Chapter 069
2009 -- H 5112 SUBSTITUTE C
Enacted 07/01/09

A N A C T
RELATING TO CENTERS FOR MEDICARE AND MEDICAID SERVICES WAIVER AND EXPENDITURE AUTHORITY

Introduced By: Representatives Costantino, Naughton, Slater, Giannini, and Almeida
Date Introduced: January 15, 2009

It is enacted by the General Assembly as follows:

SECTION 1. Chapter 42-12.4 of the General Laws entitled "The Rhode Island Medicaid Reform Act of 2008" is hereby amended by adding thereto the following sections:

42-12.4-7. Demonstration implementation - Restrictions. -- The executive office of health and human services and the department of human services may implement the global consumer choice section 1115 demonstration ("the demonstration"), project number 11W-00242/1, subject to the following restrictions:

(1) Notwithstanding the provisions of the demonstration, any change that requires the implementation of a rule or regulation or modification of a rule or regulation in existence prior to the demonstration shall require prior approval of the general assembly;

(2) Notwithstanding the provisions of the demonstration, any Category II change or Category III change, as defined in the demonstration, shall require the prior approval of the general assembly.

42-12.4-8. Demonstration termination. -- In the event the demonstration is suspended or terminated for any reason, or in the event that the demonstration expires, the department of human services, in conjunction with the executive office of health and human services, is directed and authorized to apply for and obtain all waivers in existence prior to the acceptance of the demonstration. The department of human services and the executive office of health and human services to the extent possible shall ensure that said waivers are reinstated prior to any suspension, termination, or expiration of the demonstration.

42-12.4-9. Demonstration implementation taskforce. -- (a) Purpose. The general assembly is committed to a public participatory process to implement Medicaid reform through the demonstration. To assure such a process, following final acceptance of the demonstration by the state, the executive office of health and human service and the department of human services shall establish a demonstration implementation taskforce. The taskforce shall work collaboratively with the executive office of health and human services and the department of human services to plan, design, and implement changes to the Medicaid program under the demonstration and to evaluate the impact of such changes and of the demonstration.

(b) Chair. The taskforce shall be co-chaired by a senior state official of EOHHS/DHS and a member of the community who is knowledgeable about the Medicaid program and the populations and services it funds in Rhode Island as well as with the provisions of the demonstration.

(c) Taskforce composition. There are distinct populations that receive services funded through the Medicaid program including: children and youth with special health care needs, adults and children with developmental disabilities, adults with serious and persistent mental illness and/or addiction disorders and children with severe emotional disturbance, adults with

disabilities, adults age sixty-five (65) and older and low-income children and families. It is the intent of the general assembly that the taskforce includes members who are knowledgeable about the needs of these populations and the services currently provided to them.

Members of the taskforce shall be appointed by director of the department of human services. The membership shall include: for each distinct population two (2) consumers or family members of consumers, one member of an advocacy organization and one member of a policy organization; a representative from organizations that either provide or represent entities that provide services to Medicaid beneficiaries including, but not limited to, health plans, hospitals community health centers, community mental health organizations, licensed substance abuse treatment providers, licensed health care practitioners, nursing facilities, and home and community-based service providers.

Total membership shall not exceed forty-five (45) individuals. The executive office of health and human services/department of human services shall provide necessary staff support to effectively operate the taskforce.

(d) Duration. The taskforce shall remain in effect so long as the demonstration is in effect.

(e) Meeting frequency and relationship to the permanent joint committee of the demonstration compact:

The taskforce shall meet no less than monthly and shall report on its activities to the permanent joint committee of the demonstration compact established pursuant to section 42-12.4-5. Permanent joint committee shall appoint a member to serve as a liaison to the taskforce.

SECTION 2. Section 40-8.4-19 of the General Laws in Chapter 40-8.4 entitled "Health Care For Families" is hereby amended to read as follows:

40-8.4-19. Managed health care delivery systems for families. -- (a) Notwithstanding any other provision of state law, the delivery and financing of the health care services provided under this chapter shall be provided through a system of managed care. "Managed care" is defined as systems that: integrate an efficient financing mechanism with quality service delivery; provide a "medical home" to assure appropriate care and deter unnecessary services; and place emphasis on preventive and primary care. ~~For the purposes of Medical Assistance, managed care systems are defined to include a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the department of human services, including standards pertaining to certification as an "advanced medical home".~~

(b) Enrollment in managed care health delivery systems is mandatory for individuals eligible for medical assistance under this chapter. This includes children in substitute care, children receiving Medical Assistance through an adoption subsidy, and children eligible for medical assistance based on their disability. Beneficiaries with third-party medical coverage or insurance may be exempt from mandatory managed care in accordance with rules and regulations promulgated by the department of human services for such purposes.

