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STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

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

MEMORANDUM

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

The Honorable William J. Conley, Jr.
Chairman, Senate Finance Committee

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

Date: February 1, 2018

Subject: Amendments to Articles 13 and 14 of the FY 2019 Appropriations Act (18-H-7200)

The Governor requests that Article 13 entitled "Relating to Medical Assistance" and Article 14 entitled "Relating to Medicaid Reform Act of 2008 Resolution" submitted on January 18, 2018 be amended as reflected in the attached versions.

Section 1 of Article 13 is amended for two items. First, to clarify who would be exempt from the proposal to establish co-payments for adults for Medicaid-funded services. Second, to correct an error in the date used with regards to the outpatient and inpatient hospital rate freeze. The dates should have read January 1, 2018, not January 1, 2017.

Section 4 of Article 13 is amended to clarify the intent of the proposed changes to the Graduate Medical Education (GME) program to eliminate reference to Level 1 Trauma Centers and to require the Executive Office of Health and Human Services to include mental health and substance abuse training in the use any funding appropriated for GME.

Article 14 is amended to explicitly include references to proposed changes to Managed Care Organization plan rates and the risk margin component in section (a) of the resolution. They were already identified in section (f).

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

TAM:sma 19-Amend-3

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
John Raymond, Chief Budget Analyst
Eric Beane, Secretary, Executive Office of Health and Human Services

ARTICLE 13

RELATING TO MEDICAL ASSISTANCE

SECTION 1. Sections 40-8-4, 40-8-13.4, 40-8-15 and 40-8-19 of the General Laws in Chapter 40-8 entitled "Medical Assistance" are hereby amended to read as follows:

40-8-4. ~~Direct vendor payment plan.~~ Medicaid vendor payment and beneficiary copayment.

(a) The ~~department~~ executive office of health and human services ("executive office") shall furnish medical care benefits to eligible beneficiaries through ~~a~~ direct vendor payment ~~plan~~ and/or other methodologies and plans authorized in this chapter. ~~The plan shall include, but need not be limited to, any or all of the following benefits, which benefits shall be contracted for by the director~~ Such plans and methodologies shall cover the services and supports approved as eligible for federal financial participation identified in the Medicaid state plan and any active waivers.~~:~~

~~(1) Inpatient hospital services, other than services in a hospital, institution, or facility for tuberculosis or mental diseases;~~

~~(2) Nursing services for such period of time as the director shall authorize;~~

~~(3) Visiting nurse service;~~

~~(4) Drugs for consumption either by inpatients or by other persons for whom they are prescribed by a licensed physician;~~

~~(5) Dental services; and~~

~~(6) Hospice care up to a maximum of two hundred and ten (210) days as a lifetime benefit.~~

(b) ~~For purposes of this chapter, the payment of federal Medicare premiums or other health insurance premiums by the department on behalf of eligible beneficiaries in accordance with the provisions of Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et seq., shall be deemed to be a direct vendor payment.~~

~~(c)~~ With respect to medical care benefits furnished ~~to eligible individuals~~ under this chapter, ~~or~~ Title XIX, or Title XXI of the federal Social Security Act, the ~~department~~ executive office is authorized and directed to impose~~:~~

~~(i) Nominal~~ nominal co-payments or similar charges upon ~~eligible individuals~~ adults over the age of nineteen (19) who are ~~not living with a disability and~~ eligible for Medicaid or Children's Health Insurance Program (CHIP) pursuant to §§ 40-8.4-4(b), 40-8.5-1, 40-8.12-2(a), unless exempt under this sub-section, the total of which is not to exceed five (5) percent of annual countable income in a one-year eligibility period, as follows:

(i) Copayments in the amount of eight dollars ($8.00) per visit for non-emergency services provided in a hospital emergency room; three dollars ($3.00) per inpatient hospital visit; and three dollars ($3.00) per non-preventive health physical office visit.

