



Governor's Commission on Disabilities
Executive Committee
Thursday, January 23, 2014 3:00 - 4:00 PM

John O. Pastore Center, 41 Cherry Dale Court,
 Cranston, RI 02920-3049
 (voice) 401-462-0100 (fax) 462-0106 (tty) via RI Relay 711
 (e-mail) GCD.Disabilities@gcd.ri.gov (website) www.disabilities.ri.gov



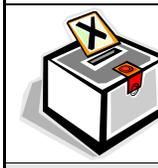
Attendees: Timothy Flynn (Chair.); Rosemary Carmody, (Vice Chair.); Casey Gartland; & Linda Ward
Absentees: Andrew Argenbright; Judi Drew; Jonathan Dupre; Sarah Everhart Skeels; Ronald McMinn; Jack Ringland; & Harvey Salvas;

Guests:
Staff: Bob Cooper, Executive Secretary



3:00 Call to Order and Acceptance of the Minutes, Timothy Flynn, Chair

Vice Chair called the meeting to order at 3:10 PM
 Introductions of Commissioners and guests



MOTION: To accept the minutes of the previous meeting as presented
 Motion moved by CG, seconded by LW, passed unanimously

Action Items:



3:05 Governor's Recommendations for the Commission FY 2014 Revised & FY 2015 Budget, Bob Cooper, Executive Secretary

Purpose/Goal: To review the Governor's Recommended Budget for the Commission and make recommendations for action by the Commission

The following is copied from the Fiscal Year 2015 [Executive Summary](#)
 The Governor recommends revised expenditures of \$1.5 million for FY 2014 for the Governor's Commission on Disabilities. This consists of \$356,352 in general revenue, \$156,330 in federal funds, \$15,930 in restricted receipts, and \$957,000 in Rhode Island Capital Plan Fund resources. Of the all funds increase of \$30,276 above the FY 2014 enacted level, general revenues decrease by \$1,359, attributable to statewide changes relating to health insurance savings; federal funds increase by \$26,341; restricted receipts increase by \$5,565; and Rhode Island Capital Plan Fund resources decrease by \$271.
 The Governor recommends total expenditures of \$1.5 million in FY 2015, including \$358,275 in general revenue, \$141,350 in federal funds, \$9,177 in restricted receipts, and \$1.0 million in Rhode Island Capital Plan Fund resources. Compared to the FY 2014 enacted budget, general revenue increase by \$564; federal funds increase by \$11,361; restricted receipts decrease by \$1,188; and Rhode Island Capital Plan Fund resources increase by \$42,729.
 The recommended FTE position authorization for revised FY 2014 and FY 2015 is 4.0 FTE positions, consistent with the FY 2014 enacted level.

Operating: Changes: 1. wages decreased **(\$2)** in both years; 2. benefits decreased **(\$1,357)** in FY 14 and **(\$1,280)** FY 15; 3. postage decreased **(\$90)** in FY 15 and 4. moving **(\$300)** in FY 15

RICAP accounts merged, per General Assembly, construction decreased **(\$50,271)** in FY 14 & increased **\$56,026** in FY 15.

Account	2012	2013	2014				2015				
	Audited	Audited	Enacted	GCD Request	Budget Rec.	Governor's Rec.	GCD-Gov	GCD Request	Budget Rec.	Governor's Rec.	GCD-Gov
Operations	\$359,572	\$314,102	\$333,428	\$328,095	\$327,077	\$326,736	(\$1,359)	\$329,423	\$328,464	\$328,056	(\$1,367)
Fellowship	\$10,350	\$13,026	\$14,718	\$14,718	\$14,718	\$14,718	\$0	\$14,718	\$14,718	\$14,718	\$0
DBE	\$11,242	\$10,299	\$9,565	\$14,898	\$14,898	\$14,898	\$0	\$15,501	\$15,501	\$15,501	\$0
General Revenue	\$381,164	\$337,427	\$357,711	\$357,711	\$356,693	\$356,352	(\$1,359)	\$359,642	\$358,683	\$358,275	(\$1,367)
NE ADA	\$6,638	\$5,217	\$25,616	\$28,865	\$28,865	\$28,865	\$0	\$26,797	\$26,797	\$26,797	\$0
HAVA Grant	\$64,349	\$96,676	\$104,373	\$127,465	\$127,465	\$127,465	\$0	\$114,553	\$114,553	\$114,553	\$0
Federal Funds	\$70,987	\$101,893	\$129,989	\$156,330	\$156,330	\$156,330	\$0	\$141,350	\$141,350	\$141,350	\$0
Donations	\$7,442	\$5,217	\$10,365	\$15,930	\$15,930	\$15,930	\$0	\$9,177	\$9,177	\$9,177	\$0
Restricted Receipts	\$7,442	\$5,217	\$10,365	\$15,930	\$15,930	\$15,930	\$0	\$9,177	\$9,177	\$9,177	\$0
Handicapped Accessibility	\$138,378	\$2,820	\$0	\$0	\$957,271	\$957,000	\$957,000	\$0	\$837,361	\$1,000,000	\$1,000,000
Accessibility to Disability Service Providers	\$0	\$0	\$247,938	\$297,938	\$0	\$0	(\$297,938)	\$234,641	\$0	\$0	(\$234,641)
Accessibility Fire Safety Renovations	\$0	\$0	\$115,833	\$115,833	\$0	\$0	(\$115,833)	\$115,833	\$0	\$0	(\$115,833)
Accessibility to Higher Education	\$0	\$0	\$593,500	\$593,500	\$0	\$0	(\$593,500)	\$593,500	\$0	\$0	(\$593,500)
RICAP	\$138,378	\$2,820	\$957,271	\$1,007,271	\$957,271	\$957,000	(\$50,271)	\$943,974	\$837,361	\$1,000,000	\$56,026
Grand Total	\$597,971	\$447,357	\$1,455,336	\$1,537,242	\$1,486,224	\$1,485,612	(\$51,630)	\$1,454,143	\$1,346,571	\$1,508,802	\$54,659



