



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Administration  
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Memorandum

**To:** The Honorable Raymond Gallison  
Chairman, House Finance Committee

The Honorable Daniel DaPonte  
Chairman, Senate Finance Committee

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

**Date:** May 7, 2015

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

The Governor requests that Articles 3, 4, and 5, respectively entitled Relating to Licensing of Hospital Facilities, Relating to Hospital Uncompensated Care, and Relating to Medical Assistance, be replaced with the attached article, entitled "The Reinventing Medicaid Act of 2015". The new article consists of statute changes to implement the recommendations of the Reinventing Medicaid Working Group.

The specific statutory purposes and policy rationales underlying each section are described below:

**Section 1**

Section 1 establishes the hospital licensing fee for FY2016 to be 5.846% of the net patient services revenue of every hospital for the hospital's first fiscal year ending on or after January 1, 2014, Subject to federal approval the license fee for all hospitals located in Washington County, RI shall be discounted by 37%.

## **Section 2**

Section 2 removes the health insurance coverage cap of \$5,000 per dependent child per policy or calendar year for early intervention services for children. The section makes further technical changes to the statute.

## **Section 3**

Section 3 removes the health insurance coverage cap of \$32,000 for applied behavior analysis for individuals with autism.

## **Section 4**

Section 4 establishes a \$465 state supplemental payment for individuals receiving supplementary and security income (SSI) payments who are eligible to receive Medicaid-funded long-term services and supports, living in a Medicaid-certified state-licensed assisted living or adult supportive housing residence, and participating in the program established by Section 13.

## **Section 5**

Section 5 eliminates the scheduled increase to Medicaid reimbursement rates to hospitals and further reduces Medicaid hospital rates (through fee-for-service and managed care) by 2.5 percent.

Section 5 authorizes the Secretary of Health and Human Services to create a Hospital Incentive Program (HIP) to provide participating licensed hospitals the ability to obtain certain payments for achieving performance goals established by the Secretary. Payments from the Hospital Incentive Program may commence no earlier than July 1, 2016. The Secretary is further authorized to seek all necessary federal waiver and state plan authorities to implement the program.

## **Section 6**

Section 6 enhances the state's ability to recover assets through liens on a deceased recipient's estate by allowing liens on property regardless of whether it forms part of the probate estate. Any transfer resulting in the imposition of a penalty period is presumed to be made for the purposes of obtaining eligibility for long-term care Medicaid, unless rebutted by clear and convincing evidence. Any such transfer may create a debt from the transferor or transferee to the Executive Office.

The section further authorizes the Secretary to impose a lien against the real property of an individual receiving long-term care Medicaid and residing in an institution who, after notice and opportunity for hearing, cannot reasonably be expected to be discharged from the medical institution and return home, unless a qualified individual is residing in the home. Any recovery

under the lien may not occur until the death of the individual's surviving spouse, if any, and other qualified individuals are not living in the home.

The section also makes technical changes to the penalty period provisions by disallowing changes to the penalty period for anything other than a return of the full fair market value of the asset transfer which resulted in the imposition of the penalty period. The section also establishes a 12% interest rate beginning six months after the appointment of an administrator for the estate.

### **Section 7**

Section 7 eliminates the nursing home inflation index adjustment scheduled to take place on October 1, 2015, and further reduces nursing home payment rates by 2.5 percent. The section also delays the per-diem rate increase for low-cost nursing homes resulting from the payment methodology transition that was scheduled to take place in October 2015.

The section authorizes the Secretary of Health and Human Services to create a Nursing Facility Incentive Program (NFIP) to provide participating licensed nursing facilities the ability to obtain certain payments for achieving performance goals established by the Secretary. Payments from the NFIP may commence no earlier than July 1, 2016. The Secretary is further authorized to seek all necessary federal waiver and state plan authorities to implement the program.

### **Section 8**

Section 8 makes technical changes to the Medical Assistance Fraud Law. The section makes it unlawful to intentionally refuse to provide representatives of the Office of Program Integrity upon reasonable request, access to information and data pertaining to services or merchandise rendered to eligible participants and former participants while recipients under the Rhode Island Medicaid program.

### **Section 9**

Section 9 reauthorizes Disproportionate Share Hospital (DSH) payments. The section modifies the base year used for calculating the distribution of DSH payments to use the most recent available data. The section updates the definition of "hospital" to include any premises included on a license pursuant to §23-17-1 et seq. regardless of changes in licensure status or change in effective control.

### **Section 10**

Section 10 repeals Section 5 of Article 18 of Chapter 145 of the Public Laws of 2014 which had established supplemental state funding for Graduate Medical Education.

### **Section 11**

Section 11 authorizes the Secretary to pursue payment methodology reforms to increase access to homemaker, personal care, assisted living, adult supportive care, and adult day services by developing Medicaid certification standards and using payment strategies designed to achieve specific quality and health outcomes, including an acuity-based tiered payment methodology.

This section gives EOHHS flexibility to create community-based supportive living programs, establish adult day services level of need criteria and acuity-based tiered payments, and implement payment reforms that encourage home- and community-based providers to provide the specialized services beneficiaries need to avoid or delay institutional care.

The section makes further technical changes to the statute.

### **Section 12**

Section 12 eliminates reference to the Assessment and Coordination Unit (ACU) which coordinates the assessment of beneficiaries for long-term care for departments under the Executive Office, among other technical changes to the statute.

### **Section 13**

Section 13 reduces Medicaid managed long-term care payment rates by 2.5 percent.

The section also repeals language which requires managed care organizations to reimburse long-term care providers not less than the rate paid by the Executive Office for such care under the Medicaid program and which restricted flexibility in payment methodologies under any duals demonstration project.

The section creates a program for beneficiaries who choose to receive Medicaid-funded assisted living, adult supportive care, or shared living long-term services and supports, using an acuity-based, tiered service and payment system that ties reimbursement to a beneficiary's level of need and specific outcome and quality measures. The section raises the cap on the amount that Medicaid-certified assisted living and adult supportive care providers are permitted to charge for room and board to include the monthly state supplement to SSI. The program will be terminated if it is not cost-effective compared to the current set of programs and services.

The section also makes enrollment in managed care mandatory for individuals eligible for long-term services and supports.

#### **Section 14**

Section 14 makes technical changes to the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals' (BHDDH) definition of an "individual program plan", also known as a "general service plan".

#### **Section 15**

Section 15 authorizes the Secretary of Health and Human Services to pursue any state plan amendments or waivers, rules and regulations, and process and procedures required to implement any Medicaid initiatives which are approved by the General Assembly.

The Office of Program Integrity is authorized to pursue certain additional program integrity opportunities to detect fraud. The Office is also empowered to propose and execute recommendations to implement corrective action to remediate federal or state audit findings.

The section also enhances the ability of departments within the Executive Office of Health and Human Services to share data by clarifying that the Secretary will have responsibility for ensuring compliance with applicable privacy laws.

Section 15 also makes certain technical changes to the statute creating the Executive Office.

#### **Section 16**

Section 16 increases the attachment point for the Children's Health Account from \$7,500 per child per service per year to \$11,000. The section makes further technical changes to the statute.

#### **Section 17**

Section 17 modifies the composition of the Children's Cabinet, by adding the Secretary of Health and Human Services and the Child Advocate, and removing certain other members. The Children's Cabinet shall produce a comprehensive, 5-year statewide plan for an integrated state child service system by December 1, 2015. The Cabinet shall also develop a strategic plan to coordinate and share data, including with outside research partners pursuant to data-sharing agreements. The Cabinet will be supported by staff from the Executive Office of Health and Human Services.

