioral healthcare, developmental disabilities and hospitals. In this capacity, the office shall:

(a) Lead the state's four (4) health and human services departments in order to:

(1) Improve the economy, efficiency, coordination, and quality of health and human services policy and planning, budgeting and financing.

(2) Design strategies and implement best practices that foster service access, consumer safety and positive outcomes.

(3) Maximize and leverage funds from all available public and private sources, including federal financial participation, grants and awards.

(4) Increase public confidence by conducting independent reviews of health and human services issues in order to promote accountability and coordination across departments.

(5) Ensure that state health and human services policies and programs are responsive to

changing consumer needs and to the network of community providers that deliver assistive services and supports on their behalf.

~~(b)~~(6) Administer ~~the federal and state medical assistance programs~~ Rhode Island Medicaid in the capacity of the single state agency authorized under title XIX of the U.S. Social Security act, 42 U.S.C. § 1396a et seq., and exercise such single state agency authority for such other federal and state programs as may be designated by the governor. Except as provided for herein, nothing in this chapter shall be construed as transferring to the secretary the powers, duties or functions conferred upon the departments by Rhode Island general laws for the management and operations of programs or services approved for federal financial participation under the authority of the Medicaid state agency.

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 ~~Global Consumer Choice Compact Waiver~~ 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 ~~any Global Consumer Choice Compact Waiver~~ 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 ~~Global Consumer Choice Compact Waiver~~ 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, ~~children~~ persons with disabilities, children in foster care, children receiving adoption assistance, adults ~~with disabilities~~ ages nineteen (19) to sixty-four (64), and ~~the elderly~~ 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 ~~the departments to utilize~~ EOHHS-wide ~~the utilization of~~ 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 ~~through the departments~~ 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 ~~across departments~~ 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; ~~and~~

(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~~. and~~

(vii) ~~Broaden access to publicly funded food and nutrition services by consolidating~~

~~agency programs and initiatives to eliminate duplication and overlap and improve the availability and quality of services; and~~

~~(viii)~~ 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 ~~CHOICES~~ unified health infrastructure project 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 ~~Implement the~~ 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.

42-7.2-6. Departments assigned to the executive office. -- Powers and duties.-(a) The departments assigned to the secretary shall:

(1) Exercise their respective powers and duties in accordance with their statutory authority and the general policy established by the governor or by the secretary acting on behalf of the governor or in accordance with the powers and authorities conferred upon the secretary by this chapter;

(2) Provide such assistance or resources as may be requested or required by the governor and/or the secretary; and

(3) Provide such records and information as may be requested or required by the governor and/or the secretary to ~~the extent allowed under~~ perform the duties set forth in subsection 6 of this chapter. Upon developing, acquiring or transferring such records and information, the secretary shall assume responsibility for complying with the provisions of any applicable general or public law, regulation, or agreement relating to the confidentiality, privacy or disclosure of such records or information.

(4) Forward to the secretary copies of all reports to the governor.

(b) Except as provided herein, no provision of this chapter or application thereof shall be construed to limit or otherwise restrict the department of children, youth and families, the department of health, the department of human services, and the department of behavioral healthcare, developmental disabilities and hospitals from fulfilling any statutory requirement or complying with any valid rule or regulation.

42-7.2-6.1. Transfer of powers and functions. -- (a) There are hereby transferred to the executive office of health and human services the powers and functions of the departments with respect to the following:

(1) ~~By July 1, 2007, fiscal~~ Fiscal services including budget preparation and review, financial management, purchasing and accounting and any related functions and duties deemed necessary by the secretary;

(2) ~~By July 1, 2007, legal~~ Legal services including applying and interpreting the law, oversight to the rule-making process, and administrative adjudication duties and any related functions and duties deemed necessary by the secretary;

(3) ~~By September 1, 2007, communications~~ Communications including those functions and services related to government relations, public education and outreach and media relations and any related functions and duties deemed necessary by the secretary;

(4) ~~By March 1, 2008, policy~~ Policy analysis and planning including those functions and services related to the policy development, planning and evaluation and any related functions and duties deemed necessary by the secretary;

(5) ~~By June 30, 2008, information~~ Information systems and data management including the financing, development and maintenance of all data-bases and information systems and platforms as well as any related operations deemed necessary by the secretary;

(6) ~~By October 1, 2009, assessment~~ Assessment and coordination for long-term care including those functions related to determining level of care or need for services, development of individual service/care plans and planning, identification of service options, the pricing of service options and choice counseling; and

(7) ~~By October 1, 2009, program~~ Program integrity, quality control and collection and recovery functions including any that detect fraud and abuse or assure that beneficiaries, providers, and third-parties pay their fair share of the cost of services, as well as any that promote alternatives to publicly financed services, such as the long-term care health insurance partnership.