MOTION: To recommend the Commission accept the Governor's Budget Recommendations for the Commission's FY 2014 Revised and FY 2015 Budget Allocations
 Motion moved by LW, seconded by CG passed unanimously



***3:30 Commission's Position on Budget Articles, Linda Ward, Chair
Legislation Committee***

Purpose/Goal: To make recommendations to the General Assembly and Governor on the impact of legislation on people with disabilities and their families

14 H 7133 Art. 25 AN ARTICLE RELATING TO MEDICAL ASSISTANCE

14 H 7133 Art. 25 AN ARTICLE RELATING TO MEDICAL ASSISTANCE

Sponsor Rep. Melo Requested by the Governor

This article would amend:

- (1) The "Rhode Island Works Program", by providing Medicaid-funded health coverage through the RItE Care managed care or a RItE Share approved plan. If a family becomes ineligible for cash assistance payments as a result of excess earnings from employment, the family/assistance unit shall continue to be eligible for medical assistance Medicaid-funded transitional health coverage under Section 1925 of title XIX of the federal social security act.
- (2) The rate methodology for payment for in state and out of state hospital services by extending the 12 month freeze for an additional 12 months until July 1, 2015.
- (3) The rates of payment to nursing facilities would also be frozen until October 1, 2015.
- (4) The Rhode Island Medicaid Reform Act of 2008:
 - (a) Nursing Facility Payment Rates – Eliminate Rate Increase that would otherwise take effect during the state fiscal year 2015;
 - (b) Medicaid Hospital Payments – Eliminate Rate Increases for Hospital Inpatient and Outpatient Payments and reduce inpatient and outpatient hospital payments by eliminating the projected rate increase for both managed care and fee-for-service for state fiscal year 2015. Also, eliminates the upper payment limit payment for outpatient services for this same period.
 - (c) Medicaid Manage Care Payments- Reduction of the projected growth in capitation payments to managed care organizations.
 - (d) High Cost Care Review and Interventions – Lower Utilization and Cost, implementing an array of interventions providing intensive services and case management for Medicaid beneficiaries with chronic and disabling conditions and special health care needs, in order to reduce utilization of high cost services by certain children enrolled in RItE Care, children with special health care needs, and elders and adults with disabilities.
 - (e) Community First Choice (1915k) Option – Increase Federal Reimbursement for Home and Community-Based Alternatives, pursue the Community First Choice (CFC) Medicaid State Plan option as part of ongoing reforms to promote home and community-based alternatives to institutionally-based long-term services and supports.
 - (f) Qualified Health Plan (QHP) Coverage for Medicaid-eligible Pregnant and Post-Partum Women – Promote QHP Coverage. Many pregnant women with income from 133 to 250 percent of the federal poverty level (FPL) will have access to coverage through a commercial plan. This initiative proposes to support enrollment/retention of coverage in these commercial plans by providing:
 - (i) a RItE Share-like premium subsidy to assist in paying for the out-of-pocket costs in a commercial plan; and
 - (ii) wraparound coverage for services available if covered through Medicaid.
 - (g) Extended Family Planning Services – Enhanced federal funds, to provide enhanced Medicaid matching funds for family planning for uninsured and underinsured people with income up to 250 percent of the federal poverty level.
 - (h) Katie Beckett Eligibility Coverage – Cost Contribution, to implement an income-based, cost-sharing requirement for families with a Katie Beckett eligible child.
 - (i) Approved Authorities: Section 1115 Waiver Demonstration Extension request – formerly known as the Global Consumer Choice Waiver – that
 - (i) continue efforts to re-balance the system of long term services and supports by assisting people in obtaining care in the most appropriate and least restrictive setting;
 - (ii) pursue utilization of care management models that offer a "health home", promote access to preventive care, and provide an integrated system of services;

