ARTICLE 9 AS AMENDED

RELATING TO HEALTH AND HUMAN SERVICES

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

(2) Families who are receiving child-care assistance and who become ineligible for child-care 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 child-care assistance ~~from October 1, 2013, to September 30, 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 child care 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 child care to be provided to a family, the department shall take into account the cost of available child-care 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 §§ 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 child care 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 2. Sections 40-8-19 and 40-8-26 of the General Laws in Chapter 40-8 entitled "Medical Assistance" are 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 that 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 shall review the current methodology for providing Medicaid payments to nursing facilities, including other long-term care services providers, and is authorized to modify the principles of reimbursement to replace the current cost based methodology rates with rates based on a price based methodology to be paid to all facilities with recognition of the acuity of patients and the relative Medicaid occupancy, and to include the following elements to be developed by the executive office:

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

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

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

(iv) Application of a fair rental value system;

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

(vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013 or October 1, 2015, but will occur on April 1, 2015. The adjustment of rates will also not occur on October 1, 2017. 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 subparagraphs (a)(2)(i)

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

(b) Transition to full implementation of rate reform. For no less than four (4) years after the initial application of the price-based methodology described in 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; for the year beginning October 1, 2017, the reimbursement for direct-care costs under this provision will be phased out in twenty-five-percent (25%) increments each year until October 1, 2021, when the reimbursement will no longer be in effect. No nursing facility shall receive reimbursement for direct care costs that is less than the rate of reimbursement for direct care costs received under the methodology in effect at the time of passage of this act; and

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

40-8-26. Community health centers.

(a) For the purposes of this section the term community health centers refers to federally qualified health centers and rural health centers.

(b) To support the ability of community health centers to provide high quality medical care to patients, the ~~department of human services~~ executive office of health and human services ("executive office") shall adopt and implement a methodology for determining a Medicaid per visit reimbursement for community health centers which is compliant with the prospective payment system provided for in the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2001. The following principles are to assure that the prospective payment rate determination methodology is part of the ~~department of human services'~~ executive office overall value purchasing approach.

(c) The rate determination methodology will (i) fairly recognize the reasonable costs of providing services. Recognized reasonable costs will be those appropriate for the organization, management and direct provision of services and (ii) provide assurances to the ~~department of human services~~ executive office that services are provided in an effective and efficient manner, consistent with industry standards. Except for demonstrated cause and at the discretion of the ~~department of human services~~ executive office, the maximum reimbursement rate for a service (e.g. medical, dental) provided by an individual community health center shall not exceed one hundred twenty-five percent (125%) of the median rate for all community health centers within Rhode Island.

(d) Community health centers will cooperate fully and timely with reporting requirements established by the ~~department~~ executive office.

(e) Reimbursement rates established through this methodology shall be incorporated into the PPS reconciliation for services provided to Medicaid eligible persons who are enrolled in a health plan on the date of service. Monthly payments by ~~DHS~~ the executive office related to PPS for persons enrolled in a health plan shall be made directly to the community health centers.

(f) Reimbursement rates established through this methodology shall be incorporated into the ~~PPS reconciliation for services provided to Medicaid eligible persons who are enrolled in a health plan on the date of service. Monthly payments by DHS related to PPS for persons enrolled in a health plan shall be made directly to the community health centers~~ actuarially certified capitation rates paid to a health plan. The health plan shall be responsible for paying the full amount

of the reimbursement rate to the community health center for each service eligible for reimbursement under the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2001. If the health plan has an alternative payment arrangement with the community health center the health plan may establish a PPS reconciliation process for eligible services and make monthly payments related to PPS for person enrolled in the health plan on the date of service. The executive office will review, at least annually, the Medicaid reimbursement rates and reconciliation methodology used by the health plans for community health centers to ensure payments to each are made in compliance with the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2001.

SECTION 3. Sections 40-8.3-2, 40-8.3-3 and 40-8.3-10 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, ~~2015~~ 2016, the period from October 1, ~~2013~~ 2014, through September 30, ~~2014~~ 2015, and for any fiscal year ending after September 30, ~~2016~~ 2017, the period from October 1, ~~2014~~ 2015, through September 30, ~~2015~~ 2016.

