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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2026

A N A C T

RELATING TO HEALTH AND SAFETY -- THE RHODE ISLAND COMPREHENSIVE
HEALTH INSURANCE PROGRAM

Introduced By: Representatives Morales, Sanchez, Cruz, Voas, Giraldo, Potter, Tanzi,
and Cotter

Date Introduced: February 27, 2026

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Title 23 of the General Laws entitled "HEALTH AND SAFETY" is hereby
2 amended by adding thereto the following chapter:

3 CHAPTER 106

4 THE RHODE ISLAND COMPREHENSIVE HEALTH INSURANCE PROGRAM

5 23-106-1. Legislative findings.

6 The general assembly hereby finds and declares as follows:

7 (1) Health care is a human right, not a commodity available only to those who can afford
8 it;

9 (2) Although the federal Affordable Care Act ("ACA") allowed states to offer more people
10 taxpayer subsidized private health insurance, the ACA has not provided universal, comprehensive,
11 affordable coverage for all Rhode Islanders:

12 (i) In 2019, about four and three-tenths percent (4.3%) of Rhode Islanders had no health
13 insurance, causing about forty-three (43) (1 per 1,000 uninsured) unnecessary deaths each year;

14 (ii) An estimated forty-five percent (45%) of Rhode Islanders are underinsured (e.g., not
15 seeking health care because of high deductibles and co-pays);

16 (3) COVID-19 exacerbated and highlighted problems with the status quo health insurance
17 system including:

18 (i) Coverage is too easily lost when health insurance is tied to jobs - between February and

1 May, 2020, about twenty-one thousand (21,000) more Rhode Islanders lost their jobs and their
2 health insurance;

3 (ii) Systemic racism is reinforced - Black and Hispanic/Latinx Rhode Islanders, who are
4 more likely to be uninsured or underinsured, have suffered the highest rates of COVID-19 mortality
5 and morbidity;

6 (iii) The fear of out-of-pocket costs for uninsured and underinsured puts everyone at risk
7 because they avoid testing and treatment;

8 (4) In 2016, sixty million (60,000,000) people separated from their job at some point during
9 the year (i.e., about forty-two percent (42%) of the American workforce) and although this chapter
10 may cause some job loss, on balance, a single-payer would increase employment in Rhode Island
11 by nearly three percent (3%);

12 (5) The existing US health insurance system has failed to control the cost of health care
13 and to provide universal access to health care in a system which is widely accepted to waste thirty
14 percent (30%) of its revenues on activities that do not improve the health of Americans;

15 (6) Every industrialized nation in the world, except the United States, offers universal
16 health care to its citizens and enjoys better health outcomes for less than two thirds (2/3) to one-
17 half (1/2) the cost;

18 (7) Health care is rationed under our current multi-payer system, despite the fact that Rhode
19 Island patients, businesses and taxpayers already pay enough to have comprehensive and universal
20 health insurance under a single-payer system;

21 (8) About one-third (1/3) of every "healthcare" dollar spent in the U.S. is wasted on
22 unnecessary administrative costs and excessive pharmaceutical company profits due to laws
23 preventing Medicare from negotiating prices and private health insurance companies lacking
24 adequate market share to effectively negotiate prices;

25 (9) Private health insurance companies are incentivized to let the cost of health care rise
26 because higher costs require health insurance companies to charge higher health insurance
27 premiums, increasing companies' revenue and stock price;

28 (10) The healthcare marketplace is not an efficient market and because it represents only
29 eighteen percent (18%) of the US domestic market, significantly restricts economic growth and
30 thus the financial well-being of every American, including every Rhode Islander;

31 (11) Rhode Islanders cannot afford to keep the current multi-payer health insurance system;

32 (i) Between 1991 and 2014, healthcare spending in Rhode Island per person rose by over
33 two hundred fifty percent (250%) rising much faster than income and greatly reducing disposable
34 income;

1 (ii) It was estimated that by 2025, the cost of health insurance for an average family of four
2 (4) will equal about one-half (1/2) of their annual income;

3 (iii) In the U.S., about two-thirds (2/3) of personal bankruptcies are medical cost-related
4 and of these, about three-fourths (3/4) had health insurance at the onset of their medical problems.
5 In no other industrialized country do people worry about going bankrupt over medical costs;

6 (12) Rhode Island private businesses bear most of the costs of employee health insurance
7 coverage and spend significant time and money choosing from a confusing array of increasingly
8 expensive plans which do not provide comprehensive coverage;

9 (13) Rhode Island employees and retirees lose significant wages and pensions as they are
10 forced to pay higher amounts of health insurance and healthcare costs;

11 (14) Rhode Island's hospitals are under increasing financial distress i.e., closing, sold to
12 out-of-state entities, attempting mergers largely due to health insurance reimbursement problems
13 that other nations do not face and are fixed by a single-payer system;

14 (15) The state and its municipalities face enormous other post-employment benefits
15 (OPEB) unfunded liabilities due mostly to health insurance costs;

16 (16) An improved Medicare-for-all style single-payer program would, based on the
17 performance of existing Medicare, eliminate fifty percent (50%) of the administrative waste in the
18 current system of private insurance before other savings achieved through meaningful negotiation
19 of prices and other savings are considered;

20 (17) The high costs of medical care could be lowered significantly if the state could
21 negotiate on behalf of all its residents for bulk purchasing, as well as gain access to usage and price
22 information currently kept confidential by private health insurers as "proprietary information;"

23 (18) Single-payer healthcare would establish a true "free market" system where doctors
24 compete for patients rather than health insurance companies dictating which patients are able to see
25 which doctors and setting reimbursement rates;

26 (19) Healthcare providers would spend significantly less time with administrative work
27 caused by multiple health insurance company requirements and barriers to care delivery and would
28 spend significantly less for overhead costs because of streamlined billing;

29 (20) Rhode Island must act because there are currently no effective state or federal laws
30 that can provide universal coverage and adequately control rising premiums, co-pays, deductibles
31 and medical costs, or prevent private insurance companies from continuing to limit available
32 providers and coverage;

33 (21) In 1962, Canada's successful single-payer program began in the province of
34 Saskatchewan (with approximately the same population as Rhode Island) and became a national

1 program within ten (10) years; and

2 (v) The proposed Rhode Island single-payer program was studied by Professor Gerald
3 Friedman at UMass Amherst in 2015 and he concluded that:

4 "Single-payer in Rhode Island will finance medical care with substantial savings compared
5 with the existing multi-payer system of public and private insurers and would improve access to
6 health care by extending coverage to the four percent (4%) of Rhode Island residents still without
7 insurance under the Affordable Care Act and expanding coverage for the growing number with
8 inadequate healthcare coverage. Single-payer would improve the economic health of Rhode Island
9 by: increasing real disposable income for most residents; reducing the burden of health care on
10 businesses and promoting increased employment; and shifting the costs of health care away from
11 working and middle-class residents".

12 **23-106-2. Legislative purpose.**

13 It is the intent of the general assembly that this chapter establish a universal,
14 comprehensive, affordable single-payer healthcare insurance program that will help control
15 healthcare costs which shall be referred to as, "the Rhode Island comprehensive health insurance
16 program" ("RICHIP"). The program will be paid for by consolidating government and private
17 payments to multiple insurance carriers into a more economical and efficient improved Medicare-
18 for-all style single-payer program and substituting lower progressive taxes for higher health
19 insurance premiums, co-pays, deductibles and costs in excess of caps. This program will save
20 Rhode Islanders from the current overly expensive, inefficient and unsustainable multi-payer health
21 insurance system that unnecessarily prevents access to medically necessary health care. The
22 program will be established after the standard of care funded by Medicaid has been raised to a
23 Medicare standard.

24 **23-106-3. Definitions.**

25 As used in this chapter:

26 (1) "Affordable Care Act" or "ACA" means the Federal Patient Protection and Affordable
27 Care Act (Pub. L. 111-148), as amended by the Federal Health Care and Education Reconciliation
28 Act of 2010 (Pub. L. 111-152), and any amendments to, or regulations or guidance issued under,
29 those acts.

30 (2) "Carrier" means either a private health insurer authorized to sell health insurance in
31 Rhode Island or a healthcare service plan, i.e., any person who undertakes to arrange for the
32 provision of healthcare services to subscribers or enrollees, or to pay for or to reimburse any part
33 of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the
34 subscribers or enrollees, or any person, whether located within or outside of this state, who solicits

1 or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost
2 of, or who undertakes to arrange or arranges for, the provision of healthcare services that are to be
3 provided, wholly or in part, in a foreign country in return for a prepaid or periodic charge paid by
4 or on behalf of the subscriber or enrollee.

5 (3) "Dependent" has the same definition as set forth in federal tax law (26 U.S.C. § 152).

6 (4) "Emergency and urgently needed services" has the same definition as set forth in the
7 federal Medicare law (42 CFR 422.113).

8 (5) "Federally matched public health program" means the state's Medicaid program under
9 Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.) and the state's Children's Health
10 Insurance Program (CHIP) under Title XXI of the Social Security Act (42 U.S.C. § 1397aa et seq.).

11 (6) "For-profit provider" means any healthcare professional or healthcare institution that
12 provides payments, profits or dividends to investors or owners who do not directly provide health
13 care.

14 (7) "Health insurance company" means any entity subject to the insurance laws and
15 regulations of this state, or subject to the jurisdiction of the health insurance commissioner, that
16 contracts or offers to contract, to provide and/or insuring health services on a prepaid basis
17 including, but not limited to, policies of accident and sickness insurance, as defined by chapter 18
18 of title 27, nonprofit hospital service corporation as defined by chapter 19 of title 27, and nonprofit
19 medical service corporation as defined in chapter 20 of title 27, a health maintenance organizations,
20 as defined in chapter 41 of title 27 and also includes a nonprofit dental service corporation, as
21 defined in chapter 20.1 of title 27, all nonprofit optometric service corporations, as defined in
22 chapter 20.2 of title 27, a domestic insurance company subject to chapter 1 of title 27 that offers or
23 provides health insurance coverage in the state, and a foreign insurance company, subject to chapter
24 2 of title 27, all pharmacy benefit managers ("PBMs") that contracts to administer or manage
25 prescription drug benefits, any plan preempted by ERISA, but subject to state control (specifically
26 state government, local government, and quasi-public agency ERISA plans).

27 (8) "Medicaid" or "medical assistance" means a program that is one of the following:

28 (i) The state's Medicaid program under Title XIX of the Social Security Act (42 U.S.C. §
29 1396 et seq.); or

30 (ii) The state's Children's Health Insurance Program under Title XXI of the Social Security
31 Act (42 U.S.C. § 1397aa et seq.).

32 (9) "Medically necessary" means medical, surgical or other services or goods (including
33 prescription drugs) required for the prevention, diagnosis, cure, or treatment of a health-related
34 condition including any such services that are necessary to prevent a detrimental change in either

1 medical or mental health status. Medically necessary services shall be provided in a cost-effective
2 and appropriate setting and shall not be provided solely for the convenience of the patient or service
3 provider. "Medically necessary" does not include services or goods that are primarily for cosmetic
4 purposes; and does not include services or goods that are experimental, unless approved pursuant
5 to § 23-106-6(b).

6 (10) "Medicare" means Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.)
7 and the programs thereunder.

8 (11) "Qualified healthcare provider" means any individual who meets requirements set
9 forth in § 23-106-7(a)(1).

10 (12) "Qualified Rhode Island resident" means any individual who is a "resident" as defined
11 by §§ 44-30-5(a)(1) and (a)(2) or a dependent of that resident.

12 (13) "Rhode Island comprehensive health insurance program" or ("RICHIP") means the
13 affordable, comprehensive and effective health insurance program as set forth in this chapter.

14 (14) "RICHIP participant" means a qualified Rhode Island resident who is enrolled in
15 RICHIP (and not disenrolled or disqualified) at the time they seek health care.

16 (15) "State-owned health insurance company" means a health insurance company owned
17 by RICHIP.

18 **23-106-4. Rhode Island comprehensive health insurance program.**

19 (a) Organization. This chapter creates the Rhode Island comprehensive health insurance
20 program ("RICHIP") as an independent state government agency.

21 (b) Board. There shall be a RICHIP board composed of nine (9) members serving terms of
22 four (4) years. Members shall be appointed by the governor with the advice and consent of the
23 senate.

24 (c) Director. A director shall be appointed by the governor, with the advice and consent of
25 the senate, to lead RICHIP and serve a term of four (4) years, subject to oversight by an executive
26 board. The director shall be compensated in accordance with the job title and job classification
27 established by the division of human resources and approved by the general assembly.

28 (d) Phase one. The board shall have the power to acquire or launch a health insurance
29 company, which shall be managed by the board. Such an acquisition will initiate phase one.

30 (1) The state-owned health insurance company shall be exempt from any reserve
31 requirements.

32 (2) The State of Rhode Island shall be responsible for funding any costs of the state-owned
33 health insurance company that may exceed the available reserves.

34 (3) The director shall be responsible for daily management of the state-owned health

1 insurance company, and the duties, powers, and responsibilities of the director shall be determined
2 by the board.

3 (4) The state-owned health insurance company shall not be exempt from taxation.

4 (e) Phase two. The board shall vote to initiate phase two. In phase two, the state-owned
5 health insurance company and federal healthcare programs such as Medicare and Medicaid shall
6 be merged into a comprehensive program, RICHIP, which shall aim to cover all residents of the
7 State of Rhode Island.

