



Governor's Commission on Disabilities'

Executive & Legislation Committees

Monday April 6, 2009 4 – 5:30 PM

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Attendees: Executive	Timothy Flynn (Vice Chair.); Rosemary Carmody; Kate McCarthy-Barnett; & Patricia Ryherd
Legislation	Timothy Flynn (Chair.); Kate McCarthy-Barnett (Vice Chair.); Jeanne Behie; Sharon Brinkworth; Rosemary C. Carmody; Linda Deschenes; Elaina Goldstein; William R. Inlow; Laura Jones; & Gwendolyn Reeve
Absent: Executive	Judi Drew; Bill Nieranowski; Lorna Ricci; & John Treat
Legislation	Liberty Goodwin; Ronald McMinn; Paula Parker; Arthur M. Plitt; Rev. Gerard O. Sabourin; Janet Spinelli; & Linda Ward

----- Minutes -----

Call to Order and Acceptance of the Minutes	Tim Flynn Chairperson	5 min.
Introductions: Chair calls the meeting to order at 4:04 PM. Members introduce themselves		
Action Items:	Discussion Leader:	Time:
Consideration of FY 2010 Budget Articles	Bob Cooper, Executive Sec.	80 min.
<p>Discussion: 09 H 5983 Article 15 Relating to Pharmaceutical Assistance to the Elderly This article would abolish the Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE) program effective January 1, 2010 by repealing chapter 42-66.2 in its entirety. Related general revenue cost savings for FY 2010 are \$1.1 million for both direct and indirect service costs. House Finance Committee Hearing 4/8/2009 @ Noon in rm 35</p>		

1-1 **ARTICLE 15**
 1-2 **RELATING TO PHARMACEUTICAL ASSISTANCE TO THE ELDERLY**
 1-3 SECTION 1. Chapter 42-66.2 of the Rhode Island General Laws entitled
 1-4 "Pharmaceutical Assistance to the Elderly Act" is hereby repealed in its entirety:
 1-5 ~~§ 42-66.2-1. Short title.— This chapter shall be known and cited as the "Pharmaceutical~~
 1-6 ~~Assistance to the Elderly Act".~~
 1-7 ~~§ 42-66.2-2. Program established.— There is established a program for pharmaceutical~~
 1-8 ~~assistance to the elderly. This program is limited to eligible persons and eligible drugs.~~
 1-9 ~~§ 42-66.2-3 Definitions.— As used in this chapter, unless the context requires otherwise:~~
 1-10 ~~(1) "Consumer" means any full-time resident of the state who fulfills the eligibility~~
 1-11 ~~requirements set forth in § 42-66.2-5. Residence for purposes of this chapter shall be in~~
 1-12 ~~accordance with the definitions and evidence standards set forth in § 17-1-3.1.~~
 1-13 ~~(2) "Contractor" means a third-party or private vendor capable of administering a~~
 1-14 ~~program of reimbursement for prescription drugs, and drug program eligibility administrative~~

1-15 support as required by the director, the vendor to be determined through a competitive bid process
1-16 in which the director awards a three (3) year contract for services.
1-17 (3) "Department" means the department of elderly affairs.
1-18 (4) "Director" means the director of the department of elderly affairs.
1-19 (5) "Eligible drugs" means insulin, injectable drugs for multiple sclerosis, and shall mean
1-20 non-injectable drugs which require a physician's prescription according to federal law and which
1-21 are contained in the following American Hospital Formulary Service pharmacologic-therapeutic
1-22 classifications categories that have not been determined by the federal "Drug Efficacy and Safety
1-23 Implementation (DESI) Commission" to lack substantial evidence of effectiveness. Eligible drugs
1-24 are limited to the following classification categories: cardiac drugs, hypotensive drugs, diuretics,
1-25 anti-diabetic agents, insulin, disposable insulin syringes, vasodilators (cardiac indications only),
1-26 anticoagulants, hemorrhologic agents, glaucoma drugs, drugs for the treatment of Parkinson's
1-27 disease, antilipemic drugs and oral antineoplastic drugs and drugs for the treatment of asthma and
1-28 other chronic respiratory diseases and prescription vitamin and mineral supplements for renal
1-29 patients, and drugs approved for the treatment of Alzheimer's disease, drugs used for the
1-30 treatment of depression, those drugs approved for the treatment of urinary incontinence, anti-
2-1 infectives, drugs used for the treatment of arthritis, drugs approved for the treatment of
2-2 osteoporosis, and neuraminidase-inhibiting drugs indicated for the treatment of influenza A and
2-3 B.
2-4 (ii) "Additional drugs" means non-injectable drugs which require a physician's
2-5 prescription according to federal law and which are contained in the American Hospital
2-6 Formulary Service pharmacologic-therapeutic classifications categories that have not been
2-7 determined by the federal "Drug Efficacy and Safety Implementation (DESI) Commission" to
2-8 lack substantial evidence of effectiveness, which are not included in the definition of drugs as
2-9 defined in this subdivision. However, this shall not include prescription drugs used for cosmetic
2-10 purposes.
2-11 (6) "Income" for the purposes of this chapter means the sum of federal adjusted gross
2-12 income as defined in the Internal Revenue Code of the United States, 26 U.S.C. § 1 et seq., and
2-13 all nontaxable income including, but not limited to, the amount of capital gains excluded from
2-14 adjusted gross income, alimony, support money, nontaxable strike benefits, cash public assistance
2-15 and relief (not including relief granted under this chapter), the gross amount of any pension or
2-16 annuity (including Railroad Retirement Act benefits, 45 U.S.C. § 231 et seq., all payments
2-17 received under the federal Social Security Act, 42 U.S.C. § 301 et seq., state unemployment
2-18 insurance laws, and veterans' disability pensions), nontaxable interest received from the federal
2-19 government or any of its instrumentalities, workers' compensation, and the gross amount of "loss
2-20 of time" insurance. It does not include gifts from nongovernmental sources, or surplus foods or
2-21 other relief in kind supplied by a public or private agency.
2-22 (7) "Pharmaceutical manufacturer" means any entity holding legal title to or possession
2-23 of a national drug code number issued by the federal food and drug administration.
2-24 (8) "Pharmacy" means a pharmacy licensed by the state of Rhode Island.
2-25 (9) [Deleted by P.L. 2008, ch. 100, art. 8, § 2].
2-26 § 42-66.2-4 Amount of payment.—The state shall pay the percentage rate of the
2-27 maximum allowable amount per prescription as formulated in the contract, as of the date of
2-28 purchase of the drug, between the contractor and participating pharmacies in accordance with the
2-29 income eligibility and co-payment shares set forth in § 42-66.2-5. The rebates generated pursuant
2-30 to § 42-66.2-10 shall be used to offset the state's payment. The pharmacy shall collect from the
2-31 consumer the percentage rate of the maximum allowable amount per prescription as formulated in
2-32 the contract, as of the date of the purchase of the eligible drug or additional drug, between the
2-33 contractor and participating pharmacies in accordance with the income eligibility and co-payment
2-34 shares set forth in § 42-66.2-5.
3-1 § 42-66.2-4.1 Catastrophic illness coverage.—The state shall pay one hundred percent

3-2 (100%) of the prescription drug costs for eligible drugs as defined in § 42-66.2-3(5) for any
3-3 consumer, as defined in § 42-66.2-3(1), who is eligible to receive pharmaceutical drug coverage
3-4 benefits under § 42-66.2-5(a)(1)(i) or (a)(2)(i) and who has expended at least one thousand five
3-5 hundred dollars (\$1,500) in total co-payments within a state fiscal year. The initial one thousand
3-6 five hundred dollars (\$1,500) paid by the consumer shall not be reimbursed by the state. The state
3-7 shall make payments under this section only until the end of the fiscal year.

