



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

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Memorandum

To: The Honorable Raymond E. Gallison, Jr.
Chairman, House Finance Committee

The Honorable Daniel DaPonte
Chairman, Senate Finance Committee

From: Thomas A. Mullaney *Thomas A. Mullaney*
Executive Director/State Budget Officer

Date: May 22, 2015

Subject: Amendments to the FY 2016 Appropriations Act (15-H-5900)

The Governor requests that the new article entitled "The Reinventing Medicaid Act of 2015", previously submitted on May 7, 2015, be replaced with the attached version. This new version contains various technical corrections and clarifications that are enumerated in the attached "Summary of Revisions" table. All modifications to the original version of the article are denoted by shading.

TAM: 15-Amend-21
Attachment

cc: Sharon Reynolds Ferland, House Fiscal Advisor
Stephen Whitney, Senate Fiscal Advisor
Michael DiBiase, Director of Administration
Jonathan Womer, Director, Office of Management and Budget
Daniel Orgel, Supervising Budget Analyst

Amendments to the Reinventing Medicaid Article – May 22, 2015

Article Section	Statutory Reference	Reason for change	Line # in prior version	Identified/Requested by:
Section 4	§40-6-27a(1)(vi)	Clarification necessary to meet Social Security Administration (SSA) requirements for state SSI-only supplement – No substantive change	23-26	SSA
	§40-6-27(4)	Reference correction	22	EOHHS
	§40-6-27(5)	Reference correction	24-26	EOHHS
	§40-6-27(7)	Reference correction	19	EOHHS
	§40-6-27(8)	Reference correction	4	EOHHS
	§40-6-27.2	Clarification of original language – no substantive change	21-24	Legislative Staff
Section 6	§40-8-15(2)	Technical correction— missing underline	14	Legislative Staff
	§40-8-15(c)	New language relating to interest charges omitted	24-26	EOHHS
	§40-8-15 new subsection (i)	New language relating to transfers of assets omitted	8-26, 1-26, 1-4	EOHHS
	§40-8-15.1(a)	Technical correction - Add subsection (a) designation	5	EOHHS
	§40-8-15.1(a)(2)	Clarification - Definition of “hearing” added	17	EOHHS
	§40-8-15.1(a)(3)	Clarification - Definition of “hearing” added	5	EOHHS
	§40-8-15.1 (4)/(e)	Technical correction – change number “4” to letter “e” to align with subsection designations	25	EOHHS
Section 7	§40-8-19(b)(2)	Clarification necessary to explain impact -- no substantive change	10-12	EOHHS
Section 8	§40-8.2-2(8)	Technical correction	1	Legislative Staff
Section 11	§40-8.9-9(f)(2)	Addition of reference necessary to meet SSA requirements – no substantive change	21-23	SSA/EOHHS
	§40-8.9-9(j)(1)	Reference correction	26	EOHHS
Section 13	§40-8.13-2(b)	Reference correction	24	Legislative Staff
Section 14	Delete Sec14 and renumber Sec14-20	Agency withdraws language		BHDDH/EOHHS

Amendments to the Reinventing Medicaid Article – May 22, 2015

Article Section	Statutory Reference	Reason for change	Line # in prior version	Identified/Requested by:
Section 15	§42-7.2-5(6)(ii)	Technical correction	1	Legislative Staff
Resolution	(a)	Technical correction	1	Legislative Staff
Resolution	(p)	Add resolution (p) subsection in lieu of former section 14 re DD payment methodology – re-letter (q) and (r)	19	BHDDH/EOHHS

1 ARTICLE (Revised 5-22-2015)

2 The Reinventing Medicaid Act of 2015

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

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

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

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

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

25 The Reinventing Medicaid Act of 2015 makes a number of statutory changes to the state
26 Medicaid program, including the creation of incentive models that reward better hospitals and nursing

1 homes for better quality and better coordination, a pilot coordinated care program that establishes person-
2 centered care and payment methods, targeted community-based programs for individuals who need
3 intensive services and managed care for Rhode Islanders with severe and persistent mental illness.

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

5 SECTION 1. Section 23-17-38.1 of the General Laws in Chapter 23-17 entitled "Licensing of
6 Health Care Facilities" is hereby amended to read as follows:

7 **§ 23-17-38.1 Hospitals – Licensing fee.** – ~~(a) There is imposed a hospital licensing fee at the rate
8 of five and four hundred eighteen thousandths percent (5.418%) upon the net patient services revenue of
9 every hospital for the hospital's first fiscal year ending on or after January 1, 2012, except that the license
10 fee for all hospitals located in Washington County, Rhode Island, shall be discounted by thirty seven
11 percent (37%). The discount for Washington County hospitals is subject to approval by the Secretary of
12 the US Department of Health and Human Services of a state plan amendment submitted by the executive
13 office of health and human services for the purpose of pursuing a waiver of the uniformity requirement
14 for the hospital license fee. This licensing fee shall be administered and collected by the tax administrator,
15 division of taxation within the department of revenue, and all the administration, collection, and other
16 provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax
17 administrator on or before July 14, 2014, and payments shall be made by electronic transfer of monies to
18 the general treasurer and deposited to the general fund. Every hospital shall, on or before June 16, 2014,
19 make a return to the tax administrator containing the correct computation of net patient services revenue
20 for the hospital fiscal year ending September 30, 2012, and the licensing fee due upon that amount. All
21 returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of
22 perjury.~~

23 (b) ~~(a)~~ There is also imposed a hospital licensing fee at the rate of five and seven hundred three
24 thousandths percent (5.703%) upon the net patient services revenue of every hospital for the hospital's
25 first fiscal year ending on or after January 1, 2013, except that the license fee for all hospitals located in
26 Washington County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for

1 Washington County hospitals is subject to approval by the Secretary of the US Department of Health and
2 Human Services of a state plan amendment submitted by the executive office of health and human
3 services for the purpose of pursuing a waiver of the uniformity requirement for the hospital license fee.
4 This licensing fee shall be administered and collected by the tax administrator, division of taxation within
5 the department of revenue, and all the administration, collection and other provisions of chapter 51 of title
6 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before July 13,
7 2015 and payments shall be made by electronic transfer of monies to the general treasurer and deposited
8 to the general fund. Every hospital shall, on or before June 15, 2015, make a return to the tax
9 administrator containing the correct computation of net patient services revenue for the hospital fiscal
10 year ending September 30, 2013, and the licensing fee due upon that amount. All returns shall be signed
11 by the hospital's authorized representative, subject to the pains and penalties of perjury.

12 (b) There is also imposed a hospital licensing fee at the rate of five and eight hundred forty-six
13 thousandths percent (5.846%) upon the net patient services revenue of every hospital for the hospital's
14 first fiscal year ending on or after January 1, 2014, except that the license fee for all hospitals located in
15 Washington County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for
16 Washington County hospitals is subject to approval by the Secretary of the US Department of Health and
17 Human Services of a state plan amendment submitted by the executive office of health and human
18 services for the purpose of pursuing a waiver of the uniformity requirement for the hospital license fee.
19 This licensing fee shall be administered and collected by the tax administrator, division of taxation within
20 the department of revenue, and all the administration, collection and other provisions of chapter 51 of title
21 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before July 11,
22 2016 and payments shall be made by electronic transfer of monies to the general treasurer and deposited
23 to the general fund. Every hospital shall, on or before June 13, 2016, make a return to the tax
24 administrator containing the correct computation of net patient services revenue for the hospital fiscal
25 year ending September 30, 2014, and the licensing fee due upon that amount. All returns shall be signed
26 by the hospital's authorized representative, subject to the pains and penalties of perjury.

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

2 (1) "Hospital" means ~~a person or governmental unit duly licensed in accordance with this chapter~~
3 ~~to establish, maintain, and operate a hospital, except a hospital whose primary service and primary bed~~
4 ~~inventory are psychiatric.~~ the actual facilities and buildings in existence in Rhode Island, licensed
5 pursuant to § 23-17-1 et seq. on June 30, 2010, and thereafter any premises included on that license,
6 regardless of changes in licensure status pursuant to § 23-17.14 (hospital conversions) and §23-17-6 (b)
7 (change in effective control), that provides short-term acute inpatient and/or outpatient care to persons
8 who require definitive diagnosis and treatment for injury, illness, disabilities, or pregnancy.

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

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

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

15 (e) The licensing fee imposed by this section shall apply to hospitals as defined herein that are
16 duly licensed on July 1, ~~2014~~ 2015, and shall be in addition to the inspection fee imposed by § 23-17-38
17 and to any licensing fees previously imposed in accordance with § 23-17-38.1.

18 SECTION 2. Section 27-18-64 of the General Laws in Chapter 27-18 entitled "Accident and
19 Sickness Insurance Policies" is hereby amended to read as follows:

20 **§27-18-64 Coverage for early intervention services.** – (a) Every individual or group hospital or
21 medical expense insurance policy or contract providing coverage for dependent children, delivered or
22 renewed in this state on or after July 1, 2004, shall include coverage of early intervention services which
23 coverage shall take effect no later than January 1, 2005. Such coverage ~~shall be limited to a benefit of five~~
24 ~~thousand dollars (\$5,000) per dependent child per policy or calendar year and shall not be subject to~~
25 deductibles and coinsurance factors. Any amount paid by an insurer under this section for a dependent
26 child shall not be applied to any annual or lifetime maximum benefit contained in the policy or contract.

1 For the purpose of this section, "early intervention services" means, but is not limited to, speech and
2 language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service
3 plan development and review, nursing services, and assistive technology services and devices for
4 dependents from birth to age three (3) who are certified by the ~~department of human services~~ executive
5 office of health and human services as eligible for services under part C of the Individuals with
6 Disabilities Education Act (20 U.S.C. § 1471 et seq.).

