ARTICLE 13

RELATING TO HUMAN SERVICES

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

35-17-1. Purpose and membership.

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

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

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

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

(e) The department of human services shall provide monthly data to the members of the caseload estimating conference by the fifteenth day of the following month. Monthly data shall include, but is not limited to, actual caseloads and expenditures for the following case assistance programs: Rhode Island Works, SSI state program, general public assistance, and child care. For individuals eligible to receive the payment under § 40-6-27(a)(1)(vi), the report shall include the number of individuals enrolled in a managed care plan receiving long-term care services and supports and the number receiving fee-for-service benefits. The executive office of health and human services shall report relevant caseload information and expenditures for the following medical assistance categories: hospitals, long-term care, managed care, pharmacy, and other medical services. In the category of managed care, caseload information and expenditures for the

following populations shall be separately identified and reported: children with disabilities, children in foster care, and children receiving adoption assistance and RIte Share enrollees under § 40-8.1-12(j). The information shall include the number of Medicaid recipients whose estate may be subject to a recovery and the anticipated amount to be collected from those subject to recovery, the total recoveries collected each month and number of estates attached to the collections and each month, the number of open cases and the number of cases that have been open longer than three months.

SECTION 2. 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)~~ one million dollars ($1,000,000), which corresponds to the amount permitted by the federal government under the state plan and set forth in the administrative rule-making process by the department. 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~~ any children in the family receiving appropriate child care under this section in accordance with the applicable sections of title 15 of the state's general laws, 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~~ the state agency or agencies designated to make such determinations in accordance with the provisions set forth herein.

(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 until their incomes exceed two hundred twenty-five percent (225%) of the applicable federal poverty guidelines. 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 3. Sections 40-6-27 and 40-6-27.2 of the General Laws in Chapter 40-6 entitled "Public Assistance Act" are hereby amended to read as follows:

40-6-27. Supplemental security income.

(a)(1) The director of the department is hereby authorized to enter into agreements on behalf of the state with the secretary of the Department of Health and Human Services or other appropriate federal officials, under the supplementary and security income (SSI) program established by title XVI of the Social Security Act, 42 U.S.C. § 1381 et seq., concerning the administration and determination of eligibility for SSI benefits for residents of this state, except as otherwise provided in this section. The state's monthly share of supplementary assistance to the supplementary security income program shall be as follows:

(i) Individual living alone:	$39.92
(ii) Individual living with others:	$51.92
(iii) Couple living alone:	$79.38
(iv) Couple living with others:	$97.30
(v) Individual living in state licensed assisted living residence:	$332.00

(vi) Individual eligible to receive Medicaid-funded long-term services and supports and living in a Medicaid certified state licensed assisted living residence or adult supportive care residence, as defined in § 23-17.24-1, participating in the program authorized under § 40-8.13-12 or an alternative, successor, or substitute program or delivery option designated for such purposes by the secretary of the executive office of health and human services:

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

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

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

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

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

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

(4) Individuals living in state licensed supportive residential care settings and assisted living residences who are receiving SSI supplemental payments under this section who are participating in the program under § 40-8.13-12 or an alternative, successor, or substitute program or delivery option, or otherwise shall be allowed to retain a minimum personal needs allowance of fifty-five dollars ($55.00) per month from their SSI monthly benefit prior to payment of any monthly fees in addition to any amounts established in an administrative rule promulgated by the secretary of the executive office of health and human services for persons eligible to receive Medicaid-funded long-term services and supports in the settings identified in subsection (a)(1)(v) and (a)(1)(vi).

(5) Except as authorized for the program authorized under § 40-8.13-12 or an alternative, successor, or substitute program, or delivery option designated by the secretary to ensure that supportive residential care or an assisted living residence is a safe and appropriate service setting, the department is authorized and directed to make a determination of the medical need and whether a setting provides the appropriate services for those persons who: (i) Have applied for or are

receiving SSI, and who apply for admission to supportive residential care setting and assisted living residences on or after October 1, 1998; or

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

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

(7) To assure access to high quality coordinated services, the executive office of health and human services is further authorized and directed to establish certification or contract standards that must be met by those state licensed supportive residential care settings, including adult supportive care homes and assisted living residences admitting or serving any persons eligible for state-funded supplementary assistance under this section or the program established under § 40-8.13-12. Such certification or contract standards shall define:

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

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

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

(8) The certification or contract standards required by this section or § 40-8.13-12 or an alternative, successor, or substitute program, or delivery option designated by the secretary shall be developed in collaboration by the departments, under the direction of the executive office of health and human services, so as to ensure that they comply with applicable licensure regulations either in effect or in development.

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

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

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

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

40-6-27.2. Supplementary cash assistance payment for certain supplemental security income recipients.

There is hereby established a $206 monthly payment for disabled and elderly individuals who, on or after July 1, 2012, receive the state supplementary assistance payment for an individual in state licensed assisted living residence under § 40-6-27 and further reside in an assisted living facility that is not eligible to receive funding under Title XIX of the Social Security Act, 42 U.S.C. § 1381 et seq. or reside in any assisted living facility financed by the Rhode Island housing and mortgage finance corporation prior to January 1, 2006, and receive a payment under § 40-6-27. Such a monthly payment shall not be made on behalf of persons participating in the program authorized under § 40-8.13-12 or an alternative, successor, or substitute program, or delivery option designated for such purposes by the secretary of the executive office of health and human services.

SECTION 4. Section 40-6.2-1.1 of the General Laws in Chapter 40-6.2 entitled "Child Care - State Subsidies" is hereby amended to read as follows:

40-6.2-1.1. Rates established.

(a) Through June 30, 2015, subject to the payment limitations in subsection (c), the maximum reimbursement rates to be paid by the departments of human services and children, youth and families for licensed childcare centers and licensed family-childcare providers shall be based on the following schedule of the 75th percentile of the 2002 weekly market rates adjusted for the average of the 75th percentile of the 2002 and the 2004 weekly market rates:

LICENSED CHILDCARE CENTERS	75th PERCENTILE OF WEEKLY MARKET RATE
INFANT	$182.00
PRESCHOOL	$150.00
SCHOOL-AGE	$135.00
LICENSED FAMILY CHILDCARE PROVIDERS	75th PERCENTILE OF WEEKLY MARKET RATE
INFANT	$150.00
PRESCHOOL	$150.00
SCHOOL-AGE	$135.00

Effective July 1, 2015, subject to the payment limitations in subsection (c), the maximum

reimbursement rates to be paid by the departments of human services and children, youth and families for licensed childcare centers and licensed family-childcare providers shall be based on the above schedule of the 75th percentile of the 2002 weekly market rates adjusted for the average of the 75th percentile of the 2002 and the 2004 weekly market rates. These rates shall be increased by ten dollars ($10.00) per week for infant/toddler care provided by licensed family-childcare providers and license-exempt providers and then the rates for all providers for all age groups shall be increased by three percent (3%). For the fiscal year ending June 30, 2018, licensed childcare centers shall be reimbursed a maximum weekly rate of one hundred ninety-three dollars and sixty-four cents ($193.64) for infant/toddler care and one hundred sixty-one dollars and seventy-one cents ($161.71) for preschool-age children.