(c) Individuals who can afford to contribute shall share in the cost. - The department of human services is authorized and directed to apply for and obtain any necessary waivers and/or state plan amendments from the secretary of the U.S. 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 beneficiaries eligible under this chapter or chapter 12.3 of title 42, with incomes equal to or greater than ~~one hundred thirty-three percent (133%)~~ one hundred fifty percent (150%) of the federal poverty level, pay a share of the costs of health coverage based on the ability to pay. The department of human services shall implement this cost-sharing obligation by regulation, and shall consider co-payments, premium shares, or other reasonable means to do so in accordance with approved provisions of appropriate waivers and/or state plan amendments approved by the secretary of the United States department of health and human services.

~~(d) All children and families receiving Medical Assistance under title 40 of the Rhode~~

~~Island general laws shall also be subject to co-payments for certain medical services as approved in the waiver and/or the applicable state plan amendment, and in accordance with rules and regulations promulgated by the department.~~

~~(e) The department of human services may provide health benefits, similar to those available through commercial health plans, to parents or relative caretakers with an income above one hundred percent (100%) of the federal poverty level who are not receiving cash assistance under the Rhode Island Temporary Assistance to Needy Families (TANF program).~~

~~(f) The department of human services is authorized to create consumer directed health care accounts, including but not limited to health opportunity accounts or health savings accounts, in order to increase and encourage personal responsibility, wellness and healthy decision-making, disease management, and to provide tangible incentives for beneficiaries who meet designated wellness initiatives.~~

SECTION 3. Section 40-8.5-1.1 of the General Laws in Chapter 40-8.5 entitled "Health Care for Elderly and Disabled Residents Act" is hereby amended to read as follows:

40-8.5-1.1. Managed health care delivery systems. -- (a) To ensure that all medical assistance beneficiaries, including the elderly and all individuals with disabilities, have access to quality and affordable health care, the department of human services is authorized to implement mandatory managed care health systems.

(b) "Managed care" is defined as systems that: integrate an efficient financing mechanism with quality service delivery; provides a "medical home" to assure appropriate care and deter unnecessary services; and place emphasis on preventive and primary care. For purposes of Medical Assistance, managed care systems are also defined to include a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the department of human services. Those medical assistance recipients who have third-party medical coverage or insurance may be exempt from mandatory managed care in accordance with rules and regulations promulgated by the department of human services. The department is further authorized to redesign benefit packages for medical assistance beneficiaries subject to appropriate federal approval.

(c) The department is authorized to obtain any approval through waiver(s) and/or state plan amendments, from the secretary of the United States department of health and human services, that are necessary to implement mandatory managed health care delivery systems for all medical assistance recipients, including the primary case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the department of human services. The waiver(s) and/or state plan amendments shall include the authorization to exempt beneficiaries with third-party medical coverage or insurance from mandatory managed care in accordance with rules and regulations promulgated by the department of human services. ~~The department may also redesign benefit packages for medical assistance beneficiaries in accordance with rules and regulations promulgated by the department.~~

(d) To ensure the delivery of timely and appropriate services to persons who become eligible for Medicaid by virtue of their eligibility for a U.S. social security administration program, the department of human services is authorized to seek any and all data sharing agreements or other agreements with the social security administration as may be necessary to receive timely and accurate diagnostic data and clinical assessments. Such information shall be used exclusively for the purpose of service planning, and shall be held and exchanged in accordance with all applicable state and federal medical record confidentiality laws and regulations.

~~(e) The department of human services and/or the executive office of health and human services is authorized and directed to apply for and obtain any necessary waiver(s) and/or state plan amendments 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 law for the purpose~~

~~of administering and implementing the goals of the Medicaid Reform Act 2008 as described in section 42-7.2-16 of the Rhode Island general laws, specifically using competitive value-based purchasing to maximize the available service options and to promote accountability and transparency in the delivery of services for all Medical Assistance beneficiaries.~~

SECTION 4. Section 40-8-29 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is hereby amended to read as follows:

40-8-29. Selective contracting. -- ~~(a)~~ Notwithstanding any other provision of state law, the department of human services is authorized to utilize selective contracting with prior general assembly approval to assure that all service expenditures under this chapter have the maximum benefit of competition, and afford Rhode Islanders the overall best value, optimal quality, and the most cost-effective care possible. Beneficiaries will be limited to using the services/products of only those providers determined in a competitive bidding process to meet the standards for best quality, performance and price set by the department in accordance with applicable federal and state laws.

~~(b) Any approved medical assistance provider who declines to participate in contracting for benefits in any one of the department's medical assistance programs, including, but not limited to any and all managed care programs, may be suspended as a participating provider and denied participation in all state operated medical assistance programs at the discretion of the department.~~

(b) For purposes of this section "selective contracting" shall mean the process for choosing providers to serve Medicaid beneficiaries based on their ability to deliver the best quality products or services, at the best value or price.