(8) ~~By January 1, 2011, client protective~~ Protective services including any such services provided to children, elders and adults with developmental and other disabilities;

(9) [Deleted by P.L. 2010, ch. 23, art. 7, § 1].

(10) ~~By July 1, 2012, the~~ The HIV/AIDS care and treatment programs.

(b) The secretary shall determine in collaboration with the department directors whether the officers, employees, agencies, advisory councils, committees, commissions, and task forces of the departments who were performing such functions shall be transferred to the office.

(c) In the transference of such functions, the secretary shall be responsible for ensuring:

(1) Minimal disruption of services to consumers;

(2) Elimination of duplication of functions and operations;

(3) Services are coordinated and functions are consolidated where appropriate;

(4) Clear lines of authority are delineated and followed;

(5) Cost-savings are achieved whenever feasible;

(6) Program application and eligibility determination processes are coordinated and, where feasible, integrated; and

(7) State and federal funds available to the office and the entities therein are allocated and utilized for service delivery to the fullest extent possible.

(d) Except as provided herein, no provision of this chapter or application thereof shall be construed to limit or otherwise restrict the departments of children, youth and families, human services, health, and behavioral healthcare, developmental disabilities, and hospitals from

fulfilling any statutory requirement or complying with any regulation deemed otherwise valid.

(e) The secretary shall prepare and submit to the leadership of the house and senate finance committees, by no later than January 1, 2010, a plan for restructuring functional responsibilities across the departments to establish a consumer centered integrated system of health and human services that provides high quality and cost-effective services at the right time and in the right setting across the life-cycle.

42-7.2-12. Medicaid program study. -- ~~(a) The secretary of the executive office of health and human services shall conduct a study of the Medicaid programs administered by the state to review and analyze the options available for reducing or stabilizing the level of uninsured Rhode Islanders and containing Medicaid spending.~~

~~(1) As part of this process, the study shall consider the flexibility afforded the state under the federal Deficit Reduction Act of 2006 and any other changes in federal Medicaid policy or program requirements occurring on or before December 31, 2006, as well as the various approaches proposed and/or adopted by other states through federal waivers, state plan amendments, public private partnerships, and other initiatives.~~

~~(2) In exploring these options, the study shall examine fully the overall administrative efficiency of each program for children and families, elders and adults with disabilities and any such factors that may affect access and/or cost including, but not limited to, coverage groups, benefits, delivery systems, and applicable cost sharing requirements.~~

~~(b) The secretary shall ensure that the study focuses broadly on the Medicaid programs administered by the executive office of health and human services and all of the state's four (4) health and human services departments, irrespective of the source or manner in which funds are budgeted or allocated. The directors of the departments shall cooperate with the secretary in preparing this study and provide any information and/or resources the secretary deems necessary to assess fully the short and long term implications of the options under review both for the state and the people and the communities the departments serve. The secretary shall submit a report and recommendations based on the findings of the study to the general assembly and the governor no later than March 1, 2007.~~

42-7.2-12.1. Human services call center study (211). -- ~~(a) The secretary of the executive office of health and human services shall conduct a feasibility and impact study of the potential to implement a statewide 211 human services call center and hotline. As part of the process, the study shall catalog existing human service information hotlines in Rhode Island, including, but not limited to, state-operated call centers and private and not-for-profit information hotlines within the state.~~

~~(1) The study shall include analysis of whether consolidation of some or all call centers into a centralized 211 human services information hotline would be economically and practically advantageous for both the public users and agencies that currently operate separate systems.~~

~~(2) The study shall include projected cost estimates for any recommended actions, including estimates of cost additions or savings to private service providers.~~

~~(b) The directors of all state departments and agencies shall cooperate with the secretary in preparing this study and provide any information and/or resources the secretary deems necessary to assess fully the short and long-term implications of the operations under review both for the state and the people and the communities the departments serve.~~

~~(c) The secretary shall submit a report and recommendations based on the findings of the study to the general assembly, the governor, and the house and senate fiscal advisors no later than February 1, 2007.~~

42-7.2-13. Severability. -- If any provision of this chapter or the application thereof to any person or circumstance is held invalid, such invalidity shall not ~~effect~~ affect other provisions or applications of the chapter, which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared to be severable.