(b) Effective July l, 2018, subject to the payment limitations in subsection (c), the maximum infant/toddler and preschool-age reimbursement rates to be paid by the departments of human services and children, youth and families for licensed childcare centers shall be implemented in a tiered manner, reflective of the quality rating the provider has achieved within the state's quality rating system outlined in § 42-12-23.1.

(1) For infant/toddler childcare, tier one shall be reimbursed two and one-half percent (2.5%) above the FY 2018 weekly amount, tier two shall be reimbursed five percent (5%) above the FY 2018 weekly amount, tier three shall be reimbursed thirteen percent (13%) above the FY 2018 weekly amount, tier four shall be reimbursed twenty percent (20%) above the FY 2018 weekly amount, and tier five shall be reimbursed thirty-three percent (33%) above the FY 2018 weekly amount.

(2) For preschool reimbursement rates, tier one shall be reimbursed two and one-half (2.5%) percent above the FY 2018 weekly amount, tier two shall be reimbursed five percent (5%) above the FY 2018 weekly amount, tier three shall be reimbursed ten percent (10%) above the FY 2018 weekly amount, tier four shall be reimbursed thirteen percent (13%) above the FY 2018 weekly amount, and tier five shall be reimbursed twenty-one percent (21%) above the FY 2018 weekly amount.

~~(c) The departments shall pay childcare providers based on the lesser of the applicable rate specified in subsection (a), or the lowest rate actually charged by the provider to any of its public or private childcare customers with respect to each of the rate categories, infant, preschool and school age.~~

~~(d)~~(c) By June 30, 2004, and biennially through June 30, 2014, the department of labor and training shall conduct an independent survey or certify an independent survey of the then current weekly market rates for childcare in Rhode Island and shall forward such weekly market rate survey

to the department of human services. The next survey shall be conducted by June 30, 2016, and triennially thereafter. The departments of human services and labor and training will jointly determine the survey criteria including, but not limited to, rate categories and sub-categories.

~~(e)~~(d) In order to expand the accessibility and availability of quality childcare, the department of human services is authorized to establish by regulation alternative or incentive rates of reimbursement for quality enhancements, innovative or specialized childcare and alternative methodologies of childcare delivery, including non-traditional delivery systems and collaborations.

~~(f)~~(e) Effective January 1, 2007, all childcare providers have the option to be paid every two (2) weeks and have the option of automatic direct deposit and/or electronic funds transfer of reimbursement payments.

(f) Effective July 1, 2019, the maximum infant/toddler reimbursement rates to be paid by the departments of human services and children, youth and families for licensed family childcare providers shall be implemented in a tiered manner, reflective of the quality rating the provider has achieved within the state's quality rating system outlined in § 42-12-23.1. Tier one shall be reimbursed two percent (2%) above the prevailing base rate for step 1 and step 2 providers, three percent (3%) above prevailing base rate for step 3 providers, and four percent (4%) above the prevailing base rate for step 4 providers; tier two shall be reimbursed five percent (5%) above the prevailing base rate; tier three shall be reimbursed eleven percent (11%) above the prevailing base rate; tier four shall be reimbursed fourteen percent (14%) above the prevailing base rate; and tier five shall be reimbursed twenty-three percent (23%) above the prevailing base rate.

SECTION 5. Sections 40-8-13.4 and 40-8-19 of the General Laws in Chapter 40-8 entitled "Medical Assistance" are hereby amended to read as follows:

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

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

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

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

DRG base price annually, making adjustments as appropriate in consideration of such elements as trends in hospital input costs; patterns in hospital coding; beneficiary access to care; and the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index. For the twelve-month (12) period beginning July 1, 2015, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of July 1, 2014. Beginning July 1, 2019, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall be 107.2% of the payment rates in effect as of July 1, 2018. Increases in the Medicaid fee-for-service DRG hospital payments for the twelve-month (12) period beginning July 1, 2020 shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national Prospective Payment System (IPPS) Hospital Input Price Index.

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

with the payment reductions will accrue directly to the Rhode Island Medicaid program through reduced managed-care-plan payments and shall not be retained by the managed-care plans; (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. Increases in the outpatient hospital payments for the twelve-month (12) period beginning July 1, 2016, may not exceed the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. Beginning July 1, 2019, the Medicaid fee-for-service outpatient rates shall be 107.2% of the payment rates in effect as of July 1, 2018. Increases in the outpatient hospital payments for the twelve-month (12) period beginning July 1, 2020 shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. With respect to the outpatient rate, (i) It is required as of January 1, 2011, until December 31, 2011, that the Medicaid managed-care payment rates between each hospital and health plan shall not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010; (ii) Increases in hospital outpatient payments for each annual twelve-month (12) period beginning January 1, 2012 until July 1, 2017, may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment System OPPS hospital price index for the applicable period; (iii) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the Medicaid managed-care outpatient payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1, 2015, the Medicaid managed-care outpatient payment rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (iv) Increases in outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2017, shall be the Centers for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each

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

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

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

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

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 Title XIX of the Social Security Act 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 1 of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013, October 1, 2014 or October 1, 2015, but will occur on April 1, 2015. The adjustment of rates will also not occur on October 1, 2017, ~~or~~ October 1, 2018 and October 1, 2019. Effective July 1, 2018, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2017, both fee-for-service and managed care, will be increased by one and one-half percent (1.5%) and further increased by one percent (1%) on October 1, 2018, and further increased by one percent (1%) on October 1, 2019. Said inflation index shall be applied without regard for the transition factors in subsections (b)(1) and (b)(2). For purposes of October 1, 2016, adjustment only, any rate increase that results from application of the inflation index to subsections (a)(2)(i) and (a)(2)(ii) shall be dedicated to increase compensation for direct-care workers in the following manner: Not less than 85% of this aggregate amount shall be expended to fund an increase in wages, benefits, or related employer costs of direct-care staff of nursing homes. For purposes of this section, direct-care staff shall include registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), certified medical technicians, housekeeping staff, laundry staff, dietary staff, or other similar employees providing direct care services; provided, however, that this definition of direct-care staff shall not include: (i) RNs and LPNs who are classified as "exempt employees" under the Federal Fair Labor Standards Act (29 U.S.C. § 201 et seq.); or (ii) CNAs, certified medical technicians, RNs, or LPNs who are contracted, or subcontracted, through a third-party vendor or staffing agency. By July 31, 2017, nursing facilities shall submit to the secretary, or designee, a certification that they have complied with the provisions of subsections (a)(2)(vi) with respect to the inflation index applied on October 1, 2016. Any facility that does not comply with terms of such certification shall be subjected to a clawback, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification.

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

the following components:

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

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

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

(4) Notwithstanding any law to the contrary, for the twelve-month (12) period beginning July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section shall not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015. Consistent with the other provisions of this chapter, nothing in this provision shall require the executive office to restore the rates to those in effect on April 1, 2015, at the end of this twelve-month (12) period.