(iii) use payments and purchasing to finance and support Medicaid initiatives that fill gaps in the integrated system of care; and
(iv) recognize and assure access to the non-medical services and supports, such as peer navigation and employment and housing stabilization services, that are essential for optimizing a person's health, wellness and safety and reduce or delay the need for long-term services and supports.
(j) Medicaid Requirements and Opportunities under the U.S. Patient Protection and Affordable Care Act of 2010 (PPACA).

ARTICLE 25

RELATING TO MEDICAL ASSISTANCE

SECTION 1. Section 40-5.2-21 of the General Laws in Chapter 40-5.2 entitled "The Rhode Island Works Program" is hereby amended to read as follows:

40-5.2-21. Eligibility for medical benefits. -- (a) Every member of any family/assistance unit eligible for cash assistance under this chapter shall be eligible for ~~medical assistance~~ ^{add} Medicaid-funded health coverage ^{add} through the RIte Care ^{add} managed care ^{add} or a RIte Share ~~programs, as determined by the~~ ^{delete} ~~department,~~ ^{delete} ^{add} approved plan ^{add} subject to the provisions of subsection 40-8-1 ~~(d)~~ ^{delete} ~~(c)~~ ^{delete} ^{add} and provided, further, ^{delete} ^{add} requiring that ^{delete} ^{add} eligibility for ^{delete} ^{add} such ~~medical assistance,~~ ^{delete} ^{add} coverage ^{add} must qualify for federal financial participation pursuant to the provisions of Title XIX of the federal social security act, 42 U.S.C. § 1396 et seq. ^{add} and, as may be appropriate, the State's approved Section 1115 demonstration waiver ^{add}.

(b) If a family becomes ineligible for cash assistance payments under this chapter as a result of excess earnings from employment, the family/assistance unit shall continue to be eligible for ~~medical assistance~~ ^{delete} ^{add} Medicaid-funded transitional health coverage under Section 1925 of title XIX of the federal social security act, 42 U.S.C. § 1396 et seq. ^{add} through ~~the~~ ^{delete} ^{add} RIte Care or RIte Share, ~~program for~~ ^{delete} ^{add} subject to the provisions of subsection 40-8-1(c) requiring that such coverage must qualify for federal financial participation pursuant to the provisions of title XIX of the federal social security act, 42 U.S.C. § 1396 et seq. and, in no case, shall extend beyond ^{add} a period of twelve (12) months or until employer paid family health care coverage begins ^{delete}, ~~subject to the provisions of subsection 40-8-1(d), whichever occurs first; and provided, further, that eligibility for such medical assistance, must qualify for federal financial participation pursuant to the provisions of title XIX of the federal social security Act, 42 U.S.C. § 1396 et seq.~~ ^{delete}

SECTION 2. Sections 40-8-13.4 and 40-8-19 of the General Laws in Chapter 40-8 entitled "Medical Assistance" are hereby amended to read as follows:

40-8-13.4. Rate methodology for payment for in state and out of state hospital services. -- (a) The executive office of health and human services 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 of health and human services shall:

(1) 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 which 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 Diagnosis Related Groups 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 Center for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index.

(B) With respect to inpatient services, (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 ninety and one tenth percent (90.1%) of the rate in effect as of June 30, 2010. Negotiated increases in inpatient hospital payments for each annual twelve (12) month 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; (ii) provided, however, for the ~~twelve (12)~~ ^{delete} ^{add} twenty-four (24) ^{add} month 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; (iii) negotiated increases in inpatient hospital payments for each

1 annual twelve (12) month period beginning July 1, ~~2014~~ ^{add}2015^{add} may not exceed the Centers for
2 Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index,
3 less Productivity Adjustment, for the applicable period; (iv) The Rhode Island executive office of health and
4 human services will develop an audit methodology and process to assure that savings associated with the payment
5 reductions will accrue directly to the Rhode Island Medicaid program through reduced managed care plan
6 payments and shall not be retained by the managed care plans; (v) All hospitals licensed in Rhode Island shall
7 accept such payment rates as payment in full; and (vi) for all such hospitals, compliance with the provisions of this
8 section shall be a condition of participation in the Rhode Island Medicaid program.