7 (b) ~~Subject to the annual limits provided in this section, insurers~~ Insurers shall reimburse certified
8 early intervention providers, who are designated as such by the ~~Department of Human Services~~ executive
9 office, for early intervention services as defined in this section at ~~rates of reimbursement equal to or~~
10 ~~greater than the prevailing integrated state/Medicaid rate for early intervention services as established by~~
11 ~~the Department of Human Services.~~

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

16 SECTION 3. Section 27-20.11-3 of the General Laws in Chapter 27-20.11 entitled "Autism
17 Spectrum Disorders" is hereby amended to read as follows:

18 **§ 27-20.11-3 Scope of coverage.** – (a) Benefits under this section shall include coverage for
19 pharmaceuticals, applied behavior analysis, physical therapy, speech therapy, psychology, psychiatric and
20 occupational therapy services for the treatment of Autism spectrum disorders, as defined in the most
21 recent edition of the DSM. Provided, however:

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

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

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

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

7 SECTION 4. Sections 40-6-27 and 40-6-27.2 of the General Laws in Chapter 40-6 entitled
8 General Public Assistance are hereby amended to read as follows:

9 **§40-6-27 Supplemental security income.** – (a)(1) The director of the department is hereby
10 authorized to enter into agreements on behalf of the state with the secretary of the U.S. Department of
11 Health and Human Services or other appropriate federal officials, under the supplementary and security
12 income (SSI) program established by title XVI of the Social Security Act, 42 U.S.C. § 1381 et seq.,
13 concerning the administration and determination of eligibility for SSI benefits for residents of this state,
14 except as otherwise provided in this section. The state's monthly share of supplementary assistance to the
15 supplementary security income program shall be as follows:

16 (i) Individual living alone: \$39.92

17 (ii) Individual living with others: \$51.92

18 (iii) Couple living alone: \$79.38

19 (iv) Couple living with others: \$97.30

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

21 (vi) Individual eligible to receive Medicaid-funded long-term services and supports and living in
22 a Medicaid certified state licensed assisted living residence or adult supportive housing care residence, as
23 defined in §23-17.24, participating in the program authorized under § 40-8.13-2.1:

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

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

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

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

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

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

20 (4) Individuals living in state licensed supportive residential care settings and assisted living
21 residences who are receiving SSI supplemental payments under this section who are participating in the
22 program under §40-8.13-2.4 or otherwise shall be allowed to retain a minimum personal needs allowance
23 of fifty-five dollars (\$55.00) per month from their SSI monthly benefit prior to payment of any monthly
24 fees in addition to any amounts established in an administrative rule promulgated by the secretary of the
25 executive office of health and human services for persons eligible to receive Medicaid-funded long-term
26 services and supports in the settings identified in subsection (a)(1)(v) and (a)(1)(vi).

1 (5) ~~Except as authorized for the program authorized under §40-8.13-2.1.~~ To ensure that
2 supportive residential care or an assisted living residence is a safe and appropriate service setting, the
3 department is authorized and directed to make a determination of the medical need and whether a setting
4 provides the appropriate services for those persons who:

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

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

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

14 (7) To assure access to high quality coordinated services, the ~~department~~ executive office of
15 health and human services is further authorized and directed to establish ~~rules specifying the payment~~
16 certification or contract standards that must be met by those state licensed supportive residential care
17 settings, including adult supportive care homes and assisted living residences admitting or serving any
18 persons eligible for state-funded supplementary assistance under this section or the program established
19 under §40-8.13-2.1. Such ~~payment certification or contract~~ standards shall define:

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

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

25 (iii) The criteria and process for granting a one time, short-term good cause exemption from the
26 ~~payment certification~~ or contract standards to a licensed supportive residential care setting or assisted

1 living residence that provides documented evidence indicating that meeting or failing to meet said
2 standards poses an undue hardship on any person eligible under this section who is a prospective or
3 current resident.

4 (8) The ~~payment certification or contract~~ standards required by this section or ~~§40-8.13-2.1~~ shall
5 be developed in collaboration by the departments, under the direction of the executive office of health and
6 human services, so as to ensure that they comply with applicable licensure regulations either in effect or
7 in development.

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

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

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

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

16 **§40-6-27.2 Supplementary cash assistance payment for certain supplemental security**
17 **income recipients.** – There is hereby established a \$206 monthly payment for disabled and elderly
18 individuals who, on or after July 1, 2012, receive the state supplementary assistance payment for an
19 individual in state licensed assisted living residence under § 40-6-27 and further reside in an assisted
20 living facility that is not eligible to receive funding under Title XIX of the Social Security Act, 42 U.S.C.
21 § 1381 et seq., ~~including through the program authorized under §40-8.13-2.1~~ or reside in any assisted
22 living facility financed by the Rhode Island housing and mortgage finance corporation prior to January 1,
23 2006, and receive a payment under § 40-6-27. Such a monthly payment shall not be made on behalf of
24 persons participating in the program authorized under §40-8.13-2.

25 SECTION 5. Section 40-8-13.4 of the General Laws in Chapter 40-8 entitled “Medical
26 Assistance” is hereby amended to read as follows:

1 **§ 40-8-13.4 Rate methodology for payment for in state and out of state hospital services.**—(a)

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

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

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

19 (B) With respect to inpatient services, (i) it is required as of January 1, 2011 until December 31,
20 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not
21 exceed ninety and one tenth percent (90.1%) of the rate in effect as of June 30, 2010. Negotiated increases
22 in inpatient hospital payments for each annual twelve (12) month period beginning January 1, 2012 may
23 not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System
24 (IPPS) Hospital Input Price index for the applicable period; (ii) provided, however, for the twenty-four
25 (24) month period beginning July 1, 2013 the Medicaid managed care payment rates between each
26 hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013 and for the

1 twelve (12) month period beginning July 1, 2015, the Medicaid managed care payment inpatient rates
2 between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the
3 payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital payments for
4 each annual twelve (12) month period beginning July 1, ~~2015-2016~~ may not exceed the Centers for
5 Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price
6 Index, less Productivity Adjustment, for the applicable period; (iv) The Rhode Island executive office of
7 health and human services will develop an audit methodology and process to assure that savings
8 associated with the payment reductions will accrue directly to the Rhode Island Medicaid program
9 through reduced managed care plan payments and shall not be retained by the managed care plans; (v) All
10 hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and (vi) for all such
11 hospitals, compliance with the provisions of this section shall be a condition of participation in the Rhode
12 Island Medicaid program.

13 (2) With respect to outpatient services and notwithstanding any provisions of the law to the
14 contrary, for persons enrolled in fee for service Medicaid, the executive office will reimburse hospitals for
15 outpatient services using a rate methodology determined by the executive office and in accordance with
16 federal regulations. Fee-for-service outpatient rates shall align with Medicare payments for similar
17 services. Notwithstanding the above, there shall be no increase in the Medicaid fee-for-service outpatient
18 rates effective on July 1, 2013 ~~or~~, July 1, 2014, or July 1, 2015. For the twelve (12) month period
19 beginning July 1, 2015, Medicaid fee-for-service outpatient rates shall not exceed ninety-seven and one-
20 half percent (97.5%) of the rates in effect as of July 1, 2014. Thereafter, changes to outpatient rates will
21 be implemented on July 1 each year and shall align with Medicare payments for similar services from the
22 prior federal fiscal year. With respect to the outpatient rate, (i) it is required as of January 1, 2011 until
23 December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan
24 shall not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010. Negotiated
25 increases in hospital outpatient payments for each annual twelve (12) month period beginning January 1,
26 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient

1 Prospective Payment System (OPPS) hospital price index for the applicable period; (ii) provided,
2 however, for the twenty-four (24) month period beginning July 1, 2013 the Medicaid managed care
3 outpatient payment rates between each hospital and health plan shall not exceed the payment rates in
4 effect as of January 1, 2013 and for the twelve (12) month period beginning July 1, 2015, the Medicaid
5 managed care outpatient payment rates between each hospital and health plan shall not exceed ninety-
6 seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (iii) negotiated
7 increases in outpatient hospital payments for each annual twelve (12) month period beginning July 1,
8 ~~2015~~ 2016 may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient
9 Prospective Payment System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the
10 applicable period.

11 (3) “Hospital” as used in this section shall mean the actual facilities and buildings in existence in
12 Rhode Island, licensed pursuant to § 23-17-1 et seq. on June 30, 2010, and thereafter any premises
13 included on that license, regardless of changes in licensure status pursuant to § 23-17.14 (hospital
14 conversions) and §23-17-6 (b) (change in effective control), that provides short-term acute inpatient
15 and/or outpatient care to persons who require definitive diagnosis and treatment for injury, illness,
16 disabilities, or pregnancy.

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

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

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

3 (f) As a condition of participation in the DRG methodology for payment of hospital services,
4 every hospital shall submit year-end settlement reports to the executive office within one year from the
5 close of a hospital's fiscal year. Should a participating hospital fail to timely submit a year-end settlement
6 report as required by this section, the executive office shall withhold financial cycle payments due by any
7 state agency with respect to this hospital by not more than ten percent (10%) until said report is
8 submitted. For hospital fiscal year 2010 and all subsequent fiscal years, hospitals will not be required to
9 submit year-end settlement reports on payments for outpatient services. For hospital fiscal year 2011 and
10 all subsequent fiscal years, hospitals will not be required to submit year-end settlement reports on claims
11 for hospital inpatient services. Further, for hospital fiscal year 2010, hospital inpatient claims subject to
12 settlement shall include only those claims received between October 1, 2009 and June 30, 2010.

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

17 **§40-8-13.5. Hospital Incentive Program (HIP).** The secretary of the executive office of health
18 and human services is authorized to seek the federal authorities required to implement a hospital incentive
19 program (HIP). The HIP shall provide the participating licensed hospitals the ability to obtain certain
20 payments for achieving performance goals established by the secretary. HIP payments shall commence no
21 earlier than July 1, 2016.