SECTION 6. 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, ~~2017~~ 2018, the period from October 1, ~~2015~~ 2016, through September 30, ~~2016~~ 2017, and for any fiscal year ending after September 30, ~~2018~~ 2019, the period from October 1, 2016, through September 30, 2017.

(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 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, September 30, 2017, ~~and~~ September 30, 2018, September 30, 2019, and September 30, 2020 shall be deemed to be five and thirty hundredths percent (5.30%).

40-8.3-3. Implementation.

~~(a) 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.~~

~~(b)~~(a) 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 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 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.

~~(c)~~(b) For federal fiscal year 2019, commencing on October 1, 2018, and ending September 30, 2019, 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~~ $142.4 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 10, 2019, and are expressly conditioned upon approval on or before July 5, 2019, 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~~ 2019 for the disproportionate share payments.

(c) For federal fiscal year 2020, commencing on October 1, 2019, and ending September 30, 2020, 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 $142.4 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 13, 2020, and are expressly conditioned upon approval on or before July 6, 2020, 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 2020 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.~~

40-8.3-10. Hospital adjustment payments.

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

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

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

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

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

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

~~(b) Each hospital in the state of Rhode Island, as defined in subdivision 3-17-38.19(b)(1), shall receive a quarterly inpatient adjustment payment each state fiscal year of an amount determined as follows:~~

~~(1) Determine the percent of the state's total Medicaid inpatient services (exclusive of physician services) provided by each hospital during each hospital's prior fiscal year;~~

~~(2) Determine the sum of all Medicaid payments to hospitals made for inpatient services (exclusive of physician services) provided during each hospital's prior fiscal year;~~

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

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

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

SECTION 7. Section 40-8.4-12 of the General Laws in Chapter 40-8.4 entitled "Health Care For Families" is hereby amended to read as follows:

40-8.4-12. RIte Share Health Insurance Premium Assistance Program.

(a) Basic RIte Share Health Insurance Premium Assistance Program. Under the terms of Section 1906 of Title XIX of the U.S. Social Security Act, 42 U.S.C. § 1396e, states are permitted to pay a Medicaid eligible person's share of the costs for enrolling in employer-sponsored health insurance (ESI) coverage if it is cost effective to do so. Pursuant to the general assembly's direction in the Rhode Island Health Reform Act of 2000, the Medicaid agency requested and obtained federal approval under § 1916, 42 U.S.C. § 1396o, to establish the RIte Share premium assistance program to subsidize the costs of enrolling Medicaid eligible persons and families in employer sponsored health insurance plans that have been approved as meeting certain cost and coverage requirements. The Medicaid agency also obtained, at the general assembly's direction, federal authority to require any such persons with access to ESI coverage to enroll as a condition of retaining eligibility providing that doing so meets the criteria established in Title XIX for obtaining federal matching funds.

(b) Definitions. For the purposes of this section, the following definitions apply:

(1) "Cost-effective" means that the portion of the ESI that the state would subsidize, as well as wrap-around costs, would on average cost less to the state than enrolling that same person/family in a managed-care delivery system.

(2) "Cost sharing" means any co-payments, deductibles, or co-insurance associated with ESI.

(3) "Employee premium" means the monthly premium share a person or family is required to pay to the employer to obtain and maintain ESI coverage.

(4) "Employer-sponsored insurance or ESI" means health insurance or a group health plan offered to employees by an employer. This includes plans purchased by small employers through the state health insurance marketplace, healthsource, RI (HSRI).

(5) "Policy holder" means the person in the household with access to ESI, typically the employee.

(6) "RIte Share-approved employer-sponsored insurance (ESI)" means an employer-sponsored health insurance plan that meets the coverage and cost-effectiveness criteria for RIte Share.

(7) "RIte Share buy-in" means the monthly amount an Medicaid-ineligible policy holder must pay toward RIte Share-approved ESI that covers the Medicaid-eligible children, young adults, or spouses with access to the ESI. The buy-in only applies in instances when household income is above one hundred fifty percent (150%) of the FPL.

(8) "RIte Share premium assistance program" means the Rhode Island Medicaid premium assistance program in which the State pays the eligible Medicaid member's share of the cost of enrolling in a RIte Share-approved ESI plan. This allows the state to share the cost of the health insurance coverage with the employer.

(9) "RIte Share Unit" means the entity within EOHHS responsible for assessing the cost-effectiveness of ESI, contacting employers about ESI as appropriate, initiating the RIte Share enrollment and disenrollment process, handling member communications, and managing the overall operations of the RIte Share program.

(10) "Third-Party Liability (TPL)" means other health insurance coverage. This insurance is in addition to Medicaid and is usually provided through an employer. Since Medicaid is always the payer of last resort, the TPL is always the primary coverage.

(11) "Wrap-around services or coverage" means any health care services not included in the ESI plan that would have been covered had the Medicaid member been enrolled in a RIte Care or Rhody Health Partners plan. Coverage of deductibles and co-insurance is included in the wrap.

Co-payments to providers are not covered as part of the wrap-around coverage.

(c) RIte Share populations. Medicaid beneficiaries subject to RIte Share include: children, families, parent and caretakers eligible for Medicaid or the Children's Health Insurance Program under this chapter or chapter 12.3 of title 42; and adults between the ages of nineteen (19) and sixty-four (64) who are eligible under chapter 8.12 of title 40, not receiving or eligible to receive Medicare, and are enrolled in managed care delivery systems. The following conditions apply:

(1) The income of Medicaid beneficiaries shall affect whether and in what manner they must participate in RIte Share as follows:

(i) Income at or below one hundred fifty percent (150%) of FPL -- Persons and families determined to have household income at or below one hundred fifty percent (150%) of the Federal Poverty Level (FPL) guidelines based on the modified adjusted gross income (MAGI) standard or other standard approved by the secretary are required to participate in RIte Share if a Medicaid-eligible adult or parent/caretaker has access to cost-effective ESI. Enrolling in ESI through RIte Share shall be a condition of maintaining Medicaid health coverage for any eligible adult with access to such coverage.

(ii) Income above one hundred fifty percent (150%) of FPL and policy holder is not Medicaid-eligible -- Premium assistance is available when the household includes Medicaid-eligible members, but the ESI policy holder (typically a parent/caretaker, or spouse) is not eligible for Medicaid. Premium assistance for parents/caretakers and other household members who are not Medicaid-eligible may be provided in circumstances when enrollment of the Medicaid-eligible family members in the approved ESI plan is contingent upon enrollment of the ineligible policy holder and the executive office of health and human services (executive office) determines, based on a methodology adopted for such purposes, that it is cost-effective to provide premium assistance for family or spousal coverage.

(d) RIte Share enrollment as a condition of eligibility. For Medicaid beneficiaries over the age of nineteen (19) enrollment in RIte Share shall be a condition of eligibility except as exempted below and by regulations promulgated by the executive office.

(1) Medicaid-eligible children and young adults up to age nineteen (19) shall not be required to enroll in a parent/caretaker relative's ESI as a condition of maintaining Medicaid eligibility if the person with access to RIte Share-approved ESI does not enroll as required. These Medicaid-eligible children and young adults shall remain eligible for Medicaid and shall be enrolled in a RIte Care plan.