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

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

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

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

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

48 (g) The provisions of this section shall be effective upon implementation of the amendments and new
49 payment methodology pursuant to this section and § 40-8-13.3, which shall in any event be no later than March 30,
50 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
51 entirety.

52 **40-8-19. Rates of payment to nursing facilities.** -- (a) Rate reform. (1) The rates to be paid by the state to
53 nursing facilities licensed pursuant to chapter 17 of title 23, and certified to participate in the Title XIX Medicaid
54 program for services rendered to Medicaid-eligible residents, shall be reasonable and adequate to meet the costs

1 which must be incurred by efficiently and economically operated facilities in accordance with 42 U.S.C. §
2 1396a(a)(13). The executive office of health and human services shall promulgate or modify the principles of
3 reimbursement for nursing facilities in effect as of July 1, 2011 to be consistent with the provisions of this section
4 and Title XIX, 42 U.S.C. § 1396 et seq., of the Social Security Act.

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

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

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

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

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

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

17 (vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be applied
18 on October 1st of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013 ^{add}or
19 on October 1, 2014^{add}, but will resume on October 1, ~~{delete}2014{delete}~~ ^{add}2015^{add}. Said inflation index shall be
20 applied without regard for the transition factor in subsection (b)(2) below.

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

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

27 (2) No facility shall lose or gain more than five dollars (\$5.00) in its total per diem rate the first year of the
28 transition. The adjustment to the per diem loss or gain may be phased out by twenty-five percent (25%) each year;
29 and

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

33 SECTION 3. The Rhode Island Medicaid Reform Act of 2008.

34 ^{add}WHEREAS, the General Assembly enacted Chapter 12.4 of Title 42 entitled "The Rhode Island
35 Medicaid Reform Act of 2008"; and

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

38 WHEREAS, Rhode Island General Law § 42-12.4-7 provides that any change that requires the
39 implementation of a rule or regulation or modification of a rule or regulation in existence prior to the
40 implementation of the global consumer choice section 1115 demonstration ("the demonstration") shall require prior
41 approval of the general assembly; and further provides that any category II change or category III change as
42 defined in the demonstration shall also require prior approval by the general assembly; and

43 WHEREAS, Rhode Island General Law § 42-7.2-5 provides that the Secretary of the Office of Health and
44 Human Services is responsible for the "review and coordination of any Global Consumer Choice Compact Waiver
45 requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or
46 category II or III changes as described in the demonstration, with "the potential to affect the scope, amount, or
47 duration of publicly-funded health care services, provider payments or reimbursements, or access to or the
48 availability of benefits and services provided by Rhode Island general and public laws"; and

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

52 (a) *Nursing Facility Payment Rates – Eliminate Rate Increase.* The Medicaid single state agency proposes
53 to eliminate the projected nursing facility rate increase that would otherwise take effect during the state fiscal year
54 2015. A category II change is required to implement this proposal under the terms and conditions of the

1 demonstration. Further, this change may also require the adoption of new or amended rules, regulations and
2 procedures.

3 (b) *Medicaid Hospital Payments – Eliminate Rate Increases for Hospital Inpatient and Outpatient*
4 *Payments.* The Medicaid single state agency proposes to reduce inpatient and outpatient hospital payments by
5 eliminating the projected rate increase for both managed care and fee-for-service for state fiscal year 2015. Also,
6 the Medicaid single state agency proposes to eliminate the upper payment limit payment for outpatient services for
7 this same period. A category II change is required to implement both aspects of this proposal under the terms and
8 conditions of the Section 1115 waiver demonstration.

9 (c) *Medicaid Manage Care Payments- Reduction.* The Medicaid agency seeks to reduce the projected
10 growth in capitation payments to managed care organizations for SFY 2015. Implementation of this reduction
11 requires a Category II change under the terms and conditions of the Medicaid demonstration to assure payment
12 rates remain actuarially sound as is required by federal laws and regulation.

13 (d) *High Cost Care Review and Interventions – Lower Utilization and Cost.* By implementing an array of
14 interventions providing intensive services and case management for Medicaid beneficiaries with chronic and
15 disabling conditions and special health care needs, the Medicaid Agency proposes to reduce utilization of high cost
16 services by certain children enrolled in RIte Care, children with special health care needs, and elders and adults
17 with disabilities. Implementation of these interventions may require category II changes to the demonstration as
18 well as adoption or amendment of rules, regulations and procedures.