8 (1) Under phase two, the duties of the director shall include:

9 (i) Employ staff and authorize reasonable expenditures, as necessary, from the RICHIP
10 trust fund, to pay program expenses and to administer the program, including creation and oversight
11 of RICHIP budgets;

12 (ii) Oversee management of the RICHIP trust fund set forth in § 23-106-11(a) to ensure
13 the operational well-being and fiscal solvency of the program, including ensuring that all available
14 funds from all appropriate sources are collected and placed into the trust fund;

15 (iii) Take any actions necessary and proper to implement the provisions of this chapter;

16 (iv) Implement standardized claims and reporting procedures;

17 (v) Provide for timely payments to participating providers through a structure that is well
18 organized and that eliminates unnecessary administrative costs, i.e., coordinate with the state
19 comptroller to facilitate billing from and payments to providers using the state's computerized
20 financial system, the Rhode Island financial and accounting network system (“RIFANS”);

21 (vi) Coordinate with federal healthcare programs, including Medicare and Medicaid, to
22 obtain necessary waivers and streamline federal funding and reimbursement;

23 (vii) Monitor billing and reimbursements to detect inappropriate behavior by providers and
24 patients and create prohibitions and penalties regarding bad faith or criminal RICHIP participation,
25 and procedures by which they will be enforced;

26 (viii) Support the development of an integrated healthcare database for healthcare planning
27 and quality assurance and ensure the legally required confidentiality of all health records it
28 contains;

29 (ix) Determine eligibility for RICHIP and establish procedures for enrollment,
30 disenrollment and disqualification from RICHIP, as well as procedures for handling complaints
31 and appeals from affected individuals, as set forth in § 29-106-5;

32 (x) Create RICHIP expenditure, status, and assessment reports including, but not limited
33 to, annual reports with the following:

34 (A) Performance of the program;

- 1 (B) Fiscal condition of the program;
- 2 (C) Recommendations for statutory changes;
- 3 (D) Receipt of payments from the federal government;
- 4 (E) Whether current year goals and priorities were met; and
- 5 (F) Future goals and priorities;
- 6 (xi) Review RICHIP collections and disbursements on at least a quarterly basis and
7 recommend adjustments needed to achieve budgetary targets and permit adequate access to care;
- 8 (xii) Develop procedures for accommodating:
- 9 (A) Employer retiree health benefits for people who have been members of RICHIP but
10 leave to live as retirees out of the state;
- 11 (B) Employer retiree health benefits for people who earned or accrued those benefits while
12 residing in the state prior to the implementation of RICHIP and live as retirees out of the state; and
- 13 (C) RICHIP coverage of healthcare services currently covered under the workers'
14 compensation system, including whether and how to continue funding for those services under that
15 system and whether and how to incorporate an element of experience rating; and
- 16 (xiii) No later than two (2) years after the initiation of phase two, develop a proposal,
17 consistent with the principles of this chapter, for provision and funding by the program of long-
18 term care coverage.
- 19 (2) Under phase two, the duties of the board shall include:
- 20 (i) Annually establish a RICHIP benefits package for participants, including a formulary
21 and a list of other medically necessary goods, as well as a procedure for handling complaints and
22 appeals relating to the benefits package, pursuant to § 23-106-6.
- 23 (ii) Establish RICHIP provider reimbursement and a procedure for handling provider
24 complaints and appeals as set forth in § 23-106-9;
- 25 (iii) Review budget proposals from providers pursuant to § 23-106-11(b); and
- 26 (iv) The board shall be subject to chapter 46 of title 42 ("open meetings").
- 27 **23-106-5. Coverage.**
- 28 (a) All qualified Rhode Island residents may participate in RICHIP. The director shall
29 establish procedures to determine eligibility, enrollment, disenrollment and disqualification,
30 including criteria and procedures by which RICHIP can:
- 31 (1) Identify, automatically enroll, and provide a RICHIP card to qualified Rhode Island
32 residents;
- 33 (2) Process applications from individuals seeking to obtain RICHIP coverage for
34 dependents after the implementation date;

- 1 (3) Ensure eligible residents are knowledgeable and aware of their rights to health care;
2 (4) Determine whether an individual should be disenrolled (e.g., for leaving the state);
3 (5) Determine whether an individual should be disqualified (e.g., for fraudulent receipt of
4 benefits or reimbursements);
5 (6) Determine appropriate actions that should be taken with respect to individuals who are
6 disenrolled or disqualified (including civil and criminal penalties); and
7 (7) Permit individuals to request review and appeal decisions to disenroll or disqualify
8 them.
9 (b) Medicare and Medicaid eligible coverage under RICHIP shall be as follows:
10 (1) If all necessary federal waivers are obtained, qualified Rhode Island residents eligible
11 for federal Medicare ("Medicare eligible residents") shall continue to pay required fees to the
12 federal government. RICHIP shall establish procedures to ensure that Medicare eligible residents
13 shall have such amounts deducted from what they owe to RICHIP under § 23-106-12(h). RICHIP
14 shall become the equivalent of qualifying coverage under Medicare part D and Medicare advantage
15 programs, and as such shall be the vendor for coverage to RICHIP participants. RICHIP shall
16 provide Medicare eligible residents benefits equal to those available to all other RICHIP
17 participants and equal to or greater than those available through the federal Medicare program. To
18 streamline the process, RICHIP shall seek to receive federal reimbursements for services and goods
19 to Medicare eligible residents and administer all Medicare funds.
20 (2) If all necessary federal waivers are obtained, RICHIP shall become the state's sole
21 Medicaid provider. RICHIP shall create procedures to enroll all qualified Rhode Island residents
22 eligible for Medicaid ("Medicaid eligible residents") in the federal Medicaid program to ensure a
23 maximum amount of federal Medicaid funds go to the RICHIP trust fund. RICHIP shall provide
24 benefits to Medicaid eligible residents equal to those available to all other RICHIP participants.
25 (3) If all necessary federal waivers are not granted from the Medicaid or Medicare
26 programs operated under Title XVIII or XIX of the Social Security Act, the Medicaid or Medicare
27 program for which a waiver is not granted shall act as the primary insurer for those eligible for such
28 coverage, and RICHIP shall serve as the secondary or supplemental plan of health insurance
29 coverage. Until such time as a waiver is granted, the plan shall not pay for services for persons
30 otherwise eligible for the same healthcare benefits under the Medicaid or Medicare program. The
31 director shall establish procedures for determining amounts owed by Medicare and Medicaid
32 eligible residents for supplemental RICHIP coverage and the extent of such coverage.
33 (4) The director may require Rhode Island residents to provide information necessary to
34 determine whether the resident is eligible for a federally matched public health program or for

1 Medicare, or any program or benefit under Medicare.

2 (5) As a condition of eligibility or continued eligibility for healthcare services under
3 RICHIP, a qualified Rhode Island resident who is eligible for benefits under Medicare shall enroll
4 in Medicare, including Parts A, B, and D.

5 (c) Veterans. RICHIP shall serve as the secondary or supplemental plan of health insurance
6 coverage for military veterans. The director shall establish procedures for determining amounts
7 owed by military veterans who are qualified residents for such supplemental RICHIP coverage and
8 the extent of such coverage.

9 (d) This chapter does not create any employment benefit, nor require, prohibit, or limit the
10 providing of any employment benefit.

11 (e) This chapter does not affect or limit collective action or collective bargaining on the
12 part of a healthcare provider with their employer or any other lawful collective action or collective
13 bargaining.

14 (f) This section shall take effect when the RICHIP board votes to initiate phase two.

15 **23-106-6. Benefits.**

16 (a) This chapter shall provide insurance coverage for services and goods (including
17 prescription drugs) deemed medically necessary by a qualified healthcare provider and that is
18 currently covered under:

19 (1) Services and goods currently covered by the federal Medicare program (Social Security
20 Act title XVIII) parts A, B and D;

21 (2) Services and goods covered by Medicaid as of January 1, 2027;

22 (3) Services and goods currently covered by the state's Children's Health Insurance
23 Program;

24 (4) Essential health benefits mandated by the Affordable Care Act; and

25 (5) Services and goods within the following categories:

26 (i) Primary and preventive care;

27 (ii) Approved dietary and nutritional therapies;

28 (iii) Inpatient care;

29 (iv) Outpatient care;

30 (v) Emergency and urgently needed care;

31 (vi) Prescription drugs and medical devices;

32 (vii) Laboratory and diagnostic services;

33 (viii) Palliative care;

34 (ix) Mental health services;

- 1 (x) Oral health, including dental services, periodontics, oral surgery, and endodontics;
- 2 (xi) Substance abuse treatment services;
- 3 (xii) Physical therapy and chiropractic services;
- 4 (xiii) Vision care and vision correction;
- 5 (xiv) Hearing services, including coverage of hearing aids;
- 6 (xv) Podiatric care;
- 7 (xvi) Comprehensive family planning, reproductive, maternity, and newborn care;
- 8 (xvii) Short-term rehabilitative services and devices;
- 9 (xviii) Durable medical equipment;
- 10 (xix) Gender affirming health care; and
- 11 (xx) Diagnostic and routine medical testing.

12 (b) Additional coverage. The director shall create a procedure that may permit additional
13 medically necessary goods and services beyond that provided by federal laws cited herein and
14 within the areas set forth in § 23-106-4, if the coverage is for services and goods deemed medically
15 necessary based on credible scientific evidence published in peer-reviewed medical literature
16 generally recognized by the relevant medical community, physician specialty society
17 recommendations, and the views of physicians practicing in relevant clinical areas and any other
18 relevant factors. The director shall create procedures for handling complaints and appeals
19 concerning the benefits package.

20 (c) Restrictions shall not apply. In order for RICHIP participants to be able to receive
21 medically necessary goods and services, this chapter shall override any state law that restricts the
22 provision or use of state funds for any medically necessary goods or services, including those
23 related to family planning and reproductive healthcare.

24 (d) Medically necessary goods:

25 (1) Prescription drug formulary:

26 (i) In general. The director shall establish a prescription drug formulary system, to be
27 approved by the board, and encourage best-practices in prescribing and discourage the use of
28 ineffective, dangerous, or excessively costly medications when better alternatives are available.

29 (ii) Promotion of generics. The formulary under this subsection shall promote the use of
30 generic medications to the greatest extent possible.

31 (iii) Formulary updates and petition rights. The formulary under this subsection shall be
32 updated frequently and the director shall create a procedure for patients and providers to make
33 requests and appeal denials to add new pharmaceuticals or to remove ineffective or dangerous
34 medications from the formulary.

1 (iv) Use of off-formulary medications. The director shall promulgate rules and regulations
2 regarding the use of off-formulary medications which allow for patient access but do not
3 compromise the formulary.

4 (v) Approved devices and equipment. The director shall present a list of medically
5 necessary devices and equipment that shall be covered by RICHIP, subject to final approval by the
6 board.

7 (vi) Bulk purchasing. The director shall seek and implement ways to obtain goods at the
8 lowest possible cost, including bulk purchasing agreements.

9 (e) This section shall take effect when the RICHIP board votes to initiate phase two.

10 **23-106-7. Providers.**

11 (a) Rhode Island providers.

12 (1) Licensing. Participating providers shall meet state licensing requirements in order to
13 participate in RICHIP. No provider whose license is under suspension or has been revoked shall
14 participate in the program.

15 (2) Participation. All providers may participate in RICHIP by providing items on the
16 RICHIP benefits list for which they are licensed. Providers may elect either to participate fully, or
17 not at all, in the program.

18 (3) For-profit providers. For-profit providers may continue to offer services and goods in
19 Rhode Island, but are prohibited from charging patients more than RICHIP reimbursement rates
20 for covered services and goods and shall notify qualified Rhode Island residents when the services
21 and goods they offer will not be reimbursed fully under RICHIP.

22 (b) Out-of-state providers. Except for emergency and urgently needed service, as set forth
23 in § 23-106-7(d), RICHIP shall not pay for healthcare services obtained outside of Rhode Island
24 unless the following requirements are met:

25 (1) The out-of-state provider agrees to accept the RICHIP rate for out-of-state providers;
26 and

27 (2) The services are medically necessary care.

28 (c) Out-of-state provider reimbursement. The program shall pay out-of-state healthcare
29 providers at a rate equal to the average rate paid by commercial insurers or Medicare for the services
30 rendered, whichever is higher.

31 (d) Out-of-state residents.

32 (1) In general. Rhode Island providers who provide any services to individuals who are not
33 RICHIP participants shall not be reimbursed by RICHIP and shall seek reimbursement from those
34 individuals or other sources.

1 (2) Emergency care exception. Nothing in this chapter shall prevent any individual from
2 receiving or any provider from providing emergency healthcare services and goods in Rhode
3 Island. The director shall adopt rules and regulations to provide reimbursement; however, the rules
4 shall reasonably limit reimbursement to protect the fiscal integrity of RICHIP. The director shall
5 implement procedures to secure reimbursement from any appropriate third-party funding source or
6 from the individual to whom the emergency services were rendered.

7 (e) This section shall take effect when the RICHIP board votes to initiate phase two.

8 **23-106-8. Cross border employees.**

9 (a) State residents employed out-of-state. If an individual is employed out-of-state by an
10 employer that is subject to Rhode Island state law, the employer and employee shall be required to
11 pay the payroll taxes as to that employee as if the employment were in the state. If an individual is
12 employed out-of-state by an employer that is not subject to Rhode Island state law, the employee
13 health coverage provided by the out-of-state employer to a resident working out-of-state shall serve
14 as the employee's primary plan of health coverage, and RICHIP shall serve as the employee's
15 secondary plan of health coverage. The director shall establish procedures for determining amounts
16 owed by residents employed out-of-state for such supplemental secondary RICHIP coverage and
17 the extent of such coverage.