(ii) Co-payments for prescription drugs in the amount of ~~one dollar ($1.00)~~ two dollars and fifty cents ($2.50) for generic drug prescriptions and ~~three~~ four dollars (~~$3.00~~ 4.00) for brand name drug prescriptions in accordance with the provisions of 42 U.S.C. § 1396, et seq.

(iii) The following persons eligible for Medicaid or CHIP are exempt from the requirement for nominal co-payments or similar charges established in this sub-section: young adults, who are ages nineteen (19) through twenty-one (21) who are eligible on the basis of receipt of federal Supplemental Security Income (SSI); adults over age nineteen (19) who are eligible on the basis of a determination of a disability by the federal Social Security Agency (SSA) or a state or local agency that makes such determinations using SSI disability criteria; persons of any age who are receiving Medicaid-funded hospice services or long-term services and supports, whether in an institutional or home or community-based-setting; American Indians and Alaska Natives who have ever received a service from the Indian Health Service, tribal health programs, or under contract health services referral; and women who are enrolled in Medicaid under the state's Breast and Cervical Cancer Treatment Program.

~~(d)~~(b) The ~~department~~ executive office is authorized and directed to promulgate rules and regulations to impose such co-payments or charges and to provide that, with respect to subdivision (ii) above, those regulations shall be effective upon filing.

~~(e)~~ (c) No state agency shall pay a vendor for medical benefits provided to a ~~recipient of assistance~~ beneficiary under this chapter until and unless the vendor has submitted a claim for payment to a commercial insurance plan, Medicare, and/or a Medicaid managed care plan, if applicable for that ~~recipient~~ beneficiary, in that order. This includes payments for skilled nursing and therapy services specifically outlined in Chapter 7, 8 and 15 of the Medicare Benefit Policy Manual.

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

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

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

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

percent (97.5%) of the payment rates in effect as of July 1, 2014. For the twelve (12) month period beginning July 1, 2018, there shall be no increase in the DRG base rate for Medicaid fee-for-service inpatient hospital services.

(ii) With respect to inpatient services, (A) It is required as of January 1, 2011 until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not exceed ninety and one tenth percent (90.1%) of the rate in effect as of June 30, 2010. Increases in inpatient hospital payments for each annual twelve-month (12) period beginning January 1, 2012 may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the applicable period; (B) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the Medicaid managed care payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1, 2015, the Medicaid managed-care payment inpatient rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (C) Increases in inpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2017, shall be the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1; (D) For the twelve (12) month period beginning July 1, 2018, the Medicaid managed care payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2017~~8~~. The executive office will develop an audit methodology and process to assure that savings associated with the payment reductions will accrue directly to the Rhode Island Medicaid program through reduced managed-care-plan payments and shall not be retained by the managed-care plans; (E) All hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and (F) For all such hospitals, compliance with the provisions of this section shall be a condition of participation in the Rhode Island Medicaid program.

(2) With respect to outpatient services and notwithstanding any provisions of the law to the contrary, for persons enrolled in fee-for-service Medicaid, the executive office will reimburse hospitals for outpatient services using a rate methodology determined by the executive office and in accordance with federal regulations. Fee-for-service outpatient rates shall align with Medicare payments for similar services. Notwithstanding the above, there shall be no increase in the Medicaid fee-for-service outpatient rates effective on July 1, 2013, July 1, 2014, or July 1, 2015. For the twelve-month (12) period beginning July 1, 2015, Medicaid fee-for-service outpatient rates shall not exceed ninety-seven and one-half percent (97.5%) of the rates in effect as of July 1, 2014. Increases in the outpatient hospital payments for the twelve-month (12) period beginning July 1, 2016, may not exceed the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. Effective July 1, 2018, there shall be no increase in the Medicaid fee-for-service outpatient hospital rates. With respect to the outpatient rate, (i) It is required as of January 1, 2011, until December 31, 2011, that the Medicaid managed-care payment rates between each hospital and health plan shall not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010; (ii) Increases in hospital outpatient payments for each annual twelve-month (12) period beginning January 1, 2012 until July 1, 2017, may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment System OPPS hospital price index for the applicable period; (iii) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the Medicaid managed-care outpatient payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1, 2015, the Medicaid managed-care outpatient payment rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (iv) Increases in outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2017, shall be the Centers for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively

to July 1. For the twelve (12) month period beginning July 1, 2018, the Medicaid managed-care outpatient payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2017~~8~~.