3-8 § 42-66.2-5 Persons eligible. — (a) Persons eligible for assistance under the provisions of
3-9 this chapter include any resident of the state who is at least sixty five (65) years of age or at least
3-10 fifty five (55) years of age and receiving social security disability benefits. State and consumer
3-11 co-payment shares for these persons shall be determined as follows:

3-12 (1) For unmarried persons or married persons living separate and apart whose income for
3-13 the calendar year immediately preceding the year in which assistance is sought is:

3-14 (i) Less than nineteen thousand three hundred forty one dollars (\$19,341) the state shall
3-15 pay sixty percent (60%) of the cost of the prescriptions and the consumer shall pay forty percent
3-16 (40%) of the cost of the prescriptions.

3-17 (ii) More than nineteen thousand three hundred forty one dollars (\$19,341) and less than,
3-18 twenty four thousand two hundred and eighty dollars (\$24,280) the state shall pay thirty percent
3-19 (30%) of the cost of the prescriptions and the consumer shall pay seventy percent (70%) of the
3-20 cost of the prescriptions; and

3-21 (iii) More than twenty four thousand two hundred and eighty dollars (\$24,280) and less
3-22 than forty two thousand four hundred and ninety three dollars (\$42,493), the state shall pay
3-23 fifteen percent (15%) of the cost of prescriptions and the consumer shall pay eighty five percent
3-24 (85%) of the cost of prescriptions.

3-25 (2) For married persons whose income for the calendar year immediately preceding the
3-26 year in which assistance is sought hereunder when combined with any income of the person's
3-27 spouse in the same year is:

3-28 (i) Twenty four thousand one hundred and seventy nine dollars (\$24,179) or less, the
3-29 state shall pay sixty percent (60%) of the cost of the prescriptions and the consumer shall pay
3-30 forty percent (40%) of the cost of the prescriptions;

3-31 (ii) More than twenty four thousand one hundred and seventy nine dollars (\$24,179) and
3-32 less than thirty thousand three hundred and fifty two dollars (\$30,352), the state shall pay thirty
3-33 percent (30%) of the cost of the prescriptions and the consumer shall pay seventy percent (70%)
3-34 of the cost of prescriptions; and

4-1 (iii) More than thirty thousand three hundred and fifty two dollars (\$30,352) and less than
4-2 forty eight thousand five hundred and sixty three dollars (\$48,563), the state shall pay fifteen
4-3 percent (15%) of the cost of prescriptions and the consumer shall pay eighty five percent (85%)
4-4 of the cost of prescriptions.

4-5 (3) Eligibility may also be determined by using income data for the ninety (90) days prior
4-6 to application for benefits and projecting that income on an annual basis. The income levels shall
4-7 not include those sums of money expended for medical and pharmaceutical that exceed three
4-8 percent (3%) of the applicant's annual income or three percent (3%) of the applicant's preceding
4-9 ninety (90) day income computed on an annual basis.

4-10 (4) For persons on social security disability benefits who are: (i) unmarried or married
4-11 and living separate and apart with income for the calendar year immediately preceding the year in
4-12 which assistance is sought that is less than forty two thousand four hundred and ninety three
4-13 dollars (\$42,493); or (ii) married with income that is less than forty eight thousand five hundred
4-14 and sixty three dollars (\$48,563) the state shall pay fifteen percent (15%) of the cost of
4-15 prescriptions and the consumer shall pay eighty five percent (85%) of the cost.

4-16 (b) On July 1 of each year, the maximum amount of allowable income for both unmarried
4-17 and married residents set forth in subsection (a) shall be increased by a percentage equal to the
4-18 percentage of the cost of living adjustment provided for social security recipients.

4-19 ~~(c) No person whose prescription drug expenses are paid or reimbursable, either in whole~~
4-20 ~~or in part, by any other plan of assistance or insurance is eligible for assistance under this section,~~
4-21 ~~until the person's prescription drug coverage for a specific covered prescription medication is~~
4-22 ~~exhausted or the specific prescription medication is not covered by the plan during a benefit year,~~
4-23 ~~and as provided in subsection (d).~~

4-24 ~~(d) The fact that some of a person's prescription drug expenses are paid or reimbursable~~
4-25 ~~under the provisions of the federal Medicare program shall not disqualify that person, if he or she~~
4-26 ~~is otherwise eligible, to receive assistance under this chapter. In those cases, the state shall pay~~
4-27 ~~the eligible percentage of the cost of those prescriptions for qualified drugs for which no payment~~
4-28 ~~or reimbursement is made by the federal government.~~

4-29 ~~(e) Eligibility for receipt of any other benefit under any other provisions of the Rhode~~
4-30 ~~Island general laws as a result of eligibility for the pharmaceutical assistance program authorized~~
4-31 ~~under this section shall be limited to those persons whose income qualify them for a sixty percent~~
4-32 ~~(60%) state co-payment share of the cost of prescriptions.~~

4-33 ~~(f) For all additional drugs, the consumer shall pay one hundred percent (100%) of the~~
4-34 ~~cost of prescriptions as set forth in § 42-66.2-4.~~

5-1 ~~(g) To promote coordination of benefits between the pharmaceutical assistance program~~
5-2 ~~created under this chapter and the Medicare Part D prescription drug program created in the~~
5-3 ~~federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, RIPAE~~
5-4 ~~enrollees must apply for and enroll in the Medicare Part D prescription drug program.~~

5-5 ~~§ 42-66.2-6 Responsibilities of department of elderly affairs.—(a) Determination of~~
5-6 ~~eligibility. The department shall adopt regulations relating to the determination of eligibility of~~
5-7 ~~prospective consumers and the determination and elimination of program abuse. The department~~
5-8 ~~has the power to declare ineligible any consumer who abuses or misuses the established~~
5-9 ~~prescription plan. The department has the power to investigate cases of suspected provider or~~
5-10 ~~consumer fraud.~~

5-11 ~~(b) Rebates for expenses prohibited. (1) A system of rebates or reimbursements to the~~
5-12 ~~consumer for pharmaceutical expenses shall be prohibited.~~

5-13 ~~(2) Subdivision (1) shall not be interpreted to exclude other consumers not participating~~
5-14 ~~in the pharmaceutical assistance to the elderly program from receiving financial offers or~~
5-15 ~~redeemable coupons that are available to only those who have paid for the service or product~~
5-16 ~~through direct cash payment, insurance premiums, or cost sharing with an employer.~~

