# ARTICLE 7 AS AMENDED

RELATING TO HEALTH AND HUMAN SERVICES

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

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

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

(c) This section shall not apply to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability income; (3) accident only; (4) long-term care; (5) Medicare supplement; (6) limited benefit health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both; and (9) other limited benefit policies.

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

**40-8-13.4. Rate methodology for payment for in state and out of state hospital services. --** (a) The executive office of health and human services ("executive office") shall

implement a new methodology for payment for in state and out of state hospital services in order to ensure access to and the provision of high quality and cost-effective hospital care to its eligible recipients.

(b) In order to improve efficiency and cost effectiveness, the executive office ~~of health and human services~~ shall:

(1)(i) With respect to inpatient services for persons in fee for service Medicaid, which is non-managed care, implement a new payment methodology for inpatient services utilizing the Diagnosis Related Groups (DRG) method of payment, which is, a patient classification method which provides a means of relating payment to the hospitals to the type of patients cared for by the hospitals. It is understood that a payment method based on ~~Diagnosis Related Groups~~ DRG may include cost outlier payments and other specific exceptions. The executive office will review the DRG payment method and the DRG base price annually, making adjustments as appropriate in consideration of such elements as trends in hospital input costs, patterns in hospital coding, beneficiary access to care, and the Center for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index. For the twelve (12) month period beginning July 1, 2015, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of July 1, 2014.

(ii) With respect to inpatient services, (A) it is required as of January 1, 2011 until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June 30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the applicable period; (B) provided, however, for the twenty-four (24) month period beginning July 1, 2013 the Medicaid managed care payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013 and for the twelve (12) month period beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (C) negotiated increases in inpatient hospital payments for each annual twelve (12) month period beginning July 1, 2016 may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (D) The ~~Rhode Island~~ executive office ~~of health and human services~~ will develop an audit methodology

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

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

(3) "Hospital" as used in this section shall mean the actual facilities and buildings in existence in Rhode Island, licensed pursuant to § 23-17-1 et seq. on June 30, 2010~~,~~ and thereafter any premises included on that license, regardless of changes in licensure status pursuant to § 23-17.14 (hospital conversions) and § 23-17-6(b) (change in effective control), that provides short-term acute inpatient and/or outpatient care to persons who require definitive diagnosis and treatment for injury, illness, disabilities, or pregnancy. Notwithstanding the preceding language, the negotiated Medicaid managed care payment rates for a court-approved purchaser that acquires a hospital through receivership, special mastership or other similar state insolvency proceedings (which court-approved purchaser is issued a hospital license after January 1, 2013) shall be based upon the newly negotiated rates between the court-approved purchaser and the health plan, and such rates shall be effective as of the date that the court-approved purchaser and the health plan execute the initial agreement containing the newly negotiated rate. The rate-setting methodology for inpatient hospital payments and outpatient hospital payments set forth in the §§ 40-8-13.4(b)(1)(ii)(C) and 40-8-13.4(b)(2), respectively, shall thereafter apply to negotiated increases for each annual twelve (12) month period as of July 1 following the completion of the first full year of the court-approved purchaser's initial Medicaid managed care contract.

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

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

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

(f) As a condition of participation in the DRG methodology for payment of hospital services, every hospital shall submit year-end settlement reports to the executive office within one year from the close of a hospital's fiscal year. Should a participating hospital fail to timely submit a year-end settlement report as required by this section, the executive office shall withhold financial cycle payments due by any state agency with respect to this hospital by not more than

ten percent (10%) until said report is submitted. For hospital fiscal year 2010 and all subsequent fiscal years, hospitals will not be required to submit year-end settlement reports on payments for outpatient services. For hospital fiscal year 2011 and all subsequent fiscal years, hospitals will not be required to submit year-end settlement reports on claims for hospital inpatient services. Further, for hospital fiscal year 2010, hospital inpatient claims subject to settlement shall include only those claims received between October 1, 2009 and June 30, 2010.