#### **Section 18**

Section 18 increases the assessment imposed upon the gross patient revenue received by every nursing facility to 6.0 percent of services, effective January 1, 2016.

#### **Section 19**

Section 19 authorizes the Secretary of Health and Human Services to undertake programmatic changes requiring the implementation or modification of a rule or regulation in existence prior to

the implementation of the global consumer choice section 1115 demonstration, or any category II change or category III change as defined in the demonstration, that are integral to the appropriations for the medical assistance program and detailed in official budgetary documents supplemental thereto.

**Section 20**

Sets forth the effective date.

TAM: 15-Amend-15  
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  
Kevin Gallagher, Office of the Governor  
Daniel Orgel, Supervising Budget Analyst

1 ARTICLE

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 residence  
23 participating in the program authorized under § 40-8.13-2.1: \$465.00

24 ~~(vi)~~ (vii) Individual living in state licensed supportive residential care settings that, depending on  
25 the population served, meet the standards set by the department of human services in conjunction with the

1 department(s) of children, youth and families, elderly affairs and/or behavioral healthcare, developmental  
2 disabilities and hospitals: \$300.00.

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

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

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

18           (4) Individuals living in state licensed supportive residential care settings and assisted living  
19 residences who are receiving SSI supplemental payments under this section who are participating in the  
20 program under §40-8.13-2.1 or otherwise shall be allowed to retain a minimum personal needs allowance  
21 of fifty-five dollars (\$55.00) per month from their SSI monthly benefit prior to payment of any monthly  
22 fees.

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

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

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

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

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

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

19 (ii) The procedures for determining whether the ~~payment~~ certifications [or contract](#) standards have  
20 been met; and

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

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

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

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

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

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

13 **§40-6-27.2 Supplementary cash assistance payment for certain supplemental security**  
14 **income recipients.** – There is hereby established a \$206 monthly payment for disabled and elderly  
15 individuals who, on or after July 1, 2012, receive the state supplementary assistance payment for an  
16 individual in state licensed assisted living residence under § 40-6-27 and further reside in an assisted  
17 living facility that is not eligible to receive funding under Title XIX of the Social Security Act, 42 U.S.C.  
18 § 1381 et seq., including through the program authorized under §40-8.13-2.1 or reside in any assisted  
19 living facility financed by the Rhode Island housing and mortgage finance corporation prior to January 1,  
20 2006, and receive a payment under § 40-6-27.

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

23 **§ 40-8-13.4 Rate methodology for payment for in state and out of state hospital services.** –(a)  
24 The executive office of health and human services shall implement a new methodology for payment for in  
25 state and out of state hospital services in order to ensure access to and the provision of high quality and  
26 cost-effective hospital care to its eligible recipients.

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

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

15 (B) With respect to inpatient services, (i) it is required as of January 1, 2011 until December 31,  
16 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not  
17 exceed ninety and one tenth percent (90.1%) of the rate in effect as of June 30, 2010. Negotiated increases  
18 in inpatient hospital payments for each annual twelve (12) month period beginning January 1, 2012 may  
19 not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System  
20 (IPPS) Hospital Input Price index for the applicable period; (ii) provided, however, for the twenty-four  
21 (24) month period beginning July 1, 2013 the Medicaid managed care payment rates between each  
22 hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013 and for the  
23 twelve (12) month period beginning July 1, 2015, the Medicaid managed care payment inpatient rates  
24 between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the  
25 payment rates in effect as of January 1, 2013; (iii) negotiated increases in inpatient hospital payments for  
26 each annual twelve (12) month period beginning July 1, ~~2015-2016~~ may not exceed the Centers for



1 Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price  
2 Index, less Productivity Adjustment, for the applicable period; (iv) The Rhode Island executive office of  
3 health and human services will develop an audit methodology and process to assure that savings  
4 associated with the payment reductions will accrue directly to the Rhode Island Medicaid program  
5 through reduced managed care plan payments and shall not be retained by the managed care plans; (v) All  
6 hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and (vi) for all such  
7 hospitals, compliance with the provisions of this section shall be a condition of participation in the Rhode  
8 Island Medicaid program.

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

1 managed care outpatient payment rates between each hospital and health plan shall not exceed ninety-  
2 seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (iii) negotiated  
3 increases in outpatient hospital payments for each annual twelve (12) month period beginning July 1,  
4 ~~2015~~ 2016 may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient  
5 Prospective Payment System (OPPS) Hospital Input Price Index, less Productivity Adjustment, for the  
6 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  
9 included on that license, regardless of changes in licensure status pursuant to § 23-17.14 (hospital  
10 conversions) and §23-17-6 (b) (change in effective control), that provides short-term acute inpatient  
11 and/or outpatient care to persons who require definitive diagnosis and treatment for injury, illness,  
12 disabilities, or pregnancy.

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

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

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

25 (f) As a condition of participation in the DRG methodology for payment of hospital services,  
26 every hospital shall submit year-end settlement reports to the executive office within one year from the

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

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

13 [§40-8-13.5. Hospital Incentive Program \(HIP\). The secretary of the executive office of health](#)  
14 [and human services is authorized to seek the federal authorities required to implement a hospital incentive](#)  
15 [program \(HIP\). The HIP shall provide the participating licensed hospitals the ability to obtain certain](#)  
16 [payments for achieving performance goals established by the secretary. HIP payments shall commence no](#)  
17 [earlier than July 1, 2016.](#)

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

20 **§ 40-8-15. Lien on deceased recipient's estate for assistance.** (a)(1) Upon the death of a  
21 recipient of medical assistance under Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et  
22 seq., the total sum of medical assistance so paid on behalf of a recipient who was fifty-five (55) years of  
23 age or older at the time of receipt of the assistance shall be and constitute a lien upon the estate, as defined  
24 in subdivision (a)(2) below, of the recipient in favor of the executive office of health and human services.  
25 The lien shall not be effective and shall not attach as against the estate of a recipient who is survived by a  
26 spouse, or a child who is under the age of twenty-one (21), or a child who is blind or permanently and

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

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

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

19 (c) The amount of medical assistance reimbursement imposed under this section shall also  
20 become a debt to the state from the person or entity liable for the payment thereof. Interest shall accrue on  
21 the debt due to the state at the rate of twelve percent (12%) per annum six months from the date of the  
22 appointment of an administrator for the estate.

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

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

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

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

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

5 (i) (a) Any transfer or assignment of assets resulting in the imposition of a penalty period shall be  
6 presumed to be made with the intent, on the part of the transferor or the transferee, to enable the transferor  
7 to obtain or maintain eligibility for long-term care Medicaid. This presumption may be rebutted only by  
8 clear and convincing evidence that the transferor's eligibility or potential eligibility for long term care  
9 medical assistance was not a basis for the transfer or assignment.

10 (b) Any transfer or assignment of assets resulting in the establishment or imposition of a penalty  
11 period may create a debt that is due and owing by the transferor or transferee to the executive office of  
12 health and human services in an amount equal to the amount of the long term care Medicaid paid by the  
13 executive office of health and human services on behalf of the transferor after the date of the transfer of  
14 assets plus interest, pursuant to section 40-8-15(c), but said amount shall not exceed the fair market value  
15 of the assets at the time of transfer. The executive office of health and human services shall be authorized  
16 to collect such debts by any legal means.

17 (c) (1) For purposes of this section, a "long-term care Medicaid beneficiary" means an individual  
18 who has applied for or is receiving Medicaid funded long-term services and supports in a licensed health  
19 facility or home or community-based setting.