5-17 ~~(c) Program criteria. The program includes the following criteria:~~

5-18 ~~(1) Collection of the co-payment by pharmacies is mandatory;~~

5-19 ~~(2) Senior citizens participating in the program are not required to maintain records of~~
5-20 ~~each transaction but shall sign a receipt for eligible and additional drugs;~~

5-21 ~~(3) A system of rebates or reimbursements to the consumer for pharmaceutical expenses~~
5-22 ~~is prohibited;~~

5-23 ~~(ii) This subdivision shall not be interpreted to exclude other consumers from receiving~~
5-24 ~~financial offers or redeemable coupons that are available to only those who have paid for the~~
5-25 ~~service or product through direct cash payment, insurance premiums, or cost sharing with an~~
5-26 ~~employer.~~

5-27 ~~(4) Prescription benefits for any single prescription may be dispensed in the amounts~~
5-28 ~~authorized by the physician, and agreed to by the consumer, up to a maximum of a one hundred~~
5-29 ~~(100) day supply or two hundred (200) doses, whichever is less and/or a one hundred (100) day~~
5-30 ~~supply or one quart of liquid, whichever is less; provided, however, that disposable insulin~~
5-31 ~~syringes are dispensed in a quantity of one hundred (100);~~

5-32 ~~(5) Experimental drugs are excluded from the program;~~

5-33 ~~(6) A system of mail order delivery for prescriptions is allowed under this program; and~~

5-34 ~~(7) Eligible and additional drugs must be dispensed within one year of the original~~
6-1 ~~prescription order.~~

6-2 ~~(d) The director shall issue an eligibility card containing a program ID number and the~~
6-3 ~~time period for which the card is valid.~~

6-4 ~~(e) The director shall provide a mechanism, within the department, to handle all public~~
6-5 ~~inquiries concerning the program.~~

6-6 ~~(f) The director shall establish a process, in accordance with the Administrative~~
6-7 ~~Procedures Act, chapter 35 of this title, to provide an appeals hearing on the determination of~~
6-8 ~~eligibility.~~

6-9 ~~(g) The director shall forward to the contractor a list of all eligible consumers.~~

6-10 ~~(h) Expenditures for multiple sclerosis drugs shall not exceed thirty thousand dollars~~
6-11 ~~(\$30,000).~~

6-12 ~~(i) Generic drug substitution is mandatory when there is an available generic drug~~
6-13 ~~equivalent.~~

6-14 ~~§ 42-66.2-7 Contract.—(a) The director is authorized and shall enter into a contract with~~
6-15 ~~the contractor for the effective administrative support of this program.~~

6-16 ~~(b) A competitive bid and contract award shall occur in accordance with the state~~
6-17 ~~Medicaid authority's competitive bid process and cycle.~~

6-18 ~~§ 42-66.2-8 Penalties.—(a) Criminal penalties. Any person who submits a false or~~
6-19 ~~fraudulent claim under this chapter, or who aids or abets another in the submission of a false or~~
6-20 ~~fraudulent claim, or who is eligible under a private, state, or federal program for prescription~~
6-21 ~~assistance and who claims or receives duplicative benefits hereunder or who otherwise violates~~
6-22 ~~any provisions of this chapter is deemed guilty of a misdemeanor and is subject to imprisonment~~
6-23 ~~for a term of not more than one year or a fine of not less than five hundred dollars (\$500), or both.~~

6-24 ~~(b) Any provider or consumer found guilty of intentionally violating the provisions of~~
6-25 ~~this chapter shall be subject to immediate termination from this program for a period of no less~~
6-26 ~~than one year.~~

6-27 ~~(c) Repayment of gain. Any provider or consumer who is found guilty under this chapter~~
6-28 ~~is subject to repay three (3) times the value of the material gain he or she received.~~

6-29 ~~§ 42-66.2-9 Annual report.—(a) The director shall submit an annual report to the~~
6-30 ~~governor, the budget officer, the chairperson of the house finance committee, the chairperson of~~
6-31 ~~the senate finance committee, and the chairperson of the board of pharmacy as established by § 5-~~
6-32 ~~19.1-4. The report shall contain the number of consumers eligible for the program, the number of~~
6-33 ~~consumers utilizing the program, the number of appeals, an outline of problems encountered in~~
6-34 ~~the administration of the program and suggested solutions to the problems, and any~~
7-1 ~~recommendations to enhance the program.~~

7-2 ~~(b) The contractor shall submit an annual report to the governor, the budget officer, the~~
7-3 ~~chairperson of the house finance committee, the chairperson of the senate finance committee, and~~
7-4 ~~the board of pharmacy as established by § 5-19.1-4. The report shall contain financial and~~
7-5 ~~utilization statistics as to drug use by therapeutic category, actuarial projections, an outline of~~
7-6 ~~problems encountered in the administration of the program, and suggested solutions to the~~
7-7 ~~problems and any recommendations to enhance the program.~~

7-8 ~~(c) [Deleted by P.L. 2008, ch. 100, art. 8, § 2].~~

7-9 ~~§ 42-66.2-10 Pharmaceutical manufacturer drug rebates.—(a) The director shall enter~~
7-10 ~~into prescription drug rebate agreements with individual pharmaceutical manufacturers under~~
7-11 ~~which the department shall receive a rebate from the pharmaceutical manufacturer equal to the~~
7-12 ~~basic rebate supplied by the manufacturer under 42 U.S.C. § 1396a for every eligible prescription~~
7-13 ~~drug dispensed under the program. Each prescription drug rebate agreement shall provide that the~~
7-14 ~~pharmaceutical manufacturer shall make quarterly rebate payments to the department equal to the~~
7-15 ~~basic rebate supplied by the manufacturer under 42 U.S.C. § 1396a for the total number of dosage~~
7-16 ~~units of each form and strength of a prescription drug which the department reports as reimbursed~~
7-17 ~~to providers of prescription drugs, provided these payments shall not be due until thirty (30) days~~
7-18 ~~following the manufacturer's receipt of utilization data from the department including the number~~

7-19 ~~of dosage units reimbursed to providers of eligible prescription drugs during the quarter for which~~
7-20 ~~payment is due.~~
7-21 ~~(b) Upon receipt of the utilization data from the department, the pharmaceutical~~
7-22 ~~manufacturer shall calculate the quarterly payment. The department may, at its expense, hire a~~
7-23 ~~mutually agreed upon independent auditor to verify the calculation and payment. In the event that~~
7-24 ~~a discrepancy is discovered between the pharmaceutical manufacturer's calculation and the~~
7-25 ~~independent auditor's calculation, the pharmaceutical manufacturer shall justify its calculations or~~
7-26 ~~make payment to the department for any additional amount due.~~
7-27 ~~(2) The pharmaceutical manufacturer may, at its expense, hire a mutually agreed upon~~
7-28 ~~independent auditor to verify the accuracy of the utilization data provided by the department. In~~
7-29 ~~the event that a discrepancy is discovered, the department shall justify its data or refund any~~
7-30 ~~excess payment to the pharmaceutical manufacturer. The department may, at its expense,~~
7-31 ~~establish a grievance adjudication procedure, which provides for independent review of~~
7-32 ~~manufacturer documentation substantiating the basic rebate amount per unit delivered under 42~~
7-33 ~~U.S.C. § 1396a. In the event that a discrepancy is discovered, the department shall justify its data~~
7-34 ~~or refund any excess payment to the pharmaceutical manufacturer.~~
8-1 ~~(c) All eligible prescription drugs of a pharmaceutical manufacturer that enters into an~~
8-2 ~~agreement pursuant to subsection (a) shall be immediately available and the cost of these eligible~~
8-3 ~~drugs shall be reimbursed and not subject to any restrictions or prior authorization requirements.~~
8-4 ~~Any prescription drug of a manufacturer that does not enter into an agreement pursuant to~~
8-5 ~~subsection (a) shall not be reimbursable, unless the department determines the eligible~~
8-6 ~~prescription drug is essential to program participants.~~
8-7 ~~(d) All rebates collected by the department from the rebate payments made for drugs for~~
8-8 ~~persons eligible under the provisions of § 42-66.2-5(a) shall be deposited in a restricted receipt~~
8-9 ~~account, hereby created within the agency and known as Pharmaceutical Rebates, to pay costs in~~
8-10 ~~accordance with the provisions of § 42-66.2-4.~~
8-11 SECTION 2. This article shall take effect as of January 1, 2010.