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

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

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

Island state plan for Medicaid, pursuant to Title XIX of the federal Social Security Act, is hereby authorized to provide for payment to hospitals for services provided to eligible recipients in accordance with this chapter.

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

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

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

40-8-15. Lien on deceased recipient's estate for assistance.

(a)(1) Upon the death of a recipient of ~~medical assistance~~ Medicaid under Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et seq., (42 U.S.C. § 1396 et seq and referred to hereinafter as the *"Act"*),the total sum ~~of medical assistance~~ for Medicaid benefits so paid on behalf of a ~~recipient~~ beneficiary who was fifty-five (55) years of age or older at the time of receipt ~~of the assistance~~ shall be and constitute a lien upon the estate, as defined in subdivision (a)(2) below, of

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

(2) For purposes of this section, the term "estate" with respect to a deceased individual shall include all real and personal property and other assets included or includable within the individual's probate estate.

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

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

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

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

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

(g) Upon the filing of a petition for admission to probate of a decedent's will or for administration of a decedent's estate, when the decedent was fifty-five (55) years or older at the time of death, a copy of said petition and a copy of the death certificate shall be sent to the executive office ~~of health and human services~~. Within thirty (30) days of a request by the executive office ~~of health and human services~~, an executor or administrator shall complete and send to the executive office ~~of health and human services~~ a form prescribed by that office and shall provide such additional information as the office may require. In the event a petitioner fails to send a copy of the petition and a copy of the death certificate to the executive office ~~of health and human services~~ and

a decedent has received ~~medical assistance~~ Medicaid benefits for which the executive office of ~~health and human services~~ is authorized to recover, no distribution and/or payments, including administration fees, shall be disbursed. Any person and /or entity that receive a distribution of assets from the decedent's estate shall be liable to the executive office ~~of health and human services~~ to the extent of such distribution.

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

(i)To assure the financial integrity of the Medicaid eligibility determination, benefit renewal, and estate recovery processes in this and related sections, the secretary of health and human services is authorized and directed to, by no later than August 1, 2018: (1), implement an automated asset verification system, as mandated by §1940 of the of Act that uses electronic data sources to verify the ownership and value of countable resources held in financial institutions and any real property for applicants and beneficiaries subject to resource and asset tests pursuant in the Act in §1902(e)(14)(D); (2) Apply the provisions required under §§1902(a)(18) and 1917(c) of the Act pertaining to the disposition of assets for less than fair market value by applicants and beneficiaries for Medicaid long-term services and supports and their spouses, without regard to whether they are subject to or excepted from resources and asset tests as mandated by federal guidance; and.(3) Pursue any state plan or waiver amendments from the U.S. Centers for Medicare and Medicaid Services and promulgate such rules, regulations, and procedures he or she deems necessary to carry out the requirements set forth herein and ensure the state plan and Medicaid policy conform and comply with applicable provisions Title XIX.

40-8-19. Rates of payment to nursing facilities.

(a) Rate reform.