22 **SECTION 6.** Section 40-8-15 of the General Laws in Chapter 40-8 entitled "Medical
23 Assistance" is hereby amended to read as follows:

24 **§ 40-8-15. Lien on deceased recipient's estate for assistance.** (a)(1) Upon the death of a
25 recipient of medical assistance under Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et
26 seq., the total sum of medical assistance so paid on behalf of a recipient who was fifty-five (55) years of

1 age or older at the time of receipt of the assistance shall be and constitute a lien upon the estate, as defined
2 in subdivision (a)(2) below, of the recipient in favor of the executive office of health and human services.
3 The lien shall not be effective and shall not attach as against the estate of a recipient who is survived by a
4 spouse, or a child who is under the age of twenty-one (21), or a child who is blind or permanently and
5 totally disabled as defined in Title XVI of the federal Social Security Act, 42 U.S.C. § 1381 et seq. The
6 lien shall attach against property of a recipient, whether or not such property is included or includible in
7 the decedent's probate estate, regardless of whether or not a probate proceeding has been commenced in
8 the probate court by the executive office of health and human services or by any other party. Provided,
9 however, that such lien shall only attach and shall only be effective against the recipient's real property,
10 whether or not included or includible in the recipient's probate estate, if such lien is recorded in the land
11 evidence records and is in accordance with subsection 40-8-15(e). Decedents who have received medical
12 assistance are subject to the assignment and subrogation provisions of §§ 40-6-9 and 40-6-10.

13 (2) For purposes of this section, the term "estate" with respect to a deceased individual shall
14 include all real and personal property and other assets whether or not included or includable within the
15 individual's probate estate.

16 (b) The executive office of health and human services is authorized to promulgate regulations to
17 implement the terms, intent, and purpose of this section and to require the legal representative(s) and/or
18 the heirs-at-law of the decedent to provide reasonable written notice to the executive office of health and
19 human services of the death of a recipient of medical assistance who was fifty-five (55) years of age or
20 older at the date of death, and to provide a statement identifying the decedent's property and the names
21 and addresses of all persons entitled to take any share or interest of the estate as legatees or distributees
22 thereof.

23 (c) The amount of medical assistance reimbursement imposed under this section shall also
24 become a debt to the state from the person or entity liable for the payment thereof.

1 (d) Upon payment of the amount of reimbursement for medical assistance imposed by this
2 section, the secretary of the executive office of health and human services, or his or her designee, shall
3 issue a written discharge of lien.

4 (e) Provided, however, that no lien created under this section shall attach nor become effective
5 upon any real property unless and until a statement of claim is recorded naming the debtor/owner of
6 record of the property as of the date and time of recording of the statement of claim, and describing the
7 real property by a description containing all of the following: (1) tax assessor's plat and lot; and (2) street
8 address. The statement of claim shall be recorded in the records of land evidence in the town or city
9 where the real property is situated. Notice of said lien shall be sent to the duly appointed executor or
10 administrator, the decedent's legal representative, if known, or to the decedent's next of kin or heirs at law
11 as stated in the decedent's last application for medical assistance.

12 (f) The executive office of health and human services shall establish procedures, in accordance
13 with the standards specified by the secretary, U.S. Department of Health and Human Services, under
14 which the executive office of health and human services shall waive, in whole or in part, the lien and
15 reimbursement established by this section if such lien and reimbursement would work an undue hardship,
16 as determined by the executive office of health and human services, on the basis of the criteria established
17 by the secretary in accordance with 42 U.S.C. § 1396p(b)(3).

18 (g) Upon the filing of a petition for admission to probate of a decedent's will or for administration
19 of a decedent's estate, when the decedent was fifty-five (55) years or older at the time of death, a copy of
20 said petition and a copy of the death certificate shall be sent to the executive office of health and human
21 services. Within thirty (30) days of a request by the executive office of health and human services, an
22 executor or administrator shall complete and send to the executive office of health and human services a
23 form prescribed by that office and shall provide such additional information as the office may require. In
24 the event a petitioner fails to send a copy of the petition and a copy of the death certificate to the
25 executive office of health and human services and a decedent has received medical assistance for which
26 the executive office of health and human services is authorized to recover, no distribution and/or

1 payments, including administration fees, shall be disbursed. Any person and /or entity that receive a
2 distribution of assets from the decedent's estate shall be liable to the executive office of health and human
3 services to the extent of such distribution.

4 (h) Compliance with the provisions of this section shall be consistent with the requirements set
5 forth in § 33-11-5 and the requirements of the affidavit of notice set forth in § 33-11-5.2. Nothing in these
6 sections shall limit the executive office of health and human services from recovery, to the extent of the
7 distribution, in accordance with all state and federal laws.

8 **§ 40-8-15.1 Lien on recipient's property.** – (a) In addition to the lien and recovery under the
9 provisions of section 40-8-15, the executive office of health and human services shall recover long term
10 care Medicaid paid for services rendered on or after the effective date of this act on behalf of an
11 individual, as defined herein, from the individual's estate, as defined in section 40-8-15, or upon the sale
12 or transfer of the individual's real property prior to the death of an individual who is a recipient of
13 medical assistance under Title XIX of the federal Social Security Act, 42 USC § 1396 et seq. The
14 executive office of health and human services may impose a lien against the real property of any
15 individual on account of long term care Medicaid paid on his or her behalf as follows:

16 (1) Pursuant to the judgment or court order on account of benefits incorrectly paid on behalf of
17 such individual; or,

18 (2) Upon the real property of an individual who is an inpatient in a nursing facility, intermediate
19 care facility for the intellectually disabled, or other licensed health facility, and the executive office of
20 health and human services determines, after notice and opportunity for a hearing, which complies with the
21 requirements of the Administrative Procedures Act, chapter 42-35, that the individual cannot reasonably
22 be expected to be discharged from the licensed health facility and return home; provided however, that
23 any such lien shall dissolve should an individual be discharged from the licensed health facility and return
24 home. No such lien may be imposed on the individual's home, if one of the following persons is lawfully
25 residing in the home:

26 (A) the spouse of such individual,

1 (B) such individual's child who is under age twenty-one (21), or is blind or permanently and
2 totally disabled as defined in Title XVI of the federal Social Security Act, 42 U.S.C. § 1381 et seq., or

3 (C) a sibling of such individual who has an equity interest in such home and who was residing in
4 such individual's home for a period of at least one year immediately before the date of the individual's
5 admission to the licensed health facility.

6 (3) If the individual as described in (2) above has received a determination notice from the
7 executive office of health and human services after notice and an opportunity for a hearing, which
8 complies with the requirements of the Administrative Procedures Act, chapter 42-35, that the above
9 conditions have been met, then a lien will be placed against the real property.

10 (b) Any recovery in the case of a lien on an individual's property under this section may be made
11 only after the death of the individual's surviving spouse, if any, and only when:

12 (1) No sibling of the individual who was residing in the individual's home for a period of at least
13 one year immediately before the date of the individual's admission to the licensed health facility, and is
14 lawfully residing in such home and who has resided in such home on a continuous basis since the day of
15 the individual's admission to the licensed health facility; and,

16 (2) No child of the individual who was residing in the individual's home for a period of at least
17 two (2) years immediately before the date of the individual's admission to the licensed health facility, and
18 who establishes to the satisfaction of the executive office of health and human services that he or she
19 provided care to such individual which permitted such individual to reside at home rather than in a
20 licensed health facility, who is lawfully residing in such home, and who has resided in such home on a
21 continuous basis since the day of the individual's admission to the licensed health facility.

22 (c) If the property is sold or transferred after the executive office of health and human services
23 has placed a lien on the property in accordance with this section, the executive office of health and human
24 services may recover all payment for services provided on or after the effective date of this act.

1 (d) The executive office of health and human services shall not be required to pay a recording fee for
2 filing any lien, notice of lien, statement of claim, or release or discharge of a lien or encumbrance filed in
3 accordance with sections 40-8-15 and 40-8-15.1.

4 (e) The executive office of health and human services shall adopt rules necessary to carry out the
5 provisions of this section.

6 SECTION 7. Section 40-8-19 of the General Laws in Chapter 40-8 entitled "Medical Assistance"
7 is hereby amended to read as follows:

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

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

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

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

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

26 (iv) Application of a fair rental value system;

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

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

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

10 (1) No nursing facility shall receive reimbursement for direct care costs that is less than the rate
11 of reimbursement for direct care costs received under the methodology in effect at the time of passage of
12 this act; and

13 (2) No facility shall lose or gain more than five dollars (\$5.00) in its total per diem rate the first
14 year of the transition. ~~The An~~ An adjustment to the per diem loss or gain may be phased out by twenty-five
15 percent (25%) each year; except, however, for the year beginning October 1, 2015, there shall be no
16 adjustment to the per diem gain or loss, gain during state fiscal year 2016, but it may resume the phase out
17 shall resume thereafter; and

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

21 (4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning July 1,
22 2015, Medicaid payment rates for nursing facilities established pursuant to this section shall not exceed
23 ninety-seven and one-half percent (97.5%) of the rates in effect on April 1, 2015.

24 **§40-8-19.2 Nursing Facility Incentive Program (NFIP).** The secretary of the executive office
25 of health and human services is authorized to seek the federal authority required to implement a nursing
26 facility incentive program (NFIP). The NFIP shall provide the participating licensed nursing facilities the

1 ability to obtain certain payments for achieving performance goals established by the secretary. NFIP
2 payments shall commence no earlier than July 1, 2016.

3 SECTION 8. Sections 40-8.2-2 to 40-8.2-4, 40-8.2-10 to 40-8.2-12, and 40-8.2-14 to 40-8.2-22
4 of the General Laws in Chapter 40-8.2 entitled "Medical Assistance Fraud " are hereby amended to read
5 as follows:

6 **§ 40-8.2-1. Short title.**- This chapter shall be known as the "Rhode Island Medical Assistance
7 Fraud Law".