19 (e) *Community First Choice (1915k) Option – Increase Federal Reimbursement for Home and Community-*
20 *Based Alternatives.* The Medicaid Agency proposed to pursue the Community First Choice (CFC) Medicaid State
21 Plan option as part of ongoing reforms to promote home and community-based alternatives to institutionally-based
22 long-term services and supports. Implementation of the CFC option requires approval of a Medicaid State Plan
23 Amendments and may require changes to the demonstration. New and amended rules, regulations and procedures
24 may also be necessary related to these program changes.

25 (f) *Qualified Health Plan (OHP) Coverage for Medicaid-eligible Pregnant and Post-Partum Women –*
26 *Promote OHP Coverage.* With the implementation of health care reform in Rhode Island, many pregnant women
27 with income from 133 to 250 percent of the federal poverty level (FPL) will have access to coverage through a
28 commercial plan. This initiative proposes to support enrollment/retention of coverage in these commercial plans by
29 providing: 1) a RIte Share-like premium subsidy to assist in paying for the out-of-pocket costs in a commercial
30 plan; and 2) wraparound coverage for services available if covered through Medicaid. Such an arrangement would
31 result in a net savings to the Medicaid program. Implementation of this initiative requires Section 1115 waiver
32 authority and may necessitate changes to EOHHS' rules, regulations and procedures.

33 (g) *Extended Family Planning Services – Enhanced federal funds.* The Medicaid agency sought Section
34 1115 demonstration waiver authority for any services and supports that are administered under current Rhode
35 Island general laws to maximize Medicaid federal matching funds. This authority would provide enhanced
36 Medicaid matching funds for family planning for uninsured and underinsured people with income up to 250
37 percent of the federal poverty level. The adoption of new or amended rules and regulations may also be required.

38 (h) *Katie Beckett Eligibility Coverage – Cost Contribution.* Under current Medicaid rules and regulations,
39 Medicaid beneficiaries receiving long-term services and supports are required to contribute to the cost of care
40 based on income to the extent feasible. The Katie Beckett State Plan Option allows children who need an
41 institutional level of care to obtain Medicaid coverage for the care they receive at home. Children eligible under
42 this option typically have family income and resources that exceed Medicaid eligibility limits; though the Katie
43 Beckett option enables these children to obtain Medicaid coverage by excluding their parents' family income and
44 resources when determining Medicaid eligibility. At present, the families of Katie Beckett children are not required
45 to contribute to the cost of Medicaid-funded care, irrespective of income. The Medicaid agency proposes to
46 implement an income-based, cost-sharing requirement for families with a Katie Beckett eligible child.
47 Implementation of this requirement requires a Category II change to the Section 1115 waiver and new and
48 amended rules, regulations and procedures.

49 (i) *Approved Authorities: Section 1115 Waiver Demonstration Extension.* The Medicaid agency proposes
50 to implement authorities approved under the Section 1115 waiver demonstration extension request – formerly
51 known as the Global Consumer Choice Waiver – that (1) continue efforts to re-balance the system of long term
52 services and supports by assisting people in obtaining care in the most appropriate and least restrictive setting; (2)
53 pursue utilization of care management models that offer a "health home", promote access to preventive care, and
54 provide an integrated system of services; (3) use payments and purchasing to finance and support Medicaid

1 [initiatives that fill gaps in the integrated system of care; and \(4\) recognize and assure access to the non-medical](#)
2 [services and supports, such as peer navigation and employment and housing stabilization services, that are essential](#)
3 [for optimizing a person's health, wellness and safety and reduce or delay the need for long term services and](#)
4 [supports.](#)

5 [\(j\) Medicaid Requirements and Opportunities under the U.S. Patient Protection and Affordable Care Act](#)
6 [of 2010 \(PPACA\). The Medicaid agency proposes to pursue any requirements and/or opportunities established](#)
7 [under the PPACA that may warrant a Medicaid State Plan Amendment, category II or III change under the terms](#)
8 [and conditions of Rhode Island's Section 1115 Waiver, its successor, or any extension thereof. Any such actions](#)
9 [the Medicaid agency takes shall not have an adverse impact on beneficiaries or cause there to be an increase in](#)
10 [expenditures beyond the amount appropriated for state fiscal year 2014; now, therefore, be it](#)

11 [RESOLVED, that the general assembly hereby approves proposals \(a\) through \(j\) listed above to amend](#)
12 [the Section 1115 demonstration waiver; and be it further](#)