20 (2) A long-term care Medicaid beneficiary shall not be penalized for the transfer of an asset if the  
21 entire amount of the transferred asset is returned to the long-term care Medicaid beneficiary. However,  
22 the penalty period shall not be reduced if a transferee returns any portion of a transferred asset or assets  
23 that is less than the fair market value of the asset or assets at the time of the initial transfer. Any return of  
24 an asset or assets that is less than the fair market value of the asset or assets at the time of the initial  
25 transfer shall not alter the ending date of the penalty period as originally determined by the executive  
26 office of health and human services. Any transfer of asset or assets, whether through the making of a gift,

1 the purchase of an annuity, or the making of a loan with a promissory note, shall result in the imposition  
2 of a penalty period calculated based upon the full fair market value of the gift, annuity purchase, or  
3 promissory note. The penalty period initially calculated shall not be reduced absent a return of the full  
4 market value of the transferred asset or assets. The executive office of health and human services shall  
5 consider the entire amount of the returned asset to be available to the transferor only from the date of  
6 return of the transferred asset, and shall not determine the transferor to be ineligible in the month the  
7 transferred asset is returned.

8 (3) If there are multiple transfers of assets to the same or different transferees, a return of  
9 anything less than the full fair market value of the transferred assets from all of the separate transferees  
10 shall not constitute a return of the entire amount of the transferred assets and as such, shall not change the  
11 ending date of the penalty period as originally determined by the executive office of health and human  
12 services as a consequence of the multiple transfers of assets.

13 (4) The conveyance and subsequent return of any amount less than full fair market value of the  
14 asset at the time of the initial transfer shall be regarded as a transfer for purposes of qualifying for long-  
15 term care Medicaid. The entire amount of such asset, regardless of any amount less than full fair market  
16 value of the asset at the time of initial transfer, shall be considered available for the purpose of  
17 determining Medicaid eligibility. Any conveyance of an asset or assets resulting in the imposition of a  
18 penalty period shall be presumed to be made with the intent, on the part of the conveyor or the conveyee,  
19 to enable the conveyor to obtain or maintain eligibility for long-term care Medicaid notwithstanding any  
20 subsequent return of any amount less than full fair market value of the asset at the time of the initial  
21 conveyance. This presumption may be rebutted only by clear and convincing evidence that the conveyor's  
22 eligibility or potential eligibility for long term care Medicaid was not a basis for the conveyance.

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

25 **§ 40-8-15.1 Lien on recipient's property.** – In addition to the lien and recovery under the  
26 provisions of section 40-8-15, the executive office of health and human services shall recover long term

1 care Medicaid paid for services rendered on or after the effective date of this act on behalf of an  
2 individual, as defined herein, from the individual's estate, as defined in section 40-8-15, or upon the sale  
3 or transfer of the individual's real property prior to the death of an individual who is a recipient of  
4 medical assistance under Title XIX of the federal Social Security Act, 42 USC § 1396 et seq. The  
5 executive office of health and human services may impose a lien against the real property of any  
6 individual on account of long term care Medicaid paid on his or her behalf as follows:

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

9 (2) Upon the real property of an individual who is an inpatient in a nursing facility, intermediate  
10 care facility for the intellectually disabled, or other licensed health facility, and the executive office of  
11 health and human services determines, after notice and opportunity for hearing, that the individual cannot  
12 reasonably be expected to be discharged from the licensed health facility and return home; provided  
13 however, that any such lien shall dissolve should an individual be discharged from the licensed health  
14 facility and return home. No such lien may be imposed on the individual's home, if one of the following  
15 persons is lawfully residing in the home:

16 (A) the spouse of such individual,

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

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

22 (3) If the individual as described in (2) above has received a determination notice from the  
23 executive office of health and human services after notice and an opportunity for a hearing, that the above  
24 conditions have been met, then a lien will be placed against the real property.

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



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

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

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

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

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

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

21 **§ 40-8-19 Rates of payment to nursing facilities.** – (a) Rate reform. (1) The rates to be paid by  
22 the state to nursing facilities licensed pursuant to chapter 17 of title 23, and certified to participate in the  
23 Title XIX Medicaid program for services rendered to Medicaid-eligible residents, shall be reasonable and  
24 adequate to meet the costs which must be incurred by efficiently and economically operated facilities in  
25 accordance with 42 U.S.C. § 1396a(a)(13). The executive office of health and human services shall  
26 promulgate or modify the principles of reimbursement for nursing facilities in effect as of July 1, 2011 to

1 be consistent with the provisions of this section and Title XIX, 42 U.S.C. § 1396 et seq., of the Social  
2 Security Act.

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

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

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

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

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

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

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

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

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

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

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

8 (4) Notwithstanding any law to the contrary, for the twelve (12) month period beginning July 1,  
9 2015, Medicaid payment rates for nursing facilities established pursuant to this section shall not exceed  
10 ninety-seven and one-half percent (97.5%) of the rates in effect on April 1, 2015.

11 §40-8-19.2 Nursing Facility Incentive Program (NFIP). The secretary of the executive office  
12 of health and human services is authorized to seek the federal authority required to implement a nursing  
13 facility incentive program (NFIP). The NFIP shall provide the participating licensed nursing facilities the  
14 ability to obtain certain payments for achieving performance goals established by the secretary. NFIP  
15 payments shall commence no earlier than July 1, 2016.

16 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  
17 of the General Laws in Chapter 40-8.2 entitled "Medical Assistance Fraud " are hereby amended to read  
18 as follows:

19 § 40-8.2-1. Short title.- This chapter shall be known as the "Rhode Island Medical Assistance  
20 Fraud Law".

21 § 40-8.2-2. Definitions.- Whenever used in this chapter:

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

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

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

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

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

8 (i) To the same provider;

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

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

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

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

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

1           ~~(8)~~ (9) "Pecuniary benefit" means benefit in the form of money, property, commercial interests,  
2 or anything else the primary significance of which is economic gain.

3           ~~(9)~~ (10) "Person" means any person or individual, natural or otherwise and includes those  
4 person(s) or entities defined by the term "provider".

5           ~~(10)~~ (11) "Provider" means any individual, individual medical vendor, firm, corporation,  
6 professional association, partnership, organization, or other legal entity that provides goods or services  
7 under the Rhode Island Medicaid program or the employee of any person or entity who, on his or her own  
8 behalf or on the behalf of his or her employer, knowingly performs any act or is knowingly responsible  
9 for an omission prohibited by this chapter.

10           ~~(11)~~ (12) "Recipient" means any person receiving medical assistance under the Rhode Island  
11 Medicaid program.

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

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

18           **§ 40-8.2-3. Prohibited acts.**- (a) It shall be unlawful for any person intentionally to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (12) Enter into an agreement, combination or conspiracy with any party other than the Rhode  
12 Island Medicaid program to obtain or aid another to obtain reimbursement or payments from the Rhode  
13 Island Medicaid program to which the person, recipient, or provider seeking reimbursement or payment is  
14 not entitled.

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

17 (14) Refuse to provide representatives of the Medicaid fraud control unit [and/or the office of](#)  
18 [program integrity](#) upon reasonable request, access to information and data pertaining to services or  
19 merchandise rendered to eligible recipients, and/or former recipients while recipients under the Rhode  
20 Island Medicaid program.

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

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



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

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

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

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

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

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

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

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

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

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

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

9 **§ 40-8.2-4. Statute of limitations.**- The statute of limitations for any violation of the provisions  
10 of this chapter shall be ten (10) years.

11 **§ 40-8.2-5. Civil remedy.**- Any person, including the ~~Rhode Island Medicaid program secretary~~  
12 of the executive office of health and human services or the office of program integrity acting on behalf of  
13 the secretary of the office, injured by any violation of the provisions of § 40-8.2-3 or § 40-8.2-4 may  
14 recover through a civil action from the persons inflicting the injury three (3) times the amount of the  
15 injury.

