



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Administration  
BUDGET OFFICE  
One Capitol Hill  
Providence, R.I. 02908-5886

MEMORANDUM

**To:** The Honorable Marvin L. Abney  
Chairman, House Finance Committee

The Honorable Daniel Da Ponte  
Chairman, Senate Finance Committee

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

**Date:** March 7, 2017

**Subject:** Amendments to Article 13 of the FY 2018 Appropriations Act  
(17-H-5175)

---

The Governor requests that the revised Article 13 entitled "Relating to Medical Assistance and Uncompensated Care" be replaced with the attached version. Requested changes, including those submitted on February 14, are highlighted in grey in the attached version of the article.

Under section 3 of the article, new language is requested to provide the Secretary of Health and Human Services the authority to seek certain waivers or implement certain changes regarding the Healthy Aging 2017 Initiative. The first change under section 40-8.9-9(a) inserts language identifying the Healthy Aging 2017 Initiative as the focus of the long-term care re-balancing system reform.

The second change under section 40-8.9-9(e) provides the Secretary with the opportunity to seek waiver authorities to obtain federal matching funds to cover optional services, including homemaker services, home modifications, respite, behavioral healthcare supports and physical therapy evaluations, to persons at risk for Medicaid funded long-term care services, in line with the Governor's healthy aging initiative objective to build age friendly communities.

The third change under section 40-8.9-9(f) provides the Secretary with the opportunity to implement payment methodology reforms that pay for value over volume and increase access to optional services that promote healthy living in the community.

The fourth change under section 40-8.9-9(g) provides the Secretary with waiver authorities to obtain federal matching funds to expand options counseling and system navigation assistance to promote enhanced community living for elders, the disabled and individuals living with BH conditions and dementia.

The fifth change under section 40-8.9-9(j) provides the Secretary with opportunity to implement payment methodology reforms that increase access to enhanced adult day services for elders and the disabled living with BH conditions and dementia.

The sixth change is the addition of a new section 6 that will add language requiring notice to OHHS prior to the closing of small estates as defined in chapter 33-24. This language is connected to the savings proposal contained in the Governor's recommended budget whereby OHHS is expected to generate \$250,000 in additional recoveries from estates.

Finally, this amendment also fixes a date overlooked in the February 14 amendment under section 40-8-13.4(1)(ii). The date is corrected from July 1, 2017 to July 1, 2018.

If you have any questions regarding these amendments, please feel free to call me or my staff at 222-6300.

TAM:-Amend-11

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  
Gregory Stack, Supervising Budget Analyst  
Carmela Corte, Supervising Budget Analyst

ARTICLE 13

RELATING TO MEDICAL ASSISTANCE AND UNCOMPENSATED CARE

SECTION 1. Sections 40-8-13.4, 40-8-19 and 40-8-26 of the General Laws in Chapter 40-8 entitled "Medical Assistance" are hereby amended to read as follows:

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

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

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

(1)(i) With respect to inpatient services for persons in fee-for-service Medicaid, which is non-managed care, implement a new payment methodology for inpatient services utilizing the Diagnosis Related Groups (DRG) method of payment, which is a patient-classification method that provides a means of relating payment to the hospitals to the type of patients cared for by the hospitals. It is understood that a payment method based on DRG may include cost outlier payments and other specific exceptions. The executive office will review the DRG-payment method and the DRG base price annually, making adjustments as appropriate in consideration of such elements as trends in hospital input costs; patterns in hospital coding; beneficiary access to care; and the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index. For the twelve-month (12) period beginning July 1, 2015, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of July 1, 2014. For the six (6) month period Beginning January 1, 2018, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall not exceed ninety-nine percent (99.0%) of the payment rates in effect as of July 1, 2017.

(ii) With respect to inpatient services, (A) It is required as of January 1, 2011 until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June 30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve-month (12) period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the applicable period; (B) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the Medicaid managed care payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1, 2015, the Medicaid managed-care payment inpatient rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (C) Negotiated increases in inpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2016, may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period; (D) For the six (6) month period Beginning July 1, 2017, the Medicaid managed care payment inpatient rates between each hospital and health plan shall not exceed ninety-nine percent (99.0%) of the payment rates in effect as of July 1, 2017; (E) The executive office will develop an audit methodology and process to assure that savings associated with the payment reductions will accrue directly to the Rhode Island Medicaid program through reduced managed-care-plan payments and shall not be retained by the managed-care plans; (F) All hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and (G) For all such hospitals, compliance with the provisions of this section shall be a condition of participation in the Rhode Island Medicaid program.