18 (b) Out-of-state residents employed in the state. The payroll tax set forth in § 23-106-12(i)
19 shall apply to any out-of-state resident who is employed or self-employed in the state. However,
20 such out-of-state residents shall be able to take a credit for amounts they spend on health benefits
21 for themselves that would otherwise be covered by RICHIP if the individual were a RICHIP
22 participant. The out-of-state resident's employer shall be able to take a credit against such payroll
23 taxes regardless of the form of the health benefit (e.g., health insurance, a self-insured plan, direct
24 services, or reimbursement for services), to ensure that the revenue proposal does not relate to
25 employment benefits in violation of the Federal Employee Retirement Income Security Act
26 ("ERISA") law. For non-employment-based spending by individuals, the credit shall be available
27 for and limited to spending for health coverage (not out-of-pocket health spending). The credit shall
28 be available without regard to how little is spent or how sparse the benefit. The credit may only be
29 taken against the payroll taxes set forth in § 23-106-12(i). Any excess amount may not be applied
30 to other tax liability. For employment-based health benefits, the credit shall be distributed between
31 the employer and employee in the same proportion as the spending by each for the benefit. The
32 employer and employee may each apply their respective portion of the credit to their respective
33 portion of the payroll taxes set forth in § 23-106-12(i). If any provision of this clause or any
34 application of it shall be ruled to violate ERISA, the provision or the application of it shall be null

1 and void and the ruling shall not affect any other provision or application of this section or this
2 chapter.

3 (c) This section shall take effect when the RICHIP board votes to initiate phase two.

4 **23-106-9. Provider reimbursement.**

5 (a) Rates for services and goods. RICHIP reimbursement rates to providers shall be
6 determined by the RICHIP board. These rates shall be equal to or greater than the federal Medicare
7 rates available to Rhode Island qualified residents that are in effect at the time services and goods
8 are provided. For outpatient behavioral health services, the minimum rate shall equal one hundred
9 fifty percent (150%) of federal Medicare rates. If the director determines that there are no such
10 federal Medicare reimbursement rates, the director shall set the minimum rate. The director shall
11 review the rates at least annually, recommend changes to the board, and establish procedures by
12 which complaints about reimbursement rates may be reviewed by the board.

13 (b) Billing and payments. Providers shall submit billing for services to RICHIP participants
14 in the form of electronic invoices entered into RIFANS, the state's computerized financial system.
15 The director shall coordinate the manner of processing and payment with the office of accounts and
16 control and the RIFANS support team within the division of information technology. Payments
17 shall be made by check or electronic funds transfer in accordance with terms and procedures
18 coordinated by the director and the office of accounts and control and consistent with the fiduciary
19 management of the RICHIP trust fund.

20 (c) Provider restrictions. In-state providers who accept any payment from RICHIP shall
21 not bill any patient for any covered benefit. In-state providers cannot use any of their operating
22 budgets for expansion, profit, excessive executive income, including bonuses, marketing, or major
23 capital purchases or leases.

24 (d) This section shall take effect when the RICHIP board votes to initiate phase two.

25 **23-106-10. Private insurance companies.**

26 (a) Non-duplication. It is unlawful for a private health insurer to sell health insurance
27 coverage to qualified Rhode Island residents that duplicates the benefits provided under this
28 chapter. Nothing in this chapter shall be construed as prohibiting the sale of health insurance
29 coverage for any additional benefits not covered by this chapter, including additional benefits that
30 an employer may provide to employees or their dependents, or to former employees or their
31 dependents (e.g., multiemployer plans can continue to provide wrap-around coverage for any
32 benefits not provided by RICHIP).

33 (b) Displaced employees. Re-education and job placement of persons employed in Rhode
34 Island-located enterprises who have lost their jobs as a result of this chapter shall be managed by

1 the Rhode Island department of labor and training or an appropriate federal retraining program. The
2 director may provide funds from RICHIP or funds otherwise appropriated for this purpose for
3 retraining and assisting job transition for individuals employed or previously employed in the fields
4 of health insurance, healthcare service plans, and other third-party payments for health care or those
5 individuals providing services to healthcare providers to deal with third-party payers for health
6 care, whose jobs may be or have been ended as a result of the implementation of the program,
7 consistent with applicable laws.

8 (c) This section shall take effect when the RICHIP board votes to initiate phase two.

9 **23-106-11. Budgeting.**

10 (a) Operating budget. Annually, the director shall create an operating budget for the
11 program that includes the costs for all benefits set forth in § 23-106-6 and the costs for RICHIP
12 administration. The director shall determine appropriate reimbursement rates for benefits pursuant
13 to § 23-106-9(a). The operating budget shall be approved by the executive board prior to
14 submission to the governor and general assembly.

15 (b) Capital expenditures. The director shall work with representatives from state entities
16 involved with provider capital expenditures including, but not limited to, the Rhode Island
17 department of administration office of capital projects, the Rhode Island health and educational
18 building corporation as well as providers to help ensure that capital expenditures proposed by
19 providers, including amounts to be spent on construction and renovation of health facilities and
20 major equipment purchases, will address healthcare needs of RICHIP participants. To the extent
21 that providers are seeking to use RICHIP funds for capital expenditures, the director shall have the
22 authority to approve or deny such expenditures.

23 (c) Prohibition against co-mingling operations and capital improvement funds. It is
24 prohibited to use funds under this chapter that are earmarked:

25 (1) For operations for capital expenditures; or

26 (2) For capital expenditures for operations.

27 (d) This section shall take effect when the RICHIP board votes to initiate phase two.

28 **23-106-12. Financing.**

29 (a) RICHIP trust fund. There shall be established a RICHIP trust fund into which funds
30 collected pursuant to this chapter are deposited and from which funds are distributed. All money
31 collected and received shall be used exclusively to finance RICHIP. The governor or general
32 assembly may provide funds to the RICHIP trust fund, but may not remove or borrow funds from
33 the RICHIP trust fund.

34 (b) Revenue proposal. After approval of the RICHIP executive board, the director shall

1 submit to the governor and the general assembly a revenue plan and, if required, legislation
2 (referred to collectively in this section as the "revenue proposal") to provide the revenue necessary
3 to finance RICHIP. The initial revenue proposal shall be submitted once waiver negotiations have
4 proceeded to a level deemed sufficient by the director and annually, thereafter. The basic structure
5 of the initial revenue proposal will be based on a consideration of:

- 6 (1) Anticipated savings from a single-payer program;
- 7 (2) Government funds available for health care;
- 8 (3) Private funds available for health care; and
- 9 (4) Replacing current regressive health insurance payments made to multiple health
10 insurance carriers with progressive contributions to a single payer (RICHIP) in order to make
11 healthcare insurance affordable and remove unnecessary barriers to healthcare access.

12 (i) Subsequent proposals shall adjust the RICHIP contributions, based on projections from
13 the total RICHIP costs in the previous year, and shall include a five (5) year plan for adjusting
14 RICHIP contributions to best meet the goals set forth in this section and § 23-106-2.

15 (c) Anticipated savings. It is anticipated that RICHIP will lower healthcare costs by:

- 16 (1) Eliminating payments to private health insurance carriers;
- 17 (2) Reducing paperwork and administrative expenses for both providers and payers created
18 by the marketing, sales, eligibility checks, network contract management, issues associated
19 multiple benefit packages, and other administrative waste associated with the current multi-payer
20 private health insurance system;

21 (3) Allowing the planning and delivery of a public health strategy for the entire population
22 of Rhode Island;

23 (4) Improving access to preventive healthcare; and

24 (5) Negotiating on behalf of the state for bulk purchasing of medical supplies and
25 pharmaceuticals.

26 (d) Federal funds. The executive office of health and human services, in collaboration with
27 the director, the board and the Medicaid office, shall seek and obtain waivers and other approvals
28 relating to Medicaid, the Children's Health Insurance Program, Medicare, federal tax exemptions
29 for health care, the ACA, and any other relevant federal programs in order that:

30 (1) Federal funds and other subsidies for health care that would otherwise be paid to the
31 state and its residents and healthcare providers, would be paid by the federal government to the
32 state and deposited into the RICHIP trust fund;

33 (2) Programs would be waived and such funding from federal programs in Rhode Island
34 would be replaced or merged into RICHIP in order that it can operate as a single-payer program;

1 (3) Maximum federal funding for health care is sought even if any necessary waivers or
2 approvals are not obtained and multiple sources of funding with RICHIP trust fund monies are
3 pooled, in order that RICHIP can act as much as possible like a single-payer program to maximize
4 benefits to Rhode Islanders; and

5 (4) Federal financial participation in the programs that are incorporated into RICHIP are
6 not jeopardized.

7 (e) State funds. State funds that would otherwise be appropriated to any governmental
8 agency, office, program, instrumentality, or institution for services and benefits covered under
9 RICHIP shall be directed into the RICHIP trust fund. Payments to the fund pursuant to this section
10 shall be in an amount equal to the money appropriated for those purposes in the fiscal year
11 beginning immediately preceding the effective date of this chapter.

12 (f) Private funds. Private grants including, but not limited to, from nonprofit corporations
13 and other funds specifically ear-marked for health care including, but not limited to, from litigation
14 against tobacco companies, opioid manufacturers, shall also be put into the RICHIP trust fund.

15 (g) Assignments from RICHIP participants. Receipt of healthcare services under the plan
16 shall be deemed an assignment by the RICHIP participant of any right to payment for services from
17 a policy of insurance, a health benefit plan or other source. The other source of healthcare benefits
18 shall pay to the fund all amounts it is obligated to pay to, or on behalf of, the RICHIP participant
19 for covered healthcare services. The director shall commence any action necessary to recover the
20 amounts due.

21 (h) Replacing current health insurance payments with progressive contributions. Instead of
22 making health insurance payments to multiple carriers including, but not limited to, for premiums,
23 co-pays deductibles, and costs in excess of caps for limited coverage, individuals and entities
24 subject to Rhode Island taxation pursuant to § 44-30-1 shall pay progressive contributions to the
25 RICHIP trust fund (referred to collectively in this section as the "RICHIP contributions") for
26 comprehensive coverage. These RICHIP contributions shall be set and adjusted over time to an
27 appropriate level to:

28 (1) Cover the actual cost of the program;

29 (2) Ensure that higher brackets of income subject to specified taxes shall be assessed at a
30 higher marginal rate than lower brackets; and

31 (3) Protect the economic welfare of small businesses, low-income earners and working
32 families through tax credits or exemptions.

33 (i) Contributions based on earned income. The amounts currently paid by employers and
34 employees for health insurance shall initially be replaced by a ten percent (10%) payroll tax, based

1 on the projected average payroll of employees over three (3) previous calendar years. The employer
2 shall pay eighty percent (80%) and the employee shall pay twenty percent (20%) of this payroll
3 tax, except that an employer may agree to pay all or part of the employee's share. Self- employed
4 individuals shall initially pay one-hundred percent (100%) of the payroll tax. The ten percent (10%)
5 initial rate will be adjusted by the director in order that higher brackets of income subject to these
6 taxes shall be assessed at a higher marginal rate than lower brackets and in order that small
7 businesses and lower income earners receive a credit or exemption.

8 (j) Contributions based on unearned income. There shall be a progressive contribution
9 based on unearned income including, but not limited to, capital gains, dividends, interest, profits,
10 and rents. Initially, the unearned income RICHIP contributions shall be equal to ten percent (10%)
11 of such unearned income. The ten percent (10%) initial rate may be adjusted by the director to
12 allow for a graduated progressive exemption or credit for individuals with lower unearned income
13 levels.

14 (e) This section shall take effect when the RICHIP board votes to initiate phase two.

15 **23-106-12. Implementation.**

16 (a) State laws and regulations.

17 (1) In general. The director shall work with the RICHIP board and receive such assistance
18 as may be necessary from other state agencies and entities to examine state laws and regulations
19 and to make recommendations necessary to conform such laws and regulations to properly
20 implement the RICHIP program. The director shall report any recommendations to the governor
21 and the general assembly.

22 (2) Anti-trust laws. The intent of this chapter is to exempt activities provided for under this
23 chapter from state antitrust laws and to provide immunity from federal antitrust laws through the
24 state action doctrine.

25 (b) Severability. If any provision or application of this chapter shall be held to be invalid,
26 or to violate or be inconsistent with any applicable federal law or regulation, that shall not affect
27 other provisions or applications of this chapter which can be given effect without that provision or
28 application; and to that end, the provisions and applications of this chapter are severable.

29 SECTION 2. Chapter 22-11 of the General Laws entitled "Joint Committee on Legislative
30 Services" is hereby amended by adding thereto the following section:

31 **22-11-4.1. Health policy staffing.**

32 The joint committee on legislative services shall fund five (5) new full-time employees
33 (FTEs) for the senate fiscal office and five (5) new FTEs for the house fiscal office exclusively
34 devoted to health policy.

1 SECTION 3. Section 27-34.3-7 of the General Laws in Chapter 27-34.3 entitled "Rhode
2 Island Life and Health Insurance Guaranty Association Act" is hereby amended to read as follows:

3 **27-34.3-7. Board of directors.**

4 (a) The board of directors of the association shall consist of:

5 (1) ~~Not less than five (5) nor more than nine (9) member insurers serving terms as~~
6 ~~established in the plan of operation~~ Nine (9) members appointed by the governor with advice and
7 consent of the senate; and

8 (2) The commissioner or the commissioner's designee shall chair the board in a non-voting
9 ex officio capacity. ~~Only member insurers shall be eligible to vote. The members of the board shall~~
10 ~~be selected by member insurers subject to the approval of the commissioner.~~ The board of directors,
11 previously established under § 27-34.1-8 [repealed], shall continue to operate in accordance with
12 the provision of this section. ~~Vacancies on the board shall be filled for the remaining period of the~~
13 ~~term by a majority vote of the remaining board members, subject to the approval of the~~
14 ~~commissioner.~~

15 (b) ~~In approving selections to the board, the commissioner shall consider, among other~~
16 ~~things, whether all member insurers are fairly represented.~~

17 (c) Members of the board may be reimbursed from the assets of the association for expenses
18 incurred by them as members of the board of directors but members of the board shall not be
19 compensated by the association for their services.