(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 non-psychiatric 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 chapter 17.14 of title 23 (hospital conversions) and 23-17-6(b) (change in effective control), that provides short-term acute inpatient and/or outpatient care to persons who require definitive diagnosis and treatment for injury, illness, disabilities, or pregnancy. Notwithstanding the preceding language, the 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 §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-month (12) period as of July 1 following the completion of the first full year of the court-approved purchaser's initial Medicaid managed care contract.

(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, September 30, 2015, September 30, 2016, ~~and~~ September 30, 2017, and September 30, 2018, shall be deemed to be five and thirty hundredths percent (5.30%).

40-8.3-3. Implementation.

~~(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 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 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.~~

~~(b)~~(a) 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 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 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 DSH Plan.

~~(c)~~(b) 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.

(c) For federal fiscal year 2018, commencing on October 1, 2017 and ending September 30, 2018, 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 $138.6 million, shall be allocated by the executive office of health and human services to 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 10, 2018 and are expressly conditioned upon approval on or before July 5, 2018 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 2018 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 40-8-13.4 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is hereby amended to read as follows:

40-8-13.4. Rate methodology for payment for in state and out of state hospital services.

(a) The executive office of health and human services ("executive office") shall implement a new methodology for payment for in-state and out-of-state hospital services in order to ensure access to, and the provision of, high-quality and cost-effective hospital care to its eligible recipients.

(b) In order to improve efficiency and cost effectiveness, the executive office shall:

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

(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~~ Increases in inpatient hospital payments for each annual twelve-month (12) period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the applicable period; (B) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the Medicaid managed care payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1, 2015, the Medicaid managed-care payment inpatient rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (C) ~~Negotiated increases~~ Increases in inpatient hospital payments for

each annual twelve-month (12) period beginning ~~July 1, 2016~~ July 1, 2017, ~~may not exceed~~ shall be the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1; (D) The executive office will develop an audit methodology and process to assure that savings associated with the payment reductions will accrue directly to the Rhode Island Medicaid program through reduced managed-care-plan payments and shall not be retained by the managed-care plans; (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-month (12) period beginning July 1, 2015, Medicaid fee-for-service outpatient rates shall not exceed ninety-seven and one-half percent (97.5%) of the rates in effect as of July 1, 2014. ~~Thereafter, increases~~ Increases in the outpatient hospital payments for ~~each annual~~ the twelve-month (12) 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~~ Increases in hospital outpatient payments for each annual twelve-month (12) period beginning January 1, 2012 until July 1,2017, may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment System OPPS hospital price index for the applicable period; (iii) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the Medicaid managed-care outpatient payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1, 2015, the Medicaid managed-care outpatient payment rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (iv) ~~negotiated increases~~ Increases in outpatient hospital payments for each annual twelve-month (12) period beginning ~~July 1, 2016~~ July 1, 2017, ~~may not exceed~~ shall

be the Centers for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1 .

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

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

(d) The secretary of the executive office is hereby authorized to promulgate such rules and regulations consistent with this chapter, and to establish fiscal procedures he or she deems necessary, for the proper implementation and administration of this chapter in order to provide payment to hospitals using the DRG-payment methodology. Furthermore, amendment of the Rhode Island state plan for 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 new payment methodology set forth in 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.

SECTION 5. Section 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:

40-8.9-9. 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.~~ As the state's Medicaid program seeks to assist more beneficiaries requiring long-term services and supports in home and community-based settings, the demand for home care workers has increased, and wages for these workers has not kept pace with neighboring states, leading to high turnover and vacancy rates in the state's home care industry, the EOHHS shall institute a one-time increase in the base-payment rates for home-care service providers to promote increased access to and an adequate supply of highly trained home health care professionals, in amount to be determined by the appropriations process, for the purpose of raising

wages for personal care attendants and home health aides to be implemented by such providers.