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

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

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

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

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

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

(iv) Application of a fair rental value system;

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

(vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013 or October 1, 2015, but will occur on April 1, 2015. Said inflation index shall be applied without regard for the transition factor in subsection (b)(2) below.

For purposes of October 1, 2016 adjustment only, any rate increase that results from application of the inflation index to section 2(i) and 2(ii) above shall be dedicated to increase compensation for direct care workers in the following manner: Not less than 85% of this aggregate amount shall be expended to fund an increase in wages, benefits, or related employer costs of direct care staff of nursing homes. For purposes of this section, direct care staff shall include Registered Nurses (RNs), Licensed Practical Nurses (LPNs), certified nursing assistants (CNAs), certified medical technicians, housekeeping staff, laundry staff, dietary staff or other similar employees providing direct care services; provided, however that this definition of direct care staff shall not include: (i) RNs and LPNs who are classified as "exempt employees" under the Federal Fair Labor Standards Act (29 USC 201 et seq); or (ii) CNAs, certified medical technicians, RNs or LPNs who are contracted or subcontracted through a third party vendor or staffing agency. By July 31, 2017, nursing facilities shall submit to the secretary or designee a certification that they have complied with the provisions of this subsection (vi) with respect to the inflation index applied on October 1, 2016. Any facility that does not comply with terms of such certification shall be subjected to a clawback, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification.

(b) Transition to full implementation of rate reform. For no less than four (4) years after the initial application of the price-based methodology described in 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~~ for the year beginning October 1, 2017, the reimbursement for direct care costs under this provision will be phased out in twenty-five (25%) percent increments each year until October 1, 2021 when the reimbursement will no longer be in effect.

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

(3) The transition plan and/or period may be modified upon full implementation of facility per diem rate increases for quality of care related measures. Said modifications shall be

submitted in a report to the general assembly at least six (6) months prior to implementation.

(4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015.

SECTION 3. Sections 40-8.3-2 and 40-8.3-3 of the General Laws in Chapter 40-8.3 entitled “Uncompensated Care” are hereby amended to read as follows:

**40-8.3-2. Definitions. --** As used in this chapter:

(1) "Base year" means for the purpose of calculating a disproportionate share payment for any fiscal year ending after September 30, ~~2014~~ 2015, the period from October 1, ~~2012~~ 2013 through September 30, ~~2013~~ 2014, and for any fiscal year ending after September 30, ~~2015~~ 2016, the period from October 1, ~~2013~~ 2014 through September 30, ~~2014~~ 2015.

(2) "Medicaid inpatient utilization rate for a hospital" means a fraction (expressed as a percentage) the numerator of which is the hospital's number of inpatient days during the base year attributable to patients who were eligible for medical assistance during the base year and the denominator of which is the total number of the hospital's inpatient days in the base year.

(3) "Participating hospital" means any nongovernment and nonpsychiatric hospital that:

(i) was licensed as a hospital in accordance with chapter 17 of title 23 during the base year; and shall mean the actual facilities and buildings in existence in Rhode Island, licensed pursuant to § 23-17-1 et seq. on June 30, 2010, and thereafter any premises included on that license, regardless of changes in licensure status pursuant to § 23-17.14 (hospital conversions) and § 23-17-6(b) (change in effective control), that provides short-term acute inpatient and/or outpatient care to persons who require definitive diagnosis and treatment for injury, illness, disabilities, or pregnancy. Notwithstanding the preceding language, the negotiated Medicaid managed care payment rates for a court-approved purchaser that acquires a hospital through receivership, special mastership or other similar state insolvency proceedings (which court-approved purchaser is issued a hospital license after January 1, 2013) shall be based upon the newly negotiated rates between the court-approved purchaser and the health plan, and such rates shall be effective as of the date that the court-approved purchaser and the health plan execute the initial agreement containing the newly negotiated rate. The rate-setting methodology for inpatient hospital payments and outpatient hospital payments set for the §§ 40-8-13.4(b)(1)(B)(iii) and 40-8-13.4(b)(2), respectively, shall thereafter apply to negotiated increases for each annual twelve (12) month period as of July 1 following the completion of the first full year of the court-approved purchaser's initial Medicaid managed care contract.