20 SECTION 4. Section 27-66-24 of the General Laws in Chapter 27-66 entitled "The Health
21 Insurance Conversions Act" is hereby amended to read as follows:

22 **27-66-24. Exceptions — Rehabilitation, liquidation, or conservation.**

23 ~~No proposed conversion shall be subject to this chapter in~~ In the event that ~~the a~~ health
24 insurance corporation, health maintenance corporation, pharmacy benefit manager, nonprofit
25 dental service corporation, managed care organization, nonprofit optometric service corporation, a
26 nonprofit hospital service corporation, nonprofit medical service corporation, or affiliate or
27 subsidiary of them, hereinafter the "insurer", is subject to an order from the superior court directing
28 the director to rehabilitate, liquidate, or conserve, as provided in §§ 27-19-28, 27-20-24, 27-41-18,
29 or chapter 14.1, 14.2, 14.3, or 14.4 of this title, certain additional conditions shall apply to the
30 insurer:

31 (1) The insolvency, financial condition, or default of the insurer at any time shall not permit
32 the insurer to fail to pay claims in a timely manner.

33 (2) Should the insurer fail to pay claims in a timely manner, those claims shall become a
34 temporary obligation of the state, who shall pay them in a timely manner. Should the state be

1 compelled to pay claims for this reason, the insurer shall owe the state a fine ten (10) times the
2 value of all claims paid.

3 (3) The insolvency, financial condition, or default of the insurer at any time shall not permit
4 the insurer to fail to pay state taxes on time. Should the insurer fail to pay taxes on time, the size of
5 the tax obligation owed shall increase by a factor of ten (10).

6 (4) The RICHIP board and its state-owned health insurance company shall be guaranteed
7 a right of first refusal to acquire the insurer before alternate buyers are considered. Any obligations
8 due to the state by the insurer shall be counted towards the purchase price of the insurer. The Rhode
9 Island life and health insurance guaranty association, created pursuant to § 27-34.3-6, shall pay the
10 costs of an acquisition by the RICHIP board or its state-owned health insurance company pursuant
11 to this section.

12 SECTION 5. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by
13 adding thereto the following chapter:

14 CHAPTER 84

15 PRIOR AUTHORIZATION OF CERTAIN HEALTH INSURANCE POLICY CHANGES

16 **27-84-1. Definitions.**

17 For purposes of this chapter:

18 "Health insurer" means any entity subject to the insurance laws and regulations of this state,
19 or subject to the jurisdiction of the health insurance commissioner, that contracts or offers to
20 contract, to provide and/or insuring health services on a prepaid basis including, but not limited to,
21 policies of accident and sickness insurance subject to chapter 18 of title 27; any nonprofit hospital
22 service corporation subject to chapter 19 of title 27; any nonprofit medical service corporation
23 subject to chapter 20 of title 27; any health maintenance organization subject to chapter 41 of title
24 27; any nonprofit dental service corporation subject to chapter 20.1 of title 27; any nonprofit
25 optometric service corporation subject to chapter 20.2 of title 27; any pharmacy benefit manager;
26 or any health benefit plan issued by the State of Rhode Island, a municipality, a quasi-public
27 agency, or any other political subdivision of the State of Rhode Island to cover employees.

28 **27-84-2. Prior authorization of general assembly.**

29 (a) Prior authorization of the general assembly shall be required for certain policy changes
30 by health insurers:

31 (1) Any change that increases the average amount charged annually to consumers on a per
32 beneficiary basis;

33 (2) Any change that in any way reduces any benefits offered to plan beneficiaries;

34 (3) Any change that increases any premiums, deductibles, or copays;

1 (4) Ceasing offering any plan a health insurer offers within the State of Rhode Island; or
2 (5) Any other change that the health insurance commissioner or attorney general shall,
3 through regulation, determine to require prior authorization of the general assembly.

4 (b) No rate reviews pursuant to those utilized in §§ 27-18-54, 27-19-30.1, 27-20-25.2, 27-
5 41-27.2, and 42-62-13 shall be construed to exempt any health insurer from the prior authorization
6 requirements of this chapter.

7 SECTION 6. Section 28-57-5 of the General Laws in Chapter 28-57 entitled "Healthy and
8 Safe Families and Workplaces Act" is hereby amended to read as follows:

9 **28-57-5. Accrual of paid sick and safe leave time.**

10 (a) All employees employed by an employer of eighteen (18) or more employees in Rhode
11 Island shall accrue a minimum of one hour of paid sick and safe leave time for every thirty five
12 (35) hours worked up to a maximum of twenty-four (24) hours during calendar year 2018, thirty-
13 two (32) hours during calendar year 2019, ~~and up to a maximum of~~ forty (40) hours per year from
14 calendar year 2020 through calendar year 2027, and one hundred sixty (160) hours per year
15 thereafter, unless the employer chooses to provide a higher annual limit in both accrual and use. In
16 determining the number of employees who are employed by an employer for compensation, all
17 employees defined in § 28-57-3(7) shall be counted.

18 (b) Employees who are exempt from the overtime requirements under 29 U.S.C. §
19 213(a)(1) of the federal Fair Labor Standards Act, 29 U.S.C. § 201 et seq., will be assumed to work
20 forty (40) hours in each workweek for purposes of paid sick and safe leave time accrual unless their
21 normal workweek is less than forty (40) hours, in which case paid sick and safe leave time accrues
22 based upon that normal workweek.

23 (c) Paid sick and safe leave time as provided in this chapter shall begin to accrue at the
24 commencement of employment or pursuant to the law's effective date [July 1, 2018], whichever is
25 later. An employer may provide all paid sick and safe leave time that an employee is expected to
26 accrue in a year at the beginning of the year.

27 (d) An employer may require a waiting period for newly hired employees of up to ninety
28 (90) days. During this waiting period, an employee shall accrue earned sick time pursuant to this
29 section or the employer's policy, if exempt under § 28-57-4(b), but shall not be permitted to use
30 the earned sick time until after he or she has completed the waiting period.

31 (e) Paid sick and safe leave time shall be carried over to the following calendar year;
32 however, an employee's use of paid sick and safe leave time provided under this chapter in each
33 calendar year shall not exceed twenty-four (24) hours during calendar year 2018, and thirty-two
34 (32) hours during calendar year 2019, and forty (40) hours per year thereafter. Alternatively, in lieu

1 of carryover of unused earned paid sick and safe leave time from one year to the next, an employer
2 may pay an employee for unused earned paid sick and safe leave time at the end of a year and
3 provide the employee with an amount of paid sick and safe leave that meets or exceeds the
4 requirements of this chapter that is available for the employee's immediate use at the beginning of
5 the subsequent year.

6 (f) Nothing in this chapter shall be construed as requiring financial or other reimbursement
7 to an employee from an employer upon the employee's termination, resignation, retirement, or
8 other separation from employment for accrued paid sick and safe leave time that has not been used.

9 (g) If an employee is transferred to a separate division, entity, or location within the state,
10 but remains employed by the same employer as defined in 29 C.F.R. § 791.2 of the federal Fair
11 Labor Standards Act, 29 U.S.C. § 201 et seq., the employee is entitled to all paid sick and safe leave
12 time accrued at the prior division, entity, or location and is entitled to use all paid sick and safe
13 leave time as provided in this act. When there is a separation from employment and the employee
14 is rehired within one hundred thirty-five (135) days of separation by the same employer, previously
15 accrued paid sick and safe leave time that had not been used shall be reinstated. Further, the
16 employee shall be entitled to use accrued paid sick and safe leave time and accrue additional sick
17 and safe leave time at the re-commencement of employment.

18 (h) When a different employer succeeds or takes the place of an existing employer, all
19 employees of the original employer who remain employed by the successor employer within the
20 state are entitled to all earned paid sick and safe leave time they accrued when employed by the
21 original employer, and are entitled to use earned paid sick and safe leave time previously accrued.

22 (i) At its discretion, an employer may loan sick and safe leave time to an employee in
23 advance of accrual by such employee.

24 (j) Temporary employees shall be entitled to use accrued paid sick and safe leave time
25 beginning on the one hundred eightieth (180) calendar day following commencement of their
26 employment, unless otherwise permitted by the employer. On and after the one hundred eightieth
27 (180) calendar day of employment, employees may use paid sick and safe leave time as it is
28 accrued. During this waiting period, an employee shall accrue earned sick time pursuant to this
29 chapter, but shall not be permitted to use the earned sick time until after he or she has completed
30 the waiting period.

31 (k) Seasonal employees shall be entitled to use accrued paid sick and safe leave time
32 beginning on the one hundred fiftieth (150) calendar day following commencement of their
33 employment, unless otherwise permitted by the employer. On and after the one hundred fiftieth
34 (150) calendar day of employment, employees may use paid sick and safe leave time as it is

1 accrued. During this waiting period, an employee shall accrue earned sick time pursuant to this
2 chapter, but shall not be permitted to use the earned sick time until after he or she has completed
3 the waiting period.

4 SECTION 7. Sections 40-8-2, 40-8-6, 40-8-10, 40-8-13, 40-8-16, 40-8-26 and 40-8-32 of
5 the General Laws in Chapter 40-8 entitled "Medical Assistance" are hereby amended to read as
6 follows:

7 **40-8-2. Definitions.**

8 As used in this chapter, unless the context shall otherwise require:

9 (1) "Dental service" means and includes emergency care, X-rays for diagnoses, extractions,
10 palliative treatment, and the refitting and relining of existing dentures and prosthesis.

11 (2) "Department" means the department of human services.

12 (3) "Director" means the ~~director of human services~~ [Medicaid director](#).

13 (4) "Drug" means and includes only drugs and biologicals prescribed by a licensed dentist
14 or physician as are either included in the United States pharmacopoeia, national formulary, or are
15 new and nonofficial drugs and remedies.

16 (5) "Inpatient" means a person admitted to and under treatment or care of a physician or
17 surgeon in a hospital or nursing facility that meets standards of and complies with rules and
18 regulations promulgated by the director.

19 (6) "Inpatient hospital services" means the following items and services furnished to an
20 inpatient in a hospital other than a hospital, institution, or facility for tuberculosis or mental
21 diseases:

22 (i) Bed and board;

23 (ii) Nursing services and other related services as are customarily furnished by the hospital
24 for the care and treatment of inpatients and drugs, biologicals, supplies, appliances, and equipment
25 for use in the hospital, as are customarily furnished by the hospital for the care and treatment of
26 patients;

27 (iii)(A) Other diagnostic or therapeutic items or services, including, but not limited to,
28 pathology, radiology, and anesthesiology furnished by the hospital or by others under arrangements
29 made by the hospital, as are customarily furnished to inpatients either by the hospital or by others
30 under such arrangements, and services as are customarily provided to inpatients in the hospital by
31 an intern or resident-in-training under a teaching program having the approval of the Council on
32 Medical Education and Hospitals of the American Medical Association or of any other recognized
33 medical society approved by the director.

34 (B) The term "inpatient hospital services" shall be taken to include medical and surgical

1 services provided by the inpatient’s physician, but shall not include the services of a private-duty
2 nurse or services in a hospital, institution, or facility maintained primarily for the treatment and
3 care of patients with tuberculosis or mental diseases. Provided, further, it shall be taken to include
4 only the following organ transplant operations: kidney, liver, cornea, pancreas, bone marrow, lung,
5 heart, and heart/lung, and other organ transplant operations as may be designated by the director
6 after consultation with medical advisory staff or medical consultants; and provided that any such
7 transplant operation is determined by the director or his or her designee to be medically necessary.
8 Prior written approval of the director, or his or her designee, shall be required for all covered organ
9 transplant operations.

10 (C) In determining medical necessity for organ transplant procedures, the state plan shall
11 adopt a case-by-case approach and shall focus on the medical indications and contra-indications in
12 each instance; the progressive nature of the disease; the existence of any alternative therapies; the
13 life-threatening nature of the disease; the general state of health of the patient apart from the
14 particular organ disease; and any other relevant facts and circumstances related to the applicant and
15 the particular transplant procedure.

16 (7) "Medicare equivalent rate" means the amount that would be paid for the relevant
17 services as furnished by the relevant group of facilities under Medicare payment principles
18 delineated in subchapter B of 42 CFR Chapter IV. Should no direct Medicare rates be available for
19 the particular service and facility group, the Medicaid director will estimate the rate. Providers will
20 have standing to bring an action in superior court for a higher rate, but intermediary insurers such
21 as managed care entities shall have no standing to bring an action for a lower rate.

22 ~~(7)~~(8) “Nursing services” means the following items and services furnished to an inpatient
23 in a nursing facility:

- 24 (i) Bed and board;
- 25 (ii) Nursing care and other related services as are customarily furnished to inpatients
26 admitted to the nursing facility, and drugs, biologicals, supplies, appliances, and equipment for use
27 in the facility, as are customarily furnished in the facility for the care and treatment of patients;
- 28 (iii) Other diagnostic or therapeutic items or services, legally furnished by the facility or
29 by others under arrangements made by the facility, as are customarily furnished to inpatients either
30 by the facility or by others under such arrangement;
- 31 (iv) Medical services provided in the facility by the inpatient’s physician, or by an intern
32 or resident-in-training of a hospital with which the facility is affiliated or that is under the same
33 control, under a teaching program of the hospital approved as provided in subsection (6); and
34 (v) A personal-needs allowance of ~~seventy-five dollars (\$75.00)~~ two hundred dollars

1 [\(\\$200\)](#) per month.

