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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2024

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A N A C T

RELATING TO HEALTH AND SAFETY -- LICENSING OF HEALTHCARE FACILITIES

Introduced By: Representatives Fellela, Serpa, Messier, Ackerman, and Costantino

Date Introduced: April 25, 2024

Referred To: House Finance

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 23-17-38.1 of the General Laws in Chapter 23-17 entitled "Licensing
2 of Healthcare Facilities" is hereby amended to read as follows:

3 **23-17-38.1. Hospitals — Licensing fee.**

4 ~~(a) There is imposed a hospital licensing fee for state fiscal year 2022 against each hospital~~
5 ~~in the state. The hospital licensing fee is equal to five and six hundred fifty six thousandths percent~~
6 ~~(5.656%) of the net patient services revenue of every hospital for the hospital's first fiscal year~~
7 ~~ending on or after January 1, 2020, except that the license fee for all hospitals located in Washington~~
8 ~~County, Rhode Island shall be discounted by thirty seven percent (37%). The discount for~~
9 ~~Washington County hospitals is subject to approval by the Secretary of the U.S. Department of~~
10 ~~Health and Human Services of a state plan amendment submitted by the executive office of health~~
11 ~~and human services for the purpose of pursuing a waiver of the uniformity requirement for the~~
12 ~~hospital license fee. This licensing fee shall be administered and collected by the tax administrator,~~
13 ~~division of taxation within the department of revenue, and all the administration, collection, and~~
14 ~~other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to~~
15 ~~the tax administrator on or before July 13, 2022, and payments shall be made by electronic transfer~~
16 ~~of monies to the general treasurer and deposited to the general fund. Every hospital shall, on or~~
17 ~~before June 15, 2022, make a return to the tax administrator containing the correct computation of~~
18 ~~net patient services revenue for the hospital fiscal year ending September 30, 2020, and the~~
19 ~~licensing fee due upon that amount. All returns shall be signed by the hospital's authorized~~

1 ~~representative, subject to the pains and penalties of perjury.~~

2 ~~(b)~~(a) There is also imposed a hospital licensing fee for state fiscal year 2023 against each
3 hospital in the state. The hospital licensing fee is equal to five and forty-two hundredths percent
4 (5.42%) of the net patient-services revenue of every hospital for the hospital's first fiscal year
5 ending on or after January 1, 2021, except that the license fee for all hospitals located in Washington
6 County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for
7 Washington County hospitals is subject to approval by the Secretary of the U.S. Department of
8 Health and Human Services of a state plan amendment submitted by the executive office of health
9 and human services for the purpose of pursuing a waiver of the uniformity requirement for the
10 hospital license fee. This licensing fee shall be administered and collected by the tax administrator,
11 division of taxation within the department of revenue, and all the administration, collection, and
12 other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to
13 the tax administrator on or before June 30, 2023, and payments shall be made by electronic transfer
14 of monies to the general treasurer and deposited to the general fund. Every hospital shall, on or
15 before May 25, 2023, make a return to the tax administrator containing the correct computation of
16 net patient-services revenue for the hospital fiscal year ending September 30, 2021, and the
17 licensing fee due upon that amount. All returns shall be signed by the hospital's authorized
18 representative, subject to the pains and penalties of perjury.

19 ~~(e)~~(b) There is ~~also~~ imposed a hospital licensing fee described in subsections ~~(d)~~(c) through
20 ~~(e)~~(f) for state fiscal years 2024 and 2025 against net patient-services revenue of every non-
21 government owned hospital as defined herein for the hospital's first fiscal year ending on or after
22 January 1, 2022. The hospital licensing fee shall have three (3) tiers with differing fees based on
23 inpatient and outpatient net patient-services revenue. The executive office of health and human
24 services, in consultation with the tax administrator, shall identify the hospitals in each tier, subject
25 to the definitions in this section, by July 15, 2023, and shall notify each hospital of its tier by August
26 1, 2023.

27 ~~(d)~~(c) Tier 1 is composed of hospitals that do not meet the description of either Tier 2 or
28 Tier 3.

29 (1) The inpatient hospital licensing fee for Tier 1 is equal to thirteen and twelve hundredths
30 percent (13.12%) of the inpatient net patient-services revenue derived from inpatient net patient-
31 services revenue of every Tier 1 hospital.

32 (2) The outpatient hospital licensing fee for Tier 1 is equal to thirteen and thirty hundredths
33 percent (13.30%) of the net patient-services revenue derived from outpatient net patient-services
34 revenue of every Tier 1 hospital.