(ii) achieved a medical assistance inpatient utilization rate of at least one percent (1%)

during the base year; and

(iii) continues to be licensed as a hospital in accordance with chapter 17 of title 23 during the payment year.

(4) "Uncompensated care costs" means, as to any hospital, the sum of: (i) the cost incurred by such hospital during the base year for inpatient or outpatient services attributable to charity care (free care and bad debts) for which the patient has no health insurance or other third-party coverage less payments, if any, received directly from such patients; and (ii) the cost incurred by such hospital during the base year for inpatient or out-patient services attributable to Medicaid beneficiaries less any Medicaid reimbursement received therefor; multiplied by the uncompensated care index.

(5) "Uncompensated care index" means the annual percentage increase for hospitals established pursuant to § 27-19-14 for each year after the base year, up to and including the payment year, provided, however, that the uncompensated care index for the payment year ending September 30, 2007 shall be deemed to be five and thirty-eight hundredths percent (5.38%), and that the uncompensated care index for the payment year ending September 30, 2008 shall be deemed to be five and forty-seven hundredths percent (5.47%), and that the uncompensated care index for the payment year ending September 30, 2009 shall be deemed to be five and thirty-eight hundredths percent (5.38%), and that the uncompensated care index for the payment years ending September 30, 2010, September 30, 2011, September 30, 2012, September 30, 2013, September 30, 2014, ~~and~~ September 30, 2015, ~~and~~ September 30, 2016, and September 30, 2017 shall be deemed to be five and thirty hundredths percent (5.30%).

**40-8.3-3. Implementation. --** ~~(a) For federal fiscal year 2014, commencing on October 1, 2013 and ending September 30, 2014, the executive office of health and human services shall submit to the Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid state plan for disproportionate share hospital payments (DSH Plan) to provide:~~

~~(1) That the disproportionate share hospital payments to all participating hospitals, not to exceed an aggregate limit of $136.8 million, shall be allocated by the executive office of health and human services to the Pool A, Pool C and Pool D components of the DSH Plan; and,~~

~~(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year inflated by uncompensated care index for all participating hospitals. The disproportionate share payments shall be made on or before July 14, 2014 and are expressly conditioned upon~~

~~approval on or before July 7, 2014 by the Secretary of the U.S. Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2014 for the disproportionate share payments.~~

~~(b)~~(a) For federal fiscal year 2015, commencing on October 1, 2014 and ending September 30, 2015, the executive office of health and human services shall submit to the Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid state plan for disproportionate share hospital payments (DSH Plan) to provide:

(1) That the ~~disproportionate share hospital payments~~ DSH Plan to all participating hospitals, not to exceed an aggregate limit of $140.0 million, shall be allocated by the executive office of health and human services to the Pool A, Pool C and Pool D components of the DSH Plan; and,

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year inflated by uncompensated care index for all participating hospitals. The ~~disproportionate share~~ DSH Plan payments shall be made on or before July 13, 2015 and are expressly conditioned upon approval on or before July 6, 2015 by the Secretary of the U.S. Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2015 for the disproportionate share payments.

~~(c)~~(b) For federal fiscal year 2016, commencing on October 1, 2015 and ending September 30, 2016, the executive office of health and human services shall submit to the Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid ~~state plan for disproportionate share hospital payments~~ ~~(~~DSH Plan~~)~~ to provide:

(1) That the disproportionate share hospital payments to all participating hospitals, not to exceed an aggregate limit of $138.2 million, shall be allocated by the executive office of health and human services to the Pool A, Pool C and Pool D components of the DSH Plan; and,

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year inflated by uncompensated care index for all participating hospitals. The ~~disproportionate~~

~~share payments~~ DSH Plan shall be made on or before July 11, 2016 and are expressly conditioned upon approval on or before July 5, 2016 by the Secretary of the U.S. Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2016 for the ~~disproportionate share payments~~ DSH Plan.