(2) There shall be a limited six-month (6) exemption from the mandatory enrollment requirement for persons participating in the RI Works program pursuant to chapter 5.2 of title 40.

(e) Approval of health insurance plans for premium assistance. The executive office of health and human services shall adopt regulations providing for the approval of employer-based health insurance plans for premium assistance and shall approve employer-based health insurance plans based on these regulations. In order for an employer-based health insurance plan to gain approval, the executive office must determine that the benefits offered by the employer-based health insurance plan are substantially similar in amount, scope, and duration to the benefits provided to Medicaid-eligible persons enrolled in a Medicaid managed-care plan, when the plan is evaluated in conjunction with available supplemental benefits provided by the office. The office shall obtain and make available to persons otherwise eligible for Medicaid identified in this section as supplemental benefits those benefits not reasonably available under employer-based health insurance plans that are required for Medicaid beneficiaries by state law or federal law or regulation. Once it has been determined by the Medicaid agency that the ESI offered by a particular employer is RIte Share-approved, all Medicaid members with access to that employer's plan are required to participate in RIte Share. Failure to meet the mandatory enrollment requirement shall result in the termination of the Medicaid eligibility of the policy holder and other Medicaid members nineteen (19) or older in the household who could be covered under the ESI until the policy holder complies with the RIte Share enrollment procedures established by the executive office.

(f) Premium Assistance. The executive office shall provide premium assistance by paying all or a portion of the employee's cost for covering the eligible person and/or his or her family under such a RIte Share-approved ESI plan subject to the buy-in provisions in this section.

(g) Buy-in. Persons who can afford it shall share in the cost. -- The executive office is authorized and directed to apply for and obtain any necessary state plan and/or waiver amendments from the secretary of the U.S. DHHS to require that persons enrolled in a RIte Share-approved employer-based health plan who have income equal to or greater than one hundred fifty percent (150%) of the FPL to buy-in to pay a share of the costs based on the ability to pay, provided that the buy-in cost shall not exceed five percent (5%) of the person's annual income. The executive office shall implement the buy-in by regulation, and shall consider co-payments, premium shares, or other reasonable means to do so.

(h) Maximization of federal contribution. The executive office of health and human services is authorized and directed to apply for and obtain federal approvals and waivers necessary to maximize the federal contribution for provision of medical assistance coverage under this section, including the authorization to amend the Title XXI state plan and to obtain any waivers necessary to reduce barriers to provide premium assistance to recipients as provided for in Title

XXI of the Social Security Act, 42 U.S.C. § 1397 et seq.

(i) Implementation by regulation. The executive office of health and human services is authorized and directed to adopt regulations to ensure the establishment and implementation of the premium assistance program in accordance with the intent and purpose of this section, the requirements of Title XIX, Title XXI and any approved federal waivers.

(j) Outreach and Reporting. The executive office of health and human services shall develop a plan to identify Medicaid eligible individuals who have access to employer sponsored insurance and increase the use of RIte Share benefits. Beginning October 1, 2019, the executive office shall submit the plan to be included as part of the reporting requirements under § 35-17-1. Starting January 1, 2020, the executive office of health and human services shall include the number of Medicaid recipients with access to employer sponsored insurance, the number of plans that did not meet the cost effectiveness criteria for RIte Share, and enrollment in the premium assistance program as part of the reporting requirements under § 35-17-1.

SECTION 8. Section 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical Assistance - Long-Term Care Service and Finance Reform" is hereby amended to read as follows:

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

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

(b) The reformed long-term-care system rebalancing goal is person centered and encourages individual self-determination, family involvement, interagency collaboration, and individual choice through the provision of highly specialized and individually tailored home-based services. Additionally, individuals with severe behavioral, physical, or developmental disabilities must have the opportunity to live safe and healthful lives through access to a wide range of

supportive services in an array of community-based settings, regardless of the complexity of their medical condition, the severity of their disability, or the challenges of their behavior. Delivery of services and supports in less costly and less restrictive community settings, will enable children, adolescents, and adults to be able to curtail, delay, or avoid lengthy stays in long-term care institutions, such as behavioral health residential-treatment facilities, long-term-care hospitals, intermediate-care facilities, and/or skilled nursing facilities.

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

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

(a) 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 42 U.S.C. § 1396n into a single system of home- and community-based services that include options for consumer direction and shared living. The resulting single home- and community-based services system shall replace and supersede all 42 U.S.C. § 1396n 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 as long as assisted-living services are a covered Medicaid benefit.

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

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

adult day services, as follows:

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

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

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

(3) 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 executive office 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.

(4) A prospective base adjustment, effective not later than July 1, 2018, of ten percent (10%) of the current base rate for home care providers, home nursing care providers, and hospice providers contracted with the executive office of health and human services and its subordinate agencies to deliver Medicaid fee-for-service personal care attendant services.

(5) A prospective base adjustment, effective not later than July l, 2018, of twenty percent (20%) of the current base rate for home care providers, home nursing care providers, and hospice providers contracted with the executive office of health and human services and its subordinate agencies to deliver Medicaid fee-for-service skilled nursing and therapeutic services and hospice care.

(6) Effective upon passage of this section, hospice provider reimbursement, exclusively for room and board expenses for individuals residing in a skilled nursing facility, shall revert to the rate methodology in effect on June 30, 2018, and these room and board expenses shall be exempted from any and all annual rate increases to hospice providers as provided for in this section.

~~(6)~~ (7) On the first of July in each year, beginning on July l, 2019, the executive office of health and human services will initiate an annual inflation increase to the base rate for home care providers, home nursing care providers, and hospice providers contracted with the executive office and its subordinate agencies to deliver Medicaid fee-for-service skilled nursing and therapeutic services and hospice care. The base rate increase shall be ~~by~~ a percentage amount equal to the New England Consumer Price Index card as determined by the United States Department of Labor for medical care and for compliance with all federal and state laws, regulations, and rules, and all national accreditation program requirements. (g) The executive office shall implement a long-term-care options counseling program to provide individuals, or their representatives, or both, with long-term-care consultations that shall include, at a minimum, information about: long-term-care options, sources, and methods of both public and private payment for long-term-care services and an assessment of an individual's functional capabilities and opportunities for maximizing independence. Each individual admitted to, or seeking admission to, a long-term-care facility, regardless of the payment source, shall be informed by the facility of the availability of the long-term-care options counseling program and shall be provided with long-term-care options consultation if they so request. Each individual who applies for Medicaid long-term-care services shall be provided with a long-term-care consultation.

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

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

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

(1) Community-based, supportive-living program established in § 40-8.13-12 or an alternative, successor, or substitute program, or delivery option designated for such purposes by

the secretary of the executive office of health and human services;

(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 9. Section 40-8.13-12 of the General Laws in Chapter 40-8.13 entitled "Long-Term Managed Care Arrangements" is hereby amended to read as follows:

40-8.13-12. Community-based supportive living program.