(2) With respect to outpatient services and notwithstanding any provisions of the law to the contrary, for persons enrolled in fee-for-service Medicaid, the executive office will reimburse hospitals for

1 outpatient services using a rate methodology determined by the executive office and in accordance with  
 2 federal regulations. Fee-for-service outpatient rates shall align with Medicare payments for similar services.  
 3 Notwithstanding the above, there shall be no increase in the Medicaid fee-for-service outpatient rates  
 4 effective on July 1, 2013, July 1, 2014, or July 1, 2015. For the twelve-month (12) period beginning July 1,  
 5 2015, Medicaid fee-for-service outpatient rates shall not exceed ninety-seven and one-half percent (97.5%)  
 6 of the rates in effect as of July 1, 2014. ~~For the six (6) month period Beginning January 1, 2018, Medicaid~~  
 7 ~~fee-for-service outpatient rates shall not exceed ninety-nine percent (99.0%) of the rates in effect as of July~~  
 8 ~~1, 2017.~~ Thereafter, increases in the outpatient hospital payments for each annual twelve-month (12) period  
 9 beginning July 1, 2016~~7~~, may not exceed the CMS national Outpatient Prospective Payment System (OPPS)  
 10 Hospital Input Price Index for the applicable period. With respect to the outpatient rate,

11 (i) It is required as of January 1, 2011, until December 31, 2011, that the Medicaid managed-care  
 12 payment rates between each hospital and health plan shall not exceed one hundred percent (100%) of the  
 13 rate in effect as of June 30, 2010;

14 (ii) Negotiated increases in hospital outpatient payments for each annual twelve-month (12) period  
 15 beginning January 1, 2012, may not exceed the Centers for Medicare and Medicaid Services national CMS  
 16 Outpatient Prospective Payment System OPPS hospital price index for the applicable period;

17 (iii) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the  
 18 Medicaid managed-care outpatient payment rates between each hospital and health plan shall not exceed  
 19 the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1,  
 20 2015, the Medicaid managed-care outpatient payment rates between each hospital and health plan shall not  
 21 exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013;

1           ~~(iv) For the six (6) month period Beginning January 1, 2018, the Medicaid managed care outpatient~~  
2     ~~payment rates between each hospital and health plan shall not exceed ninety-nine percent (99.0%) of the~~  
3     ~~payment rates in effect as of July 1, 2017;~~

4           (v) Negotiated increases in outpatient hospital payments for each annual twelve-month (12) period  
5     beginning July 1, 2016~~8~~, may not exceed the Centers for Medicare and Medicaid Services national CMS  
6     OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period.

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

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

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

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

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

22 (g) The provisions of this section shall be effective upon implementation of the new payment  
23 methodology set forth in this section and 40-8-13.3, which shall in any event be no later than March 30,

2010, at which time the provisions of §40-8-13.2, 27-19-14, 27-19-15, and 27-19-16 shall be repealed in their entirety.

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

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

- (i) A direct care rate adjusted for resident acuity;
- (ii) An indirect care rate comprised of a base per diem for all facilities;
- (iii) A rearray of costs for all facilities every three (3) years beginning October, 2015, that may or may not result in automatic per diem revisions;
- (iv) Application of a fair rental value system;
- (v) Application of a pass-through system; and
- (vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will not occur on October



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

(vii) Effective on and after July 1, 2017, modify the reimbursement methodology through the implementation of acuity-based policy adjusters.

(b) Transition to full implementation of rate reform. For no less than four (4) years after the initial application of the price-based methodology described in subdivision (a)(2) to payment rates, the executive

office of health and human services shall implement a transition plan to moderate the impact of the rate reform on individual nursing facilities. Said transition shall include the following components:

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

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

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

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

**40-8-26 Community health centers.** (a) For the purposes of this section the term community health centers refers to federally qualified health centers and rural health centers.

(b) To support the ability of community health centers to provide high quality medical care to patients, the ~~department of human services~~ executive office of health and human services ("executive

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

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

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

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

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

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

SECTION 2. Sections 40-8.3-2, ~~40-8.3-3~~ and 40-8.3-10 of the General Laws in Chapter 40-8.3 entitled "Uncompensated Care" are hereby amended to read as follows:

**40-8.3-2 Definitions.**

As used in this chapter:

(1) "Base year" means for the purpose of calculating a disproportionate share payment for any fiscal year ending after September 30, ~~2015~~ 2016, the period from October 1, ~~2013~~ 2014 through September 30, ~~2014~~ 2015, and for any fiscal year ending after September 30, ~~2016~~ 2017, the period from October 1, 2014 through September 30, 2015.