1 ~~(e)~~(d) Tier 2 is composed of high Medicaid/uninsured cost hospitals and independent
2 hospitals.

3 (1) The inpatient hospital licensing fee for Tier 2 is equal to two and sixty-three hundredths
4 percent (2.63%) of the inpatient net patient-services revenue derived from inpatient net patient-
5 services revenue of every Tier 2 hospital.

6 (2) The outpatient hospital licensing fee for Tier 2 is equal to two and sixty-six hundredths
7 percent (2.66%) of the outpatient net patient-services revenue derived from outpatient net patient-
8 services revenue of every Tier 2 hospital.

9 ~~(e)~~(e) Tier 3 is composed of hospitals that are Medicare-designated low-volume hospitals
10 and rehabilitative hospitals.

11 (1) The inpatient hospital licensing fee for Tier 3 is equal to one and thirty-one hundredths
12 percent (1.31%) of the inpatient net patient-services revenue derived from inpatient net patient-
13 services revenue of every Tier 3 hospital.

14 (2) The outpatient hospital licensing fee for Tier 3 is equal to one and thirty-three
15 hundredths percent (1.33%) of the outpatient net patient-services revenue derived from outpatient
16 net patient-services revenue of every Tier 3 hospital.

17 ~~(e)~~(f) There is also imposed a hospital licensing fee for state fiscal ~~year~~ years 2024 and
18 2025 against state-government owned and operated hospitals in the state as defined herein. The
19 hospital licensing fee is equal to five and twenty-five hundredths percent (5.25%) of the net patient-
20 services revenue of every hospital for the hospital's first fiscal year ending on or after January 1,
21 2022.

22 ~~(e)~~(g) The hospital licensing fee described in subsections ~~(e)~~(b) through ~~(e)~~(f) is subject to
23 U.S. Department of Health and Human Services approval of a request to waive the requirement
24 that healthcare-related taxes be imposed uniformly as contained in 42 C.F.R. § 433.68(d).

25 ~~(e)~~(h) This hospital licensing fee shall be administered and collected by the tax
26 administrator, division of taxation within the department of revenue, and all the administration,
27 collection, and other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the
28 licensing fee to the tax administrator before June 30 of each fiscal year, and payments shall be made
29 by electronic transfer of monies to the tax administrator and deposited to the general fund. Every
30 hospital shall, on or before August 1, 2023, make a return to the tax administrator containing the
31 correct computation of inpatient and outpatient net patient-services revenue for the hospital fiscal
32 year ending in 2022, and the licensing fee due upon that amount. All returns shall be signed by the
33 hospital's authorized representative, subject to the pains and penalties of perjury.

34 ~~(e)~~(i) For purposes of this section the following words and phrases have the following

1 meanings:

2 (1) “Gross patient-services revenue” means the gross revenue related to patient care
3 services.

4 (2) “High Medicaid/uninsured cost hospital” means a hospital for which the hospital’s
5 total uncompensated care, as calculated pursuant to § 40-8.3-2(4), divided by the hospital’s total
6 net patient-services revenues, is equal to six percent (6.0%) or greater.

7 (3) “Hospital” means the actual facilities and buildings in existence in Rhode Island,
8 licensed pursuant to § 23-17-1 et seq. on June 30, 2010, and thereafter any premises included on
9 that license, regardless of changes in licensure status pursuant to chapter 17.14 of this title (hospital
10 conversions) and § 23-17-6(b) (change in effective control), that provides short-term acute inpatient
11 and/or outpatient care to persons who require definitive diagnosis and treatment for injury, illness,
12 disabilities, or pregnancy. Notwithstanding the preceding language, the negotiated Medicaid
13 managed care payment rates for a court-approved purchaser that acquires a hospital through
14 receivership, special mastership, or other similar state insolvency proceedings (which court-
15 approved purchaser is issued a hospital license after January 1, 2013) shall be based upon the newly
16 negotiated rates between the court-approved purchaser and the health plan, and such rates shall be
17 effective as of the date that the court-approved purchaser and the health plan execute the initial
18 agreement containing the newly negotiated rate. The rate-setting methodology for inpatient hospital
19 payments and outpatient hospital payments set forth in §§ 40-8-13.4(b) and 40-8-13.4(b)(2),
20 respectively, shall thereafter apply to negotiated increases for each annual twelve-month (12)
21 period as of July 1 following the completion of the first full year of the court-approved purchaser’s
22 initial Medicaid managed care contract.

23 (4) “Independent hospitals” means a hospital not part of a multi-hospital system.