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

(b) Room and board. The executive office shall raise the cap on the amount Medicaid certified assisted living and adult supportive home care providers are permitted to charge participating beneficiaries for room and board. In the first year of the program, the monthly charges for a beneficiary living in a single room who has income at or below three hundred percent (300%)

of the Supplemental Security Income (SSI) level shall not exceed the total of both the maximum monthly federal SSI payment and the monthly state supplement authorized for persons requiring long-term services under § 40-6-27.2(a)(1)(vi), less the specified personal need allowance. For a beneficiary living in a double room, the room and board cap shall be set at eighty-five percent (85%) of the monthly charge allowed for a beneficiary living in a single room.

(c) Program cost-effectiveness. The total cost to the state for providing the state supplement and Medicaid-funded services and supports to beneficiaries participating in the program in the initial year of implementation shall not exceed the cost for providing Medicaid-funded services to the same number of beneficiaries with similar acuity needs in an institutional setting in the initial year of the operations. The program shall be terminated if the executive office determines that the program has not met this target. The state shall expand access to the program to qualified beneficiaries who opt out of an LTSS arrangement, in accordance with § 40-8.13-2, or are required to enroll in an alternative, successor, or substitute program, or delivery option designated for such purposes by the secretary of the executive office of health and human services if the enrollment in an LTSS plan is no longer an option.

SECTION 10. Section 40.1-22-13 of the General Laws in Chapter 40.1-22 entitled "Developmental Disabilities" is hereby amended to read as follows:

40.1-22-13. Visits.

No public or private developmental disabilities facility shall restrict the visiting of a client by anyone at any time of the day or night; however, in special circumstances when the client is ill or incapacitated and a visit would not be in his or her best interest, visitation may be restricted temporarily during the illness or incapacity when documented in the client's individualized program plan, as defined in § 40.1-21-4.3(7) of the general laws.

SECTION 11. Section 40.1-26-3 of the General Laws in Chapter 40.1-26 entitled "Rights for Persons with Developmental Disabilities" is hereby amended to read as follows:

40.1-26-3. Participants' rights.

In addition to any other rights provided by state or federal laws, a participant as defined in this chapter shall be entitled to the following rights:

(1) To be treated with dignity, respect for privacy and have the right to a safe and supportive environment;

(2) To be free from verbal and physical abuse;

(3)(i) To engage in any activity including employment, appropriate to his or her age, and interests in the most integrated community setting;

(ii) No participant shall be required to perform labor, which involves the essential operation

and maintenance of the agency or the regular supervision or care of other participants. Participants may however, be requested to perform labor involving normal housekeeping and home maintenance functions if such responsibilities are documented in the participant's individualized plan;

(4) To participate in the development of his or her individualized plan and to provide informed consent to its implementation or to have an advocate provide informed consent if the participant is not competent to do so;

(5) To have access to his or her individualized plan and other medical, social, financial, vocational, psychiatric, or other information included in the file maintained by the agency;

(6) To give written informed consent prior to the imposition of any plan designed to modify behavior, including those which utilizes aversive techniques or impairs the participant's liberty or to have an advocate provide written informed consent if the participant is not competent to do so. Provided, however, that if the participant is competent to provide consent but cannot provide written consent, the agency shall accept an alternate form of consent and document in the participant's record how such consent was obtained;

(7) To register a complaint regarding an alleged violation of rights through the grievance procedure delineated in § 40.1-26-5;

(8) To be free from unnecessary restraint. Restraints shall not be employed as punishment, for the convenience of the staff, or as a substitute for an individualized plan. Restraints shall impose the least possible restrictions consistent with their purpose and shall be removed when the emergency ends. Restraints shall not cause physical injury to the participant and shall be designed to allow the greatest possible comfort. Restraints shall be subject to the following conditions:

(i) Physical restraint shall be employed only in emergencies to protect the participant or others from imminent injury or when prescribed by a physician, when necessary, during the conduct of a specific medical or surgical procedure or if necessary for participant protection during the time that a medical condition exists;

(ii) Chemical restraint shall only be used when prescribed by a physician in extreme emergencies in which physical restraint is not possible and the harmful effects of the emergency clearly outweigh the potential harmful effects of the chemical restraints;

(iii) No participant shall be placed in seclusion;

(iv) The agency shall have a written policy that defines the use of restraints, the staff members who may authorize their use, and a mechanism for monitoring and controlling their use;

(v) All orders for restraint as well as the required frequency of staff observation of the participant shall be written;

(9) To have ~~reasonable~~, at any time, access to telephone communication;

(10) To receive visitors of a participant's choosing at ~~all reasonable hours~~ any time;

(11) To keep and be allowed to spend ~~a reasonable amount of~~ one's own money;

(12) To be provided advance written notice explaining the reason(s) why the participant is no longer eligible for service from the agency;

(13) To religious freedom and practice;

(14) To communicate by sealed mail or otherwise with persons of one's choosing;

(15) To select and wear one's own clothing and to keep and use one's own personal possessions;

(16) To have ~~reasonable,~~ prompt access to current newspapers, magazines and radio and television programming;

(17) To have opportunities for physical exercise and outdoor recreation;

(18)(i) To provide informed consent prior to the imposition of any invasive medical treatment including any surgical procedure or to have a legal guardian, or in the absence of a legal guardian, a relative as defined in this chapter, provide informed consent if the participant is not competent to do so. Information upon which a participant shall make necessary treatment and/or surgery decisions shall be presented to the participant in a manner consistent with his or her learning style and shall include, but not be limited to:

(A) The nature and consequences of the procedure(s);

(B) The risks, benefits and purpose of the procedure(s); and

(C) Alternate procedures available;

(ii) The informed consent of a participant or his or her legal guardian or, in the absence of a legal guardian, a relative as defined in this chapter, may be withdrawn at any time, with or without cause, prior to treatment. The absence of informed consent notwithstanding, a licensed and qualified physician may render emergency medical care or treatment to any participant who has been injured or who is suffering from an acute illness, disease, or condition if, within a reasonable degree of medical certainty, delay in initiation of emergency medical care or treatment would endanger the health of the participant;

(19) Each participant shall have a central record. The record shall include data pertaining to admissions and such other information as may be required under regulations by the department;

(20) Admissions -- As part of the procedure for the admission of a participant to an agency, each participant or applicant, or advocate if the participant or applicant is not competent, shall be fully informed, orally and in writing, of all rules, regulations, and policies governing participant conduct and responsibilities, including grounds for dismissal, procedures for discharge, and all

anticipated financial charges, including all costs not covered under federal and/or state programs, by other third party payors or by the agency's basic per diem rate. The written notice shall include information regarding the participant's or applicant's right to appeal the admission or dismissal decisions of the agency;

(21) Upon termination of services to or death of a participant, a final accounting shall be made of all personal effects and/or money belonging to the participant held by the agency. All personal effects and/or money including interest shall be promptly released to the participant or his or her heirs;

(22) Nothing in this chapter shall preclude intervention in the form of appropriate and reasonable restraint should it be necessary to protect individuals from physical injury to themselves or others.

SECTION 12. Section 42-7.2-5 of the General Laws in Chapter 42-7.2 entitled "Office of Health and Human Services" is hereby amended to read as follows:

42-7.2-5. Duties of the secretary.