8 **§ 40-8.2-2. Definitions.**- Whenever used in this chapter:

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

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

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

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

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

20 (i) To the same provider;

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

22 (iii) To an entity, which the provider intends to benefit whenever the expenditure is reimbursed,
23 or reimbursable, or claimed by a provider as being reimbursable by the Rhode Island Medicaid program
24 and when the sum or value returned is not credited to the benefit of the Rhode Island Medicaid program.

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

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

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

15 (8) (9) "Pecuniary benefit" means benefit in the form of money, property, commercial interests,
16 or anything else the primary significance of which is economic gain.

17 (9) (10) "Person" means any person or individual, natural or otherwise and includes those
18 person(s) or entities defined by the term "provider".

19 (10) (11) "Provider" means any individual, individual medical vendor, firm, corporation,
20 professional association, partnership, organization, or other legal entity that provides goods or services
21 under the Rhode Island Medicaid program or the employee of any person or entity who, on his or her own
22 behalf or on the behalf of his or her employer, knowingly performs any act or is knowingly responsible
23 for an omission prohibited by this chapter.

24 (11) (12) "Recipient" means any person receiving medical assistance under the Rhode Island
25 Medicaid program.

1 (12) (13) "Records" means all documents developed by a provider and related to the provision
2 of services reimbursed or claimed as reimbursable by the Rhode Island Medicaid program.

3 (13) (14) "Rhode Island Medicaid program" means a state administered, ~~medical assistance~~
4 health care program which is funded by the state and federal governments under Title XIX and Title XXI
5 of the U.S., Social Security Act, 42 U.S.C. § 1396 et seq and any general or public laws and administered
6 by the executive office of health and human services.

7 **§ 40-8.2-3. Prohibited acts.**- (a) It shall be unlawful for any person intentionally to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (12) Enter into an agreement, combination or conspiracy with any party other than the Rhode
25 Island Medicaid program to obtain or aid another to obtain reimbursement or payments from the Rhode

1 Island Medicaid program to which the person, recipient, or provider seeking reimbursement or payment is
2 not entitled.

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

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

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

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

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

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

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

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

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

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

2 (1) A discount or other reduction in price obtained by a person or provider of services or
3 merchandise under the Rhode Island Medicaid program, if the reduction in price is properly disclosed and
4 appropriately reflected in the costs claimed or charges made by the person or provider under the Rhode
5 Island Medicaid program.

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

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

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

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

20 **§ 40-8.2-4. Statute of limitations.**- The statute of limitations for any violation of the provisions
21 of this chapter shall be ten (10) years.

22 **§ 40-8.2-5. Civil remedy.**- Any person, including the ~~Rhode Island Medicaid program secretary~~
23 of the executive office of health and human services or the office of program integrity acting on behalf of
24 the secretary of the office, injured by any violation of the provisions of § 40-8.2-3 or § 40-8.2-4 may
25 recover through a civil action from the persons inflicting the injury three (3) times the amount of the
26 injury.

1 **§ 40-8.2-6. Civil actions brought by attorney general on behalf of persons injured by**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 **§ 40-8.2-10. Other civil remedies and criminal penalties.**- The penalties and remedies under
16 this statute are not exclusive and shall not preclude the use of any other civil remedy or the application of
17 any other criminal penalty deemed appropriate by the attorney general in accordance with federal law or
18 regulations governing Title XIX or Title XXI or the general or public laws of this state.

19 **§ 40-8.2-11. Barring or suspending participation in program.**- Whenever a provider is
20 sentenced or placed on probation for an offense under this chapter, the trial judge may, in his or her
21 discretion, order that the provider be permanently barred from further participation in the program, that
22 the provider's participation in the program be suspended for a definite period of time not exceeding two
23 (2) years, or that the provider conform to applicable federal regulations. For the purposes of this section,
24 ~~the Rhode Island Medicaid program~~ office of program integrity may submit a recommendation to the trial
25 judge as to whether the provider should be suspended or barred from the Medicaid program. Nothing

1 contained herein shall be construed to prevent the ~~Rhode Island Medicaid program~~ executive office of
2 health and human services from imposing its own administrative sanctions.

3 **§ 40-8.2-17. Stays and review of revocation orders.-** An order of the ~~Rhode Island Medicaid~~
4 ~~program~~ executive office of health and human services revoking a provider's certification may, in the
5 discretion of the program, go into immediate effect or may be stayed. Review of any order may be had in
6 accordance with the Rhode Island administrative procedures law, §§ 42-35-1 -42-35-18. If an
7 administrative hearing is claimed, the program may, in its discretion, stay the effect of a revocation until a
8 hearing is had held and a decision is rendered, and for a period not to exceed ten (10) days after the
9 administrative decision is rendered.

10 **§ 40-8.2-18. Filing and enforcement of administrative decision.-** An administrative decision,
11 not appealed, or which has been affirmed after judicial review under the Rhode Island administrative
12 procedures law, §§ 42-35-1 - 42-35-18, determining any amounts due to the ~~Rhode Island Medicaid~~
13 ~~program~~ executive office of health and human services or to a provider, may be filed with the clerk of the
14 superior court for Providence County and shall be enforceable as a judgment of that court.

15 **§ 40-8.2-19. Certification as a provider - Revocation or suspension of certification.-** Before
16 any provider of medical services receives payment from the Rhode Island Medicaid program, and as a
17 condition of receipt of payment, the provider must have in effect a valid certification of eligibility from
18 the Rhode Island ~~department of human services~~ executive office of health and human services. This
19 certification of eligibility will take the form of either a separate provider agreement or language as
20 required by federal regulations imprinted on the medical assistance billing form, which must be signed by
21 the provider. This certification may be revoked or suspended, in accordance with administrative rules to
22 be promulgated by the ~~department~~ executive office, if a provider fails to meet professional licensure
23 requirements, violates any administrative regulations of the ~~Rhode Island Medicaid program~~ executive
24 office of health and human services, does not provide proper professional services, is the subject of a
25 suspension of payments order, is convicted of Medicaid fraud, or otherwise violates any provision of this
26 chapter.

1 **§ 40-8.2-21. Suspension of payments to a provider.**- (a) ~~The Rhode Island Medicaid program~~
2 executive office of health and human services may issue a suspension of payments order if:

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

4 or

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

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

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

15 (5) ~~The Rhode Island Medicaid program~~ office of program integrity and/or the Medicaid fraud
16 control unit of the attorney general's office has been denied reasonable access to data and information by
17 the provider for the purpose of conducting activities as described in § 1903(g) of the Social Security Act,
18 42 U.S.C. § 1396b(g); or

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

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

1 satisfactory arrangement has been made for the payment of the provider or that a satisfactory arrangement
2 has been made for the payment by the provider of any such amounts.

3 **§ 40-8.2-22. Interest on overcharges.**-Any provider of services or goods contracting with the
4 ~~department of human services~~ executive office of health and human services pursuant to Title XIX or
5 Title XXI of the Social Security Act, ~~42 U.S.C. § 1396 et seq.~~, who, without intent to defraud, obtains
6 payments under this chapter in excess of the amount to which the provider is entitled, thereby becomes
7 liable for payment of the amount of the excess with payment of interest allowable by law, under § 6-26-
8 2, as was in effect on the date payment was made to the provider. The interest period will commence on
9 the date upon which payment was made and will extend to the date upon which repayment is made to the
10 state of Rhode Island.

11 SECTION 9. Sections 40-8.3-2 and 40-8.3-3 of the General Laws in Chapter 40-8.3 entitled
12 "Uncompensated Care" are hereby amended to read as follows:

13 **§ 40-8.3-2 Definitions.** – As used in this chapter:

14 (1) "Base year" means for the purpose of calculating a disproportionate share payment for any
15 fiscal year ending after September 30, ~~2013~~ 2014, the period from October 1, ~~2011~~ 2012 through
16 September 30, ~~2012~~ 2013, and for any fiscal year ending after September 30, ~~2014~~ 2015, the period from
17 October 1, ~~2012~~ 2013 through September 30, ~~2013~~ 2014.

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

22 (3) "Participating hospital" means any nongovernment and nonpsychiatric hospital that: (i) was
23 licensed as a hospital in accordance with chapter 17 of title 23 during the base year; and shall mean the
24 actual facilities and buildings in existence in Rhode Island, licensed pursuant to § 23-17-1 et seq. on June
25 30, 2010, and thereafter any premises included on that license, regardless of changes in licensure status
26 pursuant to § 23-17.14 (hospital conversions) and §23-17-6 (b) (change in effective control),

1 that provides short-term acute inpatient and/or outpatient care to persons who require definitive diagnosis
2 and treatment for injury, illness, disabilities, or pregnancy.