(c) For federal fiscal year 2017, commencing on October 1, 2016 and ending September 30, 2017, the executive office of health and human services shall submit to the Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $139.7 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and,

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year inflated by uncompensated care index for all participating hospitals. The disproportionate share payments shall be made on or before July 11, 2017 and are expressly conditioned upon approval on or before July 5, 2017 by the Secretary of the U.S. Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2017 for the disproportionate share payments.

(d) No provision is made pursuant to this chapter for disproportionate share hospital payments to participating hospitals for uncompensated care costs related to graduate medical education programs.

(e) The executive office of health and human services is directed, on at least a monthly basis, to collect patient level uninsured information, including, but not limited to, demographics, services rendered, and reason for uninsured status from all hospitals licensed in Rhode Island.

(f) Beginning with federal FY 2016, Pool D DSH payments will be recalculated by the state based on actual hospital experience. The final Pool D payments will be based on the data from the final DSH audit for each federal fiscal year. Pool D DSH payments will be redistributed among the qualifying hospitals in direct proportion to the individual qualifying hospital's uncompensated care to the total uncompensated care costs for all qualifying hospitals as determined by the DSH audit. No hospital will receive an allocation that would incur funds received in excess of audited uncompensated care costs.

SECTION 4. Section 40-8.5-1.1 of the General Laws in Chapter 40-8.5 entitled “Health Care for Elderly and Disabled Residents Act” is hereby amended to read as follows:

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

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

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

mandatory managed care in accordance with rules and regulations promulgated by the ~~department of human services~~ executive office.

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

SECTION 5. Sections 40-8.9-3, 40-8.9-4, 40-8.9-6, 40-8.9-7, 40-8.9-8 and 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical Assistance - Long-Term Care Service and Finance Reform " are hereby amended to read as follows:

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

**40-8.9-4. Unified long-term care budget. --** Beginning on July 1, 2007, a unified long-term care budget shall combine in a single line-item appropriation within the ~~department of human services budget~~ executive office of health and human services (executive office), annual ~~department of human services~~ executive office Medicaid appropriations for nursing facility and community-based long-term care services for elderly sixty-five (65) years and older and younger persons at risk of nursing home admissions (including adult day care, home health, pace, and personal care in assisted living settings). Beginning on July 1, 2007, the total system savings attributable to the value of the reduction in nursing home days including hospice nursing home days paid for by Medicaid shall be allocated in the budget enacted by the general assembly for the ensuing fiscal year for the express purpose of promoting and strengthening community-based alternatives; provided, further, beginning July 1, 2009, said savings shall be allocated within the budgets of the executive office and, as appropriate, the department of human services, ~~and the department~~ division of elderly affairs. The allocation shall include, but not be limited to, funds to support an on-going statewide community education and outreach program to provide the public

with information on home and community services and the establishment of presumptive eligibility criteria for the purposes of accessing home and community care. The home and community care service presumptive eligibility criteria shall be developed through rule or regulation on or before September 30, 2007. The allocation may also be used to fund home and community services provided by the ~~department~~ division of elderly affairs for persons eligible for Medicaid long-term care, and the co-pay program administered pursuant to section 42-66.3. Any monies in the allocation that remain unexpended in a fiscal year shall be carried forward to the next fiscal year for the express purpose of strengthening community-based alternatives.

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

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

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

**40-8.9-8. System screening. --** ~~By January 2008 the department of human services~~ The

executive office of health and human services shall develop and implement a screening strategy for the purpose of identifying entrants to the publicly financed long-term care system prior to application for eligibility as well as defining their potential service needs.