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

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

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

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

(1) Community-based supportive living program established in 40-8.13-2.12;

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

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

(k) The secretary is authorized to seek any Medicaid section 1115 waiver or state plan amendments and take any administrative actions necessary to ensure timely adoption of any new or amended rules, regulations, policies, or procedures and any system enhancements or changes, for which appropriations have been authorized, that are necessary to facilitate implementation of

the requirements of this section by the dates established. The secretary shall reserve the discretion to exercise the authority established under 42-7.2-5(6)(v) and 42-7.2-6.1, in consultation with the governor, to meet the legislative directives established herein.

SECTION 6. Section 40.1-1-13 of the General Laws in Chapter 40.1-1 entitled "Department of Behavioral Healthcare, Developmental Disabilities and Hospitals" is hereby amended to read as follows:

40.1-1-13. Powers and duties of the office.

(a) Notwithstanding any provision of the Rhode Island general laws to the contrary, the department of behavioral healthcare, developmental disabilities and hospitals shall have the following powers and duties:

(1) To establish and promulgate the overall plans, policies, objectives, and priorities for state substance-abuse education, prevention, and treatment; provided, however, that the director shall obtain and consider input from all interested state departments and agencies prior to the promulgation of any such plans or policies;

(2) Evaluate and monitor all state grants and contracts to local substance-abuse service providers;

(3) Develop, provide for, and coordinate the implementation of a comprehensive state plan for substance-abuse education, prevention, and treatment;

(4) Ensure the collection, analysis, and dissemination of information for planning and evaluation of substance-abuse services;

(5) Provide support, guidance, and technical assistance to individuals, local governments, community service providers, public and private organizations in their substance-abuse education, prevention, and treatment activities;

(6) Confer with all interested department directors to coordinate the administration of state programs and policies that directly affect substance-abuse treatment and prevention;

(7) Seek and receive funds from the federal government and private sources in order to further the purposes of this chapter;

(8) ~~To act for all purposes in the capacity of "state substance-abuse authority" as the sole designated agency with the sole responsibility for planning, coordinating, managing, implementing, and reporting on state substance-abuse planning and policy efforts as it relates to requirements set forth in pertinent federal substance-abuse laws and regulations;~~ To act in conjunction with the executive office of health and human services as the state's co-designated agency (§ 42 U.S.C. 300x-30(a)) for administering federal aid and for the purposes of the calculation of the expenditures relative to the substance abuse block grant and federal funding maintenance of effort. The

department of behavioral healthcare, developmental disabilities and hospitals, as the state's substance abuse authority, will have the sole responsibility for the planning, policy and implementation efforts as it relates to the requirements set forth in pertinent substance abuse laws and regulations including 42 U.S.C. § 300x-21 et seq.;

(9) Propose, review, and/or approve, as appropriate, proposals, policies, or plans involving insurance and managed care systems for substance-abuse services in Rhode Island;

(10) To enter into, in compliance with the provisions of chapter 2 of title 37, contractual relationships and memoranda of agreement as necessary for the purposes of this chapter;

(11) To license facilities and programs for the care and treatment of substance abusers and for the prevention of substance abuse;

(12) To promulgate rules and regulations necessary to carry out the requirements of this chapter;

(13) Perform other acts and exercise any other powers necessary or convenient to carry out the intent and purposes of this chapter;

(14) To exercise the authority and responsibilities relating to education, prevention, and treatment of substance abuse, as contained in, but not limited to, the following chapters: chapter 1.10 of title 23; chapter 10.1 of title 23; chapter 28.2 of title 23; chapter 21.2 of title 16; chapter 21.3 of title 16; chapter 50.1 of title 42; chapter 109 of title 42; chapter 69 of title 5 and § 35-4-18;

(15) To establish a Medicare Part D restricted-receipt account in the hospitals and community rehabilitation services program to receive and expend Medicare Part D reimbursements from pharmacy benefit providers consistent with the purposes of this chapter;

(16) To establish a RICLAS group home operations restricted-receipt account in the services for the developmentally disabled program to receive and expend rental income from RICLAS group clients for group home-related expenditures, including food, utilities, community activities, and the maintenance of group homes;

(17) To establish a non-Medicaid, third-party payor restricted-receipt account in the hospitals and community rehabilitation services program to receive and expend reimbursement from non-Medicaid, third-party payors to fund hospital patient services that are not Medicaid eligible; and

(18) To certify recovery housing facilities directly, or through a contracted entity, as defined by department guidelines, which includes adherence to using National Alliance for Recovery Residences (NARR) standards. In accordance with a schedule to be determined by the department, all referrals from state agencies or state-funded facilities shall be to certified houses, and only certified recovery housing facilities shall be eligible to receive state funding to deliver

recovery housing services; and.