The secretary shall be subject to the direction and supervision of the governor for the oversight, coordination and cohesive direction of state administered health and human services and in ensuring the laws are faithfully executed, not withstanding any law to the contrary. In this capacity, the Secretary of Health and Human Services shall be authorized to:

(1) Coordinate the administration and financing of health-care benefits, human services and programs including those authorized by the state's Medicaid section 1115 demonstration waiver and, as applicable, the Medicaid State Plan under Title XIX of the U.S. Social Security Act. However, nothing in this section shall be construed as transferring to the secretary the powers, duties or functions conferred upon the departments by Rhode Island public and general laws for the administration of federal/state programs financed in whole or in part with Medicaid funds or the administrative responsibility for the preparation and submission of any state plans, state plan amendments, or authorized federal waiver applications, once approved by the secretary.

(2) Serve as the governor's chief advisor and liaison to federal policymakers on Medicaid reform issues as well as the principal point of contact in the state on any such related matters.

(3)(a) Review and ensure the coordination of the state's Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or ~~category two (II) or three (III) changes~~ formal amendment changes, as described in the special terms and conditions of the state's Medicaid section 1115 demonstration waiver with the potential to affect the scope, amount or duration of publicly-funded health-care services, provider payments or reimbursements, or access to or the availability

of benefits and services as provided by Rhode Island general and public laws. The secretary shall consider whether any such changes are legally and fiscally sound and consistent with the state's policy and budget priorities. The secretary shall also assess whether a proposed change is capable of obtaining the necessary approvals from federal officials and achieving the expected positive consumer outcomes. Department directors shall, within the timelines specified, provide any information and resources the secretary deems necessary in order to perform the reviews authorized in this section;

(b) Direct the development and implementation of any Medicaid policies, procedures, or systems that may be required to assure successful operation of the state's health and human services integrated eligibility system and coordination with HealthSource RI, the state's health insurance marketplace.

(c) Beginning in 2015, conduct on a biennial basis a comprehensive review of the Medicaid eligibility criteria for one or more of the populations covered under the state plan or a waiver to ensure consistency with federal and state laws and policies, coordinate and align systems, and identify areas for improving quality assurance, fair and equitable access to services, and opportunities for additional financial participation.

(d) Implement service organization and delivery reforms that facilitate service integration, increase value, and improve quality and health outcomes.

(4) Beginning in ~~2006~~ 2020, prepare and submit to the governor, the chairpersons of the house and senate finance committees, the caseload estimating conference, and to the joint legislative committee for health-care oversight, by no later than March 15 of each year, a comprehensive overview of all Medicaid expenditures outcomes, administrative costs, and utilization rates. The overview shall include, but not be limited to, the following information:

(i) Expenditures under Titles XIX and XXI of the Social Security Act, as amended;

(ii) Expenditures, outcomes and utilization rates by population and sub-population served (e.g. families with children, persons with disabilities, children in foster care, children receiving adoption assistance, adults ages nineteen (19) to sixty-four (64), and elders);

(iii) Expenditures, outcomes and utilization rates by each state department or other municipal or public entity receiving federal reimbursement under Titles XIX and XXI of the Social Security Act, as amended; ~~and~~

(iv) Expenditures, outcomes and utilization rates by type of service and/or service provider; and

(v) Expenditures by mandatory population receiving mandatory services and, reported separately, optional services, as well as optional populations receiving mandatory services and,

reported separately, optional services for each state agency receiving Title XIX and XXI funds .

The directors of the departments, as well as local governments and school departments, shall assist and cooperate with the secretary in fulfilling this responsibility by providing whatever resources, information and support shall be necessary.

(5) Resolve administrative, jurisdictional, operational, program, or policy conflicts among departments and their executive staffs and make necessary recommendations to the governor.

(6) Assure continued progress toward improving the quality, the economy, the accountability and the efficiency of state-administered health and human services. In this capacity, the secretary shall:

(i) Direct implementation of reforms in the human resources practices of the executive office and the departments that streamline and upgrade services, achieve greater economies of scale and establish the coordinated system of the staff education, cross-training, and career development services necessary to recruit and retain a highly-skilled, responsive, and engaged health and human services workforce;

(ii) Encourage EOHHS-wide consumer-centered approaches to service design and delivery that expand their capacity to respond efficiently and responsibly to the diverse and changing needs of the people and communities they serve;

(iii) Develop all opportunities to maximize resources by leveraging the state's purchasing power, centralizing fiscal service functions related to budget, finance, and procurement, centralizing communication, policy analysis and planning, and information systems and data management, pursuing alternative funding sources through grants, awards and partnerships and securing all available federal financial participation for programs and services provided EOHHS-wide;

(iv) Improve the coordination and efficiency of health and human services legal functions by centralizing adjudicative and legal services and overseeing their timely and judicious administration;

(v) Facilitate the rebalancing of the long term system by creating an assessment and coordination organization or unit for the expressed purpose of developing and implementing procedures EOHHS-wide that ensure that the appropriate publicly-funded health services are provided at the right time and in the most appropriate and least restrictive setting;

(vi) Strengthen health and human services program integrity, quality control and collections, and recovery activities by consolidating functions within the office in a single unit that ensures all affected parties pay their fair share of the cost of services and are aware of alternative financing.

(vii) Assure protective services are available to vulnerable elders and adults with developmental and other disabilities by reorganizing existing services, establishing new services where gaps exist and centralizing administrative responsibility for oversight of all related initiatives and programs.

(7) Prepare and integrate comprehensive budgets for the health and human services departments and any other functions and duties assigned to the office. The budgets shall be submitted to the state budget office by the secretary, for consideration by the governor, on behalf of the state's health and human services agencies in accordance with the provisions set forth in § 35-3-4 of the Rhode Island general laws.

(8) Utilize objective data to evaluate health and human services policy goals, resource use and outcome evaluation and to perform short and long-term policy planning and development.

(9) Establishment of an integrated approach to interdepartmental information and data management that complements and furthers the goals of the unified health infrastructure project initiative and that will facilitate the transition to consumer-centered integrated system of state administered health and human services.

(10) At the direction of the governor or the general assembly, conduct independent reviews of state-administered health and human services programs, policies and related agency actions and activities and assist the department directors in identifying strategies to address any issues or areas of concern that may emerge thereof. The department directors shall provide any information and assistance deemed necessary by the secretary when undertaking such independent reviews.

(11) Provide regular and timely reports to the governor and make recommendations with respect to the state's health and human services agenda.

(12) Employ such personnel and contract for such consulting services as may be required to perform the powers and duties lawfully conferred upon the secretary.

(13) Assume responsibility for complying with the provisions of any general or public law or regulation related to the disclosure, confidentiality and privacy of any information or records, in the possession or under the control of the executive office or the departments assigned to the executive office, that may be developed or acquired or transferred at the direction of the governor or the secretary for purposes directly connected with the secretary's duties set forth herein.

(14) Hold the director of each health and human services department accountable for their administrative, fiscal and program actions in the conduct of the respective powers and duties of their agencies.

SECTION 13. Section 42-12.4-7 of the General Laws in Chapter 42-12.4 entitled "The Rhode Island Medicaid Reform Act of 2008" is hereby amended to read as follows:

42-12.4-7. Demonstration implementation -- Restrictions.