**40-8.9-9. Long-term care re-balancing system reform goal. --** (a) Notwithstanding any other provision of state law, the executive office of health and human services is authorized and directed to apply for and obtain any necessary waiver(s), waiver amendment(s) and/or state plan amendments from the secretary of the United States department of health and human services, and to promulgate rules necessary to adopt an affirmative plan of program design and implementation that addresses the goal of allocating a minimum of fifty percent (50%) of Medicaid long-term care funding for persons aged sixty-five (65) and over and adults with disabilities, in addition to services for persons with developmental disabilities , to home and community-based care ; provided, further, the executive office shall report annually as part of its budget submission, the percentage distribution between institutional care and home and community-based care by population and shall report current and projected waiting lists for long-term care and home and community-based care services. The executive office is further authorized and directed to prioritize investments in home and community- based care and to maintain the integrity and financial viability of all current long-term care services while pursuing this goal.

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

(c) Pursuant to federal authority procured under § 42-7.2-16 of the general laws, the executive office of health and human services is directed and authorized to adopt a tiered set of criteria to be used to determine eligibility for services. Such criteria shall be developed in collaboration with the state's health and human services departments and, to the extent feasible, any consumer group, advisory board, or other entity designated for such purposes, and shall

encompass eligibility determinations for long-term care services in nursing facilities, hospitals, and intermediate care facilities for persons with intellectual disabilities as well as home and community-based alternatives, and shall provide a common standard of income eligibility for both institutional and home and community- based care. The executive office is authorized to adopt clinical and/or functional criteria for admission to a nursing facility, hospital, or intermediate care facility for persons with intellectual disabilities that are more stringent than those employed for access to home and community-based services. The executive office is also authorized to promulgate rules that define the frequency of re- assessments for services provided for under this section. Levels of care may be applied in accordance with the following:

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

(a) the recipient transitions to home and community based services because he or she would no longer meet the level of care criteria in effect on June 30, 2015; or

(b) the recipient chooses home and community based services over the nursing facility, hospital, or intermediate care facility for persons with intellectual disabilities. For the purposes of this section, a failed community placement, as defined in regulations promulgated by the executive office, shall be considered a condition of clinical eligibility for the highest level of care. The executive office shall confer with the long-term care ombudsperson with respect to the determination of a failed placement under the ombudsperson's jurisdiction. Should any Medicaid recipient eligible for a nursing facility, hospital, or intermediate care facility for persons with intellectual disabilities as of June 30, 2015 receive a determination of a failed community placement, the recipient shall have access to the highest level of care; furthermore, a recipient who has experienced a failed community placement shall be transitioned back into his or her former nursing home, hospital, or intermediate care facility for persons with intellectual disabilities whenever possible. Additionally, residents shall only be moved from a nursing home, hospital, or intermediate care facility for persons with intellectual disabilities in a manner consistent with applicable state and federal laws.

(2) Any Medicaid recipient eligible for the highest level of care who voluntarily leaves a nursing home, hospital, or intermediate care facility for persons with intellectual disabilities shall not be subject to any wait list for home and community based services.

(3) No nursing home, hospital, or intermediate care facility for persons with intellectual disabilities shall be denied payment for services rendered to a Medicaid recipient on the grounds

that the recipient does not meet level of care criteria unless and until the executive office has:

(i) performed an individual assessment of the recipient at issue and provided written notice to the nursing home, hospital, or intermediate care facility for persons with intellectual disabilities that the recipient does not meet level of care criteria; and

(ii) the recipient has either appealed that level of care determination and been unsuccessful, or any appeal period available to the recipient regarding that level of care determination has expired.

(d) The executive office is further authorized to consolidate all home and community-based services currently provided pursuant to § 1915( c) of title XIX of the United States Code into a single system of home and community- based services that include options for consumer direction and shared living. The resulting single home and community-based services system shall replace and supersede all §1915(c) programs when fully implemented. Notwithstanding the foregoing, the resulting single program home and community-based services system shall include the continued funding of assisted living services at any assisted living facility financed by the Rhode Island housing and mortgage finance corporation prior to January 1, 2006, and shall be in accordance with chapter 66.8 of title 42 of the general laws as long as assisted living services are a covered Medicaid benefit.

(e) The executive office is authorized to promulgate rules that permit certain optional services including, but not limited to, homemaker services, home modifications, respite, and physical therapy evaluations to be offered to persons at risk for Medicaid-funded long-term care subject to availability of state-appropriated funding for these purposes.