2 ~~(8)~~[\(9\)](#) “Relative with whom the dependent child is living” means and includes the father,
3 mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister,
4 uncle, aunt, first cousin, nephew, or niece of any dependent child who maintains a home for the
5 dependent child.

6 ~~(9)~~[\(10\)](#) “Visiting nurse service” means part-time or intermittent nursing care provided by
7 or under the supervision of a registered professional nurse other than in a hospital or nursing home.

8 **40-8-6. Review of application for benefits.**

9 The director, or someone designated by him or her, shall review each application for
10 benefits filed in accordance with regulations, and shall make a determination of whether the
11 application will be honored and the extent of the benefits to be made available to the applicant, and
12 shall, within ~~thirty (30)~~ [fifteen \(15\)](#) days after the filing, notify the applicant, in writing, of the
13 determination. If the application is rejected, the notice to the applicant shall set forth therein the
14 reason therefor. The director may at any time reconsider any determination.

15 **40-8-10. Recovery of benefits paid in error.**

16 Any person, who through ~~error or mistake of himself or herself or another~~ [willful and](#)
17 [knowing fraudulent misrepresentation](#), receives medical care benefits to which he or she is not
18 entitled or with respect to which he or she was ineligible, shall be required to reimburse the state
19 for the benefits ~~paid through error or mistake~~ [that were paid out during a time period, not to exceed](#)
20 [three \(3\) years, where the person was not entitled to benefits but received them as a result of the](#)
21 [willful and knowing fraudulent misrepresentation.](#)

22 **40-8-13. Rules, regulations, and fee schedules.**

23 The director shall make and promulgate rules, regulations, and fee schedules not
24 inconsistent with state law and fiscal procedures as he or she deems necessary for the proper
25 administration of this chapter and to carry out the policy and purposes thereof, and to make the
26 department’s plan conform to the provisions of the federal Social Security Act, 42 U.S.C. § 1396
27 et seq., and any rules or regulations promulgated pursuant thereto. [Except where explicitly](#)
28 [authorized by this title, the director shall have no power to set any fee schedule below the Medicare](#)
29 [equivalent rate; provided, however, that the director shall be empowered to provide a lower rate](#)
30 [equal to the maximum rate where federal reimbursement can be obtained in the event that federal](#)
31 [reimbursement cannot be obtained for the Medicare equivalent rate. For outpatient behavioral](#)
32 [health services, the minimum fee schedule shall be set at one hundred fifty percent \(150%\) of the](#)
33 [Medicare equivalent rate. The director shall attempt to obtain federal reimbursement for billing](#)
34 [outpatient behavioral health services at one hundred fifty percent \(150%\) of the Medicare](#)

1 equivalent rate, but the state shall bear the costs of this higher rate for outpatient behavioral health
2 services even if federal reimbursement cannot be obtained. Should federal financial participation
3 be impossible to obtain for the outpatient behavioral health services rate of one hundred fifty
4 percent (150%) of the Medicare equivalent rate, the director shall impose a surtax on the tax
5 imposed on health insurers pursuant to chapter 17 of title 44 in the amount necessary to defray the
6 costs of the inability to obtain federal reimbursement for an outpatient behavioral health services
7 rate of one hundred fifty percent (150%) of the Medicare equivalent rate.

8 **40-8-16. Notification of long-term care alternative.**

9 (a) The department of human services, before authorizing care in a nursing home or
10 intermediate-care facility for a person who is eligible to receive benefits pursuant to Title XIX of
11 the federal Social Security Act, 42 U.S.C. § 1396 et seq., and who is being discharged from a
12 hospital to a nursing home, shall notify the person, in writing, of the provisions of the long-term-
13 care alternative, a home- and a community-based program.

14 (b) If a person, eligible to receive benefits pursuant to Title XIX of the federal Social
15 Security Act, requires services in a nursing home and desires to remain in his or her own home or
16 the home of a responsible relative or other adult, the person or his or her representative shall so
17 inform the department.

18 ~~(c) The department shall not make payments pursuant to Title XIX of the federal Social~~
19 ~~Security Act for benefits until written notification documenting the person's choice as to a nursing~~
20 ~~home or home- and community-based services has been filed with the department.~~

21 **40-8-26. Community health centers.**

22 (a) For the purposes of this section, the term community health centers refers to federally
23 qualified health centers and rural health centers.

24 (b) To support the ability of community health centers to provide high-quality medical care
25 to patients, the executive office of health and human services ("executive office") may adopt and
26 implement an alternative payment methodology (APM) for determining a Medicaid per-visit
27 reimbursement for community health centers ~~that is compliant with the prospective payment system~~
28 ~~(PPS) provided for in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection~~
29 ~~Act of 2000.~~ The following principles are to ensure that the APM ~~PPS~~ rate determination
30 methodology is part of the executive office overall value purchasing approach. For community
31 health centers that do not agree to the principles of reimbursement that reflect the APM ~~PPS~~,
32 EOHHS shall reimburse such community health centers at the federal PPS rate, as required per
33 section 1902(bb)(3) of the Social Security Act, 42 U.S.C. § 1396a(bb)(3). For community health
34 centers that are reimbursed at the federal PPS rate, subsections (d) through (f) of this section apply.

1 (c) The APM PPS rate determination methodology will ~~(i) Fairly recognize the reasonable~~
2 ~~costs of providing services. Recognized reasonable costs will be those appropriate for the~~
3 ~~organization, management, and direct provision of services and (ii) Provide assurances to the~~
4 ~~executive office that services are provided in an effective and efficient manner, consistent with~~
5 ~~industry standards. Except for demonstrated cause and at the discretion of the executive office, the~~
6 ~~maximum reimbursement rate for a service (e.g., medical, dental) provided by an individual~~
7 ~~community health center shall not exceed one hundred twenty five percent (125%) of the median~~
8 ~~rate for all community health centers within Rhode Island.~~ not only bill the community health center
9 on a fee-for-service basis at the Medicare equivalent rate but also make a series of quality incentive
10 payments if the community health center meets certain quality incentives. Quality incentive
11 payments shall be set at a percentage of the aggregate monthly billing. The quality incentive
12 payments shall be as follows:

13 (1) Ten percent (10%) for meeting benchmarks set by the Medicaid director for screening
14 patients for Medicaid eligibility.

15 (2) Five percent (5%) for meeting benchmarks set by the Medicaid director for enrolling
16 patients who regularly smoke tobacco in smoking cessation programs.

17 (3) Ten percent (10%) for meeting benchmarks set by the director of human services for
18 screening patients for supplemental nutrition assistance program eligibility.

19 (4) Ten percent (10%) for ensuring that no more than one percent of patients are ever not
20 offered an appointment within a month if they request one.

21 (5) Up to fifteen percent (15%) for meeting benchmarks set by the Medicaid director for
22 the improvement of air quality in patients' homes through directly funding interventions including,
23 but not limited: air quality inspections, the installation of air filters, the installation of ventilation,
24 and the replacement of gas stoves with electric stoves.

25 (6) Up to fifteen percent (15%) for meeting benchmarks set by the Medicaid director for
26 the removal or mitigation of environmental toxins in patients' homes through the direct funding of
27 removal or mitigation of environmental toxins. These toxins shall include, but shall not be limited
28 to, lead, radon, asbestos, and carbon monoxide.

29 (d) Community health centers will cooperate fully and timely with reporting requirements
30 established by the executive office.

31 (e) Reimbursement rates established through this methodology shall be incorporated into
32 the PPS reconciliation for services provided to Medicaid-eligible persons who are enrolled in a
33 health plan on the date of service. Monthly payments by the executive office related to PPS for
34 persons enrolled in a health plan shall be made directly to the community health centers.

1 (f) Reimbursement rates established through ~~this~~ the APM methodology shall not be
2 incorporated into the actuarially certified capitation rates paid to a health plan. The health plan shall
3 be responsible for paying the full amount of the reimbursement rate to the community health center
4 for each service eligible for reimbursement under the Medicare, Medicaid, and SCHIP Benefits
5 Improvement and Protection Act of 2000. If the ~~health plan has an alternative payment arrangement~~
6 ~~with the~~ community health center opts to utilize the APM methodology, the health plan ~~may~~
7 ~~establish a PPS reconciliation process for eligible services and make monthly payments related to~~
8 ~~PPS for persons enrolled in the health plan on the date of service~~ shall bear the full upside and
9 downside risk of decreased or increased costs from the APM methodology. The executive office
10 will review, at least annually, the Medicaid reimbursement rates and reconciliation methodology
11 used by the health plans for community health centers to ensure payments to each are made in
12 compliance with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of
13 2000.

14 **40-8-32. Support for certain patients of nursing facilities.**

15 (a) Definitions. For purposes of this section:

16 (1) “Applied income” shall mean the amount of income a Medicaid beneficiary is required
17 to contribute to the cost of his or her care.

18 (2) “Authorized individual” shall mean a person who has authority over the income of a
19 patient of a nursing facility, such as a person who has been given or has otherwise obtained
20 authority over a patient’s bank account; has been named as or has rights as a joint account holder;
21 or is a fiduciary as defined below.

22 (3) “Costs of care” shall mean the costs of providing care to a patient of a nursing facility,
23 including nursing care, personal care, meals, transportation, and any other costs, charges, and
24 expenses incurred by a nursing facility in providing care to a patient. Costs of care shall not exceed
25 the customary rate the nursing facility charges to a patient who pays for his or her care directly
26 rather than through a governmental or other third-party payor.

27 (4) “Fiduciary” shall mean a person to whom power or property has been formally
28 entrusted for the benefit of another, such as an attorney-in-fact, legal guardian, trustee, or
29 representative payee.

30 (5) “Nursing facility” shall mean a nursing facility licensed under chapter 17 of title 23,
31 that is a participating provider in the Rhode Island Medicaid program.

32 (6) “Penalty period” means the period of Medicaid ineligibility imposed pursuant to 42
33 U.S.C. § 1396p(c), as amended from time to time, on a person whose assets have been transferred
34 for less than fair market value.

1 (7) “Uncompensated care” — Care and services provided by a nursing facility to a
2 Medicaid applicant without receiving compensation therefore from Medicaid, Medicare, the
3 Medicaid applicant, or other source. The acceptance of any payment representing actual or
4 estimated applied income shall not disqualify the care and services provided from qualifying as
5 uncompensated care.

6 (b) Penalty period resulting from transfer. Any transfer or assignment of assets resulting in
7 the establishment or imposition of a penalty period shall create a debt that shall be due and owing
8 to a nursing facility for the unpaid costs of care provided during the penalty period to a patient of
9 that facility who has been subject to the penalty period. The amount of the debt established shall
10 not exceed the fair market value of the transferred assets at the time of transfer that are the subject
11 of the penalty period. A nursing facility may bring an action to collect a debt for the unpaid costs
12 of care given to a patient who has been subject to a penalty period, against ~~either~~ the transferor ~~or~~
13 ~~the transferee, or both~~. The provisions of this section shall not affect other rights or remedies of the
14 parties.

15 (c) Applied income. A nursing facility may provide written notice to a patient who is a
16 Medicaid recipient and any authorized individual of that patient:

17 (1) Of the amount of applied income due;

18 (2) Of the recipient’s legal obligation to pay the applied income to the nursing facility; and

19 (3) That the recipient’s failure to pay applied income due to a nursing facility not later than
20 thirty (30) days after receiving notice from the nursing facility may result in a court action to
21 recover the amount of applied income due.

22 A nursing facility that is owed applied income may, in addition to any other remedies
23 authorized under law, bring a claim to recover the applied income against a patient and any
24 authorized individual. If a court of competent jurisdiction determines, based upon clear and
25 convincing evidence, that a defendant willfully failed to pay or withheld applied income due and
26 owing to a nursing facility for more than thirty (30) days after receiving notice pursuant to
27 subsection (c), the court may award the amount of the debt owed, ~~court costs, and reasonable~~
28 ~~attorney’s fees~~ to the nursing facility.

29 (d) Effects. Nothing contained in this section shall prohibit or otherwise diminish any other
30 causes of action possessed by any such nursing facility. The death of the person receiving nursing
31 facility care shall not nullify or otherwise affect the liability of the person or persons charged with
32 the costs of care rendered or the applied income amount as referenced in this section.

33 SECTION 8. Sections 40-8-3.1, 40-8-9.1, 40-8-13.5, 40-8-15, 40-8-19.2 and 40-8-27 of
34 the General Laws in Chapter 40-8 entitled "Medical Assistance" are hereby repealed.