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

(3) "Participating hospital" means any government or nongovernment and psychiatric or non-psychiatric hospital that:

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

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

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

(4) "Uncompensated-care costs" means, as to any hospital, the sum of: (i) The cost incurred by such hospital during the base year for inpatient or outpatient services attributable to charity care (free care and bad debts) for which the patient has no health insurance or other third-party coverage less payments, if any,

received directly from such patients; and (ii) The cost incurred by such hospital during the base year for inpatient or out-patient services attributable to Medicaid beneficiaries less any Medicaid reimbursement received therefor; multiplied by the uncompensated care index.

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

**40-8.3-3. Implementation.** ~~(a) For federal fiscal year 2015, commencing on October 1, 2014 and ending September 30, 2015, the executive office of health and human services shall submit to the Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid state plan for disproportionate share hospital payments (DSH Plan) to provide:~~

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

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

1 ~~by the uncompensated care index to the total uncompensated care costs for the base year inflated by~~  
2 ~~uncompensated care index for all participating hospitals. The DSH Plan payments shall be made on or~~  
3 ~~before July 13, 2015 and are expressly conditioned upon approval on or before July 6, 2015 by the~~  
4 ~~Secretary of the U.S. Department of Health and Human Services, or his or her authorized representative,~~  
5 ~~of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial~~  
6 ~~participation in federal fiscal year 2015 for the disproportionate share payments.~~

7 ~~(b)(a)~~ For federal fiscal year 2016, commencing on October 1, 2015 and ending September 30,  
8 2016, the executive office of health and human services shall submit to the Secretary of the U.S.  
9 Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH  
10 Plan to provide:

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

14 (2) That the Pool D allotment shall be distributed among the participating hospitals in direct  
15 proportion to the individual participating hospital's uncompensated care costs for the base year, inflated  
16 by the uncompensated care index to the total uncompensated care costs for the base year inflated by  
17 uncompensated care index for all participating hospitals. The DSH Plan payments shall be made on or  
18 before July 11, 2016 and are expressly conditioned upon approval on or before July 5, 2016 by the  
19 Secretary of the U.S. Department of Health and Human Services, or his or her authorized representative,  
20 of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial  
21 participation in federal fiscal year 2016 for the DSH Plan.

1        (e)(b) For federal fiscal year 2017, commencing on October 1, 2016 and ending September 30,  
2        2017, 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 DSH  
4        Plan to provide:

5        (1) That the disproportionate share hospital payments to all participating hospitals, not to exceed  
6        an aggregate limit of \$139.7 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 DSH Plan shall be made on or before July  
12       11, 2017 and are expressly conditioned upon approval on or before July 5, 2017 by the Secretary of the  
13       U.S. Department of Health and Human Services, or his or her authorized representative, of all Medicaid  
14       state plan amendments necessary to secure for the state the benefit of federal financial participation in  
15       federal fiscal year 2017 for the disproportionate share payments.

16       (c) For federal fiscal year 2018, commencing on October 1, 2017 and ending September 30,  
17       2018, the executive office of health and human services shall submit to the Secretary of the U.S.  
18       Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH  
19       Plan to provide:

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



(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year inflated by uncompensated care index for all participating hospitals. The disproportionate share payments shall be made on or before July 10, 2018 and are expressly conditioned upon approval on or before July 5, 2018 by the Secretary of the U.S. Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2018 for the disproportionate share payments.

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

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

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

**40-8.3-10 Hospital adjustment payments.** Effective July 1, 2012 and for each subsequent year, the executive office of health and human services is hereby authorized and directed to amend its regulations for reimbursement to hospitals for inpatient and outpatient services as follows:

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

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

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

7 (3) Multiply the sum of all Medicaid payments as determined in subdivision (2) by a percentage  
8 defined as the total identified upper payment limit for all hospitals divided by the sum of all Medicaid  
9 payments as determined in subdivision (2); and then multiply that result by each hospital's percentage of  
10 the state's total Medicaid outpatient and emergency department services as determined in subdivision (1);  
11 and then multiply the immediately preceding result by fifty percent (50%) to obtain the total outpatient  
12 adjustment for each hospital to be paid each year;