~~(19) To act in conjunction with the executive office of health and human services as the state's co-designated agency for administering federal aid and for the purpose of the calculation of expenditures relative to the substance abuse block grant and federal funding maintenance of effort requirements.~~

SECTION 7. 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 will also collect and forward to house fiscal advisor, senate fiscal advisor and state budget officer, by November 1 of each year, the annual cost reports for each community based provider for the prior fiscal year.

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.

The department will also provide a list of community based providers awarded an advanced payment for residential and community based day programs, the address for each property and the value of the advancement. If the property is sold, the department must report the final sale, including the purchaser, the value of the sale and the name of the agency that operated the facility. If residential property, the department must provide the number of individuals residing in the home at the time of sale and identify the type of residential placement that the individual(s) will be moving to. The department must report if the property will continue to be licensed as a residential facility. The department will also report any newly licensed twenty-four (24) hour group home, the provider operating the facility and the number of individuals residing in the facility.

Prior to December 1, 2017, the department will provide the authorizations for community based and day program, including the unique number of individuals eligible to receive the services and at the end of each month the unique number of individuals who participated in the programs and claims processed.

SECTION 8. Section 42-7.2-2 of the General Laws in Chapter 42-7.2 entitled "Executive Office of Health and Human Services" is 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.

(6) Administer 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.

(7) ~~To act in conjunction with the department of behavioral healthcare, developmental disabilities and hospitals as the state's co-designated agency for administering federal aid and for the purpose of the calculation of expenditures relative to the substance abuse block grant and federal funding maintenance of effort requirements.~~ To act in conjunction with the department of behavioral healthcare, developmental disabilities and hospitals as the state's co-designated agency (42 U.S.C. § 300x-30(a)) for administering federal aid and for the purposes of the calculation of expenditures relative to the substance abuse block grant and federal funding maintenance of effort.

SECTION 9. Section 42-12-29 of the General Laws in Chapter 42-12 entitled "Department of Human Services" is hereby amended to read as follows:

42-12-29. Children's health account.

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

(b) Beginning ~~January 1, 2016~~ July 1, 2017, a portion of the amount collected pursuant to 42-7.4-3, up to the actual amount expended or projected to be expended by the state for the services described in 42-12-29(a), less any amount collected in excess of the prior year's funding requirement as indicated in 42-12-29(c), but in no event more than the limit set forth in 42-12-29(d) (the "child health services funding requirement"), shall be deposited in the "children's health account."~~.~~ The funds shall be used solely for the purposes of the "children's health account", and no other.

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

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

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

SECTION 10. Section 15 of Article 5 of Chapter 141 of the Public Laws of 2015 is hereby amended to read as follows:

A pool is hereby established of up to ~~$2.5 million~~$4.0 million to support Medicaid Graduate Education funding for Academic Medical Centers with level I Trauma Centers who provide care to the state's critically ill and indigent populations. The office of Health and Human Services shall utilize this pool to provide up to $5 million per year in additional Medicaid payments to support Graduate Medical Education programs to hospitals meeting all of the following criteria:

(a) Hospital must have a minimum of 25,000 inpatient discharges per year for all patients regardless of coverage.

(b) Hospital must be designated as Level I Trauma Center.

(c) Hospital must provide graduate medical education training for at least 250 interns and residents per year.

The Secretary of the Executive Office of Health and Human Services shall determine the appropriate Medicaid payment mechanism to implement this program and amend any state plan documents required to implement the payments.

Payments for Graduate Medical Education programs shall be made annually.