The executive office of health and human services and the department of human services may implement the global consumer choice section 1115 demonstration ("the demonstration"), project number 11W-00242/1, subject to the following restrictions:

(1) Notwithstanding the provisions of the demonstration, any change that requires the implementation of a rule or regulation or modification of a rule or regulation in existence prior to the demonstration shall require prior approval of the general assembly;

(2) Notwithstanding the provisions of the demonstration, any ~~Category II change or Category III change~~ formal waiver amendments, as defined in the demonstration, or state plan amendments shall require the prior approval of the general assembly.

SECTION 14. Section 42-14.6-4 of the General Laws in Chapter 42-14.6 entitled "Rhode Island All-Payer Patient-Centered Medical Home Act" is hereby amended to read as follows:

42-14.6-4. Promotion of the patient-centered medical home.

(a) Care coordination payments.

(1) The commissioner and the secretary shall convene a patient-centered medical home collaborative consisting of the entities described in subdivision 42-14.6-3(7). The commissioner shall require participation in the collaborative by all of the health insurers described above. The collaborative shall propose, by January 1, 2012, a payment system, to be adopted in whole or in part by the commissioner and the secretary, that requires all health insurers to make per-person care coordination payments to patient-centered medical homes, for providing care coordination services and directly managing on-site or employing care coordinators as part of all health insurance plans offered in Rhode Island. The collaborative shall provide guidance to the state health-care program as to the appropriate payment system for the state health-care program to the same patient-centered medical homes; the state health-care program must justify the reasons for any departure from this guidance to the collaborative.

(2) The care coordination payments under this shall be consistent across insurers and patient-centered medical homes and shall be in addition to any other incentive payments such as quality incentive payments. In developing the criteria for care coordination payments, the commissioner shall consider the feasibility of including the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to health care. The commissioner may direct the collaborative to determine a schedule for phasing in care coordination fees.

~~(3) The care coordination payment system shall be in place through July 1, 2016. Its continuation beyond that point shall depend on results of the evaluation reports filed pursuant to §~~

~~42-14.6-6.~~

~~(4)~~(3) Examination of other payment reforms. ~~By January 1, 2013, the~~ The commissioner and the secretary shall direct the collaborative to consider additional payment reforms to be implemented to support patient-centered medical homes including, but not limited to, payment structures (to medical home or other providers) that:

(i) Reward high-quality, low-cost providers;

(ii) Create enrollee incentives to receive care from high-quality, low-cost providers;

(iii) Foster collaboration among providers to reduce cost shifting from one part of the health continuum to another; and

(iv) Create incentives that health care be provided in the least restrictive, most appropriate setting.

(v) Constitute alternatives to fee for service payment, such as partial and full capitation.

~~(5)~~(4) The patient-centered medical home collaborative shall examine and make recommendations to the secretary regarding the designation of patient-centered medical homes, in order to promote diversity in the size of practices designated, geographic locations of practices designated and accessibility of the population throughout the state to patient-centered medical homes.

(b) The patient-centered medical home collaborative shall propose to the secretary for adoption, standards for the patient-centered medical home to be used in the payment system. In developing these standards, the existing standards by the national committee for quality assurance, or other independent accrediting organizations may be considered where feasible.

SECTION 15. 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 Rhode Island’s Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or changes as described in the demonstration, “with potential to affect the scope, amount, or duration of publicly-funded health care services, provider payments or reimbursements, or access to or the availability of benefits and services provided by Rhode Island general and public laws”; and

WHEREAS, In pursuit of a more cost-effective consumer choice system of care that is fiscally sound and sustainable, the Secretary of the Executive Office requests legislative approval of the following proposals to amend the Rhode Island's Medicaid section 1115 demonstration:

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

(i) Increase in-patient and out-patient hospital payment rates by seven and two tenths percent (7.2%) on July 1, 2019;

(ii) Increase nursing home rates by one percent (1%) on October 1, 2019;

(iii) Establish, effective July 1, 2019, hospice provider reimbursement, exclusively for room and board expenses for individuals residing in a skilled nursing facility, shall revert to the rate methodology in effect on June 30, 2018 and these room and board expenses shall be exempted from any and all annual rate increases to hospice providers; and

(iv) Reduce the rates for Medicaid managed care plan.

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

(b) Increase in the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) Direct Care Service Workers Wages. To further the long-term care system rebalancing goal of improving access to high quality services in the least restrictive setting, the Executive Office proposes to establish a targeted wage increase for certain community-based BHDDH developmental disability private providers and self-directed consumer direct care service workers. 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) 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, as amended, 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 and shall not cause an increase in expenditures beyond the amount appropriated for state fiscal year 2020.

Now, therefore, be it

RESOLVED, the General Assembly hereby approves the proposals under paragraphs (a) through (c) above; and be it further;

RESOLVED, the Secretary of the Executive Office is authorized to pursue and implement

any Rhode Island's Medicaid section 1115 demonstration waiver amendments, Medicaid state plan amendments, and/or changes to the applicable department's rules, regulations and procedures approved herein and as authorized by 42-12.4; and be it further

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

SECTION 16. Title 21 of the General Laws entitled "FOOD AND DRUGS" is hereby amended by adding thereto the following chapter:

CHAPTER 28.10

OPIOID STEWARDSHIP ACT

21-28.10-1. Definitions.

21-28.10-1. Definitions.

Unless the context otherwise requires, the following terms shall be construed in this chapter to have the following meanings:

(1) "Department" means the Rhode Island department of health.

(2) "Director" means the director of the Rhode Island department of health.

(3) "Distribute" means distribute as defined in § 21-28-1.02.

(4) "Distributor" means distributor as defined in § 21-28-1.02.

(5) "Manufacture" means manufacture as defined in § 21-28-1.02.

(6) "Manufacturer" means manufacturer as defined in § 21-28-1.02.

(7) "Market share" means the total opioid stewardship fund amount measured as a percentage of each manufacturer's, distributor's and wholesaler's gross, in-state, opioid sales in dollars from the previous calendar year as reported to the U.S. Drug Enforcement Administration (DEA) on its Automation of Reports and Consolidated Orders System (ARCOS) report.

(8) "Wholesaler" means wholesaler as defined in § 21-28-1.02.

21-28.10-2. Opioid registration fee imposed on manufacturers, distributors, and wholesalers.

All manufacturers, distributors, and wholesalers licensed or registered under this title or chapter 19.1 of title 5 (hereinafter referred to as "licensees"), that manufacture or distribute opioids shall be required to pay an opioid registration fee. On an annual basis, the director shall certify the amount of all revenues collected from opioid registration fees and any penalties imposed, to the general treasurer. The amount of revenues so certified shall be deposited quarterly into the opioid stewardship fund restricted receipt account established pursuant to § 21-28.10-10.

21-28.10-3. Determination of market share and registration fee.

(1) The total opioid stewardship fund amount shall be five million dollars ($5,000,000) annually, subject to downward adjustments pursuant to § 21-28.10-7.

(2) Each manufacturer's, distributor's, and wholesaler's annual opioid registration fee shall be based on that licensee's in-state market share.