3 (ii) achieved a medical assistance inpatient utilization rate of at least one percent (1%) during the
4 base year; and

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

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

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

23 ~~§ 40-8.3-3 Implementation.~~ (a) For federal fiscal year 2013, commencing on October 1, 2012
24 and ending September 30, 2013, the executive office of health and human services shall submit to the
25 Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode
26 Island Medicaid state plan for disproportionate share hospital payments (DSH Plan) to provide:

1 ~~(1) That the disproportionate share hospital payments to all participating hospitals, not to exceed~~
2 ~~an aggregate limit of \$128.3 million, shall be allocated by the executive office of health and human~~
3 ~~services to the Pool A, Pool C and Pool D components of the DSH Plan; and;~~

4 ~~(2) That the Pool D allotment shall be distributed among the participating hospitals in direct~~
5 ~~proportion to the individual participating hospital's uncompensated care costs for the base year, inflated~~
6 ~~by the uncompensated care index to the total uncompensated care costs for the base year inflated by~~
7 ~~uncompensated care index for all participating hospitals. The disproportionate share payments shall be~~
8 ~~made on or before July 15, 2013 and are expressly conditioned upon approval on or before July 8, 2013~~
9 ~~by the Secretary of the U.S. Department of Health and Human Services, or his or her authorized~~
10 ~~representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of~~
11 ~~federal financial participation in federal fiscal year 2013 for the disproportionate share payments.~~

12 (b) (a) For federal fiscal year 2014, commencing on October 1, 2013 and ending September 30,
13 2014, the executive office of health and human services shall submit to the Secretary of the U.S.
14 Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid state
15 plan for disproportionate share hospital payments (DSH Plan) to provide:

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

19 (2) That the Pool D allotment shall be distributed among the participating hospitals in direct
20 proportion to the individual participating hospital's uncompensated care costs for the base year, inflated
21 by the uncompensated care index to the total uncompensated care costs for the base year inflated by
22 uncompensated care index for all participating hospitals. The disproportionate share payments shall be
23 made on or before July 14, 2014 and are expressly conditioned upon approval on or before July 7, 2014
24 by the Secretary of the U.S. Department of Health and Human Services, or his or her authorized
25 representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of
26 federal financial participation in federal fiscal year 2014 for the disproportionate share payments.

1 (e) (b) For federal fiscal year 2015, commencing on October 1, 2014 and ending September 30,
2 2015, the executive office of health and human services shall submit to the Secretary of the U.S.
3 Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid state
4 plan for disproportionate share hospital payments (DSH Plan) to provide:

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

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

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

20 (1) That the disproportionate share hospital payments to all participating hospitals, not to exceed
21 an aggregate limit of \$135.9 million, shall be allocated by the executive office of health and human
22 services to the Pool A, Pool C and Pool D components of the DSH Plan; and,

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

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

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

7 SECTION 10. Section 5 of Article 18 of Chapter 145 of the Public Laws of 2014 is hereby
8 repealed.

9 ~~SECTION 5. A pool is hereby established of up to \$1.5 million to support Medicaid Graduate~~
10 ~~Education funding for Academic Medical Centers with level I Trauma Centers who provide care to the~~
11 ~~state's critically ill and indigent populations. The office of Health and Human Services shall utilize this~~
12 ~~pool to provide up to \$3 million per year in additional Medicaid payments to support Graduate Medical~~
13 ~~Education programs to hospitals meeting all of the following criteria:~~

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

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

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

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

22 ~~Payments for Graduate Medical Education programs shall be effective July 1, 2014.~~

23 SECTION 11. Section 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical
24 Assistance – Long-Term Care Service and Finance Reform" is hereby amended to read as follows:

25 **§ 40-8.9-9. Long-term care re-balancing system reform goal.** – (a) Notwithstanding any other
26 provision of state law, the ~~department of human services executive office of health and human services~~ is

1 authorized and directed to apply for and obtain any necessary waiver(s), waiver amendment(s) and/or
2 state plan amendments from the secretary of the United States department of health and human services,
3 and to promulgate rules necessary to adopt an affirmative plan of program design and implementation that
4 addresses the goal of allocating a minimum of fifty percent (50%) of Medicaid long-term care funding for
5 persons aged sixty-five (65) and over and adults with disabilities, in addition to services for persons with
6 developmental disabilities ~~and mental disabilities~~, to home and community-based care ~~on or before~~
7 ~~December 31, 2013~~; provided, further, the ~~executive office of health and human services~~ executive office
8 shall report annually as part of its budget submission, the percentage distribution between institutional
9 care and home and community-based care by population and shall report current and projected waiting
10 lists for long-term care and home and community-based care services. The ~~department~~ executive office is
11 further authorized and directed to prioritize investments in home and community-based care and to
12 maintain the integrity and financial viability of all current long-term care services while pursuing this
13 goal.

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

24 (c) Pursuant to federal authority procured under § 42-7.2-16 of the general laws, the ~~department~~
25 ~~of human services~~ executive office of health and human services is directed and authorized to adopt a
26 tiered set of criteria to be used to determine eligibility for services. Such criteria shall be developed in

1 collaboration with the state's health and human services departments and, to the extent feasible, any
2 consumer group, advisory board, or other entity designated for such purposes, and shall encompass
3 eligibility determinations for long-term care services in nursing facilities, hospitals, and intermediate care
4 facilities for ~~the mentally retarded~~ persons with intellectual disabilities as well as home and community-
5 based alternatives, and shall provide a common standard of income eligibility for both institutional and
6 home and community-based care. The ~~department~~ executive office is, ~~subject to prior approval of the~~
7 ~~general assembly~~, authorized to adopt clinical and/or functional criteria for admission to a nursing facility,
8 hospital, or intermediate care facility for ~~the mentally retarded~~ persons with intellectual disabilities that
9 are more stringent than those employed for access to home and community-based services. The
10 ~~department~~ executive office is also authorized to promulgate rules that define the frequency of re-
11 assessments for services provided for under this section. ~~Legislatively approved levels~~ Levels of care may
12 be applied in accordance with the following:

13 (1) The ~~department~~ executive office shall continue to apply ~~pre-waiver~~ the level of care criteria
14 in effect on June 30, 2015 for any recipient determined eligible for and receiving Medicaid recipient
15 eligible for Medicaid-funded long-term services in supports in a nursing facility, hospital, or intermediate
16 care facility for ~~the mentally retarded~~ persons with intellectual disabilities ~~as of June 30, 2009~~ on or
17 before that date, unless: (a) the recipient transitions to home and community based services because he or
18 she: ~~(a) Improves to a level where he/she would no longer meet the pre-waiver level of care criteria in~~
19 effect on June 30, 2015; or (b) ~~The individual~~ the recipient chooses home and community based services
20 over the nursing facility, hospital, or intermediate care facility for ~~the mentally retarded~~ persons with
21 intellectual disabilities. For the purposes of this section, a failed community placement, as defined in
22 regulations promulgated by the ~~department~~ executive office, shall be considered a condition of clinical
23 eligibility for the highest level of care. The ~~department~~ executive office shall confer with the long-term
24 care ombudsperson with respect to the determination of a failed placement under the ombudsperson's
25 jurisdiction. Should any Medicaid recipient eligible for a nursing facility, hospital, or intermediate care
26 facility for ~~the mentally retarded~~ persons with intellectual disabilities as of June 30, 2009 2015 receive a

1 determination of a failed community placement, the recipient shall have access to the highest level of
2 care; furthermore, a recipient who has experienced a failed community placement shall be transitioned
3 back into his or her former nursing home, hospital, or intermediate care facility for ~~the mentally retarded~~
4 persons with intellectual disabilities whenever possible. Additionally, residents shall only be moved from
5 a nursing home, hospital, or intermediate care facility for ~~the mentally retarded~~ persons with intellectual
6 disabilities in a manner consistent with applicable state and federal laws.

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

10 (3) No nursing home, hospital, or intermediate care facility for ~~the mentally retarded~~ persons
11 with intellectual disabilities shall be denied payment for services rendered to a Medicaid recipient on the
12 grounds that the recipient does not meet level of care criteria unless and until the ~~department of human~~
13 ~~services~~ executive office has: (i) performed an individual assessment of the recipient at issue and
14 provided written notice to the nursing home, hospital, or intermediate care facility for ~~the mentally~~
15 ~~retarded~~ persons with intellectual disabilities that the recipient does not meet level of care criteria; and (ii)
16 the recipient has either appealed that level of care determination and been unsuccessful, or any appeal
17 period available to the recipient regarding that level of care determination has expired.

18 (d) The ~~department of human services~~ executive office is further authorized and directed to
19 consolidate all home and community-based services currently provided pursuant to § 1915(c) of title XIX
20 of the United States Code into a single system of home and community-based services that include
21 options for consumer direction and shared living. The resulting single home and community-based
22 services system shall replace and supersede all §1915(c) programs when fully implemented.
23 Notwithstanding the foregoing, the resulting single program home and community-based services system
24 shall include the continued funding of assisted living services at any assisted living facility financed by
25 the Rhode Island housing and mortgage finance corporation prior to January 1, 2006, and shall be in

1 accordance with chapter 66.8 of title 42 of the general laws as long as assisted living services are a
2 covered Medicaid benefit.

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

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

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

14 ~~(2) (1) Development, not later than September 30, 2008, of revised or new Medicaid certification~~
15 ~~standards supporting and defining targeted rate increments to encourage~~ that increase access to service
16 ~~specialization and scheduling accommodations including but not limited to, medication and pain~~
17 ~~management, wound management, certified Alzheimer's Syndrome treatment and support programs, and~~
18 ~~work and shift differentials for night and week end services; and by using payment strategies designed to~~
19 achieve specific quality and health outcomes.

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

24 (2) Development of Medicaid certification standards for state authorized providers of adult day
25 services, excluding such providers of services authorized under §40.1-24-1(3), assisted living, and adult
26 supportive care homes (as defined under §23-17.24) that establish for each, an acuity-based, tiered service

1 and payment methodology tied to: licensure authority, level of beneficiary needs; the scope of services
2 and supports provided; and specific quality and outcome measures. The standards for adult day services
3 for persons eligible for Medicaid-funded long-term services may differ from those who do not meet the
4 clinical/functional criteria set forth in § 40-8.10-3.

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

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

22 (j) (i) To ensure persons with long-term care needs who remain living at home have adequate
23 resources to deal with housing maintenance and unanticipated housing related costs, ~~the department of~~
24 ~~human services~~ secretary is authorized to develop higher resource eligibility limits for persons ~~on~~ or
25 obtain any state plan or waiver authorities necessary to change the financial eligibility criteria for long-

1 term services and supports to enable beneficiaries receiving home and community waiver services to have
2 the resources to continue who are living in their own homes or rental units or other home-based settings.

