ARTICLE 16

RELATING TO MEDICAL ASSISTANCE

SECTION 1. 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 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 2. Sections 40-8-13.4 and 40-8-19 of the General Laws in Chapter 40-8 entitled "Medical Assistance" are hereby amended to read as follows:

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

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

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

(1)(i) With respect to inpatient services for persons in fee-for-service Medicaid, which is non-managed care, implement a new payment methodology for inpatient services utilizing the Diagnosis Related Groups (DRG) method of payment, which is a patient-classification method that provides a means of relating payment to the hospitals to the type of patients cared for by the hospitals. It is understood that a payment method based on DRG may include cost outlier payments and other specific exceptions. The executive office will review the DRG-payment method and the DRG base price annually, making adjustments as appropriate in consideration of such elements as trends in hospital input costs; patterns in hospital coding; beneficiary access to care; and the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index. For the twelve-month (12) period beginning July 1, 2015, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of July 1, 2014. For the twelve (12) month period beginning July 1, 2019, there shall be no increase in the DRG base rate for Medicaid fee-for-service inpatient hospital services.

(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) Provided, however, for the twelve (12) month period beginning July 1, 2019, the Medicaid managed care payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2019. 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. For the twelve-month (12) period beginning July 1, 2019, Medicaid fee-for-

service outpatient rates shall not exceed the rates in effect as of July 1, 2018. 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. For the twelve (12) month period beginning July 1, 2019, 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, 2019.

(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 3. Section 40-8.3-10 of the General Laws in Chapter 40-8.3 entitled "Uncompensated Care" is hereby amended to read as follows:

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 4. Effective October 1, 2019, Chapter 40-8.4 of the General Laws entitled "Health Care For Families" is hereby amended by adding thereto the following section:

40-8.4-21. Employer Public Assistance Assessment.

(a) Employer Assessment. Each employer employing no less than three hundred (300) employees within the state of Rhode Island, shall pay quarterly an assessment for each employee who is a Medicaid beneficiary for every day of the quarter, whether full- or part-time; provided, however, no nonprofit organization or governmental entity shall be considered an employer for the purposes of this section. The assessment shall be computed by multiplying the wages the employer paid any such employee by ten per cent (10%), up to an annual maximum assessment of one thousand five hundred dollars ($1,500) per Medicaid beneficiary employee. Working adults with disabilities, as further defined by regulation authorized in subsection (g), are exempted employees for whom the employer will not be charged an employer assessment under this section.

(b) Wages. For the purposes of this section, “wages” means all compensation due to an employee by reason of his or her employment.

(c) Appeal. An employer notified of a liability determination under this section may request a hearing with the department of labor and training to appeal the liability determination. The request for a hearing shall be filed not more than fifteen (15) days after the receipt of notice of the determination. The decision rendered at the conclusion of the hearing shall be considered a final agency order.

(d) Eligibility inquiries. Notwithstanding the appeal right in subsection (c), an employer may issue to the department of human services a request for review of the Medicaid eligibility of any employee for whom the employer is charged an assessment. Except where prohibited by federal law, the State is authorized to make a limited disclosure to the inquiring employer regarding the name of any Medicaid beneficiary employee for whom the employer is being assessed under subsection (a).

(e) Discrimination prohibited. No employer may take any adverse action against any employee or potential employee on the basis of the employee’s status as a Medicaid beneficiary. Any employer found to have discriminated on this basis shall be subject to a penalty prescribed in regulations promulgated pursuant to this section.

(f) Data sharing. The departments of administration, revenue, human services, and labor and training, and the executive office of health and human services are authorized to share data and information to implement this section. Data collected by the departments of administration,

revenue, human services, labor and training, or the executive office of health and human services for the implementation of this section shall not be a public record.

(g) Regulations. The departments of labor and training and human services are authorized to promulgate regulations to implement the provisions of this section, including additional parameters on which employees cause the assessment and the definition of working disabled adults exempted from the employer assessment contained in subsection (a), in consultation with the executive office of health and human services and department of revenue.

SECTION 5. Section 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical Assistance - Long-Term Care Service and Finance Reform" 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 July 1, 2019, the rate for hospice providers delivering hospice care in a skilled nursing facility shall not exceed ninety-five percent (95%) of the rate paid for non-hospice care in a skilled nursing facility.

~~(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, except those providing hospice care in skilled nursing facilities, 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 6. 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 7. 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 8. 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 9. 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, shall require the prior approval of the general assembly.

SECTION 10. 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 commissioner and the~~ 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 11. Section 15 of Article 5 of Chapter 141 of the Public Laws of 2015 is hereby repealed.

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

~~to hospitals meeting all of the following criteria:~~

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

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

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

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

~~Payments for Graduate Medical Education programs shall be made annually.~~

SECTION 12. **Effective Date.** Section of this article shall take effect October 1, 2019. The remaining sections of this article shall take effect upon passage.