24 (5) “Inpatient net patient-services revenue” means the charges related to inpatient care
25 services less (i) Charges attributable to charity care; (ii) Bad debt expenses; and (iii) Contractual
26 allowances.

27 (6) “Medicare-designated low-volume hospital” means a hospital that qualifies under 42
28 C.F.R. 412.101(b)(2) for additional Medicare payments to qualifying hospitals for the higher
29 incremental costs associated with a low volume of discharges.

30 (7) “Net patient-services revenue” means the charges related to patient care services less
31 (i) Charges attributable to charity care; (ii) Bad debt expenses; and (iii) Contractual allowances.

32 (8) “Non-government owned hospitals” means a hospital not owned and operated by the
33 state of Rhode Island.

34 (9) “Outpatient net patient-services revenue” means the charges related to outpatient care

1 services less (i) Charges attributable to charity care; (ii) Bad debt expenses; and (iii) Contractual
2 allowances.

3 (10) “Rehabilitative hospital” means Rehabilitation Hospital Center licensed by the Rhode
4 Island department of health.

5 (11) “State-government owned and operated hospitals” means a hospital facility licensed
6 by the Rhode Island department of health, owned and operated by the state of Rhode Island.

7 ~~(h)(j)~~ (i) The tax administrator in consultation with the executive office of health and human
8 services shall make and promulgate any rules, regulations, and procedures not inconsistent with
9 state law and fiscal procedures that he or she deems necessary for the proper administration of this
10 section and to carry out the provisions, policy, and purposes of this section.

11 ~~(h)(k)~~ (k) The licensing fee imposed by subsection (a) shall apply to hospitals as defined herein
12 that are duly licensed on July 1, ~~2021~~ 2022, and shall be in addition to the inspection fee imposed
13 by § 23-17-38 and to any licensing fees previously imposed in accordance with this section.

14 ~~(m) The licensing fee imposed by subsection (b) shall apply to hospitals as defined herein~~
15 ~~that are duly licensed on July 1, 2022, and shall be in addition to the inspection fee imposed by §~~
16 ~~23-17-38 and to any licensing fees previously imposed in accordance with this section.~~

17 ~~(h)(l)~~ (l) The licensing fees imposed by subsections ~~(e)(b)~~ through ~~(g)(f)~~ shall apply to
18 hospitals as defined herein that are duly licensed on July 1, 2023, and shall be in addition to the
19 inspection fee imposed by § 23-17-38 and to any licensing fees previously imposed in accordance
20 with this section.

21 SECTION 2. Section 40-8-19 of the General Laws in Chapter 40-8 entitled "Medical
22 Assistance" is hereby amended to read as follows:

23 **40-8-19. Rates of payment to nursing facilities.**

24 (a) Rate reform.

25 (1) The rates to be paid by the state to nursing facilities licensed pursuant to chapter 17 of
26 title 23, and certified to participate in Title XIX of the Social Security Act for services rendered to
27 Medicaid-eligible residents, shall be reasonable and adequate to meet the costs that must be
28 incurred by efficiently and economically operated facilities in accordance with 42 U.S.C. §
29 1396a(a)(13). The executive office of health and human services (“executive office”) shall
30 promulgate or modify the principles of reimbursement for nursing facilities in effect as of July 1,
31 2011, to be consistent with the provisions of this section and Title XIX, 42 U.S.C. § 1396 et seq.,
32 of the Social Security Act.

33 (2) The executive office shall review the current methodology for providing Medicaid
34 payments to nursing facilities, including other long-term-care services providers, and is authorized

1 to modify the principles of reimbursement to replace the current cost-based methodology rates with
2 rates based on a price-based methodology to be paid to all facilities with recognition of the acuity
3 of patients and the relative Medicaid occupancy, and to include the following elements to be
4 developed by the executive office:

5 (i) A direct-care rate adjusted for resident acuity;
6 (ii) An indirect-care [and other direct-care](#) rate comprised of a base per diem for all facilities;
7 (iii) Revision of rates as necessary based on increases in direct and indirect costs beginning
8 October 2024 utilizing data from the most recent finalized year of facility cost report. The per diem
9 rate components deferred in subsections (a)(2)(i) and (a)(2)(ii) of this section shall be adjusted
10 accordingly to reflect changes in direct and indirect care costs since the previous rate review;

11 (iv) Application of a fair-rental value system;