13 [RESOLVED, that the secretary of the office of health and human services is authorized to pursue and](#)
14 [implement any waiver amendments, category II or category III changes, state plan amendments and/or changes to](#)
15 [the applicable department's rules, regulations and procedures approved herein and as authorized by § 42-12.4-7^{\(add\)}.](#)

16 SECTION 4. This article shall take effect upon passage.

	<p>Motion: To recommend the Commission take a position on 14 H 7133 Article 25 An Article Relating to Medical Assistance, sections: (d) High Cost Care Review and Interventions - Lower Utilization and Cost; (f) Qualified Health Plan (QHP) Coverage for Medicaid-eligible Pregnant and Post-Partum Women - Promote QHP Coverage; (h) Katie Beckett Eligibility Coverage - Cost Contribution; and (i) Approved Authorities: Section 1115 Waiver Demonstration Extension, Staff directed to get additional information on reasons for other changes and what are the administrative cost. Motion moved by CG seconded by LW, passed unanimously</p>
	<p>14 H 7133 Art. 26 AN ARTICLE RELATING TO CHILDREN, YOUTH, AND FAMILIES</p>
<p>This article would authorize the department of children, youth, and families, in the case of a person aged 19 years or older with a "functional developmental disability", who is receiving services under this section may, at the discretion of the director, to be transferred to the developmental disabilities program of the department of behavioral healthcare, developmental disabilities and hospitals, provided that he or she qualifies as eligible for services through the department of behavioral healthcare, developmental disabilities and hospitals. This article shall take effect upon passage.</p>	

1 **ARTICLE 26**

2 **RELATING TO CHILDREN, YOUTH, AND FAMILIES**

3 SECTION 1. Section 42-72-5 of the General Laws in Chapter 42-72 entitled "Department of Children,
4 Youth, and Families" is hereby amended to read as follows:

5 **42-72-5. Powers and scope of activities.** -- (a) The department is the principal agency of the state to
6 mobilize the human, physical and financial resources available to plan, develop, and evaluate a comprehensive and
7 integrated statewide program of services designed to ensure the opportunity for children to reach their full
8 potential. The services include prevention, early intervention, out-reach, placement, care and treatment, and after-
9 care programs; provided, however, that the department notifies the state police and cooperates with local police
10 departments when it receives and/or investigates a complaint of sexual assault on a minor and concludes that
11 probable cause exists to support the allegations(s). The department also serves as an advocate for the needs of
12 children.

13 (b) To accomplish the purposes and duties, as set forth in this chapter, the director is authorized and
14 empowered:

- 1 (1) To establish those administrative and operational divisions of the department that the director
2 determines is in the best interests of fulfilling the purposes and duties of this chapter;
- 3 (2) To assign different tasks to staff members that the director determines best suit the purposes of this
4 chapter;
- 5 (3) To establish plans and facilities for emergency treatment, relocation and physical custody of abused or
6 neglected children which may include, but are not limited to, homemaker/educator child case aides, specialized
7 foster family programs, day care facilities, crisis teams, emergency parents, group homes for teenage parents,
8 family centers within existing community agencies, and counseling services;
- 9 (4) To establish, monitor, and evaluate protective services for children including, but not limited to,
10 purchase of services from private agencies and establishment of a policy and procedure manual to standardize
11 protective services;
- 12 (5) To plan and initiate primary and secondary treatment programs for abused and neglected children;
- 13 (6) To evaluate the services of the department and to conduct periodic comprehensive needs assessment;
- 14 (7) To license, approve, monitor, and evaluate all residential and non-residential child care institutions,
15 group homes, foster homes, and programs;
- 16 (8) To recruit and coordinate community resources, public and private;
- 17 (9) To promulgate rules and regulations concerning the confidentiality, disclosure and expungement of
18 case records pertaining to matters under the jurisdiction of the department;
- 19 (10) To establish a minimum mandatory level of twenty (20) hours of training per year and provide
20 ongoing staff development for all staff; provided, however, all social workers hired after June 15, 1991, within the
21 department shall have a minimum of a bachelor's degree in social work or a closely related field, and must be
22 appointed from a valid civil service list;
- 23 (11) To establish procedures for reporting suspected child abuse and neglect pursuant to chapter 11 of title
24 40;
- 25 (12) To promulgate all rules and regulations necessary for the execution of departmental powers pursuant
26 to the Administrative Procedures Act, chapter 35 of title 42;
- 27 (13) To provide and act as a clearinghouse for information, data and other materials relative to children;
- 28 (14) To initiate and carry out studies and analysis which will aid in solving local, regional and statewide
29 problems concerning children;
- 30 (15) To represent and act on behalf of the state in connection with federal grant programs applicable to
31 programs for children in the functional areas described in this chapter;
- 32 (16) To seek, accept, and otherwise take advantage of all federal aid available to the department, and to
33 assist other agencies of the state, local agencies, and community groups in taking advantage of all federal grants
34 and subventions available for children;
- 35 (17) To review and coordinate those activities of agencies of the state and of any political subdivision of
36 the state which affect the full and fair utilization of community resources for programs for children, and initiate
37 programs that will help assure utilization;
- 38 (18) To administer the pilot juvenile restitution program, including the overseeing and coordinating of all
39 local community based restitution programs, and the establishment of procedures for the processing of payments to
40 children performing community service; and
- 41 (19) To adopt rules and regulations which:
42 (i) For the twelve (12) month period beginning on October 1, 1983, and for each subsequent twelve (12)
43 month period, establish specific goals as to the maximum number of children who will remain in foster care for a
44 period in excess of two (2) years; and
45 (ii) Are reasonably necessary to implement the child welfare services and foster care programs;
- 46 (20) May establish and conduct seminars for the purpose of educating children regarding sexual abuse;
- 47 (21) To establish fee schedules by regulations for the processing of requests from adoption placement
48 agencies for adoption studies, adoption study updates, and supervision related to interstate and international
49 adoptions. The fee shall equal the actual cost of the service(s) rendered, but in no event shall the fee exceed two
50 thousand dollars (\$2,000);
- 51 (22) To be responsible for the education of all children who are placed, assigned, or otherwise
52 accommodated for residence by the department in a state operated or supported community residence licensed by a
53 Rhode Island state agency. In fulfilling this responsibility the department is authorized to enroll and pay for the
54 education of students in the public schools or, when necessary and appropriate, to itself provide education in