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

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

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

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

21 (3) Multiply the sum of all Medicaid payments as determined in subdivision (2) by a percentage  
22 defined as the total identified upper payment limit for all hospitals divided by the sum of all Medicaid  
23 payments as determined in subdivision (2); and then multiply that result by each hospital's percentage of

1 the state's total Medicaid inpatient services as determined in subdivision (1); and then multiply the  
2 immediately preceding result by fifty percent (50%) to obtain the total inpatient adjustment for each  
3 hospital to be paid each year;

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

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

10 SECTION 3. Section 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical Assistance  
11 - Long-Term Care Service and Finance Reform" are hereby amended to read as follows

12 **40-8.9-9. Long-term care re-balancing system reform goal.**- (a) Notwithstanding any other  
13 provision of state law, the executive office of health and human services is authorized and directed to apply  
14 for and obtain any necessary waiver(s), waiver amendment(s) and/or state plan amendments from the  
15 secretary of the United States department of health and human services, and to promulgate rules necessary  
16 to adopt ~~an affirmative plan of program design and implementation that addresses~~ the goals of ~~allocating~~  
17 ~~the Healthy Aging 2017 Initiative and further the state's ongoing commitment to achieving~~ a minimum of  
18 fifty percent (50%) of Medicaid long-term care funding for persons aged sixty-five (65) and over and adults  
19 with disabilities, in addition to services for persons with developmental disabilities , to home and  
20 community-based care ; provided, further, the executive office shall report annually as part of its budget  
21 submission, the percentage distribution between institutional care and home and community-based care by  
22 population and shall report current and projected waiting lists for long-term care and home and community-  
23 based care services. The executive office is further authorized and directed to prioritize investments in home

1 and community- based care and to maintain the integrity and financial viability of all current long-term care  
2 services while pursuing this goal.

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

13 (c) Pursuant to federal authority procured under 42-7.2-16 of the general laws, the executive office  
14 of health and human services is directed and authorized to adopt a tiered set of criteria to be used to  
15 determine eligibility for services. Such criteria shall be developed in collaboration with the state's health  
16 and human services departments and, to the extent feasible, any consumer group, advisory board, or other  
17 entity designated for such purposes, and shall encompass eligibility determinations for long-term care  
18 services in nursing facilities, hospitals, and intermediate care facilities for persons with intellectual  
19 disabilities as well as home and community-based alternatives, and shall provide a common standard of  
20 income eligibility for both institutional and home and community- based care. The executive office is  
21 authorized to adopt clinical and/or functional criteria for admission to a nursing facility, hospital, or  
22 intermediate care facility for persons with intellectual disabilities that are more stringent than those  
23 employed for access to home and community-based services. The executive office is also authorized to

1 promulgate rules that define the frequency of re- assessments for services provided for under this section.

2 Levels of care may be applied in accordance with the following:

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

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

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

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

4           (3) No nursing home, hospital, or intermediate care facility for persons with intellectual disabilities  
5 shall be denied payment for services rendered to a Medicaid recipient on the grounds that the recipient does  
6 not meet level of care criteria unless and until the executive office has:

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

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

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

21           (e) The executive office is authorized to promulgate rules that permit certain optional services  
22 including, but not limited to, homemaker services, home modifications, respite, behavioral health care  
23 supports and physical therapy evaluations to be offered to persons at risk for Medicaid-funded long-term

care subject to availability of state-appropriated funding for these purposes. To further the goals of the Healthy Aging 2017 Initiative, the secretary shall also seek any waiver authorities, in accordance with 40-8.9-5, to obtain federal matching funds to cover state investments allocated to these optional services when provided to: Medicaid beneficiaries eligible under this chapter at §40-8.10-3 who are at risk for LTSS and elders 65 and older who are not eligible for Medicaid and qualify for the division of elderly affairs co-pay program under §42-66.3. In addition, the secretary shall also seek waiver authority as may be required to access federal matching funds for to implement and enhance the LTSS screening program, established in §40-8.9-8, for identifying and addressing the needs of persons who are at risk for Medicaid LTSS.