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

13 (vi) Adjustment of rates by the change in a recognized national nursing home inflation
14 index to be applied on October 1 of each year, beginning October 1, 2012. This adjustment will not
15 occur on October 1, 2013, October 1, 2014, or October 1, 2015, but will occur on April 1, 2015.
16 The adjustment of rates will also not occur on October 1, 2017, October 1, 2018, October 1, 2019,
17 and October 2022. Effective July 1, 2018, rates paid to nursing facilities from the rates approved
18 by the Centers for Medicare and Medicaid Services and in effect on October 1, 2017, both fee-for-
19 service and managed care, will be increased by one and one-half percent (1.5%) and further
20 increased by one percent (1%) on October 1, 2018, and further increased by one percent (1%) on
21 October 1, 2019. Effective October 1, 2022, rates paid to nursing facilities from the rates approved
22 by the Centers for Medicare and Medicaid Services and in effect on October 1, 2021, both fee-for-
23 service and managed care, will be increased by three percent (3%). In addition to the annual nursing
24 home inflation index adjustment, there shall be a base rate staffing adjustment of one-half percent
25 (0.5%) on October 1, 2021, one percent (1.0%) on October 1, 2022, and one and one-half percent
26 (1.5%) on October 1, 2023. The inflation index shall be applied without regard for the transition
27 factors in subsections (b)(1) and (b)(2). For purposes of October 1, 2016, adjustment only, any rate
28 increase that results from application of the inflation index to subsections (a)(2)(i) and (a)(2)(ii)
29 shall be dedicated to increase compensation for direct-care workers in the following manner: Not
30 less than 85% of this aggregate amount shall be expended to fund an increase in wages, benefits,
31 or related employer costs of direct-care staff of nursing homes. For purposes of this section, direct-
32 care staff shall include registered nurses (RNs), licensed practical nurses (LPNs), certified nursing
33 assistants (CNAs), certified medical technicians, housekeeping staff, laundry staff, dietary staff, or
34 other similar employees providing direct-care services; provided, however, that this definition of

1 direct-care staff shall not include: (i) RNs and LPNs who are classified as “exempt employees”
2 under the federal Fair Labor Standards Act (29 U.S.C. § 201 et seq.); or (ii) CNAs, certified medical
3 technicians, RNs, or LPNs who are contracted, or subcontracted, through a third-party vendor or
4 staffing agency. By July 31, 2017, nursing facilities shall submit to the secretary, or designee, a
5 certification that they have complied with the provisions of this subsection (a)(2)(vi) with respect
6 to the inflation index applied on October 1, 2016. Any facility that does not comply with the terms
7 of such certification shall be subjected to a clawback, paid by the nursing facility to the state, in the
8 amount of increased reimbursement subject to this provision that was not expended in compliance
9 with that certification.

10 (3) Commencing on October 1, 2021, eighty percent (80%) of any rate increase that results
11 from application of the inflation index to subsections (a)(2)(i) and (a)(2)(ii) of this section shall be
12 dedicated to increase compensation for all eligible direct-care workers in the following manner on
13 October 1, of each year.

14 (i) For purposes of this subsection, compensation increases shall include base salary or
15 hourly wage increases, benefits, other compensation, and associated payroll tax increases for
16 eligible direct-care workers. This application of the inflation index shall apply for Medicaid
17 reimbursement in nursing facilities for both managed care and fee-for-service. For purposes of this
18 subsection, direct-care staff shall include registered nurses (RNs), licensed practical nurses (LPNs),
19 certified nursing assistants (CNAs), certified medication technicians, licensed physical therapists,
20 licensed occupational therapists, licensed speech-language pathologists, mental health workers
21 who are also certified nurse assistants, physical therapist assistants, housekeeping staff, laundry
22 staff, dietary staff or other similar employees providing direct-care services; provided, however
23 that this definition of direct-care staff shall not include:

24 (A) RNs and LPNs who are classified as “exempt employees” under the federal Fair Labor
25 Standards Act (29 U.S.C. § 201 et seq.); or

26 (B) CNAs, certified medication technicians, RNs or LPNs who are contracted or
27 subcontracted through a third-party vendor or staffing agency.

28 (4)(i) By July 31, 2021, and July 31 of each year thereafter, nursing facilities shall submit
29 to the secretary or designee a certification that they have complied with the provisions of subsection
30 (a)(3) of this section with respect to the inflation index applied on October 1. The executive office
31 of health and human services (EOHHS) shall create the certification form nursing facilities must
32 complete with information on how each individual eligible employee’s compensation increased,
33 including information regarding hourly wages prior to the increase and after the compensation
34 increase, hours paid after the compensation increase, and associated increased payroll taxes. A

1 collective bargaining agreement can be used in lieu of the certification form for represented
2 employees. All data reported on the compliance form is subject to review and audit by EOHHS.
3 The audits may include field or desk audits, and facilities may be required to provide additional
4 supporting documents including, but not limited to, payroll records.