42-7.2-16. Medicaid System Reform 2008. -- (a) The executive office of health and human services, in conjunction with the department of human services, the department of children youth and families, the department of health and the department of behavioral healthcare, developmental disabilities, and hospitals, is authorized to design options that further the reforms in ~~the~~ Medicaid ~~program~~ initiated in 2008 to ensure ~~so that it is a person-centered, financially sustainable, cost-effective, and opportunity driven program~~ that the program: utilizes competitive and value based purchasing to maximize the available service options, ~~promote~~ promotes accountability and transparency, and encourage and reward encourages and rewards healthy outcomes, independence, and responsible choices; promotes efficiencies and the coordination of services across all health and human services agencies; and ensures the state will have a fiscally sound source of publicly-financed health care for Rhode Islanders in need.

(b) Principles and Goals. In developing and implementing this system of reform, the executive office of health and human services and the four (4) health and human services departments shall pursue the following principles and goals:

(1) Empower consumers to make reasoned and cost-effective choices about their health by providing them with the information and array of service options they need and offering rewards for healthy decisions;

(2) Encourage personal responsibility by assuring the information available to

beneficiaries is easy to understand and accurate, provide that a fiscal intermediary is provided when necessary, and adequate access to needed services;

(3) When appropriate, promote community-based care solutions by transitioning beneficiaries from institutional settings back into the community and by providing the needed assistance and supports to beneficiaries requiring long-term care or residential services who wish to remain, or are better served in the community;

(4) Enable consumers to receive individualized health care that is outcome-oriented, focused on prevention, disease management, recovery and maintaining independence;

(5) Promote competition between health care providers to ensure best value purchasing, to leverage resources and to create opportunities for improving service quality and performance;

(6) Redesign purchasing and payment methods to assure fiscal accountability and encourage and to reward service quality and cost-effectiveness by tying reimbursements to evidence-based performance measures and standards, including those related to patient satisfaction; and

(7) Continually improve technology to take advantage of recent innovations and advances that help decision makers, consumers and providers to make informed and cost-effective decisions regarding health care.

(c) The executive office of health and human services shall annually submit a report to the governor and the general assembly ~~commencing on a date no later than July 1, 2009~~ describing the status of the administration and implementation of the ~~Global Waiver Compact~~ Medicaid Section 1115 demonstration waiver.

42-7.2-16.1. Reinventing Medicaid Act of 2015. -- (a) The Rhode Island Medicaid program is an integral component of the state's health care system that provides crucial services and supports to many Rhode Islanders. As the program's reach has expanded, the costs of the program have continued to rise and the delivery of care has become more fragmented and uncoordinated. Given the crucial role of the Medicaid program to the state, it is of compelling importance that the state conduct a fundamental restructuring of its Medicaid program that achieves measurable improvement in health outcomes for the people and transforms the health care system to one that pays for the outcomes and quality they deserve at a sustainable, predictable and affordable cost.

(b) The Working Group to Reinvent Medicaid, which was established to refine the principles and goals of the Medicaid reforms begun in 2008, was directed to present to the general assembly and the governor initiatives to improve the value, quality, and outcomes of the health care funded by the Medicaid program.

42-7.2-18. Program integrity division. -- (a) There is hereby established a program integrity division within the office of health and human services to effectuate the transfer of functions pursuant to subdivision 42-7.2-6.1(a)(7). The purposes of this division are:

(1) To develop and implement a statewide strategy to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance fraud; ~~and~~

(2) To oversee and coordinate state and local efforts to investigate and eliminate Medicaid and public assistance fraud and to recover state and federal funds~~.~~; and

(3) To pursue any opportunities to enhance health and human services program integrity efforts available under the federal Affordable Care Act of 2010, or any such federal or state laws or regulations pertaining to publicly-funded health and human services administered by the departments assigned to the executive office.