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

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

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

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

(3) ~~By October 1, 2016, institute an increase in the base payment rates for home care service providers, in an amount to be determined through the appropriations process, for the purpose of implementing a wage pass through program for personal care attendants and home health aides assisting long term care beneficiaries. On or before September 1, 2016, Medicaid funded home health providers seeking to participate in the program shall submit to the secretary, for his or her approval, a written plan describing and attesting to the manner in which the increased payment rates shall be passed through to personal care attendants and home health aides in their salaries or wages less any attendant costs incurred by the provider for additional payroll taxes, insurance contributions, and other costs required by federal or state law, regulation, or policy and directly attributable to the wage pass through program established in this section. Any such providers contracting with a Medicaid managed care organization shall develop the plan for the wage pass through program in conjunction with the managed care entity and shall include an assurance by the provider that the base rate increase is implemented in accordance with the goal of raising the wages of the health workers targeted in this subsection. Participating providers who do not comply with the terms of their wage pass through plan shall be subject to a clawback, paid by the provider to the state, for any portion of the rate increase administered under this section that the secretary deems appropriate. As the state's Medicaid program seeks to assist more beneficiaries requiring long-term services and supports in home and community-based settings, the demand for home care workers has increased, and wages for these workers has not kept pace with neighboring states, leading to high turnover and vacancy rates in the state's home care industry, the EOHHS shall institute a one-time increase in the base-payment rates for home-care service providers to promote increased access to and an adequate supply of highly trained home health care professionals, in amount to be determined by the appropriations process, for the purpose of raising wages for personal care attendants and home health aides to be implemented by such providers: (i)~~



1 by October 1, 2017, and (ii) in a manner that meets specifications related to implementation and reporting  
2 approved by the secretary.

3 (g) The executive office shall implement a long-term care options counseling program to provide  
4 individuals, or their representatives, or both, with long-term care consultations that shall include, at a  
5 minimum, information about: long-term care options, sources, and methods of both public and private  
6 payment for long-term care services and an assessment of an individual's functional capabilities and  
7 opportunities for maximizing independence. Each individual admitted to, or seeking admission to a long-  
8 term care facility, regardless of the payment source, shall be informed by the facility of the availability of  
9 the long-term care options counseling program and shall be provided with long-term care options  
10 consultation if they so request. Each individual who applies for Medicaid long-term care services shall be  
11 provided with a long-term care consultation. In accordance with §40-8.9-5, the secretary shall seek any  
12 waiver authorities required to obtain federal matching funds to expand access to options counseling services  
13 that include, but are not limited to, enhanced LTSS information and referral, system navigation and  
14 assistance, and person-centered consultation about service delivery choices.

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

22 (i) To ensure persons with long-term care needs who remain living at home have adequate resources  
23 to deal with housing maintenance and unanticipated housing related costs, the secretary is authorized to

1 develop higher resource eligibility limits for persons or obtain any state plan or waiver authorities necessary  
2 to change the financial eligibility criteria for long-term services and supports to enable beneficiaries  
3 receiving home and community waiver services to have the resources to continue living in their own homes  
4 or rental units or other home-based settings.

5 (j) The executive office shall implement, no later than January 1, 2016, the following home and  
6 community-based service and payment reforms upon obtaining the federal authorities provided for in 40-  
7 8.9-5:

8 (1) By no later than January 1, 2016, the following home and community based service and payment  
9 reforms:

10 (a) Community-based supportive living program established in 40-8.13-2.12;  
11 (2) ~~(b)~~ Adult day services level of need criteria and acuity-based, tiered payment methodology; and  
12 ~~(3)~~ (c) Payment reforms that encourage home and community-based providers to provide the  
13 specialized services and accommodations beneficiaries need to avoid or delay institutional care.

14 (2) On or before January 1, 2018, expansion of the community-based supportive living program,  
15 established as a pilot in §40-8.13-2.12, to all Medicaid LTSS beneficiaries who meet the applicable  
16 eligibility requirements without regard for payment and delivery system, including those receiving care on  
17 a fee-for-services basis. Upon being determined eligible to participate in the program, such beneficiaries  
18 may qualify for the supplemental assistance established under §40-6-27(a), but only to the extent that annual  
19 state appropriations allow.

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

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

SECTION 4. Section 42-12-29 of the General Laws in Chapter 42-12 entitled "Department of Human Services" is hereby amended to read as follows:

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

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

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

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

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

SECTION 5. Section 15 of Article 5 of Chapter 141 of the Public Laws of 2015 is hereby repealed.

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

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

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

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

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

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

5       ~~SECTION 6. Chapter 33-24 entitled "Small Estates" is hereby amended by adding thereto the~~  
6       ~~following section:~~

7       ~~**33-24-4. Notice to the executive office of health and human services required.** In order to close~~  
8       ~~an estate pursuant to this chapter, notice as required by 33-11-5.1 and 33-11-5.2 shall be required with~~  
9       ~~respect to the executive office of health and human services.~~

10       ~~SECTION 67.~~ This article shall take effect upon passage.