(f) To promote the expansion of home and community-based service capacity, the executive office is authorized to pursue payment methodology reforms that increase access to homemaker, personal care (home health aide), assisted living, adult supportive care homes, and adult day services, as follows:

(1) Development, of revised or new Medicaid certification standards that increase access to service specialization and scheduling accommodations by using payment strategies designed to achieve specific quality and health outcomes.

(2) Development of Medicaid certification standards for state authorized providers of adult day services, excluding such providers of services authorized under § 40.1-24-1(3), assisted living, and adult supportive care (as defined under § 23-17.24) that establish for each, an acuity-based, tiered service and payment methodology tied to: licensure authority, level of beneficiary needs; the scope of services and supports provided; and specific quality and outcome measures.

The standards for adult day services for persons eligible for Medicaid-funded long-term

services may differ from those who do not meet the clinical/functional criteria set forth in § 40-8.10-3.

(3) By October 1, 2016, institute an increase in the base payment rates for home care service providers, in an amount to be determined through the appropriations process, for the purpose of implementing a wage pass-through program for personal care attendants and home health aides assisting long-term care beneficiaries. On or before September 1, 2016, Medicaid-funded home health providers seeking to participate in the program shall submit to the secretary for his or her approval a written plan describing and attesting to the manner in which the increased payment rates shall be passed through to personal care attendants and home health aides in their salaries or wages less any attendant costs incurred by the provider for additional payroll taxes, insurance contributions and other costs required by federal or state law, regulation, or policy and directly attributable to the wage pass through program established in this section. Any such providers contracting with a Medicaid managed care organization shall develop the plan for the wage pass-through program in conjunction with the managed care entity and shall include an assurance by the provider that the base-rate increase is implemented in accordance with the goal of raising the wages of the health workers targeted in this subsection. Participating providers who do not comply with the terms of their wage pass-through plan shall be subject to a clawback, paid by the provider to the state, for any portion of the rate increase administered under this section that the secretary deems appropriate.

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

(h) The executive office is also authorized, subject to availability of appropriation of funding, and federal Medicaid-matching funds, to pay for certain services and supports necessary to transition or divert beneficiaries from institutional or restrictive settings and optimize their health and safety when receiving care in a home or the community . The secretary is authorized to obtain any state plan or waiver authorities required to maximize the federal funds available to support expanded access to such home and community transition and stabilization services;

provided, however, payments shall not exceed an annual or per person amount.

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

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

(1) Community-based supportive living program established in § 40-8.13-2.1;

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

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

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

SECTION 6. 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 principles under managed care. --** (a) 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, 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. Therefore, any managed long-term care arrangement shall include a requirement that the managed care organization reimburse providers for services in accordance with 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 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 7. Section 40-5.2-20 of the General Laws in Chapter 40-5.2 entitled "The Rhode Island Works Program" is hereby amended to read as follows:

**40-5.2-20. Child care assistance. --** Families or assistance units eligible for childcare assistance.

(a) The department shall provide appropriate child care to every participant who is eligible for cash assistance and who requires child care in order to meet the work requirements in accordance with this chapter.

(b) Low-Income child care. - The department shall provide child care to all other working families with incomes at or below one hundred eighty percent (180%) of the federal poverty level if, and to the extent, such other families require child care in order to work at paid employment as defined in the department's rules and regulations. Beginning October 1, 2013, the department shall also provide child care to families with incomes below one hundred eighty percent (180%) of the federal poverty level if, and to the extent, such families require child care to participate on a short-term basis, as defined in the department's rules and regulations, in training, apprenticeship, internship, on-the-job training, work experience, work immersion, or other job-readiness/job-attachment program sponsored or funded by the human resource investment council (governor's workforce board) or state agencies that are part of the coordinated program system pursuant to § 42-102-11.