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

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

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

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

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

(iv) Application of a fair rental value system;

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

(vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be applied on October 1st of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013 or October 1, 2015, but will occur on April 1, 2015. The rate adjustment that occurs on October 1, 2018 will not exceed an increase of one (1) percent. Said inflation index shall be applied without regard for the transition factors in subsections (b)(1) and (b)(2) below. For purposes of October 1, 2016, adjustment only, any rate increase that results from

application of the inflation index to subparagraphs (a)(2)(i) and (a)(2)(ii) shall be dedicated to increase compensation for direct-care workers in the following manner: Not less than 85% of this aggregate amount shall be expended to fund an increase in wages, benefits, or related employer costs of direct-care staff of nursing homes. For purposes of this section, direct-care staff shall include registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), certified medical technicians, housekeeping staff, laundry staff, dietary staff, or other similar employees providing direct care services; provided, however, that this definition of direct-care staff shall not include: (i) RNs and LPNs who are classified as "exempt employees" under the Federal Fair Labor Standards Act (29 U.S.C. § 201 et seq.); or (ii) CNAs, certified medical technicians, RNs, or LPNs who are contracted, or subcontracted, through a third-party vendor or staffing agency. By July 31, 2017, nursing facilities shall submit to the secretary, or designee, a certification that they have complied with the provisions of this subparagraph (a)(2)(vi) with respect to the inflation index applied on October 1, 2016. Any facility that does not comply with terms of such certification shall be subjected to a clawback, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification.

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

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

~~receive reimbursement for direct care costs that is less than the rate of reimbursement for direct care costs received under the methodology in effect at the time of passage of this act;~~ and

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

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

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

SECTION 2. Section 40-8.3-10 of the General Laws in Chapter 40-8.3 entitled "Uncompensated Care" is hereby amended to read as follows:

40-8.3-10. Hospital adjustment payments.

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3. Section 40-8.4-12 of the General Laws in Chapter 40-8.4 entitled "Health Care for Families" is hereby amended to read as follows:

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

(a) Basic RIte Share Health Insurance Premium Assistance Program. ~~The office of health and human services is authorized and directed to amend the medical assistance Title XIX state plan to implement the provisions of section 1906 of Title XIX of the Social Security Act, 42 U.S.C. section 1396e, and establish the Rhode Island health insurance premium assistance program for RIte Care eligible families with incomes up to two hundred fifty percent (250%) of the federal poverty level who have access to employer-based health insurance. The state plan amendment shall require eligible families with access to employer-based health insurance to enroll themselves and/or their family in the employer-based health insurance plan as a condition of participation in the RIte Share program under this chapter and as a condition of retaining eligibility for medical assistance under chapters 5.1 and 8.4 of this title and/or chapter 12.3 of title 42 and/or premium assistance under this chapter, provided that doing so meets the criteria established in section 1906 of Title XIX for obtaining federal matching funds and the department has determined that the person's and/or the family's enrollment in the employer-based health insurance plan is cost-effective and the department has determined that the employer-based health insurance plan meets the criteria set forth in subsection (d). The department shall provide premium assistance by paying all or a portion of the employee's cost for covering the eligible person or his or her family under the employer-based health insurance plan, subject to the cost sharing provisions in subsection (b), and provided that the premium assistance is cost-effective in accordance with Title XIX, 42 U.S.C. section 1396~~

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

(b) ~~Individuals who can afford it shall share in the cost. The office of health and human services is authorized and directed to apply for and obtain any necessary waivers from the secretary of the United States Department of Health and Human Services, including, but not limited to, a waiver of the appropriate sections of Title XIX, 42 U.S.C. section 1396 et seq., to require that families eligible for RIte Care under this chapter or chapter 12.3 of title 42 with incomes equal to or greater than one hundred fifty percent (150%) of the federal poverty level pay a share of the costs of health insurance based on the person's ability to pay, provided that the cost sharing shall not exceed five percent (5%) of the person's annual income. The department of human services shall implement the cost-sharing by regulation, and shall consider co-payments, premium shares or other reasonable means to do so.~~ Definitions. - For the purposes of this subsection, the following definitions apply:

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

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

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

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

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

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

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

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

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

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

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

(c) ~~Current RIte Care enrollees with access to employer-based health insurance. The office of health and human services shall require any family who receives RIte Care or whose family receives RIte Care on the effective date of the applicable regulations adopted in accordance with subsection (f) to enroll in an employer-based health insurance plan at the person's eligibility redetermination date or at an earlier date determined by the department, provided that doing so meets the criteria established in the applicable sections of Title XIX, 42 U.S.C. section 1396 et seq., for obtaining federal matching funds and the department has determined that the person's and/or the family's enrollment in the employer-based health insurance plan is cost-effective and has determined that the health insurance plan meets the criteria in subsection (d). The insurer shall accept the enrollment of the person and/or the family in the employer-based health insurance plan without regard to any enrollment season restrictions~~. RIte Share Populations. Medicaid beneficiaries subject to RIte Share include: children, families, parent and caretakers eligible for Medicaid or the Children's Health Insurance Program under this chapter or chapter 42-12.3; and adults between the ages of 19 and 64 who are eligible under chapters 40-8.5 and 40-8.12, not receiving or eligible to receive Medicare, and are enrolled in managed care delivery systems. The following conditions apply:

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

(i) Income at or below 150% of FPL -- Persons and families determined to have household income at or below 150% of the Federal Poverty Level (FPL) guidelines based on the modified adjusted gross income (MAGI) standard or other standard approved by the secretary are required to participate in RIte Share if a Medicaid-eligible adult or parent/caretaker has access to cost-

effective ESI. Enrolling in ESI through RIte Share shall be a condition of maintaining Medicaid health coverage for any eligible adult with access to such coverage.

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

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

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

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

~~(d)~~ (e) Approval of health insurance plans for premium assistance. The office of health and human services shall adopt regulations providing for the approval of employer-based health insurance plans for premium assistance and shall approve employer-based health insurance plans based on these regulations. In order for an employer-based health insurance plan to gain approval, the ~~department~~ executive office must determine that the benefits offered by the employer-based health insurance plan are substantially similar in amount, scope, and duration to the benefits

provided to ~~RIte Care~~ Medicaid-eligible persons ~~by the RIte Care program~~ enrolled in Medicaid managed care plan, when the plan is evaluated in conjunction with available supplemental benefits provided by the office. The office shall obtain and make available as sto persons otherwise eligible for ~~RIte Care~~ Medicaid identified in this section as supplemental benefits those benefits not reasonably available under employer-based health insurance plans which are required for ~~RIte Care eligible persons~~ Medicaid beneficiaries by state law or federal law or regulation. Once it has been determined by the Medicaid agency that the ESI offered by a particular employer is RIte Share-approved, all Medicaid members with access to that employer's plan are required participate in RIte Share. Failure to meet the mandatory enrollment requirement shall result in the termination of the Medicaid eligibility of the policy holder and other Medicaid members nineteen (19) or older in the household that could be covered under the ESI until the policy holder complies with the RIte Share enrollment procedures established by the executive office.

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

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

~~(e)~~ (h) Maximization of federal contribution. The office of health and human services is authorized and directed to apply for and obtain federal approvals and waivers necessary to maximize the federal contribution for provision of medical assistance coverage under this section,

including the authorization to amend the Title XXI state plan and to obtain any waivers necessary to reduce barriers to provide premium assistance to recipients as provided for in Title XXI of the Social Security Act, 42 U.S.C. section 1397 et seq.

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

SECTION 4. Section 15 of Article 5 of Chapter 141 of the Public Laws of 2015 is hereby amended to read as follows:

A pool is hereby established of up to ~~$4.0~~ 1.5 million to support Medicaid Graduate Education funding for Academic Medical Centers ~~with level I Trauma Centers~~ who provide care to the state's critically ill and indigent populations. The executive office shall use this pool to support Graduate Medical Education program and research in areas including but not limited to mental health and substance abuse. ~~The office of Health and Human Services shall utilize this pool to provide up to $5 million per year in additional Medicaid payments to support Graduate Medical Education programs to hospitals meeting all of the following criteria:~~

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

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

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

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

Payments for Graduate Medical Education programs shall be made annually.

SECTION 5. This Article shall take effect upon passage.