(b) The program integrity division shall provide advice and make recommendations, as necessary, to the secretary of health and human services and all departments assigned to the office to effectuate the purposes of the division. The division shall also propose and execute, with the secretary's approval, recommendations that assure the office and the departments implement in a timely and effective manner corrective actions to remediate any federal and/or state audit findings when warranted.

(c) The division shall have the following powers and duties:

(1) To conduct a census of local, state, and federal efforts to address Medicaid and public assistance fraud in this state, including fraud detection, prevention, and prosecution, in order to discern overlapping missions, maximize existing resources, and strengthen current programs;

(2) To develop a strategic plan for coordinating and targeting state and local resources for preventing and prosecuting Medicaid and public assistance fraud. The plan must identify methods to enhance multi-agency efforts that contribute to achieving the state's goal of eliminating Medicaid and public assistance fraud;

(3) To identify methods to implement innovative technology and data sharing in consultation with the office of digital excellence in order to detect and analyze Medicaid and public assistance fraud with speed and efficiency~~.~~; Such methods as may be effective as a means of detecting incidences of fraud, assisting in directing the focus of an investigation or audit, and determining the amounts a provider owes as the result of such an investigation or audit conducted by the division, a department assigned to the office, Rhode Island Department of Attorney General Medicaid Fraud Control Unit, the U.S. Department of Health and Human Services'

Office of Inspector General, the U.S. Department of Justice's Federal Bureau of Investigation, or an authorized agent thereof.

(4) To develop and promote, in consultation with federal, state and local law enforcement agencies , crime prevention services and educational programs that serve the public; and

(5) To develop and implement electronic fraud monitoring systems and provide training for all Medicaid provider and managed care organizations on the use of such systems and other fraud detection and prevention mechanisms, concerning, but not limited to the following:

(i) Coverage and billing policies;

(ii) Participant-centered planning and options available;

(iii) Covered and non-covered services;

(iv) Provider accountability and responsibilities;

(v) Claim submission policies and procedures; and

(vi) Reconciling claim activity.

(d) The division shall annually prepare and submit a report on its activities and recommendations, by January 1, to the president of the senate, the speaker of the house of representatives, the governor, and the chairs of the house of representatives and senate finance committees.

SECTION 21. Chapter 42-72.5 of the General Laws entitled, "Children's Cabinet" is hereby amended to read as follows:

42-72.5-1. Establishment. -- There is established within the executive branch of state government a children's cabinet. The cabinet shall ~~be comprised of:~~ include, but not be limited to: the director of the department of administration; the secretary of the executive office of health and human services; the director of the department of children, youth, and families; the director of the department of ~~mental health, retardation, and hospitals;~~ behavioral healthcare, developmental disabilities, and hospitals; the director of the department of health; the commissioner of ~~higher~~ post-secondary education; the commissioner of elementary and secondary education; the director of the department of human services; ~~the chief information officer;~~ the director of the department of labor and training; the child advocate; ~~the director of the department of elderly affairs;~~ and the ~~director of policy in the governor's office.~~ governor or his or her designee. The governor shall designate one of the members of the cabinet to be chairperson.

42-72.5-2. Policy and goals. -- The children's cabinet shall:

(1) Meet at least monthly to address all issues, especially those that cross departmental lines, and relate to children's needs and services;

(2) Review, amend, and propose all interagency agreements necessary to provide

coordinated services to children;

(3) Produce an annual comprehensive children's budget, to be submitted with other budget documents to the general assembly;

(4) Produce, by ~~July 1, 1992,~~ December 1, 2015, a comprehensive, five (5) year statewide plan and proposed budget for an integrated state child service system. This plan shall be submitted to the governor~~, and to the chairperson of the permanent legislative commission on the department of children, youth, and families~~; the speaker of the house of representatives and the president of the senate, and updated annually thereafter;

(5) ~~Report on its activities at least three (3) times per year to the permanent legislative commission on the department of children, youth, and families; and~~

(6) Develop a strategic plan to ~~design and implement a single, secure, universal student identifier system that does not involve a student's social security number and that will~~ coordinate and share data to foster interagency communication, increase efficiency of service delivery, and simultaneously protect children's legitimate expectations of privacy and rights to confidentiality. This shall include data-sharing with research partners, pursuant to data-sharing agreements, that maintains data integrity and protects the security and confidentiality of these records. Any such data-sharing agreements shall comply with all privacy and security requirements of federal and state law and regulation governing the use of such data. Any universal student identifier now in use by the state or developed in the future shall not involve a student's social security number.