MOTION: To have asked the following questions asked regarding 09 H 5983 Article 15 Relating to Pharmaceutical Assistance to the Elderly:

1. What is the alternative to RIPAE that will cover the middle income seniors?
2. Who does this impact; # of current beneficiary who are:
 - a. 55 to 65 on SSDI (who are not able to enroll in Medicare for 2 years after becoming eligible for SSDI),
 - b. 65 or older,
 - c. People using RIPAE when they fall into the Medicare Part D "Donut Hole"?
3. What were the FY 2008 RIPAE expenditures on drug purchases?
4. How many RIPAE recipients did not enroll in Medicare Part D and what is the plan for their transfer when there may be late enrollment penalties?
5. What is the estimated cost of converting RIPAE into a wrap a-round benefit, just filling in the donut hole?

GR/SB passed unanimously

Discussion: **09 H 5983 Article 30 RELATING TO LONG TERM CARE SERVICE REFORM FOR MEDICAID ELIGIBLE INDIVIDUALS**

This article would create a new chapter 40-8.10 that would provide standards to ensure that all Medicaid recipients eligible for long-term care have access to the full continuum of services they

need.

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

“Preventive services” would mean homemaker services, minor environmental modifications, physical therapy evaluation and services and respite services.

Highest level of care would be for individuals who are determined, based on medical need, to require the institutional level of care will have the choice to receive services in a long-term care institution or in a home and community-based setting.

High level of care would be for individuals who are determined, based on medical need, to benefit from home and community-based services.

Preventive level of care would be for individuals who do not presently need an institutional level of care but who need services targeted at preventing admission, re-admissions or reducing lengths of stay in an institution.

A long-term care options counseling program would provide individuals or their representative, or both, with long term care consultations that shall include, at a minimum, information about long-term care options, sources and methods of both public and private payment for long term care services, and an assessment of an individual’s functional capabilities and opportunities for maximizing independence.

Core and preventative home and community based services would be provided only to those individuals who meet one of the levels of care. Other long term care services, such as medication management, may be provided to Medicaid eligible recipients who have established the requisite need as determined by the Assessment and Coordination Unit (ACU). Access to institutional and community based supports and services shall be through the Assessment and Coordination Unit (ACU).

This article shall take effect upon passage. Any rules or regulations necessary or advisable to implement the provisions of section 1 this article shall be effective immediately as an emergency rule upon the department’s filing thereof with the secretary of state as it is hereby found that the current fiscal crisis in this state has caused an imminent peril to public health, safety and welfare, and the department is hereby exempted from the requirements of sections 42-35-3(b) and 42-35-4(b)(2) relating to agency findings of imminent peril to public health, safety and welfare and the filing of statements of the agency’s reasons thereof.

House Finance Committee Hearing 4/9/2009 @ Noon in rm 35

ARTICLE 30

RELATING TO LONG TERM CARE SERVICE REFORM FOR MEDICAID ELIGIBLE INDIVIDUALS

SECTION 1. Title 40 of the General Laws entitled “HUMAN SERVICES” is hereby amended by adding thereto the following chapter:

CHAPTER 40-8.10

LONG TERM CARE SERVICE REFORM FOR MEDICAID ELIGIBLE INDIVIDUALS

40-8.10-1. Purpose. -- (a) In order to ensure that all Medicaid recipients eligible for long-term care have access to the full continuum of services they need, the secretary of the executive office of health and human services, in collaboration with the director of the department of human

1-11 services and the directors of the departments of children youth and families, elderly affairs,
1-12 health, and mental health, retardation and hospitals, shall offer eligible Medicaid recipients the
1-13 full range of services as allowed under the terms and conditions of the Rhode Island Global
1-14 Consumer Choice Compact 1115a Demonstration Waiver, including institutional services and the
1-15 home and community based services provided for under the previous Medicaid Section 1915 (c)
1-16 waivers, as well as additional services for medication management, transition services and other
1-17 authorized services as defined in this chapter, in order to meet the individual needs of the
1-18 Medicaid recipient.

1-19 **40-8.10-2. Definitions.--** As used in this chapter,
1-20 (a) “Core services” mean homemaker services, environmental modifications (home
1-21 accessibility adaptations, special medical equipment (minor assistive devices), meals on wheels (
1-22 home delivered meals), ~~personal emergency response (PERS)~~ RI special needs emergency registry, licensed
practical nurse services,
1-23 community transition services, residential supports, day supports, supported employment,
1-24 supported living arrangements, private duty nursing, supports for consumer direction (supports
1-25 facilitation), participant directed goods and services, case management, senior companion
1-26 services, assisted living, personal care assistance services and respite and restorative services.
1-27 (b) “Preventive services” mean homemaker services, minor environmental modifications,
1-28 physical therapy evaluation and services and respite services.

(c) “activities of daily living assessment” includes but is not limited to programs that evaluate an
individual’s capacity for self-care and his or her ability to function independently in the context of everyday
living and which, where necessary, may recommend rehabilitative services (e.g., independent living skills
instruction), supportive services (e.g., attendant care, personal care or home health care), assistive devices,
home modification or an alternative residential setting. Activities of daily living include bathing, eating,
dressings, mobility, transferring from bed to chair and using the toilet. Most assessments also include
instrumental activities of daily living such as using the telephone, taking medication, money management,
housework, meal preparation, laundry and grocery shopping. The assessment tool could also be the personal
capacity inventory utilized by the division of developmental disabilities, and/or assessment of the need for
supported living that may include an evaluation for adequate and effective coping skills, role functioning,
behavior control and judgment necessary to live safely in the community, participate in self care and
treatment, and manage the effects of his or her illness.