16 **§ 40-8.2-6. Civil actions brought by attorney general on behalf of persons injured by**  
17 **violations of chapter.**- (a) The attorney general may bring a civil action in superior court in the name of  
18 the state, as parens patriae on behalf of persons residing in this state, to secure monetary relief as provided  
19 in this section for injuries sustained by such persons by reason of any violation of this chapter. The court  
20 shall exclude from the amount of monetary relief awarded in an action any amount of monetary relief:

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (g) In any action under this section the fact that a person or public body has not dealt directly  
26 with the defendant shall not bar or otherwise limit recovery. Provided, however, that the court shall

1 exclude from the amount of monetary relief which duplicates amounts which have been awarded for the  
2 same injury.

3 **§ 40-8.2-10. Other civil remedies and criminal penalties.**- The penalties and remedies under  
4 this statute are not exclusive and shall not preclude the use of any other civil remedy or the application of  
5 any other criminal penalty [deemed appropriate by the attorney general in accordance with federal law or](#)  
6 [regulations governing Title XIX or Title XXI or the general or public laws of this state.](#)

7 **§ 40-8.2-11. Barring or suspending participation in program.**- Whenever a provider is  
8 sentenced or placed on probation for an offense under this chapter, the trial judge may, in his or her  
9 discretion, order that the provider be permanently barred from further participation in the program, that  
10 the provider's participation in the program be suspended for a definite period of time not exceeding two  
11 (2) years, or that the provider conform to applicable federal regulations. For the purposes of this section,  
12 ~~the Rhode Island Medicaid program~~ [office of program integrity](#) may submit a recommendation to the trial  
13 judge as to whether the provider should be suspended or barred from the [Medicaid](#) program. Nothing  
14 contained herein shall be construed to prevent the ~~Rhode Island Medicaid program~~ [executive office of](#)  
15 [health and human services](#) from imposing its own administrative sanctions.

16 **§ 40-8.2-17. Stays and review of revocation orders.**- An order of the ~~Rhode Island Medicaid~~  
17 ~~program~~ [executive office of health and human services](#) revoking a provider's certification may, in the  
18 discretion of the program, go into immediate effect or may be stayed. Review of any order may be had in  
19 accordance with the Rhode Island administrative procedures law, §§ 42-35-1 -42-35-18. If an  
20 administrative hearing is claimed, the program may, in its discretion, stay the effect of a revocation until a  
21 hearing is ~~had~~ [held](#) and a decision is rendered, and for a period not to exceed ten (10) days after the  
22 administrative decision is rendered.

23 **§ 40-8.2-18. Filing and enforcement of administrative decision.**- An administrative decision,  
24 not appealed, or which has been affirmed after judicial review under the Rhode Island administrative  
25 procedures law, §§ 42-35-1 - 42-35-18, determining any amounts due to the ~~Rhode Island Medicaid~~

1 ~~program~~ [executive office of health and human services](#) or to a provider, may be filed with the clerk of the  
2 superior court for Providence County and shall be enforceable as a judgment of that court.

3 **§ 40-8.2-19. Certification as a provider - Revocation or suspension of certification.**- Before  
4 any provider of medical services receives payment from the Rhode Island Medicaid program, and as a  
5 condition of receipt of payment, the provider must have in effect a valid certification of eligibility from  
6 the Rhode Island ~~department of human services~~ [executive office of health and human services](#). This  
7 certification of eligibility will take the form of either a separate provider agreement or language as  
8 required by federal regulations imprinted on the medical assistance billing form, which must be signed by  
9 the provider. This certification may be revoked or suspended, in accordance with administrative rules to  
10 be promulgated by the ~~department~~ [executive office](#), if a provider fails to meet professional licensure  
11 requirements, violates any administrative regulations of the ~~Rhode Island Medicaid program~~ [executive](#)  
12 [office of health and human services](#), does not provide proper professional services, is the subject of a  
13 suspension of payments order, is convicted of Medicaid fraud, or otherwise violates any provision of this  
14 chapter.

15 **§ 40-8.2-21. Suspension of payments to a provider.**- (a) The ~~Rhode Island Medicaid program~~  
16 [executive office of health and human services](#) may issue a suspension of payments order if:

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

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

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

25 (4) The [office of program integrity or the](#) Medicaid fund control unit of the attorney general's  
26 office has been denied reasonable access to information by a provider which pertains to a patient or

1 resident of a long term residential care facility or to a former patient or resident of a long term residential  
2 care facility; or

3 (5) The ~~Rhode Island Medicaid program~~ office of program integrity and/or the Medicaid fraud  
4 control unit of the attorney general's office has been denied reasonable access to data and information by  
5 the provider for the purpose of conducting activities as described in § 1903(g) of the Social Security Act,  
6 42 U.S.C. § 1396b(g); or

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

10 (b) Any such order of the ~~Rhode Island Medicaid program~~ executive office of health and human  
11 services may cease to be effective at such time as the ~~program~~ office of program integrity is satisfied that  
12 the provider is participating in substantial negotiations which seek to remedy the conditions which gave  
13 rise to its order of suspension of payments, or that amounts are no longer due from the provider or that a  
14 satisfactory arrangement has been made for the payment of the provider or that a satisfactory arrangement  
15 has been made for the payment by the provider of any such amounts.

16 **§ 40-8.2-22. Interest on overcharges.**-Any provider of services or goods contracting with the  
17 ~~department of human services~~ executive office of health and human services pursuant to Title XIX or  
18 Title XXI of the Social Security Act., ~~42 U.S.C. § 1396 et seq.~~, who, without intent to defraud, obtains  
19 payments under this chapter in excess of the amount to which the provider is entitled, thereby becomes  
20 liable for payment of the amount of the excess with payment of interest allowable by law, under § 6-26-  
21 2, as was in effect on the date payment was made to the provider. The interest period will commence on  
22 the date upon which payment was made and will extend to the date upon which repayment is made to the  
23 state of Rhode Island.

24 SECTION 9. Sections 40-8.3-2 and 40-8.3-3 of the General Laws in Chapter 40-8.3 entitled  
25 “Uncompensated Care” are hereby amended to read as follows:

26 **§ 40-8.3-2 Definitions.** – As used in this chapter:

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

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

9 (3) "Participating hospital" means any nongovernment and nonpsychiatric hospital that: (i) was  
10 licensed as a hospital in accordance with chapter 17 of title 23 during the base year; and shall mean the  
11 actual facilities and buildings in existence in Rhode Island, licensed pursuant to § 23-17-1 et seq. on June  
12 30, 2010, and thereafter any premises included on that license, regardless of changes in licensure status  
13 pursuant to § 23-17.14 (hospital conversions) and §23-17-6 (b) (change in effective control),  
14 that provides short-term acute inpatient and/or outpatient care to persons who require definitive diagnosis  
15 and treatment for injury, illness, disabilities, or pregnancy.

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

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

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

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

11 ~~§ 40-8.3-3 Implementation.— (a) For federal fiscal year 2013, commencing on October 1, 2012~~  
12 ~~and ending September 30, 2013, the executive office of health and human services shall submit to the~~  
13 ~~Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode~~  
14 ~~Island Medicaid state plan for disproportionate share hospital payments (DSH Plan) to provide:~~

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

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



1           ~~(a)~~ (a) For federal fiscal year 2014, commencing on October 1, 2013 and ending September 30,  
2 2014, 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 14, 2014 and are expressly conditioned upon approval on or before July 7, 2014  
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 2014 for the disproportionate share payments.