1 accordance with the regulations of the board of regents for elementary and secondary education either directly or
2 through contract;

3 (23) To develop multidisciplinary service plans, in conjunction with the department of health, at hospitals
4 prior to the discharge of any drug-exposed babies. The plan requires the development of a plan using all health care
5 professionals.

6 (24) To be responsible for the delivery of appropriate mental health services to seriously emotionally
7 disturbed children and children with functional developmental disabilities. Appropriate mental health services may
8 include hospitalization, placement in a residential treatment facility, or treatment in a community based setting.
9 The department is charged with the responsibility for developing the public policy and programs related to the
10 needs of seriously emotionally disturbed children and children with functional developmental disabilities.

11 In fulfilling its responsibilities the department shall:

12 (i) Plan a diversified and comprehensive network of programs and services to meet the needs of seriously
13 emotionally disturbed children and children with functional developmental disabilities;

14 (ii) Provide the overall management and supervision of the state program for seriously emotionally
15 disturbed children and children with functional developmental disabilities;

16 (iii) Promote the development of programs for preventing and controlling emotional or behavioral
17 disorders in children;

18 (iv) Coordinate the efforts of several state departments and agencies to meet the needs of seriously
19 emotionally disturbed children and children with functional developmental disabilities and to work with private
20 agencies serving those children;

21 (v) Promote the development of new resources for program implementation in providing services to
22 seriously emotionally disturbed children and children with functional developmental disabilities.

23 The department shall adopt rules and regulations, which are reasonably necessary to implement a program
24 of mental health services for seriously emotionally disturbed children.

25 Each community, as defined in chapter 7 of title 16, shall contribute to the department, at least in
26 accordance with rules and regulations to be adopted by the department, at least its average per pupil cost for special
27 education for the year in which placement commences, as its share of the cost of educational services furnished to a
28 seriously emotionally disturbed child pursuant to this section in a residential treatment program which includes the
29 delivery of educational services.

30 "Seriously emotionally disturbed child" means any person under the age of eighteen (18) years or any
31 person under the age of twenty-one (21) years who began to receive services from the department prior to attaining
32 eighteen (18) years of age and has continuously received those services thereafter who has been diagnosed as
33 having an emotional, behavioral or mental disorder under the current edition of the Diagnostic and Statistical
34 Manual and that disability has been on-going for one year or more or has the potential of being ongoing for one
35 year or more, and the child is in need of multi-agency intervention, and the child is in an out-of-home placement or
36 is at risk of placement because of the disability.

37 A child with a "functional developmental disability" means any person under the age of eighteen (18)
38 years, or any person under the age of twenty-one (21) years who began to receive services from the department
39 prior to attaining eighteen (18) years of age and has continuously received those services thereafter.