SECTION 11. RELATING TO MEDICAID REFORM ACT OF 2008 RESOLUTION

Section 1. 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 legislative enactment is required pursuant to Rhode Island General Laws

42-12.4-1, et seq.; and

WHEREAS, Rhode Island General Law 42-7.2-5(3)(a) provides that the Secretary of the Executive Office of Health and Human Services ("Executive Office") is responsible for the review and coordination of any Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or category II or III changes as described in the demonstration, "with potential to affect the scope, amount, or duration of publicly-funded health care services, provider payments or reimbursements, or access to or the availability of benefits and services provided by Rhode Island general and public laws"; and

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

(a) Provider Rates -- Adjustments. The Executive Office proposes to:

~~(i) Eliminate hospital payments by the projected increases in hospital rates that would otherwise take effect during the state fiscal year 2018 and reduce the hospital payments by one percent on January 1, 2018.~~

~~(ii)~~(i) ~~Adjust acuity based payment rates to nursing facilities and eliminate~~ Eliminate the annual increase in rates that would otherwise take-effect on October 1, 2017;

~~(iii) Change the acuity based policy adjustor for payments to hospitals for behavioral health services;~~ and

~~(iv)~~(ii) Reduce rates for Medicaid managed care plan administration.

Implementation of adjustments may require amendments to the Rhode Island's Medicaid State Plan and/or Section 1115 waiver under the terms and conditions of the demonstration. Further, adoption of new or amended rules, regulations and procedures may also be required.

(b) 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 their income toward ~~in~~ the cost of care. The Executive Office is seeking to enhance the agency's capacity to collect these payments in a timely and equitable manner. The Executive Office may require federal State Plan and/or waiver authority to implement these enhancements. Amended rules, regulations and procedures may also be required.

(c) Community Health Centers – Alternative payment methodology. To pursue more transparent, better coordinated, and cost-effective care delivery, the Executive Office proposes to revise the Rhode Island's Principles of Reimbursement for Federally Qualified Health Centers, as amended July 2012, to include in its monthly capitation payments to the health plans the total cost

of providing care to the Medicaid plan members the Community Health Centers serve. Pursuing such revisions may also require amendments to the Medicaid state plan and/or other federal authorities.

(d) Healthy Aging Initiative and LTSS System Reform. The Executive Office proposes to further the goals of the Healthy Aging Initiative and LTSS system rebalancing by pursuing:

~~(i) Integrated Care Initiative (ICI) – Demonstration amendment. New enrollment patterns in managed care and fee-for-services Medicaid that will promote the Healthy Aging Initiative goals of achieving greater utilization of home and community based long term services and supports options.~~

~~(ii)~~(i) Process Review and Reform. A review of access to Medicaid-funded LTSS for the purpose of reforming existing processes to streamline eligibility determination procedures, promote options counseling and person-centered planning, and to further the goals of rebalancing the LTSS system while preserving service quality, choice and cost-effectiveness.

Implementation of these changes may require Section 1115 waiver authority under the terms and conditions of the demonstration. New and/or amended rules, regulations and procedures may also be necessary to implement this proposal. Accordingly, the Executive Office may require State Plan or the Section 1115 waiver to foster greater access to home and community-based services. Implementation of such changes may also require the adoption of rules, regulations and/or procedures.

~~(e) Estate Recoveries and Liens. Proposed changes in Executive Office policies pertaining to estate recoveries and liens may require new or amended State Plan and/or Section 1115 waiver authorities. Implementation of these changes may also require new and/or amended rules, regulations and procedures.~~

~~(f)~~(e) Federal Financing Opportunities. The Executive Office proposes to review Medicaid requirements and opportunities under the U.S. Patient Protection and Affordable Care Act of 2010 (PPACA) and various other recently enacted federal laws and pursue any changes in the Rhode Island Medicaid program that promote service quality, access and cost-effectiveness that may warrant a Medicaid State Plan amendment or amendment under the terms and conditions of Rhode Island's Section 1115 Waiver, its successor, or any extension thereof. Any such actions by the Executive Office shall not have an adverse impact on beneficiaries or cause there to be an increase in expenditures beyond the amount appropriated for state fiscal year 2018. Now, therefore, be it:

RESOLVED, the General Assembly hereby approves proposals and be it further;

RESOLVED, the Secretary of the Executive Office 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 12. Section 1 of this Article shall take effect on October 1, 2017. The remainder of this Article shall take effect upon passage.