16           ~~(a)~~ (b) For federal fiscal year 2015, commencing on October 1, 2014 and ending September 30,  
17 2015, 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 state  
19 plan for 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 \$136.8 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 13, 2015 and are expressly conditioned upon approval on or before July 6, 2015  
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 2015 for the disproportionate share payments.

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

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

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

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

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

24 ~~SECTION 5. A pool is hereby established of up to \$1.5 million to support Medicaid Graduate~~  
25 ~~Education funding for Academic Medical Centers with level I Trauma Centers who provide care to the~~  
26 ~~state's critically ill and indigent populations. The office of Health and Human Services shall utilize this~~

1 ~~pool to provide up to \$3 million per year in additional Medicaid payments to support Graduate Medical~~  
2 ~~Education programs to hospitals meeting all of the following criteria:~~

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

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

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

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

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

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

14 **§ 40-8.9-9. Long-term care re-balancing system reform goal.** – (a) Notwithstanding any other  
15 provision of state law, the ~~department of human services~~ executive office of health and human services is  
16 authorized and directed to apply for and obtain any necessary waiver(s), waiver amendment(s) and/or  
17 state plan amendments from the secretary of the United States department of health and human services,  
18 and to promulgate rules necessary to adopt an affirmative plan of program design and implementation that  
19 addresses the goal of allocating a minimum of fifty percent (50%) of Medicaid long-term care funding for  
20 persons aged sixty-five (65) and over and adults with disabilities, in addition to services for persons with  
21 developmental disabilities ~~and mental disabilities~~, to home and community-based care ~~on or before~~  
22 ~~December 31, 2013~~; provided, further, the ~~executive office of health and human services~~ executive office  
23 shall report annually as part of its budget submission, the percentage distribution between institutional  
24 care and home and community-based care by population and shall report current and projected waiting  
25 lists for long-term care and home and community-based care services. The ~~department~~ executive office is  
26 further authorized and directed to prioritize investments in home and community-based care and to

1 maintain the integrity and financial viability of all current long-term care services while pursuing this  
2 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  
7 live safe and healthful lives through access to a wide range of supportive services in an array of  
8 community-based settings, regardless of the complexity of their medical condition, the severity of their  
9 disability, or the challenges of their behavior. Delivery of services and supports in less costly and less  
10 restrictive community settings, will enable children, adolescents and adults to be able to curtail, delay or  
11 avoid lengthy stays in long-term care institutions, such as behavioral health residential treatment facilities,  
12 long-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 ~~department~~  
14 ~~of human services~~ executive office of health and human services is directed and authorized to adopt a  
15 tiered set of criteria to be used to determine eligibility for services. Such criteria shall be developed in  
16 collaboration with the state's health and human services departments and, to the extent feasible, any  
17 consumer group, advisory board, or other entity designated for such purposes, and shall encompass  
18 eligibility determinations for long-term care services in nursing facilities, hospitals, and intermediate care  
19 facilities for ~~the mentally retarded~~ persons with intellectual disabilities as well as home and community-  
20 based alternatives, and shall provide a common standard of income eligibility for both institutional and  
21 home and community-based care. The ~~department~~ executive office is, ~~subject to prior approval of the~~  
22 ~~general assembly~~, authorized to adopt clinical and/or functional criteria for admission to a nursing facility,  
23 hospital, or intermediate care facility for ~~the mentally retarded~~ persons with intellectual disabilities that  
24 are more stringent than those employed for access to home and community-based services. The  
25 ~~department~~ executive office is also authorized to promulgate rules that define the frequency of re-

1 assessments for services provided for under this section. ~~Legislatively approved levels~~ Levels of care may  
2 be applied in accordance with the following:

3 (1) The ~~department~~ executive office shall continue to apply ~~pre-waiver the~~ level of care criteria  
4 in effect on June 30, 2015 for any recipient determined eligible for and receiving ~~Medicaid-recipient~~  
5 ~~eligible for~~ Medicaid-funded long-term services in supports in a nursing facility, hospital, or intermediate  
6 care facility for ~~the mentally-retarded~~ persons with intellectual disabilities ~~as of June 30, 2009~~ on or  
7 before that date, unless: (a) the recipient transitions to home and community based services because he or  
8 she: ~~(a) Improves to a level where he/she~~ would no longer meet the ~~pre-waiver~~ level of care criteria in  
9 effect on June 30, 2015; or (b) ~~The individual~~ the recipient chooses home and community based services  
10 over the nursing facility, hospital, or intermediate care facility for ~~the mentally-retarded~~ persons with  
11 intellectual disabilities. For the purposes of this section, a failed community placement, as defined in  
12 regulations promulgated by the ~~department~~ executive office, shall be considered a condition of clinical  
13 eligibility for the highest level of care. The ~~department~~ executive office shall confer with the long-term  
14 care ombudsperson with respect to the determination of a failed placement under the ombudsperson's  
15 jurisdiction. Should any Medicaid recipient eligible for a nursing facility, hospital, or intermediate care  
16 facility for ~~the mentally-retarded~~ persons with intellectual disabilities as of June 30, ~~2009~~ 2015 receive a  
17 determination of a failed community placement, the recipient shall have access to the highest level of  
18 care; furthermore, a recipient who has experienced a failed community placement shall be transitioned  
19 back into his or her former nursing home, hospital, or intermediate care facility for ~~the mentally-retarded~~  
20 persons with intellectual disabilities whenever possible. Additionally, residents shall only be moved from  
21 a nursing home, hospital, or intermediate care facility for ~~the mentally-retarded~~ persons with intellectual  
22 disabilities in a manner consistent with applicable state and federal laws.

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

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

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

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

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

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

4 ~~(2) (1) Development, not later than September 30, 2008, of revised or new Medicaid certification~~  
5 ~~standards supporting and defining targeted rate increments to encourage that increase access to service~~  
6 ~~specialization and scheduling accommodations including but not limited to, medication and pain~~  
7 ~~management, wound management, certified Alzheimer's Syndrome treatment and support programs, and~~  
8 ~~work and shift differentials for night and week-end services; and by using payment strategies designed to~~  
9 ~~achieve specific quality and health outcomes.~~

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

14 ~~(2) Development of Medicaid certification standards for state authorized providers of adult day~~  
15 ~~services, excluding such providers of services authorized under 40.1-24-1(3), assisted living and adult~~  
16 ~~supportive care homes that establish for each, an acuity-based, tiered service and payment methodology~~  
17 ~~tied to: level of beneficiary needs; the scope of services and supports provided; and specific quality and~~  
18 ~~outcome measures. The standards for adult day services for persons eligible for Medicaid-funded long-~~  
19 ~~term services may differ from those who do not meet the clinical/functional criteria set forth in § 40-8.10-~~  
20 ~~3.~~

21 ~~(g) The department, in collaboration with the executive office of human services, executive office~~  
22 ~~shall implement a long-term care options counseling program to provide individuals or their~~  
23 ~~representatives, or both, with long-term care consultations that shall include, at a minimum, information~~  
24 ~~about: long-term care options, sources and methods of both public and private payment for long-term care~~  
25 ~~services and an assessment of an individual's functional capabilities and opportunities for maximizing~~  
26 ~~independence. Each individual admitted to or seeking admission to a long-term care facility regardless of~~

1 the payment source shall be informed by the facility of the availability of the long-term care options  
2 counseling program and shall be provided with long-term care options consultation if they so request.  
3 Each individual who applies for Medicaid long-term care services shall be provided with a long-term care  
4 consultation.