5 (ii) Any facility that does not comply with the terms of certification shall be subjected to a
6 clawback and twenty-five percent (25%) penalty of the unspent or impermissibly spent funds, paid
7 by the nursing facility to the state, in the amount of increased reimbursement subject to this
8 provision that was not expended in compliance with that certification.

9 (iii) In any calendar year where no inflationary index is applied, eighty percent (80%) of
10 the base rate staffing adjustment in that calendar year pursuant to subsection (a)(2)(vi) of this
11 section shall be dedicated to increase compensation for all eligible direct-care workers in the
12 manner referenced in subsections (a)(3)(i), (a)(3)(i)(A), and (a)(3)(i)(B) of this section.

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

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

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

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

30 (4) Notwithstanding any law to the contrary, for the twelve-month (12) period beginning
31 July 1, 2015, Medicaid payment rates for nursing facilities established pursuant to this section shall
32 not exceed ninety-eight percent (98%) of the rates in effect on April 1, 2015. Consistent with the
33 other provisions of this chapter, nothing in this provision shall require the executive office to restore
34 the rates to those in effect on April 1, 2015, at the end of this twelve-month (12) period.

1 SECTION 3. Sections 40-8.3-2 and 40-8.3-3 of the General Laws in Chapter 40-8.3 entitled
2 "Uncompensated Care" are hereby amended to read as follows:

3 **40-8.3-2. Definitions.**

4 As used in this chapter:

5 (1) "Base year" means, for the purpose of calculating a disproportionate share payment for
6 any fiscal year ending after September 30, ~~2022~~ 2023, the period from October 1, ~~2020~~ 2021,
7 through September 30, ~~2021~~ 2022, and for any fiscal year ending after September 30, ~~2023~~ 2024,
8 the period from October 1, ~~2021~~ 2022, through September 30, ~~2022~~ 2023.

9 (2) "Medicaid inpatient utilization rate for a hospital" means a fraction (expressed as a
10 percentage), the numerator of which is the hospital's number of inpatient days during the base year
11 attributable to patients who were eligible for medical assistance during the base year and the
12 denominator of which is the total number of the hospital's inpatient days in the base year.

13 (3) "Participating hospital" means any nongovernment and nonpsychiatric hospital that:

14 (i) Was licensed as a hospital in accordance with chapter 17 of title 23 during the base year
15 and shall mean the actual facilities and buildings in existence in Rhode Island, licensed pursuant to
16 § 23-17-1 et seq. on June 30, 2010, and thereafter any premises included on that license, regardless
17 of changes in licensure status pursuant to chapter 17.14 of title 23 (hospital conversions) and § 23-
18 17-6(b) (change in effective control), that provides short-term, acute inpatient and/or outpatient
19 care to persons who require definitive diagnosis and treatment for injury, illness, disabilities, or
20 pregnancy. Notwithstanding the preceding language, the negotiated Medicaid managed care
21 payment rates for a court-approved purchaser that acquires a hospital through receivership, special
22 mastership, or other similar state insolvency proceedings (which court-approved purchaser is issued
23 a hospital license after January 1, 2013), shall be based upon the newly negotiated rates between
24 the court-approved purchaser and the health plan, and the rates shall be effective as of the date that
25 the court-approved purchaser and the health plan execute the initial agreement containing the newly
26 negotiated rate. The rate-setting methodology for inpatient hospital payments and outpatient
27 hospital payments set forth in §§ 40-8-13.4(b)(1)(ii)(C) and 40-8-13.4(b)(2), respectively, shall
28 thereafter apply to negotiated increases for each annual twelve-month (12) period as of July 1
29 following the completion of the first full year of the court-approved purchaser's initial Medicaid
30 managed care contract;

31 (ii) Achieved a medical assistance inpatient utilization rate of at least one percent (1%)
32 during the base year; and

33 (iii) Continues to be licensed as a hospital in accordance with chapter 17 of title 23 during
34 the payment year.

1 (4) “Uncompensated-care costs” means, as to any hospital, the sum of: (i) The cost incurred
2 by the hospital during the base year for inpatient or outpatient services attributable to charity care
3 (free care and bad debts) for which the patient has no health insurance or other third-party coverage
4 less payments, if any, received directly from such patients; ~~and~~ (ii) The cost incurred by the hospital
5 during the base year for inpatient or outpatient services attributable to Medicaid beneficiaries less
6 any Medicaid reimbursement received therefor; ~~multiplied by the uncompensated care index; and~~
7 (iii) The sum of subsections (4)(i) and 4(ii) of this section shall be offset by the estimated hospital’s
8 commercial equivalent rates state directed payment for the current SFY in which the
9 disproportionate share hospital (DHS) payment is made. The sum of subsections (4)(i), (4)(ii) and
10 (4)(iii) of this section shall be multiplied by the uncompensated care index.