1 ~~**40-8-3.1. Life estate in property—Retained powers.**~~

2 ~~When an applicant or recipient of Medicaid owns a life estate in property that is his or her~~
3 ~~principal place of residence with the reserved power and authority, during his or her lifetime, to~~
4 ~~sell, convey, mortgage, or otherwise dispose of the real property without the consent or joinder by~~
5 ~~the holder(s) of the remainder interest, the principal place of residence shall not be regarded as an~~
6 ~~excluded resource for the purpose of Medicaid eligibility, unless the applicant or recipient~~
7 ~~individually, or through his or her guardian, conservator, or attorney in fact, conveys all outstanding~~
8 ~~remainder interest to him or herself.~~

9 ~~An applicant or recipient who, by a deed created, executed and recorded on or before June~~
10 ~~30, 2014, has reserved a life estate in property that is his or her principal place of residence with~~
11 ~~the reserved power and authority, during his or her lifetime, to sell, convey, mortgage, or otherwise~~
12 ~~dispose of the real property without the consent or joinder by the holder(s) of the remainder interest,~~
13 ~~shall not be ineligible for Medicaid on the basis of the deed, regardless of whether the transferee of~~
14 ~~the remainder interest is a person or persons, trust, or entity.~~

15 ~~**40-8-9.1. Notice.**~~

16 ~~Whenever an individual who is receiving medical assistance under this chapter transfers~~
17 ~~an interest in real or personal property, the individual shall notify the executive office of health and~~
18 ~~human services within ten (10) days of the transfer. The notice shall be sent to the individual's local~~
19 ~~office and the legal office of the executive office of health and human services and include, at a~~
20 ~~minimum, the individual's name, social security number or, if different, the executive office of~~
21 ~~health and human services identification number, the date of transfer, and the dollar value, if any,~~
22 ~~paid or received by the individual who received benefits under this chapter. In the event an~~
23 ~~individual fails to provide notice required by this section to the executive office of health and human~~
24 ~~services and in the event an individual has received medical assistance, any individual and/or entity,~~
25 ~~who knew or should have known that the individual failed to provide the notice and who receives~~
26 ~~any distribution of value as a result of the transfer, shall be liable to the executive office of health~~
27 ~~and human services to the extent of the value of the transfer. Moreover, any such individual shall~~
28 ~~be subject to the provisions of § 40-6-15 and any remedy provided by applicable state and federal~~
29 ~~laws and rules and regulations. Failure to comply with the notice requirements set forth in the~~
30 ~~section shall not affect the marketability of title to real estate transferred while the transferor is~~
31 ~~receiving medical assistance.~~

32 ~~**40-8-13.5. Hospital Incentive Program (HIP).**~~

33 ~~The secretary of the executive office of health and human services is authorized to seek the~~
34 ~~federal authorities required to implement a hospital incentive program (HIP). The HIP shall provide~~

1 ~~the participating licensed hospitals the ability to obtain certain payments for achieving performance~~
2 ~~goals established by the secretary. HIP payments shall commence no earlier than July 1, 2016.~~

3 **40-8-15. Lien on deceased recipient's estate for assistance.**

4 (a)(1) ~~Upon the death of a recipient of Medicaid under Title XIX of the federal Social~~
5 ~~Security Act (42 U.S.C. § 1396 et seq. and referred to hereinafter as the "Act"), the total sum for~~
6 ~~Medicaid benefits so paid on behalf of a beneficiary who was fifty-five (55) years of age or older~~
7 ~~at the time of receipt shall be and constitute a lien upon the estate, as defined in subsection (a)(2),~~
8 ~~of the beneficiary in favor of the executive office of health and human services ("executive office").~~
9 ~~The lien shall not be effective and shall not attach as against the estate of a beneficiary who is~~
10 ~~survived by a spouse, or a child who is under the age of twenty-one (21), or a child who is blind or~~
11 ~~permanently and totally disabled as defined in Title XVI of the federal Social Security Act, 42~~
12 ~~U.S.C. § 1381 et seq. The lien shall attach against property of a beneficiary, which is included or~~
13 ~~includable in the decedent's probate estate, regardless of whether or not a probate proceeding has~~
14 ~~been commenced in the probate court by the executive office or by any other party. Provided,~~
15 ~~however, that such lien shall only attach and shall only be effective against the beneficiary's real~~
16 ~~property included or includable in the beneficiary's probate estate if such lien is recorded in the~~
17 ~~land evidence records and is in accordance with subsection (e). Decedents who have received~~
18 ~~Medicaid benefits are subject to the assignment and subrogation provisions of §§ 40-6-9 and 40-6-~~
19 ~~10.~~

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

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

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

31 (d) ~~Upon payment of the amount of reimbursement for Medicaid benefits imposed by this~~
32 ~~section, the secretary of the executive office, or his or her designee, shall issue a written discharge~~
33 ~~of lien.~~

34 (e) ~~Provided, however, that no lien created under this section shall attach nor become~~

1 ~~effective upon any real property unless and until a statement of claim is recorded naming the~~
2 ~~debtor/owner of record of the property as of the date and time of recording of the statement of~~
3 ~~claim, and describing the real property by a description containing all of the following: (1) Tax~~
4 ~~assessor's plat and lot; and (2) Street address. The statement of claim shall be recorded in the~~
5 ~~records of land evidence in the town or city where the real property is situated. Notice of the lien~~
6 ~~shall be sent to the duly appointed executor or administrator, the decedent's legal representative, if~~
7 ~~known, or to the decedent's next of kin or heirs at law as stated in the decedent's last application~~
8 ~~for Medicaid benefits.~~

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

15 ~~(g) Upon the filing of a petition for admission to probate of a decedent's will or for~~
16 ~~administration of a decedent's estate, when the decedent was fifty-five (55) years or older at the~~
17 ~~time of death, a copy of the petition and a copy of the death certificate shall be sent to the executive~~
18 ~~office. Within thirty (30) days of a request by the executive office, an executor or administrator~~
19 ~~shall complete and send to the executive office a form prescribed by that office and shall provide~~
20 ~~such additional information as the office may require. In the event a petitioner fails to send a copy~~
21 ~~of the petition and a copy of the death certificate to the executive office and a decedent has received~~
22 ~~Medicaid benefits for which the executive office is authorized to recover, no distribution and/or~~
23 ~~payments, including administration fees, shall be disbursed. Any person and/or entity that receives~~
24 ~~a distribution of assets from the decedent's estate shall be liable to the executive office to the extent~~
25 ~~of such distribution.~~

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

30 ~~(i) To ensure the financial integrity of the Medicaid eligibility determination, benefit~~
31 ~~renewal, and estate recovery processes in this and related sections, the secretary of health and~~
32 ~~human services is authorized and directed to, by no later than August 1, 2018: (1) Implement an~~
33 ~~automated asset verification system, as mandated by § 1940 of the Act, that uses electronic data~~
34 ~~sources to verify the ownership and value of countable resources held in financial institutions and~~

1 ~~any real property for applicants and beneficiaries subject to resource and asset tests pursuant to the~~
2 ~~Act in § 1902(e)(14)(D); (2) Apply the provisions required under §§ 1902(a)(18) and 1917(e) of~~
3 ~~the Act pertaining to the disposition of assets for less than fair market value by applicants and~~
4 ~~beneficiaries for Medicaid long term services and supports and their spouses, without regard to~~
5 ~~whether they are subject to or exempted from resources and asset tests as mandated by federal~~
6 ~~guidance; and (3) Pursue any state plan or waiver amendments from the United States Centers for~~
7 ~~Medicare and Medicaid Services and promulgate such rules, regulations, and procedures he or she~~
8 ~~deems necessary to carry out the requirements set forth herein and ensure the state plan and~~
9 ~~Medicaid policy conform and comply with applicable provisions of Title XIX.~~

10 ~~**40-8-19.2. Nursing Facility Incentive Program (NFIP).**~~

11 ~~The secretary of the executive office of health and human services is authorized to seek the~~
12 ~~federal authority required to implement a nursing facility incentive program (NFIP). The NFIP~~
13 ~~shall provide the participating licensed nursing facilities the ability to obtain certain payments for~~
14 ~~achieving performance goals established by the secretary. NFIP payments shall commence no~~
15 ~~earlier than July 1, 2016.~~

16 ~~**40-8-27. Cooperation by providers.**~~

17 ~~Medicaid providers who employ individuals applying for benefits under any chapter of this~~
18 ~~title shall comply in a timely manner with requests made by the department for any documents~~
19 ~~describing employer sponsored health insurance coverage or benefits the provider offers that are~~
20 ~~necessary to determine eligibility for the state's premium assistance program pursuant to § 40-8.4-~~
21 ~~12. Documents requested by the department may include, but are not limited to, certificates of~~
22 ~~coverage or a summary of benefits and employee obligations. Upon receiving notification that the~~
23 ~~department has determined that the employee is eligible for premium assistance under § 40-8.4-12,~~
24 ~~the provider shall accept the enrollment of the employee and his or her family in the employer-~~
25 ~~based health insurance plan without regard to any seasonal enrollment restrictions, including open-~~
26 ~~enrollment restrictions, and/or the impact on the employee's wages. Additionally, the Medicaid~~
27 ~~provider employing such persons shall not offer "pay in lieu of benefits." Providers who do not~~
28 ~~comply with the provisions set forth in this section shall be subject to suspension as a participating~~
29 ~~Medicaid provider.~~

30 SECTION 9. Sections 40-8.4-5, 40-8.4-10, 40-8.4-12, 40-8.4-15 and 40-8.4-19 of the
31 General Laws in Chapter 40-8.4 entitled "Health Care for Families" are hereby amended to read as
32 follows:

33 ~~**40-8.4-5. Managed care.**~~

34 The delivery and financing of the healthcare services provided under this chapter ~~shall~~ may

1 be provided through a system of managed care. ~~A managed care system integrates an efficient~~
2 ~~financing mechanism with quality service delivery; provides a “medical home” to ensure~~
3 ~~appropriate care and deter unnecessary and inappropriate care; and places emphasis on preventive~~
4 ~~and primary health care.~~ Beginning July 1, 2030, all payments shall be provided directly by the
5 state without an intermediate payment to a managed care entity or other form of health insurance
6 company, unless it is owned by the state. Beginning July 1, 2026, no new contracts may be entered
7 into between the Medicaid office and an intermediate payor such as a managed care entity or other
8 form of health insurance company for the payment of healthcare services pursuant to this chapter,
9 unless it is owned by the state.

10 **40-8.4-10. Regulations.**

11 (a) The ~~department of human services~~ Medicaid director is authorized to promulgate any
12 regulations necessary to implement this chapter.

13 (b) When promulgating any rule or regulation necessary to implement this chapter, or any
14 rule or regulation related to RItE Care, the ~~department~~ Medicaid director shall send the notice
15 referred to in § 42-35-3 and a true copy of the rule referred to in § 42-35-4 of the Rhode Island
16 administrative procedures act to each of the co-chairpersons of the permanent joint committee on
17 health care oversight established by § 40-8.4-14.

18 **40-8.4-12. RItE Share health insurance premium assistance program.**

19 (a) **Basic RItE Share health insurance premium assistance program.** Under the terms
20 of Section 1906 of Title XIX of the U.S. Social Security Act, 42 U.S.C. § 1396e, states are permitted
21 to pay a Medicaid-eligible person’s share of the costs for enrolling in employer-sponsored health
22 insurance (ESI) coverage if it is cost-effective to do so. Pursuant to the general assembly’s direction
23 in the Rhode Island health reform act of 2000, the Medicaid agency requested and obtained federal
24 approval under § 1916, 42 U.S.C. § 1396o, to establish the RItE Share premium assistance program
25 to subsidize the costs of enrolling Medicaid-eligible persons and families in employer-sponsored
26 health insurance plans that have been approved as meeting certain cost and coverage requirements.
27 ~~The Medicaid agency also obtained, at the general assembly’s direction, federal authority to require~~
28 ~~any such persons with access to ESI coverage to enroll as a condition of retaining eligibility~~
29 ~~providing that doing so meets the criteria established in Title XIX for obtaining federal matching~~
30 ~~funds.~~

31 (b) **Definitions.** For the purposes of this section, the following definitions apply:

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

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

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

5 (4) “Employer-sponsored insurance” or “ESI” means health insurance or a group health
6 plan offered to employees by an employer. This includes plans purchased by small employers
7 through the state health insurance marketplace, healthsource, RI (HSRI).

8 (5) “Policy holder” means the person in the household with access to ESI, typically the
9 employee.

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

13 (7) “RIte Share buy-in” means the monthly amount an Medicaid-ineligible policy holder
14 must pay toward RIte Share-approved ESI that covers the Medicaid-eligible children, young adults,
15 or spouses with access to the ESI. The buy-in only applies in instances when household income is
16 above one hundred fifty percent (150%) of the FPL.

17 (8) “RIte Share premium assistance program” means the Rhode Island Medicaid premium
18 assistance program in which the State pays the eligible Medicaid member’s share of the cost of
19 enrolling in a RIte Share-approved ESI plan. This allows the state to share the cost of the health
20 insurance coverage with the employer.

21 (9) “RIte Share unit” means the entity within the executive office of health and human
22 services (EOHHS) responsible for assessing the cost-effectiveness of ESI, contacting employers
23 about ESI as appropriate, initiating the RIte Share enrollment and disenrollment process, handling
24 member communications, and managing the overall operations of the RIte Share program.

25 (10) “Third-party liability (TPL)” means other health insurance coverage. This insurance
26 is in addition to Medicaid and is usually provided through an employer. Since Medicaid is always
27 the payer of last resort, the TPL is always the primary coverage.

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

32 (c) **RIte Share populations.** Medicaid beneficiaries ~~subject to~~ [eligible for](#) RIte Share
33 include: children, families, parent and caretakers eligible for Medicaid or the children’s health
34 insurance program (CHIP) under this chapter or chapter 12.3 of title 42; and adults between the

1 ages of nineteen (19) and sixty-four (64) who are eligible under chapter 8.12 of this title, not
2 receiving or eligible to receive Medicare, and are enrolled in managed care delivery systems. The
3 following conditions apply:

4 (1) The income of Medicaid beneficiaries shall affect whether and in what manner they
5 ~~must~~ may participate in RItE Share as follows:

6 (i) Income at or below one hundred fifty percent (150%) of FPL — Persons and families
7 determined to have household income at or below one hundred fifty percent (150%) of the federal
8 poverty level (FPL) guidelines based on the modified adjusted gross income (MAGI) standard or
9 other standard approved by the secretary are required to participate in RItE Share if a Medicaid-
10 eligible adult or parent/caretaker has access to cost-effective ESI. Enrolling in ESI through RItE
11 Share shall be a condition of maintaining Medicaid health coverage for any eligible adult with
12 access to such coverage.