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

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

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

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

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

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

24 (k) The secretary is authorized to seek any Medicaid section 1115 waiver or state plan  
25 amendments and take any administrative actions necessary to ensure timely adoption of any new or  
26 amended rules, regulations, policies, or procedures and any system enhancements or changes, for which



1 [appropriations have been authorized, that are necessary to facilitate implementation of the requirements of](#)  
2 [this section by the dates established. The secretary shall reserve the discretion to exercise the authority](#)  
3 [established under §§ 42-7.2-5\(6\)\(v\) and 42-7.2-6.1, in consultation with the governor, to meet the](#)  
4 [legislative directives established herein.](#)

5 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  
6 the General Laws in Chapter 40-8.10 entitled “Long Term Care Service Reform for Medicaid Eligible  
7 Individuals” are hereby amended to read as follows:

8 **§ 40-8.10-1 Purpose.** – (a) In order to ensure that all Medicaid recipients eligible for long-term  
9 care have access to the full continuum of services they need, the secretary of the executive office of health  
10 and human services, in collaboration with the ~~director of the department of human services and the~~  
11 ~~directors of the departments of children youth and families, elderly affairs, health, and mental health,~~  
12 ~~retardation and hospitals,~~ [directors of EOHHS departments,](#) shall offer eligible Medicaid recipients the  
13 full range of services as allowed under the terms and conditions of the Rhode Island ~~Global Consumer~~  
14 ~~Choice Compact 1115a Demonstration Waiver~~ [Medicaid section 1115 demonstration waiver](#), including  
15 institutional services and the home and community based services provided for under the previous  
16 Medicaid Section 1915(c) waivers, as well as additional services for medication management, transition  
17 services and other authorized services as defined in this chapter, in order to meet the individual needs of  
18 the Medicaid recipient.

19 **§ 40-8.10-2 Definitions.** – As used in this chapter,

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

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

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

18 (b) Levels of care for long-term care institutions (behavioral health residential treatment facilities,  
19 long-term care hospitals, intermediate care facilities and/or skilled nursing facilities), for which  
20 alternative community-based services and supports are available, shall be established pursuant to the §  
21 40-8.9-9. The structure of the three (3) levels of care is as follows:

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

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

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

4 (c) Determinations of levels of care and the provision of long term care health services shall be  
5 determined in accordance with this section and shall be in accordance with the applicable provisions of §  
6 40-8.9-9.

7 **§ 40-8.10-4 Long-term Care Assessment and Coordination ~~Assessment and Coordination~~**

8 **Unit (ACU).** – (a) ~~The department of human services, in collaboration with the~~ The executive office of  
9 health and human services, ~~shall~~ implement a long-term care options counseling program to provide  
10 individuals or their representative, or both, with long-term care consultations that shall include, at a  
11 minimum, information about long-term care options, sources and methods of both public and private  
12 payment for long term care services, information on caregiver support services, including respite care,  
13 and an assessment of an individual's functional capabilities and opportunities for maximizing  
14 independence. Each individual admitted to or seeking admission to a long-term care facility, regardless of  
15 the payment source, shall be informed by the facility of the availability of the long-term care options  
16 counseling program and shall be provided with a long-term care options consultation, if he or she so  
17 requests. Each individual who applies for Medicaid long-term care services shall be provided with a long-  
18 term care consultation.

19 (b) Core and preventative home and community based services defined and delineated in § 40-  
20 8.10-2 shall be provided only to those individuals who meet one of the levels of care provided for in this  
21 chapter. Other long term care services authorized by the federal government, such as medication  
22 management, may also be provided to Medicaid eligible recipients who have established the requisite  
23 need. ~~as determined by the Assessment and Coordination Unit (ACU). Access to institutional and~~  
24 ~~community based supports and services shall be through the Assessment and Coordination Unit (ACU).~~  
25 ~~The provision of Medicaid funded long term care services and supports shall be based upon a~~  
26 ~~comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social~~

1 ~~and environmental needs of each applicant for these services or programs. The assessment shall serve as~~  
2 ~~the basis for the development and provision of an appropriate plan of care for the applicant.~~

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

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

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

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

17 **§ 40-8.10-5 Payments.** – The ~~department of human services~~ executive office of health and  
18 human services shall not make payment for a person receiving a long-term home health care program,  
19 while payments are being made for that person for inpatient care in a skilled nursing and/or intermediate  
20 care facility or hospital.

21 **§ 40-8.10-6 Rules and regulations.** – The secretary of the executive office of health and human  
22 services, the directors of the department of human services, the ~~department~~ division of elderly affairs, the  
23 department of children youth and families and the department of ~~mental health retardation and hospitals~~  
24 behavioral healthcare, development disabilities and hospitals are hereby authorized to promulgate rules  
25 and regulations necessary to implement all provisions of this chapter and to seek necessary federal

1 approvals in accordance with the provisions of the ~~Global Compact Waiver~~ [state's Medicaid section 1115](#)  
2 [demonstration waiver](#).

3 SECTION 13. Section 40-8.13-2 of the General Laws in Chapter 40-8.13 entitled "Long-Term  
4 Managed Care Arrangements" is amended to read as follows:

5 ~~§ 40-8.13-2 **Beneficiary choice.**—Any managed long-term care arrangement shall offer~~  
6 ~~beneficiaries the option to decline participation and remain in traditional Medicaid and, if a duals~~  
7 ~~demonstration project, traditional Medicare. Beneficiaries must be provided with sufficient information to~~  
8 ~~make an informed choice regarding enrollment, including:~~

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

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

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

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

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

22 § 40-8.13-2. Community-Based Supportive Living Program. (a) To expand the number of  
23 community-based service options, the executive office of health and human services shall establish a  
24 program for beneficiaries opting to participate in managed care long-term care arrangements under this  
25 chapter who choose to receive Medicaid-funded assisted living, adult supportive care home, or shared  
26 living long-term care services and supports. As part of the program, the executive office shall implement

1 Medicaid certification or, as appropriate, managed care contract standards for state authorized providers  
2 of these services that establish an acuity-based, tiered service and payment system that ties  
3 reimbursements to: beneficiary's clinical/functional level of need; the scope of services and supports  
4 provided; and specific quality and outcome measures. Such standards shall set the base level of Medicaid  
5 state plan and waiver services that each type of provider must deliver, the range of acuity-based service  
6 enhancements that must be made available to beneficiaries with more intensive care needs, and the  
7 minimum state licensure and/or certification requirements a provider must meet to participate in the pilot  
8 at each service/payment level. The standards shall also establish any additional requirements, terms or  
9 conditions a provider must meet to ensure beneficiaries have access to high quality, cost effective care.

10 (b) **Room and board.** The executive office shall raise the cap on the amount Medicaid certified  
11 assisted living and adult supportive home care providers are permitted to charge participating  
12 beneficiaries for room and board. In the first year of the program, the monthly charges for a beneficiary  
13 living in a single room who has income at or below three hundred percent (300%) of the Supplemental  
14 Security Income (SSI) level shall not exceed the total of both the maximum monthly federal SSI payment  
15 and the monthly state supplement authorized for persons requiring long-term services under § 40-6-27.2,  
16 less the specified personal need allowance. For a beneficiary living in a double room, the room and board  
17 cap shall be set at eighty-five percent (85%) of the monthly charge allowed for a beneficiary living in a  
18 single room.

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

25 § 40-8.13-5 ~~Financial savings under managed care~~ **Financial principles under managed**  
26 **care.** – To the extent that financial savings are a goal under any managed long-term care arrangement, it

1 is the intent of the legislature to achieve such savings through administrative efficiencies, care  
2 coordination, ~~and~~ improvements in care outcomes and in a way that encourages the highest quality care  
3 for patients and maximizes value for the managed care organization and the state. ~~rather than through~~  
4 ~~reduced reimbursement rates to providers.~~ Therefore, any managed long-term care arrangement shall  
5 include a requirement that the managed care organization reimburse providers for services in accordance  
6 with ~~the following:~~ these principles. Notwithstanding any law to the contrary, for the twelve (12) month  
7 period beginning July 1, 2015, Medicaid managed long term care payment rates to nursing facilities  
8 established pursuant to this section shall not exceed ninety-seven and one-half percent (97.5%) of the  
9 rates in effect on April 1, 2015.