(c) No family/assistance unit shall be eligible for child care assistance under this chapter if the combined value of its liquid resources exceeds ten thousand dollars ($10,000). Liquid resources are defined as any interest(s) in property in the form of cash or other financial instruments or accounts that are readily convertible to cash or cash equivalents. These include, but are not limited to, cash, bank, credit union, or other financial institution savings, checking, and money market accounts; certificates of deposit or other time deposits; stocks; bonds; mutual funds; and other similar financial instruments or accounts. These do not include educational savings accounts, plans, or programs; retirement accounts, plans, or programs; or accounts held jointly with another adult, not including a spouse. The department is authorized to promulgate rules and regulations to determine the ownership and source of the funds in the joint account.

(d) As a condition of eligibility for child care assistance under this chapter, the parent or caretaker relative of the family must consent to, and must cooperate with, the department in establishing paternity, and in establishing and/or enforcing child support and medical support orders for all children in the family in accordance with title 15, as amended, unless the parent or caretaker relative is found to have good cause for refusing to comply with the requirements of this subsection.

(e) For purposes of this section, "appropriate child care" means child care, including infant, toddler, pre-school, nursery school, school-age, that is provided by a person or organization qualified, approved, and authorized to provide such care by the department of children, youth, and families, or by the department of elementary and secondary education, or

such other lawful providers as determined by the department of human services, in cooperation with the department of children, youth and families and the department of elementary and secondary education.

(f)(1) Families with incomes below one hundred percent (100%) of the applicable federal poverty level guidelines shall be provided with free childcare. Families with incomes greater than one hundred percent (100%) and less than one hundred eighty (180%) of the applicable federal poverty guideline shall be required to pay for some portion of the childcare they receive, according to a sliding-fee scale adopted by the department in the department's rules.

(2) ~~For a thirty-six (36) month period beginning October 1, 2013, the child care subsidy transition program shall function within the department of human services. Under this program, families~~ Families who are ~~already~~ receiving childcare assistance and who become ineligible for childcare assistance as a result of their incomes exceeding one hundred eighty percent (180%) of the applicable federal poverty guidelines shall continue to be eligible for childcare assistance from October 1, 2013, to September 30, ~~2016~~ 2017, or until their incomes exceed two hundred twenty-five percent (225%) of the applicable federal poverty guidelines, whichever occurs first. To be eligible, such families must continue to pay for some portion of the childcare they receive, as indicated in a sliding-fee scale adopted in the department's rules and in accordance with all other eligibility standards.

(g) In determining the type of childcare to be provided to a family, the department shall take into account the cost of available childcare options; the suitability of the type of care available for the child; and the parent's preference as to the type of child care.

(h) For purposes of this section, "income" for families receiving cash assistance under § 40-5.2-11 means gross earned income and unearned income, subject to the income exclusions in subdivisions 40-5.2-10(g)(2) and 40-5.2-10(g)(3), and income for other families shall mean gross, earned and unearned income as determined by departmental regulations.

(i) The caseload estimating conference established by chapter 17 of title 35 shall forecast the expenditures for childcare in accordance with the provisions of § 35-17-1.

(j) In determining eligibility for child care assistance for children of members of reserve components called to active duty during a time of conflict, the department shall freeze the family composition and the family income of the reserve component member as it was in the month prior to the month of leaving for active duty. This shall continue until the individual is officially discharged from active duty.

SECTION 8. Section 40.1-22-39 of the General Laws in Chapter 40.1-22 entitled "Developmental Disabilities" is hereby amended to read as follows:

**40.1-22-39. Monthly reports to the general assembly. --** On or before the fifteenth (15th) day of each month, the department shall provide a monthly report of monthly caseload and expenditure data pertaining to eligible developmentally disabled adults to the chairperson of the house finance committee, the chairperson of the senate finance committee, the house fiscal advisor, the senate fiscal advisor, and the state budget officer. The monthly report shall be in such form, and in such number of copies, and with such explanation as the house and senate fiscal advisors may require. It shall include, but is not limited to, the number of cases and expenditures from the beginning of the fiscal year at the beginning of the prior month, cases added and denied during the prior month, expenditures made, and the number of cases and expenditures at the end of the month. The information concerning cases added and denied shall include summary information and profiles of the service demand request for eligible adults meeting the state statutory definition for services from the division of developmental disabilities as determined by the division, including age, Medicaid eligibility and agency selection placement with a list of the services provided, and the reasons for the determinations of ineligibility for those cases denied.