40 The term "functional developmental disability" includes autism spectrum disorders and means a severe,
41 chronic disability of a person which:

42 (a) Is attributable to a mental or physical impairment or combination of mental physical impairments;

43 (b) Is manifested before the person attains age eighteen (18);

44 (c) Is likely to continue indefinitely;

45 (d) Results in age- appropriate substantial functional limitations in three (3) or more of the following areas
46 of major life activity.

47 (i) Self-care;

48 (ii) Receptive and expressive language;

49 (iii) Learning;

50 (iv) Mobility;

51 (v) Self-direction;

52 (vi) Capacity for Independent Living; and

53 (vii) Economic self-sufficiency; and

1 (e) Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care,
2 treatment, or other services which are of life-long or extended duration and are individually planned and
3 coordinated.

4 Funding for these clients shall include funds that are transferred to the Department of Human Services as
5 part of the Managed Health Care program transfer. However, the expenditures relating to these clients shall not be
6 part of the Department of Human Services' Caseload estimated for the semi-annual Caseload Estimating
7 Conference. The expenditures shall be accounted for separately.

8 (25) To provide access to services to any person under the age of eighteen (18) years or any person under
9 the age of twenty-one (21) years who began to receive child welfare services from the department prior to attaining
10 eighteen (18) years of age, has continuously received those services and elects to continue to receive such services
11 after attaining the age of eighteen (18) years. The assembly has included funding in the FY 2008 Department of
12 Children, Youth and Families budget in the amount of \$10.5 million from all sources of funds and \$6.0 million
13 from general revenues to provide a managed system to care for children serviced between 18 to 21 years of age.
14 The department shall manage this caseload to this level of funding.

15 (26) To develop and maintain, in collaboration with other state and private agencies, a comprehensive
16 continuum of care in this state for children in the care and custody of the department or at risk of being in state
17 care. This continuum of care should be family-centered and community-based with the focus of maintaining
18 children safely within their families or, when a child cannot live at home, within as close proximity to home as
19 possible based on the needs of the child and resource availability. The continuum should include community-based
20 prevention, family support and crisis intervention services as well as a full array of foster care and residential
21 services, including residential services designed to meet the needs of children who are seriously emotionally
22 disturbed, children who have a functional developmental disability and youth who have juvenile justice issues. The
23 director shall make reasonable efforts to provide a comprehensive continuum of care for children in the care and
24 custody of the DCYF, taking into account the availability of public and private resources and financial
25 appropriations and the director shall submit an annual report to the general assembly as to the status of his or her
26 efforts in accordance with the provisions of subsection 42-72-4(b)(13).

27 (27) To administer funds under the John H. Chafee Foster Care Independence and Educational And
28 Training Voucher (ETV) Programs of Title IV-E of the Social Security Act, and the DCYF Higher Education
29 Opportunity Grant Program as outlined in RIGL § 42-72.8, in accordance with rules and regulations as
30 promulgated by the director of the department.

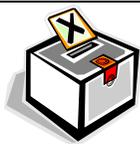
31 (c) In order to assist in the discharge of his or her duties, the director may request from any agency of the
32 state information pertinent to the affairs and problems of children.

33 (d) [Deleted by P.L. 2008, ch. 9, art. 16, § 2.]

34 (e) [Deleted by P.L. 2008, ch. 9, art. 16, § 2.]

35 ^{add}(f) Notwithstanding the provisions of subsections 42-72-5 (b)(24) and 42-72-5(b)(25), a person aged 19
36 years or older with a "functional developmental disability", as defined in subsection 42-72-5 (b)(24), who is
37 receiving services under this section may, at the discretion of the director, be transferred to the developmental
38 disabilities program of the department of behavioral healthcare, developmental disabilities and hospitals, provided
39 that he or she qualifies as eligible for services under § 40.1-1-8.1 through the department of behavioral healthcare,
40 developmental disabilities and hospitals.^{add}

41 SECTION 2. This article shall take effect upon passage.



Motion: To recommend the Commission take a position on 14 H 7133
Article 26 An Article Relating to Children, Youth, and Families, it should
be amended to include non-DCYF high school graduates and young
adults with behavioral health care needs. Staff directed to get additional
information on reasons for other changes and what are the costs.
Motion moved by CG, seconded by LW, passed/unanimously



3:55 Agenda for the Next Meeting, Timothy Flynn

Purpose/Goal: To set the agenda for the next meeting.

Discussion:

	Staff should continue recruiting applicants for the spring fellowships, Committee will meet at the call of the Chair.
	MOTION: To adjourn at 4:01 PM Motion moved by LW, seconded by RC, passed unanimously