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

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

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

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

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

16 SECTION 12: Sections 40-8.10-1, 40-8.10-2, 40-8.10-3, 40-8.10-4, 40-8.10-5, and 40-8.10-6 of
17 the General Laws in Chapter 40-8.10 entitled "Long Term Care Service Reform for Medicaid Eligible
18 Individuals" are hereby amended to read as follows:

19 **§ 40-8.10-1 Purpose.** – (a) In order to ensure that all Medicaid recipients eligible for long-term
20 care have access to the full continuum of services they need, the secretary of the executive office of health
21 and human services, in collaboration with the ~~director of the department of human services and the~~
22 ~~directors of the departments of children youth and families, elderly affairs, health, and mental health,~~
23 ~~retardation and hospitals,~~ directors of EOHHS departments, shall offer eligible Medicaid recipients the
24 full range of services as allowed under the terms and conditions of the Rhode Island ~~Global Consumer~~
25 ~~Choice Compact 1115a Demonstration Waiver~~ Medicaid section 1115 demonstration waiver, including
26 institutional services and the home and community based services provided for under the previous

1 Medicaid Section 1915(c) waivers, as well as additional services for medication management, transition
2 services and other authorized services as defined in this chapter, in order to meet the individual needs of
3 the Medicaid recipient.

4 **§ 40-8.10-2 Definitions.** – As used in this chapter,

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

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

14 **40-8.10-3 Levels of care.** – (a) ~~The secretary of the executive office of health and human~~
15 ~~services shall coordinate responsibilities for long-term care assessment in accordance with the provisions~~
16 ~~of this chapter within the department of human services, and with the cooperation of the directors of the~~
17 ~~department of elderly affairs, the department of children, youth and families, and the department of~~
18 ~~mental health, retardation and hospitals. Assessments conducted by each department's staff shall be~~
19 ~~coordinated through the Assessment Coordination Unit (ACU). Members of each department's staff~~
20 ~~responsible for assessing level of care, developing care plans, and determining budgets will meet on a~~
21 ~~regular basis in order to ensure that services are provided in a uniform and consistent manner. Importance~~
22 ~~shall be placed upon the proper and consistent determination of levels of care across the state departments~~
23 ~~for each long-term care setting, including behavioral health residential treatment facilities, long-term care~~
24 ~~hospitals, intermediate care facilities, and/or skilled nursing facilities. Three (3) appropriate Specialized~~
25 ~~plans of care that meet the needs of the individual Medicaid recipients shall be coordinated and consistent~~
26 ~~across all state departments. The development of care plans shall be person-centered and shall support~~

1 individual self-determination, family involvement, when appropriate, individual choice and
2 interdepartmental collaboration.

3 (b) Levels of care for long-term care institutions (behavioral health residential treatment facilities,
4 long-term care hospitals, intermediate care facilities and/or skilled nursing facilities), for which
5 alternative community-based services and supports are available, shall be established pursuant to the §
6 40-8.9-9. The structure of the three (3) levels of care is as follows:

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

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

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

15 (c) Determinations of levels of care and the provision of long term care health services shall be
16 determined in accordance with this section and shall be in accordance with the applicable provisions of §
17 40-8.9-9.

18 **§ 40-8.10-4 Long-term Care Assessment and Coordination** ~~Assessment and Coordination~~

19 ~~Unit (ACU).~~ – (a) ~~The department of human services, in collaboration with the~~ The executive office of
20 health and human services, shall implement a long-term care options counseling program to provide
21 individuals or their representative, or both, with long-term care consultations that shall include, at a
22 minimum, information about long-term care options, sources and methods of both public and private
23 payment for long term care services, information on caregiver support services, including respite care,
24 and an assessment of an individual's functional capabilities and opportunities for maximizing
25 independence. Each individual admitted to or seeking admission to a long-term care facility, regardless of
26 the payment source, shall be informed by the facility of the availability of the long-term care options

1 counseling program and shall be provided with a long-term care options consultation, if he or she so
2 requests. Each individual who applies for Medicaid long-term care services shall be provided with a long-
3 term care consultation.

4 (b) Core and preventative home and community based services defined and delineated in § 40-
5 8.10-2 shall be provided only to those individuals who meet one of the levels of care provided for in this
6 chapter. Other long term care services authorized by the federal government, such as medication
7 management, may also be provided to Medicaid eligible recipients who have established the requisite
8 need, ~~as determined by the Assessment and Coordination Unit (ACU). Access to institutional and~~
9 ~~community-based supports and services shall be through the Assessment and Coordination Unit (ACU).~~
10 ~~The provision of Medicaid funded long term care services and supports shall be based upon a~~
11 ~~comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social~~
12 ~~and environmental needs of each applicant for these services or programs. The assessment shall serve as~~
13 ~~the basis for the development and provision of an appropriate plan of care for the applicant.~~

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

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

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

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

4 **§ 40-8.10-5 Payments.** – The ~~department of human services~~ executive office of health and
5 human services shall not make payment for a person receiving a long-term home health care program,
6 while payments are being made for that person for inpatient care in a skilled nursing and/or intermediate
7 care facility or hospital.

8 **§ 40-8.10-6 Rules and regulations.** – The secretary of the executive office of health and human
9 services, the directors of the department of human services, the ~~department~~ division of elderly affairs, the
10 department of children youth and families and the department of ~~mental health retardation and hospitals~~
11 behavioral healthcare, development disabilities and hospitals are hereby authorized to promulgate rules
12 and regulations necessary to implement all provisions of this chapter and to seek necessary federal
13 approvals in accordance with the provisions of the ~~Global Compact Waiver~~ state's Medicaid section 1115
14 demonstration waiver.

15 SECTION 13. Section 40-8.13-2 of the General Laws in Chapter 40-8.13 entitled “Long-Term
16 Managed Care Arrangements” is amended to read as follows:

17 **§ 40-8.13-2 Beneficiary choice.** — ~~Any managed long term care arrangement shall offer~~
18 ~~beneficiaries the option to decline participation and remain in traditional Medicaid and, if a duals~~
19 ~~demonstration project, traditional Medicare. Beneficiaries must be provided with sufficient information to~~
20 ~~make an informed choice regarding enrollment, including:~~

21 (1) ~~Any changes in the beneficiary's payment or other financial obligations with respect to long term~~
22 ~~care services and supports as a result of enrollment;~~

23 (2) ~~Any changes in the nature of the long term care services and supports available to the beneficiary as~~
24 ~~a result of enrollment, including specific descriptions of new services that will be available or existing~~
25 ~~services that will be curtailed or terminated;~~

26 (3) ~~A contact person who can assist the beneficiary in making decisions about enrollment;~~

1 (4) Individualized information regarding whether the managed care organization's network includes the
2 health care providers with whom beneficiaries have established provider relationships. Directing
3 beneficiaries to a website identifying the plan's provider network shall not be sufficient to satisfy this
4 requirement; and

5 (5) The deadline by which the beneficiary must make a choice regarding enrollment, and the length of
6 time a beneficiary must remain enrolled in a managed care organization before being permitted to change
7 plans or opt out of the arrangement.

8 **§ 40-8.13-2. Community-Based Supportive Living Program.** (a) To expand the number of
9 community-based service options, the executive office of health and human services shall establish a
10 program for beneficiaries opting to participate in managed care long-term care arrangements under this
11 chapter who choose to receive Medicaid-funded assisted living, adult supportive care home, or shared
12 living long-term care services and supports. As part of the program, the executive office shall implement
13 Medicaid certification or, as appropriate, managed care contract standards for state authorized providers
14 of these services that establish an acuity-based, tiered service and payment system that ties
15 reimbursements to: beneficiary's clinical/functional level of need; the scope of services and supports
16 provided; and specific quality and outcome measures. Such standards shall set the base level of Medicaid
17 state plan and waiver services that each type of provider must deliver, the range of acuity-based service
18 enhancements that must be made available to beneficiaries with more intensive care needs, and the
19 minimum state licensure and/or certification requirements a provider must meet to participate in the pilot
20 at each service/payment level. The standards shall also establish any additional requirements, terms or
21 conditions a provider must meet to ensure beneficiaries have access to high quality, cost effective care.

22 (b) **Room and board.** The executive office shall raise the cap on the amount Medicaid certified
23 assisted living and adult supportive home care providers are permitted to charge participating
24 beneficiaries for room and board. In the first year of the program, the monthly charges for a beneficiary
25 living in a single room who has income at or below three hundred percent (300%) of the Supplemental
26 Security Income (SSI) level shall not exceed the total of both the maximum monthly federal SSI payment

1 and the monthly state supplement authorized for persons requiring long-term services under § 40-6-
2 27-2(a)(1)(vi), less the specified personal need allowance. For a beneficiary living in a double room, the
3 room and board cap shall be set at eighty-five percent (85%) of the monthly charge allowed for a
4 beneficiary living in a single room.

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

11 § 40-8.13-5 Financial savings under managed care Financial principles under managed
12 care. – To the extent that financial savings are a goal under any managed long-term care arrangement, it
13 is the intent of the legislature to achieve such savings through administrative efficiencies, care
14 coordination, and improvements in care outcomes and in a way that encourages the highest quality care
15 for patients and maximizes value for the managed care organization and the state. rather than through
16 reduced reimbursement rates to providers. Therefore, any managed long-term care arrangement shall
17 include a requirement that the managed care organization reimburse providers for services in accordance
18 with the following: these principles. Notwithstanding any law to the contrary, for the twelve (12) month
19 period beginning July 1, 2015, Medicaid managed long term care payment rates to nursing facilities
20 established pursuant to this section shall not exceed ninety-seven and one-half percent (97.5%) of the
21 rates in effect on April 1, 2015.