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

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

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

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

20 SECTION 14. Section 40.1-21-4.3 of the General Laws in Chapter 40.1 entitled  
21 “department of behavioral healthcare developmental disabilities and hospitals” is hereby  
22 amended to read as follows:

23 § 40.1-21-4.3 **Definitions.** – As used in this chapter and in chapter 22 of this title the words:

24 (1) "Ancillary services" means those services provided, and shall include, but not be limited to,  
25 transportation, housing, housing adaptation, personal attendant care, and homemaker services.

1 (2) "Case management" means the implementation of an individual's program by providing  
2 information, by referral to appropriate service providers, by procurement of services, and by the  
3 coordination of the necessary services.

4 (3) "Department" means the Rhode Island department of ~~mental health, retardation,~~ [behavioral](#)  
5 [healthcare, developmental disabilities](#) and hospitals.

6 (4) "Developmental services" means those services provided to developmentally disabled adults,  
7 and shall include, but not be limited to, habilitation and rehabilitation services, and day services.

8 (5) "Developmentally disabled adult" means a person, eighteen (18) years old or older and not  
9 under the jurisdiction of the department of children, youth, and families who is either a mentally retarded  
10 developmentally disabled adult or is a person with a severe, chronic disability which:

11 (i) Is attributable to a mental or physical impairment or combination of mental and physical  
12 impairments;

13 (ii) Is manifested before the person attains age twenty-two (22);

14 (iii) Is likely to continue indefinitely;

15 (iv) Results in substantial functional limitations in three (3) or more of the following areas of  
16 major life activity:

17 (A) Self care,

18 (B) Receptive and expressive language,

19 (C) Learning,

20 (D) Mobility,

21 (E) Self-direction,

22 (F) Capacity for independent living,

23 (G) Economic self-sufficiency; and

24 (v) Reflects the person's need for a combination and sequence of special, interdisciplinary, or  
25 generic care, treatment, or other services, which are of lifelong or extended duration and are individually



1 planned and coordinated. For purposes of funding, it is understood that students enrolled in school will  
2 continue to receive education from their local education authority in accordance with § 16-24-1 et seq.

3 (6) "Diagnosis and evaluation" means a process to determine whether and to what extent an  
4 individual is developmentally disabled and a study of the individual's condition, situation, and needs  
5 which lead to a recommendation of what services, if any, would benefit the individual.

6 (7) "Individualized program plan" or "general service plan" means a plan, however named, which  
7 includes, but shall not be limited to, the following:

8 (i) An evaluation of the strengths, difficulties, needs, and goals of the individual;

9 (ii) A description of those services found to be necessary or appropriate to assist the individual in  
10 realizing his or her potential for self-sufficiency in major life activities;

11 (iii) A description of the agencies and/or individuals, which are proposed to provide each of the  
12 recommended services;

13 (iv) The intermediate and long-range objectives for the individual's development and habilitation;

14 (v) The expected duration for the provision of the services;

15 (vi) A description of the tests and other evaluative devices used and their results;

16 (vii) Proposed criteria for monitoring and evaluating the success of the services in meeting the  
17 individual's needs; ~~and~~

18 (viii) The signatures of the preparers of the plan and the date; and

19 (ix) The plan shall be written annually.

20 ~~The individual program plan shall indicate developmental, supportive, or ancillary services by function~~  
21 ~~and frequency, the manner of subsidy and delivery and the categories of need for services such as~~  
22 ~~transportation, job training, or occupation, housing, housing adaptation, personal attendant care,~~  
23 ~~homemaker, or other services. This plan shall be reviewed at least annually; provided, however, that~~  
24 ~~authorizations for services and funding issued prior to July 1, 2011 are null and void. Authorizations will~~  
25 ~~be paid at the rate effective in the quarter the service was provided.~~

1 (8) "Mentally retarded developmentally disabled adult" means a person eighteen (18) years old or  
2 older and not under the jurisdiction of the department of children, youth, and families, with significant  
3 sub-average, general intellectual functioning two (2) standard deviations below the norm, existing  
4 concurrently with deficits in adaptive behavior and manifested during the developmental period. For  
5 purposes of funding, it is understood that students enrolled in school will continue to receive education  
6 from their local education authority in accordance with § 16-24-1 et seq.

7 (9) "Service broker" means that individual who assists in facilitating the connection between the  
8 developmentally disabled person and the services required by the individual program plan.

9 (10) "Subsidized access to service" means the provisions of financial resources through vouchers  
10 to a developmentally disabled person to enable the person to gain access to appropriate generic and/or  
11 special services as required by the individual program plan.

12 (11) "Supportive services" means those services provided to developmentally disabled adults, and  
13 shall include, but not be limited to, occupational therapy, physical therapy, psychological services,  
14 counseling, nursing services, and medical services.

15 SECTION 15. 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 Laws  
16 in Chapter 42-7.2 entitled "Executive Office of Health and Human Services" are hereby amended to read  
17 as follows:

18 **§ 42-7.2-2. Executive office of health and human services.**-There is hereby established within  
19 the executive branch of state government an executive office of health and human services to serve as the  
20 principal agency of the executive branch of state government for managing the departments of children,  
21 youth and families, health, human services, and behavioral healthcare, developmental disabilities and  
22 hospitals. In this capacity, the office shall:

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

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

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

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

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

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

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

17 **§ 42-7.2-4. Responsibilities of the secretary.-** (a) The secretary shall be responsible to the  
18 governor for supervising the executive office of health and human services and for managing and  
19 providing strategic leadership and direction to the four (4) departments.

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

1           **§ 42-7.2-5. Duties of the secretary.**

2           The secretary shall be subject to the direction and  
3 supervision of the governor for the oversight, coordination and cohesive direction of state administered  
4 health and human services and in ensuring the laws are faithfully executed, notwithstanding any law to  
5 the contrary. In this capacity, the Secretary of Health and Human Services shall be authorized to:

6           (1) Coordinate the administration and financing of health care benefits, human services and  
7 programs including those authorized by the ~~Global Consumer Choice Compact Waiver~~ [the state's](#)  
8 [Medicaid section 1115 demonstration waiver](#) and, as applicable, the Medicaid State Plan under Title XIX  
9 of the US Social Security Act. However, nothing in this section shall be construed as transferring to the  
10 secretary the powers, duties or functions conferred upon the departments by Rhode Island public and  
11 general laws for the administration of federal/state programs financed in whole or in part with Medicaid  
12 funds or the administrative responsibility for the preparation and submission of any state plans, state plan  
13 amendments, or authorized federal waiver applications, once approved by the secretary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 **§ 42-7.2-6. Departments assigned to the executive office - Powers and duties.**-(a) The  
10 departments assigned to the secretary shall:

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

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

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

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

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



1            **§ 42-7.2-6.1. Transfer of powers and functions.**-(a) There are hereby transferred to the

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

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

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

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

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

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

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

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

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

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

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

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

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

9 (1) Minimal disruption of services to consumers;

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

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

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

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

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

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

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

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

1           ~~§ 42-7.2-12. Medicaid program study.~~ (a) The secretary of the executive office of health and  
2 human services shall conduct a study of the Medicaid programs administered by the state to review and  
3 analyze the options available for reducing or stabilizing the level of uninsured Rhode Islanders and  
4 containing Medicaid spending.