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

22 (d) **RItE Share enrollment ~~as not~~ a condition of eligibility.** RItE Share enrollment shall
23 be purely voluntary and shall never be a condition of eligibility for Medicaid. ~~For Medicaid~~
24 ~~beneficiaries over the age of nineteen (19), enrollment in RItE Share shall be a condition of~~
25 ~~eligibility except as exempted below and by regulations promulgated by the executive office.~~

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

31 ~~(2) There shall be a limited six-month (6) exemption from the mandatory enrollment~~
32 ~~requirement for persons participating in the RI works program pursuant to chapter 5.2 of this title.~~

33 (e) **Approval of health insurance plans for premium assistance.** The executive office of
34 health and human services shall adopt regulations providing for the approval of employer-based

1 health insurance plans for premium assistance and shall approve employer-based health insurance
2 plans based on these regulations. In order for an employer-based health insurance plan to gain
3 approval, the executive office must determine that the benefits offered by the employer-based
4 health insurance plan are substantially similar in amount, scope, and duration to the benefits
5 provided to Medicaid-eligible persons enrolled in a Medicaid managed care plan, when the plan is
6 evaluated in conjunction with available supplemental benefits provided by the office. The office
7 shall obtain and make available to persons otherwise eligible for Medicaid identified in this section
8 as supplemental benefits those benefits not reasonably available under employer-based health
9 insurance plans that are required for Medicaid beneficiaries by state law or federal law or
10 regulation. ~~Once it has been determined by the Medicaid agency that the ESI offered by a particular
11 employer is RItE Share approved, all Medicaid members with access to that employer's plan are
12 required to participate in RItE Share. Failure to meet the mandatory enrollment requirement shall
13 result in the termination of the Medicaid eligibility of the policy holder and other Medicaid
14 members nineteen (19) or older in the household who could be covered under the ESI until the
15 policy holder complies with the RItE Share enrollment procedures established by the executive
16 office.~~

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

20 (g) **Buy-in.** Persons who can afford it shall share in the cost. — The executive office is
21 authorized and directed to apply for and obtain any necessary state plan and/or waiver amendments
22 from the Secretary of the United States Department of Health and Human Services (DHHS) to
23 require that persons enrolled in a RItE Share-approved employer-based health plan who have
24 income equal to or greater than one hundred fifty percent (150%) of the FPL to buy-in to pay a
25 share of the costs based on the ability to pay, provided that the buy-in cost shall not exceed five
26 percent (5%) of the person's annual income. The executive office shall implement the buy-in by
27 regulation, and shall consider co-payments, premium shares, or other reasonable means to do so.

28 (h) **Maximization of federal contribution.** The executive office of health and human
29 services is authorized and directed to apply for and obtain federal approvals and waivers necessary
30 to maximize the federal contribution for provision of medical assistance coverage under this
31 section, including the authorization to amend the Title XXI state plan and to obtain any waivers
32 necessary to reduce barriers to provide premium assistance to recipients as provided for in Title
33 XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq.

34 (i) **Implementation by regulation.** The executive office of health and human services is

1 authorized and directed to adopt regulations to ensure the establishment and implementation of the
2 premium assistance program in accordance with the intent and purpose of this section, the
3 requirements of Title XIX, Title XXI, and any approved federal waivers.

4 ~~(j) **Outreach and reporting.** The executive office of health and human services shall
5 develop a plan to identify Medicaid eligible individuals who have access to employer sponsored
6 insurance and increase the use of RItE Share benefits. Beginning October 1, 2019, the executive
7 office shall submit the plan to be included as part of the reporting requirements under § 35-17-1.
8 Starting January 1, 2020, the executive office of health and human services shall include the number
9 of Medicaid recipients with access to employer sponsored insurance, the number of plans that did
10 not meet the cost effectiveness criteria for RItE Share, and enrollment in the premium assistance
11 program as part of the reporting requirements under § 35-17-1.~~

12 ~~(k) **Employer sponsored insurance.** The executive office of health and human services
13 shall dedicate staff and resources to reporting monthly as part of the requirements under § 35-17-1
14 which employer sponsored insurance plans meet the cost effectiveness criteria for RItE Share.
15 Information in the report shall be used for screening for Medicaid enrollment to encourage RItE
16 Share participation. By October 1, 2021, the report shall include any employers with 300 or more
17 employees. By January 1, 2022, the report shall include employers with 100 or more employees.
18 The January report shall also be provided to the chairperson of the house finance committee; the
19 chairperson of the senate finance committee; the house fiscal advisor; the senate fiscal advisor; and
20 the state budget officer.~~

21 **40-8.4-15. Advisory commission on health care.**

22 (a) There is hereby established an advisory commission to be known as the “advisory
23 commission on health care” to advise the director of the department of human services on all
24 matters relating to the RItE Care and RItE Share programs, and other matters concerning access for
25 all Rhode Islanders to quality health care in the most affordable, economical manner. The director
26 of the department of human services shall serve ex officio as chairperson. The director shall appoint
27 the eighteen (18) members:

- 28 (1) Three (3) of whom shall represent the healthcare providers;
- 29 (2) ~~Three (3) of whom shall represent the healthcare insurers;~~
- 30 (3) Three (3) of whom shall represent healthcare consumers or consumer organizations;
- 31 (4) Two (2) of whom shall represent organized labor;
- 32 (5) One of whom shall be the health care advocate in the office of the attorney general; and
- 33 (6) ~~Three (3) of whom shall represent employers; and~~
- 34 (7) ~~Three (3)~~ Nine (9) of whom shall be other members of the public.

1 (b) The commission may study all aspects of the provisions of the RIte Care and RIte Share
2 programs involving purchasers of health care, including employers, consumers, and the state, health
3 insurers, providers of health care, and healthcare facilities, and all matters related to the interaction
4 among these groups, including methods to achieve more effective and timely resolution of disputes,
5 better communication, speedier, more reliable and less-costly administrative processes, claims,
6 payments, and other reimbursement matters, and the application of new processes or technologies
7 to such issues.

8 (c) Members of the commission shall be appointed in the month of July, each to hold office
9 until the last day of June in the second year of his or her appointment or until his or her successor
10 is appointed by the director.

11 (d) The commission shall meet at least quarterly, and the initial meeting of the commission
12 shall take place on or before September 15, 2000. The commission may meet more frequently than
13 quarterly at the call of the chair or at the call of any three (3) members of the commission.

14 (e) Members of the permanent joint committee on health care oversight established
15 pursuant to § 40-8.4-14 shall be notified of each meeting of the commission and shall be invited to
16 participate.

17 **40-8.4-19. ~~Managed healthcare delivery systems for families~~ Cost sharing.**

18 ~~(a) Notwithstanding any other provision of state law, the delivery and financing of the~~
19 ~~healthcare services provided under this chapter shall be provided through a system of managed~~
20 ~~care. "Managed care" is defined as systems that: integrate an efficient financing mechanism with~~
21 ~~quality service delivery; provide a "medical home" to ensure appropriate care and deter~~
22 ~~unnecessary services; and place emphasis on preventive and primary care.~~

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

29 ~~(c)~~ Individuals who can afford to contribute shall share in the cost. The department of
30 human services is authorized and directed to apply for and obtain any necessary waivers and/or
31 state plan amendments from the Secretary of the United States Department of Health and Human
32 Services, including, but not limited to, a waiver of the appropriate sections of Title XIX, 42 U.S.C.
33 § 1396 et seq., to require that beneficiaries eligible under this chapter or chapter 12.3 of title 42,
34 with incomes equal to or greater than one hundred fifty percent (150%) of the federal poverty level,

1 pay a share of the costs of health coverage based on the ability to pay. The department of human
2 services shall implement this cost-sharing obligation by regulation, and shall consider co-payments,
3 premium shares, or other reasonable means to do so in accordance with approved provisions of
4 appropriate waivers and/or state plan amendments approved by the Secretary of the United States
5 Department of Health and Human Services.

6 SECTION 10. Section 40-8.4-13 of the General Laws in Chapter 40-8.4 entitled "Health
7 Care for Families" is hereby repealed.

8 **40-8.4-13. Utilization of available employer-based health insurance.**

9 ~~To the extent permitted under Titles XIX and XXI of the Social Security Act, 42 U.S.C. §
10 1396 et seq. and 42 U.S.C. § 1397aa et seq., or by waiver from the Secretary of the United States
11 Department of Health and Human Services, the department of human services shall adopt
12 regulations to restrict eligibility for Rite Care under this chapter and/or chapter 12.3 of title 42, or
13 the Rite Share program under § 40-8.4-12, for certain periods of time for certain individuals or
14 families who have access to, or have refused or terminated employer-based health insurance and
15 for certain periods of time for certain individuals but not including children whose employer has
16 terminated their employer-based health insurance. The department is authorized and directed to
17 amend the medical assistance Title XIX and XXI state plans, and/or to seek and obtain appropriate
18 federal approvals or waivers to implement this section.~~

19 SECTION 11. Sections 40-8.5-1 and 40-8.5-1.1 of the General Laws in Chapter 40-8.5
20 entitled "Health Care for Elderly and Disabled Residents Act" are hereby amended to read as
21 follows:

22 **40-8.5-1. Categorically needy medical assistance coverage.**

23 The department of human services is hereby authorized and directed to amend its Title XIX
24 state plan to provide for categorically needy medical assistance coverage as permitted pursuant to
25 Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as amended, to individuals who are
26 sixty-five (65) years or older or are disabled, as determined under § 1614(a)(3) of the Social
27 Security Act, 42 U.S.C. § 1382c(a)(3), as amended, whose income does not exceed ~~one hundred~~
28 ~~percent (100%)~~ one hundred thirty-three percent (133%) of the federal poverty level (as revised
29 annually) applicable to the individual's family size, and whose resources do not exceed four
30 thousand dollars (\$4,000) per individual, or six thousand dollars (\$6,000) per couple. The
31 department shall provide medical assistance coverage to such elderly or disabled persons in the
32 same amount, duration, and scope as provided to other categorically needy persons under the state's
33 Title XIX state plan.

34 **40-8.5-1.1. Managed healthcare delivery systems.**

1 (a) The delivery and financing of the healthcare services provided under this chapter may
2 be provided through a system of managed care. Beginning July 1, 2030, all payments shall be
3 provided directly by the state without an intermediate payment to a managed care entity or other
4 form of health insurance company. Beginning July 1, 2026, no new contracts may be entered into
5 between the Medicaid office and an intermediate payor such as a managed care entity or other form
6 of health insurance company for the payment of healthcare services pursuant to this chapter. To
7 ~~ensure that all medical assistance beneficiaries, including the elderly and all individuals with~~
8 ~~disabilities, have access to quality and affordable health care, the executive office of health and~~
9 ~~human services (“executive office”) is authorized to implement mandatory managed care health~~
10 ~~systems.~~

11 (b) ~~“Managed care” is defined as systems that: integrate an efficient financing mechanism~~
12 ~~with quality service delivery; provide a “medical home” to ensure appropriate care and deter~~
13 ~~unnecessary services; and place emphasis on preventive and primary care. For purposes of this~~
14 ~~section, managed care systems may also be defined to include a primary care case management~~
15 ~~model, community health teams, and/or other such arrangements that meet standards established~~
16 ~~by the executive office and serve the purposes of this section. Managed care systems may also~~
17 ~~include services and supports that optimize the health and independence of beneficiaries who are~~
18 ~~determined to need Medicaid funded long term care under chapter 8.10 of this title or to be at risk~~
19 ~~for the care under applicable federal state plan or waiver authorities and the rules and regulations~~
20 ~~promulgated by the executive office. Any Medicaid beneficiaries who have third party medical~~
21 ~~coverage or insurance may be provided such services through an entity certified by, or in a~~
22 ~~contractual arrangement with, the executive office or, as deemed appropriate, exempt from~~
23 ~~mandatory managed care in accordance with rules and regulations promulgated by the executive~~
24 ~~office.~~

25 (c) ~~In accordance with § 42-12.4-7, the executive office is authorized to obtain any approval~~
26 ~~through waiver(s), category II or III changes, and/or state plan amendments, from the Secretary of~~
27 ~~the United States Department of Health and Human Services, that are necessary to implement~~
28 ~~mandatory, managed healthcare delivery systems for all Medicaid beneficiaries. The waiver(s),~~
29 ~~category II or III changes, and/or state plan amendments shall include the authorization to extend~~
30 ~~managed care to cover long term care services and supports. Authorization shall also include, as~~
31 ~~deemed appropriate, exempting certain beneficiaries with third party medical coverage or~~
32 ~~insurance from mandatory managed care in accordance with rules and regulations promulgated by~~
33 ~~the executive office.~~

34 (d) To ensure the delivery of timely and appropriate services to persons who become

1 eligible for Medicaid by virtue of their eligibility for a United States Social Security Administration
2 program, the executive office is authorized to seek any and all data-sharing agreements or other
3 agreements with the Social Security Administration as may be necessary to receive timely and
4 accurate diagnostic data and clinical assessments. This information shall be used exclusively for
5 the purpose of service planning, and shall be held and exchanged in accordance with all applicable
6 state and federal medical record confidentiality laws and regulations.