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

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

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

4 ~~(2) For a managed long-term care arrangement that is not a duals demonstration project, the~~
5 ~~managed care organization shall reimburse providers in an amount not less than the rate that would be~~
6 ~~paid for the same care by EOHHS under the Medicaid program.~~

7 SECTION 14. Sections 42-7.2-2, 42-7.2-5, 42-7.2-6.1, 42-7.2-16, 42-7.2-18 of the General
8 Laws in Chapter 42-7.2 entitled “ Executive Office of Health and Human Services“ are hereby amended
9 to read as follows:

10 **§ 42-7.2-2. Executive office of health and human services.**-There is hereby established within
11 the executive branch of state government an executive office of health and human services to serve as the
12 principal agency of the executive branch of state government for managing the departments of children,
13 youth and families, health, human services, and behavioral healthcare, developmental disabilities and
14 hospitals. In this capacity, the office shall:

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

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

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

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

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

24 (5) Ensure that state health and human services policies and programs are responsive to changing
25 consumer needs and to the network of community providers that deliver assistive services and supports on
26 their behalf.

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

8 **§ 42-7.2-4. Responsibilities of the secretary.** (a) The secretary shall be responsible to the
9 governor for supervising the executive office of health and human services and for managing and
10 providing strategic leadership and direction to the four (4) departments.

11 (b) Notwithstanding the provisions set forth in this chapter, the governor shall appoint the
12 directors of the departments within the executive office of health and human services. Directors appointed
13 to those departments shall continue to be subject to the advice and consent of the senate and shall
14 continue to hold office as set forth in §§ 42-6-1 et seq. and 42-72-1(c). Provided, however, that the
15 directors shall be accountable directly to the secretary, acting on the governor's behalf, for the
16 responsible, effective and efficient execution of health and human services policy and budget priorities
17 established in general or public law, by rule or regulation, or executive order.

18 **§ 42-7.2-5. Duties of the secretary.** The secretary shall be subject to the direction and
19 supervision of the governor for the oversight, coordination and cohesive direction of state administered
20 health and human services and in ensuring the laws are faithfully executed, notwithstanding any law to
21 the contrary. In this capacity, the Secretary of Health and Human Services shall be authorized to:

22 (1) Coordinate the administration and financing of health care benefits, human services and
23 programs including those authorized by the ~~Global Consumer Choice Compact Waiver~~ the state's
24 Medicaid section 1115 demonstration waiver and, as applicable, the Medicaid State Plan under Title XIX
25 of the US Social Security Act. However, nothing in this section shall be construed as transferring to the
26 secretary the powers, duties or functions conferred upon the departments by Rhode Island public and

1 general laws for the administration of federal/state programs financed in whole or in part with Medicaid
2 funds or the administrative responsibility for the preparation and submission of any state plans, state plan
3 amendments, or authorized federal waiver applications, once approved by the secretary.

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

6 (3) (a) Review and ensure the coordination of any ~~Global Consumer Choice Compact Waiver~~ the
7 state's Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives and
8 proposals requiring amendments to the Medicaid state plan or category two (II) or three (III) changes, as
9 described in the special terms and conditions of the ~~Global Consumer Choice Compact Waiver~~ the state's
10 Medicaid section 1115 demonstration waiver with the potential to affect the scope, amount or duration of
11 publicly-funded health care services, provider payments or reimbursements, or access to or the
12 availability of benefits and services as provided by Rhode Island general and public laws. The secretary
13 shall consider whether any such changes are legally and fiscally sound and consistent with the state's
14 policy and budget priorities. The secretary shall also assess whether a proposed change is capable of
15 obtaining the necessary approvals from federal officials and achieving the expected positive consumer
16 outcomes. Department directors shall, within the timelines specified, provide any information and
17 resources the secretary deems necessary in order to perform the reviews authorized in this section;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 ~~(vii) Broaden access to publicly funded food and nutrition services by consolidating agency programs and~~
19 ~~initiatives to eliminate duplication and overlap and improve the availability and quality of services; and~~

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

23 (7) Prepare and integrate comprehensive budgets for the health and human services departments
24 and any other functions and duties assigned to the office. The budgets shall be submitted to the state
25 budget office by the secretary, for consideration by the governor, on behalf of the state's health and

1 human services agencies in accordance with the provisions set forth in § 35-3-4 of the Rhode Island
2 general laws.

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

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

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

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

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

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

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

1 **§ 42-7.2-6. Departments assigned to the executive office - Powers and duties.**-(a) The

2 departments assigned to the secretary shall:

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

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

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

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

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

19 **§ 42-7.2-6.1. Transfer of powers and functions.**-(a) There are hereby transferred to the

20 executive office of health and human services the powers and functions of the departments with respect to
21 the following:

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

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

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

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

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

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

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

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

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

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

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

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

5 (1) Minimal disruption of services to consumers;

6 (2) Elimination of duplication of functions and operations;

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

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

9 (5) Cost-savings are achieved whenever feasible;

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

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

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

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

23 ~~§ 42-7.2-12. Medicaid program study. (a) The secretary of the executive office of health and~~
24 ~~human services shall conduct a study of the Medicaid programs administered by the state to review and~~
25 ~~analyze the options available for reducing or stabilizing the level of uninsured Rhode Islanders and~~
26 ~~containing Medicaid spending.~~

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

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

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

18 ~~§ 42-7.2-12.1. Human services call center study (211).~~ (a) ~~The secretary of the executive office~~
19 ~~of health and human services shall conduct a feasibility and impact study of the potential to implement a~~
20 ~~statewide 211 human services call center and hotline. As part of the process, the study shall catalog~~
21 ~~existing human service information hotlines in Rhode Island, including, but not limited to, state-operated~~
22 ~~call centers and private and not-for-profit information hotlines within the state.~~

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

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

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

7 ~~(c) The secretary shall submit a report and recommendations based on the findings of the study to~~
8 ~~the general assembly, the governor, and the house and senate fiscal advisors no later than February 1,~~
9 ~~2007.~~

10 **§ 42-7.2-13. Severability.**-If any provision of this chapter or the application thereof to any person
11 or circumstance is held invalid, such invalidity shall not effect affect other provisions or applications of
12 the chapter, which can be given effect without the invalid provision or application, and to this end the
13 provisions of this chapter are declared to be severable.

14 **§ 42-7.2-16. Medicaid System Reform 2008.**(a) The executive office of health and human
15 services, in conjunction with the department of human services, the department of children youth and
16 families, the department of health and the department of behavioral healthcare, developmental disabilities,
17 and hospitals, is authorized to design options that further the reforms in the Medicaid program initiated in
18 2008 to ensure so that it is a person-centered, financially sustainable, cost-effective, and opportunity
19 driven program that the program: utilizes competitive and value based purchasing to maximize the
20 available service options, ~~promote~~ promotes accountability and transparency, and ~~encourage and reward~~
21 encourages and rewards healthy outcomes, independence, and responsible choices; promotes efficiencies
22 and the coordination of services across all health and human services agencies; and ensures the state will
23 have a fiscally sound source of publicly-financed health care for Rhode Islanders in need.

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

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

4 (2) Encourage personal responsibility by assuring the information available to beneficiaries is
5 easy to understand and accurate, provide that a fiscal intermediary is provided when necessary, and
6 adequate access to needed services;

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

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

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

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

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

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

25 **§ 42-7.2-16.1. Reinventing Medicaid Act of 2015.** (a) The Rhode Island Medicaid program is an
26 integral component of the state's health care system that provides crucial services and supports to many

1 Rhode Islanders. As the program's reach has expanded, the costs of the program have continued to rise
2 and the delivery of care has become more fragmented and uncoordinated. Given the crucial role of the
3 Medicaid program to the state, it is of compelling importance that the state conduct a fundamental
4 restructuring of its Medicaid program that achieves measurable improvement in health outcomes for the
5 people and transforms the health care system to one that pays for the outcomes and quality they deserve at
6 a sustainable, predictable and affordable cost.

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

11 (c) Notwithstanding any other provision of law, the Secretary of Health and Human Services is
12 authorized to undertake those programmatic changes requiring the implementation of a rule or regulation
13 or modification of a rule or regulation in existence prior to the implementation of the global consumer
14 choice section 1115 demonstration, or any category II change or category III change as defined in the
15 demonstration, that are integral to the appropriations for the medical assistance program contained in
16 Article 1 of the FY2016 Appropriations Act and detailed in official budgetary documents supplemental
17 thereto.

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

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

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

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

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

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

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

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

18 (3) To identify methods to implement innovative technology and data sharing in consultation with
19 the office of digital excellence in order to detect and analyze Medicaid and public assistance fraud with
20 speed and efficiency; Such methods as may be effective as a means of detecting incidences of fraud,
21 assisting in directing the focus of an investigation or audit, and determining the amounts a provider owes
22 as the result of such an investigation or audit conducted by the division, a department assigned to the
23 office, Rhode Island Department of Attorney General Medicaid Fraud Control Unit, the U.S. Department
24 of Health and Human Services' Office of Inspector General, the U.S. Department of Justice's Federal
25 Bureau of Investigation, or an authorized agent thereof.

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

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

6 (i) Coverage and billing policies;

7 (ii) Participant-centered planning and options available;

8 (iii) Covered and non-covered services;

9 (iv) Provider accountability and responsibilities;

10 (v) Claim submission policies and procedures; and

11 (vi) Reconciling claim activity.