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

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

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

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

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

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

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

10 ~~(c) The secretary shall submit a report and recommendations based on the findings of the study to~~  
11 ~~the general assembly, the governor, and the house and senate fiscal advisors no later than February 1,~~  
12 ~~2007.~~

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

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

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

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

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

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

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

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

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

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

24 (c) The executive office of health and human services shall annually submit a report to the  
25 governor and the general assembly ~~commencing on a date no later than July 1, 2009~~ describing the status

1 of the administration and implementation of the ~~Global Waiver Compact~~ Medicaid Section 1115  
2 demonstration waiver.

3 **§ 42-7.2-16.1. Reinventing Medicaid Act of 2015.** (a) The Rhode Island Medicaid program is an  
4 integral component of the state's health care system that provides crucial services and supports to many  
5 Rhode Islanders. As the program's reach has expanded, the costs of the program have continued to rise  
6 and the delivery of care has become more fragmented and uncoordinated. Given the crucial role of the  
7 Medicaid program to the state, it is of compelling importance that the state conduct a fundamental  
8 restructuring of its Medicaid program that achieves measurable improvement in health outcomes for the  
9 people and transforms the health care system to one that pays for the outcomes and quality they deserve at  
10 a sustainable, predictable and affordable cost.

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

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

22 **§ 42-7.2-18. Program integrity division.**-(a) There is hereby established a program integrity  
23 division within the office of health and human services to effectuate the transfer of functions pursuant to  
24 subdivision 42-7.2-6.1(a)(7). The purposes of this division are:

25 (1) To develop and implement a statewide strategy to coordinate state and local agencies, law  
26 enforcement entities, and investigative units in order to increase the effectiveness of programs and

1 initiatives dealing with the prevention, detection, and prosecution of Medicaid and public assistance  
2 fraud; ~~and~~

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

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

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

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

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

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

22 (3) To identify methods to implement innovative technology and data sharing in consultation with  
23 the office of digital excellence in order to detect and analyze Medicaid and public assistance fraud with  
24 speed and efficiency; Such methods as may be effective as a means of detecting incidences of fraud,  
25 assisting in directing the focus of an investigation or audit, and determining the amounts a provider owes  
26 as the result of such an investigation or audit conducted by the division, a department assigned to the

1 [office, Rhode Island Department of Attorney General Medicaid Fraud Control Unit, the U.S. Department](#)  
2 [of Health and Human Services' Office of Inspector General, the U.S. Department of Justice's Federal](#)  
3 [Bureau of Investigation, or an authorized agent thereof.](#)

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

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

9 (i) Coverage and billing policies;

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

11 (iii) Covered and non-covered services;

12 (iv) Provider accountability and responsibilities;

13 (v) Claim submission policies and procedures; and

14 (vi) Reconciling claim activity.

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

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

20 **§42-12-29 Children's health account.** – (a) There is created within the general fund a restricted  
21 receipt account to be known as the "children's health account." All money in the account shall be utilized  
22 by the ~~department of human services~~ [executive office of health and human services](#) to effectuate coverage  
23 for the following service categories: (1) home health services, which include pediatric private duty  
24 nursing and certified nursing assistant services; (2) comprehensive, evaluation, diagnosis, assessment,  
25 referral and evaluation (CEDARR) services, which include CEDARR family center services, home based  
26 therapeutic services, personal assistance services and supports (PASS) and kids connect services and (3)



1 child and adolescent treatment services (CAITS). All money received pursuant to this section shall be  
2 deposited in the children's health account. The general treasurer is authorized and directed to draw his or  
3 her orders on the account upon receipt of properly authenticated vouchers from the ~~department of human~~  
4 ~~services~~ executive office.

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

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

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

21 (e) The children's health account shall be exempt from the indirect cost recovery provisions of §  
22 35-4-27 of the general laws.

23 SECTION 17: Chapter 42-72.5 of the General Laws entitled, "Children's Cabinet" is hereby  
24 amended to read as follows:

25 **§ 42-72.5-1. Establishment.** - There is established within the executive branch of state  
26 government a children's cabinet. The cabinet shall ~~be comprised of:~~ include, but not be limited to: the

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

9 **§ 42-72.5-2 Policy and goals.** – The children's cabinet shall:

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

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

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

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

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

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

1 [with research partners, pursuant to data-sharing agreements, that maintains data integrity and protects the](#)  
2 [security and confidentiality of these records.](#)

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

8 SECTION 18: Section 44-51-3 of the General Laws in Chapter 44-51 entitled “Nursing Facility  
9 Provider Assessment Act” is hereby amended to read as follows:

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

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

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

24 (d) If, after applying the applicable federal law and/or rules, regulations, or standards relating to  
25 health care providers, the tax administrator determines that the assessment rate established in subsection  
26 (b) of this section exceeds the maximum rate of assessment that federal law will allow without reduction

1 in federal financial participation, then the tax administrator is directed to reduce the assessment to a rate  
2 equal to the maximum rate which the federal law will allow without reduction in federal participation.  
3 Provided, however, that the authority of the tax administrator to lower the assessment rate established in  
4 subsection (b) of this section shall be limited solely to such determination.

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

9 SECTION 19. Rhode Island Medicaid Reform Act of 2008.

10 WHEREAS, the General Assembly enacted Chapter 12.4 of Title 42 entitled “The Rhode Island  
11 Medicaid Reform Act of 2008”; and

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

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

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

24 (a) *Nursing Facility Payment Rates and Incentive Program.* The executive office of health and  
25 human services proposes to eliminate the projected nursing facility rate increase that would otherwise

1 take effect during the state fiscal year 2016. In addition, the executive office proposes to establish a  
2 nursing facility incentive program which ties certain payments to nursing facilities in state fiscal year  
3 (SFY) 2017 to specific performance-based outcomes. Implementation of these initiatives may require  
4 amendments to the Rhode Island’s Medicaid state plan and/or Section 11115 waiver under the terms and  
5 conditions of the demonstration. Further, implementation of these initiatives may require the adoption of  
6 new or amended rules, regulations and procedures.

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

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

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

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

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

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

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

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

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

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

1           (l) Medicaid Eligibility Criteria and System Processes – Review and Realignment. The EOHHS  
2 proposes to review state policies related to each Medicaid eligibility coverage group to ensure application,  
3 renewal, and service delivery requirements pose the least administrative burden on beneficiaries and  
4 provide the maximum amount of financial participation allowed under applicable federal laws and  
5 regulations. Changes in the section 1115 waiver and/or state plan may be required to implement any  
6 changes deemed necessary by the secretary necessary as a result of this review. New and amended rules,  
7 regulations and procedures may also be required.

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

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

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

22           (p) Approved Authorities: Section 1115 Waiver Demonstration Extension. The Medicaid agency  
23 proposes to continue implementation of authorities approved under the Section 1115 waiver  
24 demonstration extension request – formerly known as the Global Consumer Choice Waiver – that (1)  
25 continue efforts to re-balance the system of long term services and supports by assisting people in  
26 obtaining care in the most appropriate and least restrictive setting; (2) pursue utilization of care

1 management models that offer a “health home”, promote access to preventive care, and provide an  
2 integrated system of services; (3) use payments and purchasing to finance and support Medicaid  
3 initiatives that fill gaps in the integrated system of care; and (4) recognize and assure access to the non-  
4 medical services and supports, such as peer navigation and employment and housing stabilization  
5 services, that are essential for optimizing a person’s health, wellness and safety and reduce or delay the  
6 need for long term services and supports.

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

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

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

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

21 SECTION 20: This article shall take effect upon passage, except that Section 10 shall take effect  
22 as of July 1, 2014.