SECTION 5. Chapter 40-8 of the General Laws entitled "Medical Assistance" is hereby amended by adding thereto the following section:

40-8-30. Suspension of participating providers. -- Any approved medical assistance provider who declines to participate in contracting for benefits in any one of the department's medical assistance programs, including, but not limited to, any and all managed care programs, may be suspended as a participating provider and denied participation in all state operated medical assistance programs at the discretion of the department. Prior to suspension, a participating provider shall have the right to appeal such suspension to a state administrative hearing officer, in accordance with the rules of the department of human services.

SECTION 6. Section 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical Assistance - Long-Term Care Service and Finance Reform" is hereby amended to read as follows:

40-8.9-9. Long-term care re-balancing system reform goal. -- (a) Notwithstanding any other provision of state law, the department of human services is authorized and directed to apply for and obtain any necessary waiver(s), waiver amendment(s) and/or state plan amendments from the secretary of the United States department of health and human services, and to promulgate rules necessary to adopt an affirmative plan of program design and implementation that addresses the goal of allocating a minimum of fifty percent (50%) of Medicaid long-term care funding for persons aged sixty-five (65) and over and adults with disabilities excluding services for persons with developmental disabilities to home and community-based care on or before December 31, ~~2012~~ 2013; provided, further, the executive office of health and human services shall report annually as part of its budget submission, the percentage distribution between institutional care and home and community-based care by population and shall report current and projected waiting lists for long-term care and home and community-based care services. The department is further authorized and directed to prioritize investments in home and community-based care and to maintain the integrity and financial viability of all current long-term care services while pursuing

this goal.

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

(c) Pursuant to federal authority procured under section 42-7.2-16 of the general laws, the department of human services is directed and authorized to adopt a tiered set of criteria to be used to determine eligibility for services. Such criteria shall be developed in collaboration with the state's health and human services departments and shall encompass eligibility determinations for services in nursing facilities, hospitals, and intermediate care facilities for the mentally retarded as well as home and community-based alternatives, and shall provide a common standard of income eligibility for both institutional and home and community-based care. The department is, subject to prior approval of the general assembly, authorized to adopt criteria for admission to a nursing facility, hospital, or intermediate care facility for the mentally retarded that are more stringent than those employed for access to home and community-based services. The department is also authorized to promulgate rules that define the frequency of re-assessments for services provided for under this section. Legislatively approved levels of care may be applied in accordance with the following:

(1) The department shall apply pre-waiver level of care criteria for any Medicaid recipient eligible for a nursing facility, hospital, or intermediate care facility for the mentally retarded as of June 30, 2009, unless the recipient transitions to home and community based services because he or she: (a) Improves to a level where he/she would no longer meet the pre-waiver level of care criteria; or (b) The individual chooses home and community based services over the nursing facility, hospital, or intermediate care facility for the mentally retarded. For the purposes of this section, a failed community placement, as defined in regulations promulgated by the department, shall be considered a condition of clinical eligibility for the highest level of care. The department shall confer with the long-term care ombudsperson with respect to the determination of a failed placement under the ombudsperson’s jurisdiction. Should any Medicaid recipient eligible for a nursing facility, hospital, or intermediate care facility for the mentally retarded as of June 30, 2009 receive a determination of a failed community placement, the recipient shall have access to the highest level of care; furthermore, a recipient who has experienced a failed community placement shall be transitioned back into his or her former nursing home, hospital, or intermediate care facility for the mentally retarded whenever possible. Additionally, residents shall only be moved from a nursing home, hospital, or intermediate care facility for the mentally retarded in a manner consistent with applicable state and federal laws.

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

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

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

(e) The department of human services is authorized to promulgate rules that permit certain optional services including, but not limited to, homemaker services, home modifications, respite, and physical therapy evaluations to be offered subject to availability of state-appropriated funding for these purposes.

(f) To promote the expansion of home and community-based service capacity, the department of human services is authorized and directed to pursue rate reform for homemaker, personal care (home health aide) and adult day care services, as follows:

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

(2) Development, not later than September 30, 2008, of certification standards supporting and defining targeted rate increments to encourage service specialization and scheduling accommodations including, but not limited to, medication and pain management, wound management, certified Alzheimer's Syndrome treatment and support programs, and shift differentials for night and week-end services; and

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

(h) The department of human services is also authorized, subject to availability of appropriation of funding, to pay for certain non-Medicaid reimbursable expenses necessary to transition residents back to the community; provided, however, payments shall not exceed an annual or per person amount.

(i) To assure the continued financial viability of nursing facilities, the department of human services is authorized and directed to develop a proposal for revisions to section 40-8-19 that reflect the changes in cost and resident acuity that result from implementation of this re-balancing goal. Said proposal shall be submitted to the governor and the general assembly on or before January 1, 2010.

SECTION 7. This act shall take effect upon passage.

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