1-29 **40-8.10-3. Levels of Care.--** (a) The secretary of the executive office of health and
1-30 human services shall coordinate responsibilities for long-term care assessment in accordance with
1-31 the provisions of this chapter within the department of human services, and with the cooperation
2-1 of the directors of the department of elderly affairs, the department of children, youth and
2-2 families , and the department of mental health, retardation and hospitals. Assessments conducted
2-3 by each department’s staff shall be coordinated through the Assessment Coordination Unit
2-4 (ACU). Members of each department’s staff responsible for assessing level of care, developing
2-5 care plans, and determining budgets will meet on a regular basis in order to ensure that services
2-6 are provided in a uniform and consistent manner. Importance shall be placed upon the proper and
2-7 consistent determination of levels of care across the state departments for each long-term care
2-8 setting, including behavioral health residential treatment facilities, long-term care hospitals,
2-9 intermediate care facilities, and/or skilled nursing facilities. Three (3) appropriate plans of care
2-10 that meet the needs of the individual Medicaid recipients shall be coordinated and consistent
2-11 across all state departments. The development of care plans shall be person-centered and shall
2-12 support individual self-determination, family involvement, when appropriate, individual choice
2-13 and interdepartmental collaboration.

2-14 (b) Levels of care for long-term care institutions (behavioral health residential treatment
2-15 facilities, long-term care hospitals, intermediate care facilities and /or skilled nursing facilities),
2-16 for which alternative community-based services and supports are available, shall be established
2-17 pursuant to the section 40-8.9-9. The structure of the three (3) levels of care is as follows:

2-18 (i) Highest level of care. Individuals who are determined, based on medical need or activities of daily living assessment, to
2-19 require the institutional level of care will have the choice to receive services in a long-term care
2-20 institution or in a home and community-based setting.
2-21 (ii) High level of care. Individuals who are determined, based on medical need or activities of daily
2-22 living assessment, to benefit
2-23 from home and community-based services.
2-24 (iii) Preventive level of care. Individuals who do not presently need an institutional level
2-25 of care but who need services targeted at preventing admission, re-admissions or reducing lengths
2-26 of stay in an institution.
2-27 (c) Determinations of levels of care and the provision of long term care health services
2-28 shall be determined in accordance with this section and shall be in accordance with the applicable
2-29 provisions of section 40-8.9-9.
2-30 **40-8.10-4. Assessment and Coordination Unit (ACU). --** (a) The department of human
2-31 services, in collaboration with the executive office of health and human services, shall implement
2-32 a long-term care options counseling program to provide individuals or their representative, or
2-33 both, with long-term care consultations that shall include, at a minimum, information about long-
2-34 term care options, sources and methods of both public and private payment for long term care
3-1 services, and an assessment of an individual's functional capabilities and opportunities for
3-2 maximizing independence. Each individual admitted to or seeking admission to a long- term
3-3 care facility, regardless of the payment source, shall be informed by the facility of the availability
3-4 of the long-term care options counseling program and shall be provided with a long-term care
3-5 options consultation, if he or she so requests. Each individual who applies for Medicaid long-term
3-6 care services shall be provided with a long-term care consultation.
3-7 (b) Core and preventative home and community based services defined and delineated in
3-8 section 40-8.10-2 shall be provided only to those individuals who meet one of the levels of care
3-9 provided for in this chapter. Other long term care services authorized by the federal government,
3-10 such as medication management, may also be provided to Medicaid eligible recipients who have
3-11 established the requisite need as determined by the Assessment and Coordination Unit (ACU).
3-12 Access to institutional and community based supports and services shall be through the
3-13 Assessment and Coordination Unit (ACU). The provision of Medicaid-funded long-term care
3-14 services and supports shall be based upon a comprehensive assessment that shall include, but not
3-15 be limited to, an evaluation of the medical, social and environmental needs of each applicant for
3-16 these services or programs. The assessment shall serve as the basis for the development and
3-17 provision of an appropriate plan of care for the applicant.
3-18 (c) The ACU shall assess the financial eligibility of beneficiaries to receive long-term
3-19 care services and supports in accordance with the applicable provisions of section 40-8.9-9.
3-20 (d) The ACU shall be responsible for conducting assessments; determining a level of care
3-21 for applicants for medical assistance; developing service plans; pricing a service budget and
3-22 developing a voucher when appropriate; making referrals to appropriate settings; maintaining a
3-23 component of the unit that will provide training to and will educate consumers, discharge
3-24 planners and providers; tracking utilization; monitoring outcomes; and reviewing service/care
3-25 plan changes. The ACU shall provide interdisciplinary high cost case reviews and choice
3-26 counseling for eligible recipients.
3-27 (e) The assessments for individuals conducted in accordance with this section shall serve
3-28 as the basis for individual budgets for those medical assistance recipients eligible to receive
3-29 services utilizing a self-directed delivery system.
3-30 (f) Nothing in this section shall prohibit the secretary of the executive office of health and
3-31 human services, or the directors of that office's departments from utilizing community agencies
3-32 or contractors when appropriate to perform assessment functions outlined in this chapter.
40-8.10-5. Payments.-- The department of human services shall not make payment for a

3-33 [person receiving a long-term home health care program, while payments are being made for that](#)
3-34 [person for inpatient care in a skilled nursing and/or intermediate care facility or hospital.](#)

4-1 **[40-8.10-6. Rules and Regulations.](#)**-- The secretary of the executive office of health and
4-2 [human services, the directors of the department of human services, the department of elderly](#)
4-3 [affairs, the department of children youth and families and the department of mental health](#)
4-4 [retardation and hospitals are hereby authorized to promulgate rules and regulations necessary to](#)
4-5 [implement all provisions of this chapter and to seek necessary federal approvals in accordance](#)
4-6 [with the provisions of the Global Compact Waiver.](#)

4-7 ~~—SECTION 2. This article shall take effect upon passage. Any rules or regulations~~
4-8 ~~necessary or advisable to implement the provisions of section 1 this article shall be effective~~
4-9 ~~immediately as an emergency rule upon the department's filing thereof with the secretary of state~~
4-10 ~~as it is hereby found that the current fiscal crisis in this state has caused an imminent peril to~~
4-11 ~~public health, safety and welfare, and the department is hereby exempted from the requirements~~
4-12 ~~of sections 42-35-3(b) and 42-35-4(b)(2) relating to agency findings of imminent peril to public~~
4-13 ~~health, safety and welfare and the filing of statements of the agency's reasons thereof.~~

MOTION: To oppose, unless amended 09 H 5983 Article 30 Relating To Long Term Care Service Reform For Medicaid Eligible Individuals, so the assessment system includes the independent living/vocational assessment in addition to the medical assessment system. PR/JB passed unanimously

Discussion: **09 H 5983 Article 31 RELATING TO RHODE ISLAND GLOBAL CONSUMER DEMONSTRATION WAIVER**

This article authorizes the department of human services, in collaboration with the executive office of health and human services, to obtain any necessary state plan amendments to the 1115a Global Demonstration Waiver where provided in the Rhode Island General Laws. The departments are authorized to proceed for federal approval in accordance with the global waiver.