The department shall also provide monthly the number of individuals in a shared living arrangement and how many may have returned to a 24-hour residential placement in that month. The department shall also report monthly any and all information for the consent decree that has been submitted to the federal court as well as the number of unduplicated individuals employed, the place of employment and the number of hours working.

The department shall also provide the amount of funding allocated to individuals above the assigned resource levels, the number of individuals and the assigned resource level and the reasons for the approved additional resources.

The department shall also provide the amount of patient liability to be collected and the amount collected as well as the number of individuals who have a financial obligation.

SECTION 9. Rhode Island Medicaid Reform Act of 2008 Resolution.

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 Law § 42-12.4-1, et seq. for federal waiver requests and/or state plan amendments; and

WHEREAS, Rhode Island General Law § 42-7.2-5 provides that the Secretary of the Executive Office of Health and Human Services (hereafter “the Secretary’) 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) Beneficiary Liability Collection Enhancements* – Federal laws and regulations require beneficiaries who are receiving Medicaid-funded long-term services and supports (LTSS) to pay a portion of any excess income they may have once eligibility has been determined toward in the cost of care. The amount the beneficiary is obligated to pay is referred to as a *liability* or *cost-share* and must be used solely for the purpose of offsetting the agency's payment for the LTSS provided. The EOHHS is seeking to implement new methodologies that will make it easier for beneficiaries to make these payments and enhance the agency's capacity to collect them in a timely and equitable manner. The EOHHS may require federal state plan and/or waiver authority to implement these new methodologies. Amended rules, regulations and procedures may also be required.

(b) *Increase in LTSS Home Care Provider Wages.* To further the goal of rebalancing the long-term care system to promote home and community based alternatives, the EOHHS proposes to establish a wage-pass through program targeting certain home health care professionals. Implementation of the program may require amendments to the Medicaid State Plan and/or section 1115 demonstration waiver due to changes in payment methodologies.

(c) *Alternative Payment Arrangements* – The EOHHS proposes to leverage all available resources by repurposing funds derived from various savings initiatives and obtaining federal financial participation for costs not otherwise matchable to expand the reach and enhance the effectiveness of 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. EOHHS proposes to fund the R.I. Health System Transformation Program by seeking federal authority for federal financial participation (FFP) in financing both Costs Not Otherwise Matchable (CNOMS) and Designated State Health Programs (DSHPs) that either not previously utilized although authorized or were not authorized for federal financial participation prior to June 1, 2016 and for which authority is obtained after June 1, 2016. Utilizing the funds made available by this new authority for federal financial participation, the R.I. Health System Transformation Program will make payments to

health care providers to reward and encourage improvements in clinical quality, patient experience and health system integration. Eligibility for these Health System Transformation Program payments will be made to health care providers participating in Alternative Payment Arrangements including, but not limited to, accountable entities and to those engaged in electronic exchange of clinical information necessary for optimal management of patient care.

(d) *Federal Financing Opportunities.* The EOHHS proposes to review Medicaid requirements and opportunities under the U.S. Patient Protection and Affordable Care Act of 2010 and various other recently enacted federal laws and pursue any changes in the Rhode Island Medicaid program that promote service quality, access and cost-effectiveness that may warrant a Medicaid State Plan Amendment or amendment under the terms and conditions of Rhode Island's section 1115 Waiver, its successor, or any extension thereof. Any such actions the EOHHS takes shall not have an adverse impact on beneficiaries or cause an increase in expenditures beyond the amount appropriated for state fiscal year 2017; now, therefore, be it

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

RESOLVED, that the Secretary 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 10. This article shall take effect upon passage, except as otherwise provided herein.