42-72.5-3. Cooperation required. -- The ~~division of planning in the department of administration~~ executive office of health and human services shall provide staff support to the children's cabinet in preparing the integrated state child service system plan as required by this chapter. All departments represented on the children's cabinet shall cooperate with the ~~division of planning~~ executive office of health and human services to facilitate the purposes of this chapter.

SECTION 22. Rhode Island Medicaid Reform Act of 2008.

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

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

WHEREAS, Rhode Island General Law § 42-7.2-5 provides that the Secretary of the Office of Health and Human Services is responsible for the review and coordination of any Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or category II or III changes as described in the demonstration, with "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 provided by Rhode Island general and public laws"; and

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

(a) Nursing Facility Payment Rates and Incentive Program. The executive office of health and human services proposes to eliminate the projected nursing facility rate increase that would otherwise take effect during the state fiscal year 2016. In addition, the executive office proposes to establish a nursing facility incentive program which ties certain payments to nursing facilities in state fiscal year (SFY) 2017 to specific performance-based outcomes. Implementation of these initiatives 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, implementation of these initiatives may require the adoption of new or amended rules, regulations and procedures.

(b) Medicaid Hospital Payments Reform – Eliminate Rate Increases for Hospital Inpatient and Outpatient Payments, Incentive Program. In its role as the Medicaid Single State Agency, the EOHHS proposes to reduce inpatient and outpatient hospital payments by eliminating the projected rate increase for both managed care and fee-for-service for state fiscal year (SFY) 2016. Also, the EOHHS proposes to adopt alternative payment strategies for certain hospital services. A payment incentive program for participating hospitals is proposed for SFY 2017 that will support performance targets identified by the secretary. Changes in the Medicaid state plan and/or section 1115 waiver authority are required to implement these initiatives.

(c) Pilot Coordinated Care Program. The executive office of health and human services proposes to establish a coordinated care program with a community provider that uses shared savings model. Creating a new service delivery option may require authority under the Medicaid waiver demonstration and may necessitate amendments to the state plan. The adoption of new or amended rules may also be required.

(d) Medicaid Managed Care Contracts – Improved Efficiency. The EOHHS seeks to realign managed care contracts to focus on paying for value, coordinating health care delivery across providers, and modifying risk/gain sharing arrangements. Implementation of these changes may require section 1115 waiver or state plan authorities.

(e) Long-term care arrangements. Implementation of Medicaid reinvention policy initiatives authorized by law or in the SFY 2016 budget that result in managed care contractual arrangements may require new or amended section 1115 and/or state plan authorities.

(f) Integrated Care Initiative (ICI) – Enrollment. The EOHHS proposes to establish

mandatory enrollment for all Medicaid beneficiaries including but not limited to beneficiaries receiving long-term services and supports through the ICI, including those who are dually eligible for Medicaid and Medicare. Implementation of mandatory enrollment requires section 1115 waiver authority under the terms and conditions of the demonstration. New and/or amended rules, regulations and procedures are also necessary to implement this proposal.

(g) Behavioral Health --Coordinated Care Management. To improve health outcomes, the state is pursuing development of a population-based health home approach that uses an alternative payment methodology to maximize the cost-effectiveness and quality of services provided to persons living with serious mental illness. Implementation of this approach may require amendments to the Medicaid state plan and section 1115 waiver authorities as well as adoption or amendment of rules, regulations and procedures.

(h) Community Health Teams and Targeted Services. The EOHHS proposes to use community health teams to provide services and supports to beneficiaries with intensive care needs. Implementation of the initiative may require additional section 1115 waiver authorities. New and amended rules, regulations and procedures may also be necessary related to these program changes.