House Finance Committee Hearing 4/9/2009 @ Noon in rm 35

1-1 **ARTICLE 31**
1-2 **RELATING TO RHODE ISLAND GLOBAL CONSUMER DEMONSTRATION WAIVER**

1-3 SECTION 1. Section 40-8-17 of the General Laws in Chapter 40-8 entitled "Medical
1-4 Assistance" is hereby amended to read as follows:

1-5 **40-8-17. Waiver request – Formulation.** -- (a) Formation. The department of human
1-6 services, in conjunction with the executive office of health and human services, is directed and
1-7 authorized to apply for and obtain any necessary waiver(s), waiver amendment(s) and/or state
1-8 plan amendments from the secretary of the United States department of health and human
1-9 services, including, but not limited to, a § 1115a global demonstration waiver that provides
1-10 program flexibility in exchange for federal budgetary certainty and under which Rhode Island
1-11 will operate all facets of the state's Medicaid program, except as may be explicitly exempted
1-12 under any applicable public or general laws.

1-13 [\(b\) Authority.- Effective April 1, 2009, where provided in Rhode Island General Laws](#)
1-14 [that the department of human services, in collaboration with the executive office of health and](#)
1-15 [human services, is authorized to obtain any necessary state plan amendments to the § 1115a](#)
1-16 [Global Demonstration Waiver, the department of human services, in collaboration with the](#)
1-17 [executive office of health an human services, is authorized to proceed for federal approval in](#)
1-18 [accordance with the special terms and conditions of the Rhode Island Global Consumer](#)
1-19 [Demonstration Waiver effective January 16, 2009.](#)

1-20 SECTION 2. This article shall take effect upon passage.

MOTION: To opposed unless amended to require legislative authorization for any

category I & II change 09 H 5983 Article 31 Relating to Rhode Island Global Consumer Demonstration Waiver PR/JB

Discussion: **09 H 5983 Article 34 RELATING TO LONG-TERM CARE SERVICE AND FINANCE REFORM**

This article establishes the department of human services' authorization to set separate criteria for admission to long-term care institutions that are more stringent than those employed for access to home and community-based services. The article replaces wording regarding juvenile detention centers and psychiatric facilities with the words long-term care institutions, such as behavioral health residential treatment facilities, long-term care hospitals. The article also allows the department to establish rules that define the frequency of reassessments for services provided.

House Finance Committee Hearing 4/9/2009 @ Noon in rm 35

ARTICLE 34

RELATING TO LONG-TERM CARE SERVICE AND FINANCE PROGRAM

SECTION 1. 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 to home and community-based care on or before December 31, 2012. 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 long-term care institutions, such as behavioral health residential treatment facilities, ~~juvenile detention centers, psychiatric facilities, and/or long-term care hospitals,~~ intermediate care facilities and/or skilled nursing facilities.

(c) (1) Pursuant to federal authority procured under § 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 need based eligibility determinations for services in ~~nursing facilities, hospitals, and intermediate care facilities for the mentally retarded as well as home~~ institutions for long-term care and community-based alternatives; Separate needs based criteria may be established taking into account the long-term care institution for which alternative community-based services and supports are available. The department is authorized to adopt criteria for admission to long-term care institutions 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.

2-9 (2) ~~The department is authorized to and shall~~ provide a common standard of ~~income~~
2-10 financial eligibility for both institutional and home and community-based care. ~~The department is~~
2-11 ~~authorized to adopt criteria for admission to a nursing facility, hospital, or intermediate care~~
2-12 ~~facility for the mentally retarded that are more stringent than those employed for access to home~~
2-13 ~~and community-based services. The department is also authorized to promulgate rules that define~~
2-14 ~~the frequency of re-assessments for services provided for under this section.~~

2-15 (d) The department of human services is further authorized and directed to consolidate all
2-16 home and community-based services currently provided pursuant to § 1915(c) of title XIX of the
2-17 United States Code into a single program of home and community-based services that include
2-18 options for consumer direction and shared living. The resulting single home and community-
2-19 based services program shall replace and supersede all § 1915(c) programs when fully
2-20 implemented. Notwithstanding the foregoing, the resulting single program home and community-
2-21 based services program shall include the continued funding of assisted living services at any
2-22 assisted living facility financed by the Rhode Island housing and mortgage finance corporation
2-23 prior to January 1, 2006, and shall be in accordance with chapter 66.8 of title 42 of the general
2-24 laws as long as assisted living services are a covered Medicaid benefit.

2-25 (e) The department of human services is authorized to promulgate rules that permit
2-26 certain optional services including, but not limited to, homemaker services, home modifications,
2-27 respite, and physical therapy evaluations to be offered subject to availability of state-appropriated
2-28 funding for these purposes.

2-29 (f) To promote the expansion of home and community-based service capacity, the
2-30 department of human services is authorized and directed to pursue rate reform for providers of
2-31 homemaker, personal care (home health aide) and adult day care services, as follows: (1) A
2-32 prospective base adjustment effective, not later than July 1, 2008, across all departments and
2-33 programs, of ten percent (10%) of the existing standard or average rate, contingent upon a
2-34 demonstrated increase in the state-funded or Medicaid caseload by June 30, 2009;

3-1 (2) Development, not later than September 30, 2008, of certification standards
3-2 supporting and defining targeted rate increments to encourage service specialization and
3-3 scheduling accommodations including, but not limited to, medication and pain management,
3-4 wound management, certified Alzheimer's Syndrome treatment and support programs, and shift
3-5 differentials for night and week-end services; and

3-6 (3) Development and submission to the governor and the general assembly, not later
3-7 than December 31, 2008, of a proposed rate-setting methodology for home and community-based
3-8 services to assure coverage of the base cost of service delivery as well as reasonable coverage of
3-9 changes in cost caused by wage inflation.

3-10 (h) The department of human services is also authorized, subject to availability of
3-11 appropriation of funding, to pay for certain ~~non-Medicaid reimbursable~~ expenses necessary to
3-12 transition residents back to the community; provided, however, payments shall not exceed an
3-13 annual or per person amount.

3-14 ~~(i) To assure the continued financial viability of nursing facilities, the department of~~
3-15 ~~human services is authorized and directed to develop a proposal for revisions to § 40-8-19 that~~
3-16 ~~reflect the changes in cost and resident acuity that result from implementation of this re-balancing~~
3-17 ~~goal. Said proposal shall be submitted to the governor and the general assembly on or before~~
3-18 ~~January 1, 2010.~~

3-19 SECTION 2. This article shall take effect upon passage.

MOTION: To support subsection(c) and ask a question on (b) regarding modifying the residential treatment facilities to only encompass behavioral health in 09 H 5983 Article 34 Relating to Long-Term Care Service and Finance Reform KMcCB/GR passed unanimously

Discussion: **09 H 5983 Article 39 RELATING TO EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

This article authorizes the establishment of both a program integrity unit and an assessment and coordination unit for long-term care within the executive office. The article would transfer from the departments to the secretariat the powers and functions by October 1, 2009 for: assessment and coordination for long-term care including those functions related to determining level of care or need for services, development of individual service/care plans and planning, identification of service options, the pricing of service options and choice counseling; and program integrity, quality control and collection and recovery functions including any that detect fraud and abuse or assure that beneficiaries, providers, and third-parties pay their fair share of the cost of services, as well as any that promote alternatives to publicly financed services, such as the long-term care health insurance partnership. The secretary would also prepare and submit to the leadership of the house and senate finance committees, by no later than January 1, 2010, a plan for restructuring functional responsibilities across the departments to establish a consumer centered integrated system of health and human services that provides high quality and cost-effective services at the right time and in the right setting across the life cycle.