11 (5) “Uncompensated-care index” means the annual percentage increase for hospitals
12 established pursuant to § 27-19-14 [repealed] for each year after the base year, up to and including
13 the payment year; provided, however, that the uncompensated-care index for the payment year
14 ending September 30, 2007, shall be deemed to be five and thirty-eight hundredths percent (5.38%),
15 and that the uncompensated-care index for the payment year ending September 30, 2008, shall be
16 deemed to be five and forty-seven hundredths percent (5.47%), and that the uncompensated-care
17 index for the payment year ending September 30, 2009, shall be deemed to be five and thirty-eight
18 hundredths percent (5.38%), and that the uncompensated-care index for the payment years ending
19 September 30, 2010, September 30, 2011, September 30, 2012, September 30, 2013, September
20 30, 2014, September 30, 2015, September 30, 2016, September 30, 2017, September 30, 2018,
21 September 30, 2019, September 30, 2020, September 30, 2021, September 30, 2022, September
22 30, 2023, ~~and~~ September 30, 2024, and September 30, 2025 shall be deemed to be five and thirty
23 hundredths percent (5.30%).

24 **40-8.3-3. Implementation.**

25 ~~(a) For federal fiscal year 2022, commencing on October 1, 2021, and ending September~~
26 ~~30, 2022, the executive office of health and human services shall submit to the Secretary of the~~
27 ~~United States Department of Health and Human Services a state plan amendment to the Rhode~~
28 ~~Island Medicaid DSH Plan to provide:~~

29 ~~(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of~~
30 ~~\$145.1 million, shall be allocated by the executive office of health and human services to the Pool~~
31 ~~D component of the DSH Plan; and~~

32 ~~(2) That the Pool D allotment shall be distributed among the participating hospitals in direct~~
33 ~~proportion to the individual participating hospital’s uncompensated care costs for the base year,~~
34 ~~inflated by the uncompensated care index to the total uncompensated care costs for the base year~~

~~inflated by the uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before June 30, 2022, and are expressly conditioned upon approval on or before July 5, 2022, by the Secretary of the United States Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2022 for the disproportionate share payments.~~

~~(b)(a)~~ For federal fiscal year 2023, commencing on October 1, 2022, and ending September 30, 2023, the executive office of health and human services shall submit to the Secretary of the United States Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of \$159.0 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated-care costs for the base year, inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by the uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before June 15, 2023, and are expressly conditioned upon approval on or before June 23, 2023, by the Secretary of the United States Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2023 for the disproportionate share payments.

~~(e)(b)~~ For federal fiscal year 2024, commencing on October 1, 2023, and ending September 30, 2024, the executive office of health and human services shall submit to the Secretary of the United States Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of \$14.8 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated-care costs for the base year, inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by the uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before June 15, 2024, and are expressly conditioned upon approval

1 on or before June 23, 2024, by the Secretary of the United States Department of Health and Human
2 Services, or his or her authorized representative, of all Medicaid state plan amendments necessary
3 to secure for the state the benefit of federal financial participation in federal fiscal year 2024 for
4 the disproportionate share payments.

5 (c) For federal fiscal year, 2025, commencing on October 1, 2024, and ending September
6 30, 2025, the executive office of health and human services shall submit to the Secretary of the
7 United States Department of Health and Human Services a state plan amendment to the Rhode
8 Island Medicaid DSH Plan to provide:

9 (1) That the DHS Plan to all participating hospitals, not to exceed an aggregate limit of
10 fourteen million, seven hundred thousand dollars (\$14,700,000), shall be allocated by the executive
11 office of health and human services to the Pool D component of the DSH Plan; and

12 (2) That the Pool D allotment shall be distributed among the participating hospitals in direct
13 proportion to the individual participating hospital's uncompensated-care costs for the base year,
14 inflated by the uncompensated-care index to the total uncompensated-care costs for the base year
15 inflated by the uncompensated-care index of all participating hospitals. The disproportionate share
16 payments shall be made on or before June 23, 2025, by the Secretary of the United States
17 Department of Health and Human Services, or their authorized representative, of all Medicaid state
18 plan amendments necessary to secure for the state the benefit of federal financial participating in
19 federal fiscal year 2025 for the disproportionate share payments.