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

15 SECTION 15. Section 42-12-29 of the General Laws in Chapter 42-12 entitled "Department of
16 Human Services" is hereby amended to read as follows:

17 **§42-12-29 Children's health account.** – (a) There is created within the general fund a restricted
18 receipt account to be known as the "children's health account." All money in the account shall be utilized
19 by the ~~department of human services~~ executive office of health and human services to effectuate coverage
20 for the following service categories: (1) home health services, which include pediatric private duty
21 nursing and certified nursing assistant services; (2) comprehensive, evaluation, diagnosis, assessment,
22 referral and evaluation (CEDARR) services, which include CEDARR family center services, home based
23 therapeutic services, personal assistance services and supports (PASS) and kids connect services and (3)
24 child and adolescent treatment services (CAITS). All money received pursuant to this section shall be
25 deposited in the children's health account. The general treasurer is authorized and directed to draw his or

1 her orders on the account upon receipt of properly authenticated vouchers from the ~~department of human~~
2 ~~services executive office.~~

3 (b) Beginning January 1, 2016, a portion of the amount collected pursuant to § 42-7.4-3, up to the
4 actual amount expended or projected to be expended by the state for the services described in § 42-12-
5 29(a), less any amount collected in excess of the prior year's funding requirement as indicated in § 42-12-
6 29(c), but in no event more than the limit set forth in § 42-12-29(d) (the "child health services funding
7 requirement"), shall be deposited in the "children's health account". The funds shall be used solely for the
8 purposes of the "children's health account", and no other.

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

15 (d) The total amount required to be deposited into the children's health account shall be
16 equivalent to the amount paid by the ~~department of human services executive office~~ for all services, as
17 listed in subsection (a), but not to exceed ~~seven thousand five hundred dollars (\$7,500)~~ eleven thousand
18 dollars (\$11,000) per child per service per year.

19 (e) The children's health account shall be exempt from the indirect cost recovery provisions of §
20 35-4-27 of the general laws.

21 SECTION 16: Chapter 42-72.5 of the General Laws entitled, "Children's Cabinet" is hereby
22 amended to read as follows:

23 **§ 42-72.5-1. Establishment.** - There is established within the executive branch of state
24 government a children's cabinet. The cabinet shall ~~be comprised of:~~ include, but not be limited to: the
25 director of the department of administration; the secretary of the executive office of health and human
26 services; the director of the department of children, youth, and families; the director of the department of

1 ~~mental health, retardation, and hospitals; behavioral healthcare, developmental disabilities, and hospitals;~~
2 the director of the department of health; the commissioner of ~~higher-post-secondary~~ education; the
3 commissioner of elementary and secondary education; the director of the department of human services;
4 ~~the chief information officer;~~ the director of the department of labor and training; the child advocate; the
5 ~~director of the department of elderly affairs; and the director of policy in the governor's office. governor~~
6 or his or her designee. The governor shall designate one of the members of the cabinet to be chairperson.

7 **§ 42-72.5-2 Policy and goals.** – The children's cabinet shall:

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

10 (2) Review, amend, and propose all interagency agreements necessary to provide coordinated
11 services to children;

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

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

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

21 (6) Develop a strategic plan to ~~design and implement a single, secure, universal student identifier~~
22 ~~system that does not involve a student's social security number and that will~~ coordinate and share data to
23 foster interagency communication, increase efficiency of service delivery, and simultaneously protect
24 children's legitimate expectations of privacy and rights to confidentiality. This shall include data-sharing
25 with research partners, pursuant to data-sharing agreements, that maintains data integrity and protects the
26 security and confidentiality of these records.

1 **§ 42-72.5-3 Cooperation required.** – ~~The division of planning in the department of~~
2 ~~administration~~ executive office of health and human services shall provide staff support to the children's
3 cabinet in preparing the integrated state child service system plan as required by this chapter. All
4 departments represented on the children's cabinet shall cooperate with the ~~division of planning~~ executive
5 office of health and human services to facilitate the purposes of this chapter.

6 SECTION 17: Section 44-51-3 of the General Laws in Chapter 44-51 entitled “Nursing Facility
7 Provider Assessment Act” is hereby amended to read as follows:

8 **§ 44-51-3. Imposition of assessment – Nursing facilities.**–(a) For purposes of this section, a
9 "nursing facility" means a person or governmental unit licensed in accordance with chapter 17 of title 23
10 to establish, maintain, and operate a nursing facility.

11 (b) An assessment is imposed upon the gross patient revenue received by every nursing facility
12 in each month beginning January 1, 2008 through December 31, 2015, at a rate of five and one-half
13 percent (5.5%) for services provided on or after January 1, 2008. An assessment is imposed upon the
14 gross patient revenue by every nursing facility in each month beginning January 1, 2016 at a rate of six
15 percent (6%) for services provided on or after January 1, 2016. Every provider shall pay the monthly
16 assessment no later than the twenty-fifth (25th) day of each month following the month of receipt of gross
17 patient revenue.

18 (c) The assessment imposed by this section shall be repealed on the effective date of the repeal or
19 a restricted amendment of those provisions of the Medicaid Voluntary Contribution and Provider-Specific
20 Tax Amendments of 1991 (P.L. 102-234) that permit federal financial participation to match state funds
21 generated by taxes.

22 (d) If, after applying the applicable federal law and/or rules, regulations, or standards relating to
23 health care providers, the tax administrator determines that the assessment rate established in subsection
24 (b) of this section exceeds the maximum rate of assessment that federal law will allow without reduction
25 in federal financial participation, then the tax administrator is directed to reduce the assessment to a rate
26 equal to the maximum rate which the federal law will allow without reduction in federal participation.

1 Provided, however, that the authority of the tax administrator to lower the assessment rate established in
2 subsection (b) of this section shall be limited solely to such determination.

3 (e) In order that the tax administrator may properly carry out his/her responsibilities under this
4 section, the ~~director~~ secretary of the ~~department of human services~~ executive office of health and human
5 services shall notify the tax administrator of any ~~damages~~ changes in federal law and/or any rules,
6 regulations, or standards which affect any rates for health care provider assessments.

7 SECTION 18. Rhode Island Medicaid Reform Act of 2008.

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

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

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

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

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

1 amendments to the Rhode Island's Medicaid state plan and/or Section 1115 1115 waiver under the
2 terms and conditions of the demonstration. Further, implementation of these initiatives may require the
3 adoption of new or amended rules, regulations and procedures.

4 (b) *Nursing Facility Bed Tax – Increase Rate.* The executive office proposes to increase the
5 nursing facility bed tax to the maximum of 6%. Amendments to the Medicaid state plan amendment
6 and/or the state's section 1115 may be necessary to obtain federal authority to effectuate this proposal.

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

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

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

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

1 (g) Integrated Care Initiative (ICI) – Enrollment. The EOHHS proposes to establish mandatory
2 enrollment for all Medicaid beneficiaries including but not limited to beneficiaries receiving long-term
3 services and supports through the ICI, including those who are dually eligible for Medicaid and Medicare.
4 Implementation of mandatory enrollment requires section 1115 waiver authority under the terms and
5 conditions of the demonstration. New and/or amended rules, regulations and procedures are also
6 necessary to implement this proposal.

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

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

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

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

24 (l) Medicaid Eligibility Criteria and System Processes – Review and Realignment. The EOHHS
25 proposes to review state policies related to each Medicaid eligibility coverage group to ensure application,
26 renewal, and service delivery requirements pose the least administrative burden on beneficiaries and

1 provide the maximum amount of financial participation allowed under applicable federal laws and
2 regulations. Changes in the section 1115 waiver and/or state plan may be required to implement any
3 changes deemed necessary by the secretary necessary as a result of this review. New and amended rules,
4 regulations and procedures may also be required.

5 (m) *Reform of Long-term Care Eligibility Criteria* – The EOHHS proposes to reform the
6 clinical/functional eligibility used to determine access to the highest and high level of care to reflect
7 regional and national standards and promote greater utilization of non-institutional care settings by
8 beneficiaries with lower acuity care needs. Section 1115 waiver authority is required to implement the
9 reform in clinical/functional criteria. Amendments to related rules, regulations and procedures are also
10 necessary.

11 (n) *Estate Recoveries and Liens* – Proposed legislative changes in EOHHS policies pertaining to
12 estate recoveries and liens may require new or amended state plan and/or section 1115 waiver authorities.
13 Implementation of these changes will also require amendments to current EOHHS rules and procedures.

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

19 (p) *Payment Methodology for Services to Adults with Developmental Disabilities.* The
20 department of behavioral healthcare developmental disabilities and hospitals proposes to revise the
21 payment methodology and/or rates for services provided to adults with developmental disabilities
22 pursuant to the individual services plans defined in §40.1-2.1-4.3. Amendments to the section 1115
23 waiver and/or the Medicaid state plan may be required to implement any alternative payment
24 methodology, arrangements or rates. New and amended rules, regulations and procedures may also be
25 required.

1 (q) Approved Authorities: Section 1115 Waiver Demonstration Extension. The Medicaid agency
2 proposes to continue implementation of authorities approved under the Section 1115 waiver
3 demonstration extension request – formerly known as the Global Consumer Choice Waiver – that (1)
4 continue efforts to re-balance the system of long term services and supports by assisting people in
5 obtaining care in the most appropriate and least restrictive setting; (2) pursue utilization of care
6 management models that offer a “health home”, promote access to preventive care, and provide an
7 integrated system of services; (3) use payments and purchasing to finance and support Medicaid
8 initiatives that fill gaps in the integrated system of care; and (4) recognize and assure access to the non-
9 medical services and supports, such as peer navigation and employment and housing stabilization
10 services, that are essential for optimizing a person’s health, wellness and safety and reduce or delay the
11 need for long term services and supports.

12 (r) ACA Opportunities --Medicaid Requirements and Opportunities under the U.S. Patient
13 Protection and Affordable Care Act of 2010 (PPACA). The EOHHS proposes to pursue any requirements
14 and/or opportunities established under the PPACA that may warrant a Medicaid State Plan Amendment
15 or amendment under the terms and conditions of Rhode Island’s Section 1115 Waiver, its successor, or
16 any extension thereof. Any such actions the EOHHS takes shall not have an adverse impact on
17 beneficiaries or cause there to be an increase in expenditures beyond the amount appropriated for state
18 fiscal year 2016. Now, therefore, be it

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

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

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

1 SECTION 19: This article shall take effect upon passage, except that Section 10 shall take effect
2 as of July 1, 2014.