House Finance Committee Hearing 4/6/2009 @ 10 AM in rm 35

1-1 **ARTICLE 39**
1-2 **RELATING TO EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**
1-3 SECTION 1. Sections 42-7.2-2, 42-7.2-5 and 42-7.2-6.1 of the General Laws in Chapter
1-4 42-7.2 entitled "Office of Health and Human Services" are hereby amended to read as follows:
1-5 **42-7.2-2. Executive office of health and human services.** -- There is hereby established
1-6 within the executive branch of state government an executive office of health and human services
1-7 to serve as the principal agency of the executive branch of state government for managing the
1-8 departments of children, youth and families, elderly affairs, health, human services, and mental
1-9 health, retardation and hospitals. In this capacity, the office shall:
1-10 (a) Lead the state's five health and human services departments in order to:
1-11 (1) Improve the economy, efficiency, coordination, and quality of health and human
1-12 services policy and planning, budgeting and financing.
1-13 (2) Design strategies and implement best practices that foster service access, consumer
1-14 safety and positive outcomes.
1-15 (3) Maximize and leverage funds from all available public and private sources,
1-16 including federal financial participation, grants and awards.
1-17 (4) Increase public confidence by conducting independent reviews of health and human
1-18 services issues in order to promote accountability and coordination across departments.
1-19 (5) Ensure that state health and human services policies and programs are responsive to
1-20 changing consumer needs and to the network of community providers that deliver assistive
1-21 services and supports on their behalf.
1-22 (b) Supervise the administrations of federal and state medical assistance programs by
1-23 acting as the single state agency authorized under title XIX of the U.S. Social Security act, 42
1-24 U.S.C. § 1396a et seq., notwithstanding any general or public law or regulation to the contrary,
1-25 and exercising such single state agency authority for such other federal and state programs as may
1-26 be designated by the governor. Except as provided for herein, Nothing nothing in this chapter
1-27 shall be construed as transferring to the secretary: (1) The powers, duties or functions conferred
1-28 upon the departments by Rhode Island general laws for the administration of the foregoing
1-29 federal and state programs; or (2) The administrative responsibility for the preparation and
1-30 submission of any state plans, state plan amendments, or federal waiver applications, as may be
2-1 approved from time to time by the secretary with respect to the foregoing federal and state

2-2 programs.

2-3 **42-7.2-5. Duties of the secretary.** -- The secretary shall be subject to the direction and

2-4 supervision of the governor for the oversight, coordination and cohesive direction of state

2-5 administered health and human services and in ensuring the laws are faithfully executed, not

2-6 withstanding any law to the contrary. In this capacity, the Secretary of Health and Human

2-7 Services shall be authorized to:

2-8 (1) Coordinate the administration and financing of health care benefits, human services

2-9 and programs including those authorized by the [Global Consumer Choice Compact Waiver and,](#)

2-10 [as applicable, the](#) Medicaid State Plan under Title XIX of the US Social Security Act. However,

2-11 nothing in this section shall be construed as transferring to the secretary the powers, duties or

2-12 functions conferred upon the departments by Rhode Island public and general laws for the

2-13 administration of federal/state programs financed in whole or in part with Medicaid funds or the

2-14 administrative responsibility for the preparation and submission of any state plans, state plan

2-15 amendments, or authorized federal waiver applications.

2-16 (2) Serve as the governor's chief advisor and liaison to federal policymakers on

2-17 Medicaid reform issues as well as the principal point of contact in the state on any such related

2-18 matters.

2-19 (3) Review and ensure the coordination of any ~~new departmental waiver~~ [Global](#)

2-20 [Consumer Choice Compact Waiver](#) requests and renewals as well as any initiatives and proposals

2-21 requiring amendments to the Medicaid state plan [or category one \(I\) or two \(II\) changes, as](#)

2-22 [described in the special terms and conditions of the Global Consumer Choice Compact Waiver](#)

2-23 with the potential to affect the scope, amount or duration of publicly-funded health care services,

2-24 provider payments or reimbursements, or access to or the availability of benefits and services as

2-25 provided by Rhode Island general and public laws. The secretary shall consider whether any such

2-26 ~~waivers or amendments~~ [changes](#) are legally and fiscally sound and consistent with the state's

2-27 policy and budget priorities. The secretary shall also assess whether a proposed ~~waiver or~~

2-28 ~~amendment~~ [change](#) is capable of obtaining the necessary approvals from federal officials and

2-29 achieving the expected positive consumer outcomes. Department directors shall, within the

2-30 timelines specified, provide any information and resources the secretary deems necessary in order

2-31 to perform the reviews authorized in this section;

2-32 (4) Beginning in 2006, prepare and submit to the governor, the chairpersons of the

2-33 house and senate finance committees, the caseload estimating conference, and to the joint

2-34 legislative committee for health care oversight, by no later than ~~February 1~~ [March 15](#) of each

3-1 year, a comprehensive overview of all Medicaid expenditures outcomes, and utilization rates. The

3-2 overview shall include, but not be limited to, the following information:

3-3 (i) Expenditures under Titles XIX and XXI of the Social Security Act, as amended;

3-4 (ii) Expenditures, outcomes and utilization rates by population and sub-population

3-5 served (e.g. families with children, children with disabilities, children in foster care, children

3-6 receiving adoption assistance, adults with disabilities, and the elderly);

3-7 (iii) Expenditures, outcomes and utilization rates by each state department or other

3-8 municipal or public entity receiving federal reimbursement under Titles XIX and XXI of the

3-9 Social Security Act, as amended; and

3-10 (iv) Expenditures, outcomes and utilization rates by type of service and/or service

3-11 provider. The directors of the departments, as well as local governments and school departments,

3-12 shall assist and cooperate with the secretary in fulfilling this responsibility by providing whatever

3-13 resources, information and support shall be necessary.

3-14 (5) Resolve administrative, jurisdictional, operational, program, or policy conflicts

3-15 among departments and their executive staffs and make necessary recommendations to the

3-16 governor.

3-17 (6) Assure continued progress toward improving the quality, the economy, the

3-18 accountability and the efficiency of state-administered health and human services. In this

3-19 capacity, the secretary shall:

3-20 (i) Direct implementation of reforms in the human resources practices of the

3-21 departments that streamline and upgrade services, achieve greater economies of scale and

3-22 establish the coordinated system of the staff education, cross- training, and career development

3-23 services necessary to recruit and retain a highly-skilled, responsive, and engaged health and

3-24 human services workforce;

3-25 (ii) Encourage the departments to utilize consumer-centered approaches to service

3-26 design and delivery that expand their capacity to respond efficiently and responsibly to the

3-27 diverse and changing needs of the people and communities they serve;

3-28 (iii) Develop all opportunities to maximize resources by leveraging the state's

3-29 purchasing power, centralizing fiscal service functions related to budget, finance, and

3-30 procurement, centralizing communication, policy analysis and planning, and information systems

3-31 and data management, pursuing alternative funding sources through grants, awards and

3-32 partnerships and securing all available federal financial participation for programs and services

3-33 provided through the departments; ~~and~~

3-34 (iv) Improve the coordination and efficiency of health and human services legal

4-1 functions by centralizing adjudicative and legal services and overseeing their timely and judicious

4-2 administration- ;

4-3 (v) Facilitate the rebalancing of the long term system by creating an assessment and

4-4 coordination organization or unit for the expressed purpose of developing and implementing

4-5 procedures across departments that ensure that the appropriate publicly-funded health services are

4-6 provided at the right time and in the most appropriate and least restrictive setting; and

4-7 (vi) Strengthen health and human services program integrity, quality control and

4-8 collections, and recovery activities by consolidating functions within the office in a single unit

4-9 that ensures all affected parties pay their fair share of the cost of services and are aware of

4-10 alternative financing.