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

23 (e) The executive office of health and human services is directed, on at least a monthly
24 basis, to collect patient-level uninsured information, including, but not limited to, demographics,
25 services rendered, and reason for uninsured status from all hospitals licensed in Rhode Island.

26 (f) [Deleted by P.L. 2019, ch. 88, art. 13, § 6.]

27 SECTION 4. Section 40.1-8.5-8 of the General Laws in Chapter 40.1-8.5 entitled
28 "Community Mental Health Services" is hereby amended to read as follows:

29 **40.1-8.5-8. Certified community behavioral health clinics.**

30 (a) The executive office of health and human services is authorized and directed to submit
31 to the Secretary of the United States Department of Health and Human Services a state plan
32 amendment for the purposes of establishing Certified Community Behavioral Health Clinics in
33 accordance with Section 223 of the federal Protecting Access to Medicare Act of 2014.

34 (b) The executive office of health and human services shall amend its Title XIX state plan

1 pursuant to Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI [42 U.S.C § 1397 et seq.] of the
2 Social Security Act as necessary to cover all required services for persons with mental health and
3 substance use disorders at a certified community behavioral health clinic through a monthly
4 bundled payment methodology that is specific to each organization’s anticipated costs and inclusive
5 of all required services within Section 223 of the federal Protecting Access to Medicare Act of
6 2014. Such certified community behavioral health clinics shall adhere to the federal model,
7 including payment structures and rates. [Any change in federal requirements and/or guidance may](#)
8 [result in and necessitate the executive office of health and human services delaying the](#)
9 [implementation of such certified clinics.](#)

10 (c) A certified community behavioral health clinic means any licensed behavioral health
11 organization that meets the federal certification criteria of Section 223 of the Protecting Access to
12 Medicare Act of 2014. The department of behavioral healthcare, developmental disabilities and
13 hospitals shall define additional criteria to certify the clinics including, but not limited to, the
14 provision of these services:

- 15 (1) Outpatient mental health and substance use services;
- 16 (2) Twenty-four (24) hour mobile crisis response and hotline services;
- 17 (3) Screening, assessment, and diagnosis, including risk assessments;
- 18 (4) Person-centered treatment planning;
- 19 (5) Primary care screening and monitoring of key indicators of health risks;
- 20 (6) Targeted case management;
- 21 (7) Psychiatric rehabilitation services;
- 22 (8) Peer support and family supports;
- 23 (9) Medication-assisted treatment;
- 24 (10) Assertive community treatment; and
- 25 (11) Community-based mental health care for military service members and veterans.

26 (d) Subject to the approval from the United States Department of Health and Human
27 Services’ Centers for Medicare & Medicaid Services, the certified community behavioral health
28 clinic model pursuant to this chapter shall be established by ~~February 1, 2024~~ [July 1, 2024](#), and
29 include any enhanced Medicaid match for required services or populations served.

30 (e) By August 1, 2022, the executive office of health and human services will issue the
31 appropriate purchasing process and vehicle for organizations that want to participate in the Certified
32 Community Behavioral Health Clinic model program.

33 (f) The organizations will submit a detailed cost report developed by the department of
34 behavioral healthcare, developmental disabilities and hospitals with approval from the executive

1 office of health and human services, that includes the cost for the organization to provide the
2 required services.

3 (g) The department of behavioral healthcare, developmental disabilities and hospitals, in
4 coordination with the executive office of health and human services, will prepare an analysis of
5 proposals, determine how many behavioral health clinics can be certified in FY 2024 and the costs
6 for each one. Funding for the Certified Behavioral Health Clinics will be included in the FY 2024
7 budget recommended by the Governor.

8 (h) The executive office of health and human services shall apply for the federal Certified
9 Community Behavioral Health Clinics Demonstration Program if another round of funding
10 becomes available.

11 SECTION 5. Rhode Island Medicaid Reform Act of 2008 Resolution.

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

14 WHEREAS, A legislative enactment is required pursuant to Rhode Island General Laws
15 section 42-12.4-1, et seq.; and

16 WHEREAS, Rhode Island General Laws section 42-7.2-5(3)(i) provides that the secretary
17 of the executive office of health and human Services is responsible for the review and coordination
18 of any Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives
19 and proposals requiring amendments to the Medicaid state plan or category II or III changes as
20 described in the demonstration, “with potential to affect the scope, amount, or duration of publicly-
21 funded health care services, provider payments or reimbursements, or access to or the availability
22 of benefits and services provided by Rhode Island general and public laws”; and

23 WHEREAS, In pursuit of a more cost-effective consumer choice system of care that is
24 fiscally sound and sustainable, the secretary requests legislative approval of the following proposals
25 to amend the demonstration; and

26 WHEREAS, Implementation of adjustments may require amendments to the Rhode
27 Island’s Medicaid state plan and/or section 1115 waiver under the terms and conditions of the
28 demonstration. Further, adoption of new or amended rules, regulations and procedures may also be
29 required:

30 (a) Nursing Facility Payment Technical Correction. The executive office of health and
31 human services will clarify that the “other direct care” component of the nursing facility per diem
32 may be revised as necessary based on increases from the most recently finalized year of the cost
33 report used in the State’s rate review.