(3) The following sales will not be included when determining a manufacturer's, distributor's, or wholesaler's market share:

(i) The gross, in-state opioid sales attributed to the sale of buprenorphine or methadone;

(ii) The gross, in-state opioid sales sold or distributed directly to opioid treatment programs, data-waivered practitioners, or hospice providers licensed pursuant to chapter 17 of title 23;

(iii) Any sales from those opioids manufactured in Rhode Island, but whose final point of delivery or sale is outside of Rhode Island; and

(iv) Any sales of anesthesia or epidurals as defined in regulation by the department.

(4) The department shall provide to the licensee, in writing, on or before October 15, 2019, the licensee's market share for the 2018 calendar year. Thereafter, the department shall notify the licensee, in writing, on or before October 15 of each year, of its market share for the prior calendar year based on the opioids sold or distributed for the prior calendar year.

21-28.10-4. Reports and records.

(a) Each manufacturer, distributor, and wholesaler licensed to manufacture or distribute opioids in the state of Rhode Island shall provide to the director a report detailing all opioids sold or distributed by such manufacturer or distributor in the state of Rhode Island. Such report shall include:

(1) The manufacturer's, distributor's, or wholesaler's name, address, phone number, DEA registration number, and controlled substance license number issued by the department;

(2) The name, address, and DEA registration number of the entity to whom the opioid was sold or distributed;

(3) The date of the sale or distribution of the opioids;

(4) The gross receipt total, in dollars, of all opioids sold or distributed;

(5) The name and National Drug Code of the opioids sold or distributed;

(6) The number of containers and the strength and metric quantity of controlled substance in each container of the opioids sold or distributed; and

(7) Any other elements as deemed necessary or advisable by the director.

(b) Initial and future reports.

Such information shall be reported annually to the department via ARCOS or in such other form as defined or approved by the director; provided, however, that the initial report provided pursuant to subsection (a) of this section shall consist of all opioids sold or distributed in the state of Rhode Island for the 2018 calendar year, and shall be submitted by August 1, 2019. Subsequent

annual reports shall be submitted by April 1 of each year based on the actual opioid sales and distributions of the prior calendar year.

21-28.10-5. Payment of market share.

The licensee shall make payments quarterly to the department with the first payment of its market share due on January 1, 2020; provided, that the amount due on January 1, 2020 shall be for the full amount of the payment for the 2018 calendar year, with subsequent payments to be due and owing on the first day of every quarter thereafter.

21-28.10-6. Rebate of market share.

In any year for which the director determines that a licensee failed to report information required by this chapter, those licensees complying with this chapter shall receive a reduced assessment of their market share in the following year equal to the amount in excess of any overpayment in the prior payment period.

21-28.10-7. Licensee opportunity to appeal.

(a) A licensee shall be afforded an opportunity to submit information to the department documenting or evidencing that the market share provided to the licensee (or amounts paid thereunder), pursuant to § 21-28.10-3(4), is in error or otherwise not warranted. The department may consider and examine such additional information that it determines to be reasonably related to resolving the calculation of a licensee's market share, which may require the licensee to provide additional materials to the department. If the department determines thereafter that all or a portion of such market share, as determined by the director pursuant to § 21-28.10-3(4), is not warranted, the department may:

(1) Adjust the market share;

(2) Adjust the assessment of the market share in the following year equal to the amount in excess of any overpayment in the prior payment period; or

(3) Refund amounts paid in error.

(b) Any person aggrieved by a decision of the department relating to the calculation of market share may appeal that decision to the superior court, which shall have power to review such decision, and the process by which such decision was made, as prescribed in chapter 35 of title 42.

(c) A licensee shall also have the ability to appeal its assessed opioid registration fee if the assessed fee amount exceeds the amount of profit the licensee obtains through sales in the state of products described in § 21-28.10-3. The department may, exercising discretion as it deems appropriate, waive or decrease fees as assessed pursuant to § 21-28.10-3 if a licensee can demonstrate that the correctly assessed payment will pose undue hardship to the licensee's continued activities in state. The department shall be allowed to request, and the licensee shall

furnish to the department, any information or supporting documentation validating the licensee's request for waiver or reduction under this subsection. Fees waived under this section shall not be reapportioned to other licensees which have payments due under this chapter.

21-28.10-8. Departmental annual reporting.

By January of each calendar year, the department of behavioral healthcare, developmental disabilities and hospitals (BHDDH), the executive office of health and human services (EOHHS), the department of children, youth and families (DCYF), the Rhode Island department of education (RIDE), the Rhode Island office of veterans' affairs (RIOVA), the department of corrections (DOC), and the department of labor and training (DLT) shall report annually to the governor, the speaker of the house, and the senate president which programs in their respective departments were funded using monies from the opioid stewardship fund and the total amount of funds spent on each program.

21-28.10-9. Penalties.

(a) The department may assess a civil penalty in an amount not to exceed one thousand dollars ($1,000) per day against any licensee that fails to comply with this chapter.

(b)(1) In addition to any other civil penalty provided by law, where a licensee has failed to pay its market share in accordance with § 21-28.10-5, the department may also assess a penalty of no less than ten percent (10%) and no greater than three hundred percent (300%) of the market share due from such licensee.

(2) In addition to any other criminal penalty provided by law, where a licensee has failed to pay its market share in accordance with § 21-28.10-5, the department may also assess a penalty of no less than ten percent (10%) and no greater than fifty percent (50%) of the market share due from such licensee.

21-28.10-10. Creation of opioid stewardship fund.

(a) There is hereby established, in the custody of the department, a restricted receipt account to be known as the "opioid stewardship fund."

(b) Monies in the opioid stewardship fund shall be kept separate and shall not be commingled with any other monies in the custody of the department.

(c) The opioid stewardship fund shall consist of monies appropriated for the purpose of such account, monies transferred to such account pursuant to law, contributions consisting of promises or grants of any money or property of any kind or value, or any other thing of value, including grants or other financial assistance from any agency of government and monies required by the provisions of this chapter or any other law to be paid into or credited to this account.

(d) Monies of the opioid stewardship fund shall be available to provide opioid treatment,

recovery, prevention, education services, and other related programs, subject to appropriation by the general assembly.

21-28.10-11. Allocation.

The monies, when allocated, shall be paid out of the opioid stewardship fund and subject to the approval of the director and the approval of the director of the department of behavioral healthcare, developmental disabilities and hospitals (BHDDH), pursuant to the provisions of this chapter.

21-28.10-12. Severability.

If any clause, sentence, paragraph, subdivision, or section of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, or section directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

21-28.10-13. Rules and regulations.

The director may prescribe rules and regulations, not inconsistent with law, to carry into effect the provisions of chapter 28.10 of title 21, which rules and regulations, when reasonably designed to carry out the intent and purpose of this chapter, are prima facie evidence of its proper interpretation. Such rules and regulations may be amended, suspended, or revoked, from time to time and in whole or in part, by the director. The director may prescribe, and may furnish, any forms necessary or advisable for the administration of this chapter.

SECTION 17. This article shall take effect upon passage.