4-11 (7) Prepare and integrate comprehensive budgets for the health and human services

4-12 departments and any other functions and duties assigned to the office. The budgets shall be

4-13 submitted to the state budget office by the secretary, for consideration by the governor, on behalf

4-14 of the state's health and human services in accordance with the provisions set forth in § 35-3-4 of

4-15 the Rhode Island general laws.

4-16 (8) Utilize objective data to evaluate health and human services policy goals, resource

4-17 use and outcome evaluation and to perform short and long-term policy planning and

4-18 development.

4-19 (9) Establishment of an integrated approach to interdepartmental information and data

4-20 management that complements and furthers the goals of the CHOICES initiative and that will

4-21 facilitate the transition to consumer-centered system of state administered health and human

4-22 services.

4-23 (10) At the direction of the governor or the general assembly, conduct independent

4-24 reviews of state-administered health and human services programs, policies and related agency

4-25 actions and activities and assist the department directors in identifying strategies to address any

4-26 issues or areas of concern that may emerge thereof. The department directors shall provide any

4-27 information and assistance deemed necessary by the secretary when undertaking such

4-28 independent reviews.

4-29 (11) Provide regular and timely reports to the governor and make recommendations with

4-30 respect to the state's health and human services agenda.

4-31 (12) Employ such personnel and contract for such consulting services as may be

4-32 required to perform the powers and duties lawfully conferred upon the secretary.

4-33 (13) Implement the provisions of any general or public law or regulation related to the

4-34 disclosure, confidentiality and privacy of any information or records, in the possession or under

5-1 the control of the executive office or the departments assigned to the executive office, that may be

5-2 developed or acquired for purposes directly connected with the secretary's duties set forth herein.
5-3 (14) Hold the director of each health and human services department accountable for
5-4 their administrative, fiscal and program actions in the conduct of the respective powers and duties
5-5 of their agencies.

5-6 **42-7.2-6.1. Transfer of powers and functions.** -- (a) There are hereby transferred to the
5-7 executive office of health and human services the powers and functions of the departments with
5-8 respect to the following:

5-9 (1) By July 1, 2007, fiscal services including budget preparation and review, financial
5-10 management, purchasing and accounting and any related functions and duties deemed necessary
5-11 by the secretary;

5-12 (2) By July 1, 2007, legal services including applying and interpreting the law,
5-13 oversight to the rule-making process, and administrative adjudication duties and any related
5-14 functions and duties deemed necessary by the secretary;

5-15 (3) By September 1, 2007, communications including those functions and services
5-16 related to government relations, public education and outreach and media relations and any
5-17 related functions and duties deemed necessary by the secretary;

5-18 (4) By March 1, 2008, policy analysis and planning including those functions and
5-19 services related to the policy development, planning and evaluation and any related functions and
5-20 duties deemed necessary by the secretary; ~~and~~

5-21 (5) By June 30, 2008, information systems and data management including the
5-22 financing, development and maintenance of all data-bases and information systems and platforms
5-23 as well as any related operations deemed necessary by the secretary;

5-24 (6) By October 1, 2009, assessment and coordination for long-term care including those
5-25 functions related to determining level of care or need for services, development of individual
5-26 service/care plans and planning, identification of service options, the pricing of service options
5-27 and choice counseling; and

5-28 (7) By October 1, 2009, program integrity, quality control and collection and recovery
5-29 functions including any that detect fraud and abuse or assure that beneficiaries, providers, and
5-30 third-parties pay their fair share of the cost of services, as well as any that promote alternatives to
5-31 publicly financed services, such as the long-term care health insurance partnership.

5-32 (b) The secretary shall determine in collaboration with the department directors whether
5-33 the officers, employees, agencies, advisory councils, committees, commissions, and task forces of
5-34 the departments who were performing such functions shall be transferred to the office. ~~Duties that~~
6-1 ~~are incidental to the performance of the functions transferred to the office in subpart (a) shall~~
6-2 ~~remain with the departments providing that the employees responsible thereof are performing~~
6-3 ~~functions that have not been transferred.~~

6-4 (c) In the transference of such functions, the secretary shall be responsible for ensuring:

6-5 (1) Minimal disruption of services to consumers;

6-6 (2) Elimination of duplication of functions and operations;

6-7 (3) Services are coordinated and functions are consolidated where appropriate;

6-8 (4) Clear lines of authority are delineated and followed;

6-9 (5) Cost-savings are achieved whenever feasible;

6-10 (6) Program application and eligibility determination processes are coordinated and,
6-11 where feasible, integrated; and

6-12 (7) State and federal funds available to the office and the entities therein are allocated
6-13 and utilized for service delivery to the fullest extent possible.

6-14 (d) Except as provided herein, no provision of this chapter or application thereof shall
6-15 be construed to limit or otherwise restrict the departments of children, youth and families, human
6-16 services, elderly affairs, health, and mental health, retardation, and hospitals from fulfilling any
6-17 statutory requirement or complying with any regulation deemed otherwise valid.

6-18 (e) The secretary shall prepare and submit to the leadership of the house and senate

- 6-19 [finance committees, by no later than January 1, 2010, a plan for restructuring functional](#)
- 6-20 [responsibilities across the departments to establish a consumer centered integrated system of](#)
- 6-21 [health and human services that provides high quality and cost-effective services at the right time](#)
- 6-22 [and in the right setting across the life-cycle.](#)

6-23 SECTION 2. This article shall take effect upon passage.

<p>MOTION: To raise a question regarding the potential of a conflict of interest for the assessment unit and the integrity unit both being functions in the same entity, 09 H 5983 Article 39 Relating To Executive Office Of Health And Human Services PR/GR passed unanimously</p>		
<p>MOTION: To urge the General Assembly to act quickly on H 5112 & S 53, creating the implementation task force and legislative oversight mechanism. BI/RC passed unanimously.</p>		
Announcements and Scheduling of Meetings	Chairperson	5 min.
<p>The Executive Committee meetings to meet on nominations for reappointment of Commissioners whose terms expire on 5-1-09 and new appointments to fill vacancies.</p>		
Next Legislation Cmte. meeting will be on:	Monday April 13 th	Starting at: 3:30 PM
Adjournment:	Chairperson adjourned the meeting at 5:37 PM.	
Resource persons:	Bob Cooper, Committee Staff	