34 (b) DSH Uncompensated Care Calculation. The executive office of health and human

1 services proposes to seek approval from the federal centers for Medicare and Medicaid services to
2 evaluate the impact of the recently enacted hospital directed payments for payments as a percentage
3 of commercial equivalent rates in the calculation of base year uncompensated care used for
4 disproportionate share hospital payments.

5 (c) Provider Reimbursement Rates. The secretary of the executive office of health and
6 human services is authorized to pursue and implement any waiver amendments, state plan
7 amendments, and/or changes to the applicable department's rules, regulations, and procedures
8 required to implement updates to Medicaid provider reimbursement rates consisting of rate
9 increases equal to one third (1/3) of the increases recommended in the Social and Human Service
10 Programs Review Final Report produced by the office of the health insurance commissioner
11 pursuant to Rhode Island General Laws section 42-14.5-3(t)(2)(x) and including any revisions to
12 these recommendations noted by the executive office of health and human services in its SFY 25
13 budget submission. except that one hundred (100) percent of the recommended rate increases for
14 Early Intervention shall be implemented in SFY 25, rather than one third of the increases. This shall
15 further include the recommendation that these rate updates shall be effective on October 1, 2024.

16 (d) Federal Financing Opportunities. The executive off health and human services proposes
17 that it shall review Medicaid requirements and opportunities under the U.S. Patient Protection and
18 Affordable Care Act of 2010 (PPACA) and various other recently enacted federal laws and pursue
19 any changes in the Rhode Island Medicaid program that promote, increase and enhance service
20 quality, access and cost-effectiveness that may require a Medicaid state plan amendment or
21 amendment under the terms and conditions of Rhode Island's section 1115 waiver, its successor,
22 or any extension thereof. Any such actions by the executive office of health and human services
23 shall not have an adverse impact on beneficiaries or cause there to be an increase in expenditures
24 beyond the amount appropriated for state fiscal year 2025.

25 (e) Adjust Medicaid reimbursement for dental procedures performed in ambulatory
26 centers. All of the following shall apply to the new Healthcare Common Procedure Coding System
27 (HCPCS) procedure code G0330, which was adopted by the EOHHS as of January 1, 2024:

28 (1) EOHHS shall not reimburse ambulatory surgical centers based solely on the length of
29 the procedure. As of July 1, 2024, EOHHS shall reimburse ambulatory surgical centers so that
30 services billed under procedure code G0330 are reimbursed at ninety-five percent (95%) of the
31 total payment rate listed on the Medicare Part B Hospital Outpatient Prospective Payment System
32 (OPPS), in effect as of January 1, 2024. Starting January 1, 2025, and each year thereafter, EOHHS
33 shall update these rates annually so that services are reimbursed at ninety-five percent (95%) of the
34 Medicare Part B OPPTS payment rate, in effect as of January 1, for that procedure code; and

1 (2) Because services billed under procedure code G0330 are surgical procedures and not
2 traditional dental procedures, all Medicaid benefit plans shall be required to cover these procedures.

3 Now, therefore, be it:

4 RESOLVED, That the General Assembly hereby approves the proposals stated above in
5 the recitals; and be it further;

6 RESOLVED, That the secretary of the executive office of health and human services is
7 authorized to pursue and implement any waiver amendments, state plan amendments, and/or
8 changes to the applicable department's rules, regulations and procedures approved herein and as
9 authorized by Rhode Island General Laws section 42-12.4; and be it further;

10 RESOLVED, That this Joint Resolution shall take effect on July 1, 2024.

11 SECTION 6. This act shall take effect upon passage, except for Section 6 which shall take
12 effect as of July 1, 2024.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO HEALTH AND SAFETY -- LICENSING OF HEALTHCARE FACILITIES

1 This act would amend various provisions relative to hospital licensing fees, would redefine
2 base year for purposes of calculating disproportionate share payments for fiscal years.

3 This act would take effect upon passage, except for Section 6 which would take effect as
4 of July 1, 2024.

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