(i) Implementation of Home and Health Stabilization Services. The EOHHS may implement an innovative home and health stabilization program that targets beneficiaries who have complex needs and are homeless, at risk for homelessness, or transitioning from high cost intensive care settings back into the community. Implementation of this program requires Section 1115 waiver authority and may necessitate changes to EOHHS' rules, regulations and procedures.

(j) STOP Program Established. The Medicaid agency proposes to establish a new Sobering Treatment Opportunity Program (STOP). Section 1115 demonstration waiver authority for this program may be required and the adoption of new or amended rules and regulations.

(k) Medicaid Eligibility Criteria and System Processes – Review and Realignment. The EOHHS proposes to review state policies related to each Medicaid eligibility coverage group to ensure application, renewal, and service delivery requirements pose the least administrative burden on beneficiaries and provide the maximum amount of financial participation allowed under applicable federal laws and regulations. Changes in the section 1115 waiver and/or state plan may be required to implement any changes deemed necessary by the secretary necessary as a result of this review. New and amended rules, regulations and procedures may also be required.

(l) Reform of Long-term Care Eligibility Criteria – The EOHHS proposes to reform the clinical/functional eligibility used to determine access to the highest and high level of care to reflect regional and national standards and promote greater utilization of non-institutional care

settings by beneficiaries with lower acuity care needs. Section 1115 waiver authority is required to implement the reform in clinical/functional criteria. Amendments to related rules, regulations and procedures are also necessary.

(m) Alternative Payment Arrangements – The EOHHS proposes to develop and implement alternative payment arrangements that maximize value and cost-effectiveness, and tie payments to improvements in service quality and health outcomes. Amendments to the section 1115 waiver and/or the Medicaid state plan may be required to implement any alternative payment arrangements the EOHHS is authorized to pursue.

(n) Behavioral Healthcare Services Reform – As part of its reform implementation plan for achieving integrated, coordinated care of those with chronic mental illness, the department of behavioral healthcare, developmental disabilities, and hospitals, in partnership with the executive office of health and human services, shall include the option for at least one population-based arrangement, pilot, contract, or agreement for the care of those with chronic mental illness.

The goal of this population-based arrangement shall be to test and evaluate this arrangement as an effective means of realizing total improved health outcomes for the population, improved quality of care, and the more efficient and effective utilization of resources.

The department, in partnership with the executive office of health and human services, will be given the authority to execute contracts with Medicaid and/or the contracted managed care entity/entities to achieve the alternative payment methodology for the population specified. These arrangements are targeted to be executed and implemented by September 1, 2015.

(o) Payment Methodology for Services to Adults with Developmental Disabilities. The department of behavioral healthcare developmental disabilities and hospitals proposes to revise the payment methodology and/or rates for services provided to adults with developmental disabilities pursuant to the individual services plans defined in §40.1-21-4.3. Amendments to the section 1115 waiver and/or the Medicaid state plan may be required to implement any alternative payment methodology, arrangements or rates. New and amended rules, regulations and procedures may also be required. The office of health and human services shall certify that sufficient funding exists within the current appropriation to implement the changes.

(p) Approved Authorities: Section 1115 Waiver Demonstration Extension. The Medicaid agency proposes to continue implementation of authorities approved under the Section 1115 waiver demonstration extension request – formerly known as the Global Consumer Choice Waiver – that (1) continue efforts to re-balance the system of long term services and supports by assisting people in obtaining care in the most appropriate and least restrictive setting; (2) pursue utilization of care management models that offer a "health home", promote access to preventive

care, and provide an integrated system of services; (3) use payments and purchasing to finance and support Medicaid initiatives that fill gaps in the integrated system of care; and (4) recognize and assure access to the non-medical services and supports, such as peer navigation and employment and housing stabilization services, that are essential for optimizing a person's health, wellness and safety and reduce or delay the need for long term services and supports.

(q) ACA Opportunities --Medicaid Requirements and Opportunities under the U.S. Patient Protection and Affordable Care Act of 2010 (PPACA). The EOHHS proposes to pursue any requirements and/or opportunities established under the PPACA 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 the EOHHS takes shall not have an adverse impact on beneficiaries or cause there to be an increase in expenditures beyond the amount appropriated for state fiscal year 2016. Now, therefore, be it

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

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

RESOLVED, that this joint resolution shall take effect upon passage.

SECTION 23. This article shall take effect upon passage.