7 SECTION 12. Sections 40-8.12-2 and 40-8.12-3 of the General Laws in Chapter 40-8.12
8 entitled "Health Care for Adults" are hereby amended to read as follows:

9 **40-8.12-2. Eligibility.**

10 (a) Medicaid coverage for nonpregnant adults without children. There is hereby
11 established, effective January 1, 2014, a category of Medicaid eligibility pursuant to Title XIX of
12 the Social Security Act, as amended by the U.S. Patient Protection and Affordable Care Act (ACA)
13 of 2010, 42 U.S.C. § 1396u-1, for adults ages nineteen (19) to sixty-four (64) who do not have
14 dependent children and do not qualify for Medicaid under Rhode Island general laws applying to
15 families with children and adults who are blind, aged, or living with a disability. The executive
16 office of health and human services is directed to make any amendments to the Medicaid state plan
17 and waiver authorities established under Title XIX necessary to implement this expansion in
18 eligibility and ensure the maximum federal contribution for health insurance coverage provided
19 pursuant to this chapter.

20 (b) Income. The secretary of the executive office of health and human services is authorized
21 and directed to amend the Medicaid Title XIX state plan and, as deemed necessary, any waiver
22 authority to effectuate this expansion of coverage to any Rhode Islander who qualifies for Medicaid
23 eligibility under this chapter with income at or below one hundred and thirty-three percent (133%)
24 of the federal poverty level, based on modified adjusted-gross income.

25 (c) Delivery system. ~~The executive office of health and human services is authorized and~~
26 ~~directed to apply for and obtain any waiver authorities necessary to provide persons eligible under~~
27 ~~this chapter with managed, coordinated healthcare coverage consistent with the principles set forth~~
28 ~~in chapter 12.4 of title 42, pertaining to a healthcare home. Beginning July 1, 2030, all payments~~
29 shall be provided directly by the state without an intermediate payment to a managed care entity or
30 other form of health insurance company. Beginning July 1, 2026, no new contracts may be entered
31 into between the Medicaid office and an intermediate payor such as a managed care entity or other
32 form of health insurance company for the payment of healthcare services pursuant to this chapter.

33 **40-8.12-3. Premium assistance program.**

34 ~~(a)~~ The executive office of health and human services is directed to amend its rules and

1 regulations to implement a premium assistance program for adults with dependent children,
2 enrolled in the state’s health-benefits exchange, whose annual income and resources meet the
3 guidelines established in § 40-8.4-4 in effect on December 1, 2013. The premium assistance will
4 pay one-half of the cost of a commercial plan that a parent may incur after subtracting the cost-
5 sharing requirement under § 40-8.4-4 as of December 31, 2013, and any applicable federal tax
6 credits available. The office is also directed to amend the 1115 waiver demonstration extension and
7 the medical assistance Title XIX state plan for this program if it is determined that it is eligible for
8 funding pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.

9 ~~(b) The executive office of health and human services shall require any individual receiving~~
10 ~~benefits under a state funded, healthcare assistance program to apply for any health insurance for~~
11 ~~which he or she is eligible, including health insurance available through the health benefits~~
12 ~~exchange. Nothing shall preclude the state from using funds appropriated for Affordable Care Act~~
13 ~~transition expenses to reduce the impact on an individual who has been transitioned from a state~~
14 ~~program to a health insurance plan available through the health benefits exchange. It shall not be~~
15 ~~deemed cost effective for the state if it would result in a loss of benefits or an increase in the cost~~
16 ~~of healthcare services for the person above an amount deemed de minimus as determined by state~~
17 ~~regulation.~~

18 SECTION 13. Chapter 40-8.13 of the General Laws entitled "Long-Term Managed Care
19 Arrangements" is hereby repealed in its entirety.

20 ~~CHAPTER 40-8.13~~

21 ~~Long Term Managed Care Arrangements~~

22 ~~**40-8.13-1. Definitions.**~~

23 ~~For purposes of this section the following terms shall have the meanings indicated:~~

24 ~~(1) “Beneficiary” means an individual who is eligible for medical assistance under the~~
25 ~~Rhode Island Medicaid state plan established in accordance with 42 U.S.C. § 1396, and includes~~
26 ~~individuals who are additionally eligible for benefits under the Medicare program (42 U.S.C. §~~
27 ~~1395 et seq.) or other health plan.~~

28 ~~(2) “Duals demonstration project” means a demonstration project established pursuant to~~
29 ~~the financial alignment demonstration established under section 2602 of the Patient Protection and~~
30 ~~Affordable Care Act (Pub. L. No. 111-148) [42 U.S.C. § 1315b], involving a three-way contract~~
31 ~~between Rhode Island, the federal Centers for Medicare and Medicaid Services (“CMS”), and~~
32 ~~qualified health plans, and covering healthcare services provided to beneficiaries.~~

33 ~~(3) “EOHHS” means the Rhode Island executive office of health and human services.~~

34 ~~(4) “EOHHS level of care tool” refers to a set of criteria established by EOHHS and used~~

1 ~~in January, 2014 to determine the long-term care needs of a beneficiary as well as the appropriate~~
2 ~~setting for delivery of that care.~~

3 ~~(5) “Long-term care services and supports” means a spectrum of services covered by the~~
4 ~~Rhode Island Medicaid program and/or the Medicare program, that are required by individuals with~~
5 ~~functional impairments and/or chronic illness, and includes skilled or custodial nursing facility~~
6 ~~care, as well as various home and community-based services.~~

7 ~~(6) “Managed care organization” means any health plan, health maintenance organization,~~
8 ~~managed care plan, or other person or entity that enters into a contract with the state under which~~
9 ~~it is granted the authority to arrange for the provision of, and/or payment for, long-term care~~
10 ~~supports and services to eligible beneficiaries under a managed long-term care arrangement.~~

11 ~~(7) “Managed long-term care arrangement” means any arrangement under which a~~
12 ~~managed care organization is granted some or all of the responsibility for providing and/or paying~~
13 ~~for long-term care services and supports that would otherwise be provided or paid under the Rhode~~
14 ~~Island Medicaid program. The term includes, but is not limited to, a duals demonstration project,~~
15 ~~and/or phase I and phase II of the integrated care initiative established by the executive office of~~
16 ~~health and human services.~~

17 ~~(8) “Plan of care” means a care plan established by a nursing facility in accordance with~~
18 ~~state and federal regulations and that identifies specific care and services provided to a beneficiary.~~

19 **40-8.13-2. Beneficiary choice.**

20 ~~Any managed long-term care arrangement shall offer beneficiaries the option to decline~~
21 ~~participation and remain in traditional Medicaid and, if a duals demonstration project, traditional~~
22 ~~Medicare. Beneficiaries must be provided with sufficient information to make an informed choice~~
23 ~~regarding enrollment, including:~~

24 ~~(1) Any changes in the beneficiary’s payment or other financial obligations with respect to~~
25 ~~long-term care services and supports as a result of enrollment;~~

26 ~~(2) Any changes in the nature of the long-term care services and supports available to the~~
27 ~~beneficiary as a result of enrollment, including specific descriptions of new services that will be~~
28 ~~available or existing services that will be curtailed or terminated;~~

29 ~~(3) A contact person who can assist the beneficiary in making decisions about enrollment;~~

30 ~~(4) Individualized information regarding whether the managed care organization’s network~~
31 ~~includes the healthcare providers with whom beneficiaries have established provider relationships.~~
32 ~~Directing beneficiaries to a website identifying the plan’s provider network shall not be sufficient~~
33 ~~to satisfy this requirement; and~~

34 ~~(5) The deadline by which the beneficiary must make a choice regarding enrollment, and~~

1 ~~the length of time a beneficiary must remain enrolled in a managed care organization before being~~
2 ~~permitted to change plans or opt out of the arrangement.~~

3 ~~**40-8.13-3. Ombudsman process.**~~

4 ~~EOHHS shall designate an ombudsperson to advocate for beneficiaries enrolled in a~~
5 ~~managed long term care arrangement. The ombudsperson shall advocate for beneficiaries through~~
6 ~~complaint and appeal processes and ensure that necessary healthcare services are provided. At the~~
7 ~~time of enrollment, a managed care organization must inform enrollees of the availability of the~~
8 ~~ombudsperson, including contact information.~~

9 ~~**40-8.13-4. Provider/plan liaison.**~~

10 ~~EOHHS shall designate an individual, not employed by or otherwise under contract with a~~
11 ~~participating managed care organization, who shall act as liaison between healthcare providers and~~
12 ~~managed care organizations, for the purpose of facilitating communications and ensuring that issues~~
13 ~~and concerns are promptly addressed.~~

14 ~~**40-8.13-5. Financial principles under managed care.**~~

15 ~~(a) To the extent that financial savings are a goal under any managed long term care~~
16 ~~arrangement, it is the intent of the legislature to achieve savings through administrative efficiencies,~~
17 ~~care coordination, improvements in care outcomes and in a way that encourages the highest quality~~
18 ~~care for patients and maximizes value for the managed care organization and the state. Therefore,~~
19 ~~any managed long term care arrangement shall include a requirement that the managed care~~
20 ~~organization reimburse providers for services in accordance with these principles. Notwithstanding~~
21 ~~any law to the contrary, for the twelve month (12) period beginning July 1, 2015, Medicaid~~
22 ~~managed long term care payment rates to nursing facilities established pursuant to this section shall~~
23 ~~not exceed ninety eight percent (98.0%) of the rates in effect on April 1, 2015.~~

24 ~~(1) For a duals demonstration project, the managed care organization:~~

25 ~~(i) Shall not combine the rates of payment for post acute skilled and rehabilitation care~~
26 ~~provided by a nursing facility and long term and chronic care provided by a nursing facility in order~~
27 ~~to establish a single payment rate for dual eligible beneficiaries requiring skilled nursing services;~~

28 ~~(ii) Shall pay nursing facilities providing post acute skilled and rehabilitation care or long~~
29 ~~term and chronic care rates that reflect the different level of services and intensity required to~~
30 ~~provide these services; and~~

31 ~~(iii) For purposes of determining the appropriate rate for the type of care identified in~~
32 ~~subsection (a)(1)(ii) of this section, the managed care organization shall pay no less than the rates~~
33 ~~that would be paid for that care under traditional Medicare and Rhode Island Medicaid for these~~
34 ~~service types. The managed care organization shall not, however, be required to use the same~~

1 ~~payment methodology.~~

2 ~~The state shall not enter into any agreement with a managed care organization in connection~~
3 ~~with a duals demonstration project unless that agreement conforms to this section, and any existing~~
4 ~~such agreement shall be amended as necessary to conform to this subsection.~~

5 ~~(2) For a managed long term care arrangement that is not a duals demonstration project,~~
6 ~~the managed care organization shall reimburse providers in an amount not less than the amount that~~
7 ~~would be paid for the same care by the executive office of health and human services under the~~
8 ~~Medicaid program. The managed care organization shall not, however, be required to use the same~~
9 ~~payment methodology as the executive office of health and human services.~~

10 ~~(3) Notwithstanding any provisions of the general or public laws to the contrary, the~~
11 ~~protections of subsections (a)(1) and (a)(2) of this section may be waived by a nursing facility in~~
12 ~~the event it elects to accept a payment model developed jointly by the managed care organization~~
13 ~~and skilled nursing facilities, that is intended to promote quality of care and cost effectiveness,~~
14 ~~including, but not limited to, bundled payment initiatives, value based purchasing arrangements,~~
15 ~~gainsharing, and similar models.~~

16 ~~(b) Notwithstanding any law to the contrary, for the twelve month (12) period beginning~~
17 ~~July 1, 2015, Medicaid managed long term care payment rates to nursing facilities established~~
18 ~~pursuant to this section shall not exceed ninety eight percent (98.0%) of the rates in effect on April~~
19 ~~1, 2015.~~

20 **40-8.13-6. Payment incentives.**

21 ~~In order to encourage quality improvement and promote appropriate utilization incentives~~
22 ~~for providers in a managed long term care arrangement, a managed care organization may use~~
23 ~~incentive or bonus payment programs that are in addition to the rates identified in § 40-8.13-5.~~

24 **40-8.13-7. Willing provider.**

25 ~~A managed care organization must contract with and cover services furnished by any~~
26 ~~nursing facility licensed under chapter 17 of title 23 and certified by CMS that provides Medicaid-~~
27 ~~covered nursing facility services pursuant to a provider agreement with the state, provided that the~~
28 ~~nursing facility is not disqualified under the managed care organization's quality standards that are~~
29 ~~applicable to all nursing facilities; and the nursing facility is willing to accept the reimbursement~~
30 ~~rates described in § 40-8.13-5.~~

31 **40-8.13-8. Level-of-care tool.**

32 ~~A managed long term care arrangement must require that all participating managed care~~
33 ~~organizations use only the EOHHS level of care tool in determining coverage of long term care~~
34 ~~supports and services for beneficiaries. EOHHS may amend the level of care tool provided that~~

1 ~~any changes are established in consultation with beneficiaries and providers of Medicaid-covered~~
2 ~~long term care supports and services, and are based upon reasonable medical evidence or~~
3 ~~consensus, in consideration of the specific needs of Rhode Island beneficiaries. Notwithstanding~~
4 ~~any other provisions herein, however, in the case of a duals demonstration project, a managed care~~
5 ~~organization may use a different level of care tool for determining coverage of services that would~~
6 ~~otherwise be covered by Medicare, since the criteria established by EOHHS are directed towards~~
7 ~~Medicaid-covered services; provided, that the level of care tool is based on reasonable medical~~
8 ~~evidence or consensus in consideration of the specific needs of Rhode Island beneficiaries.~~

9 **40-8.13-9. Case management/plan of care.**

10 ~~No managed care organization acting under a managed long term care arrangement may~~
11 ~~require a provider to change a plan of care if the provider reasonably believes that such an action~~
12 ~~would conflict with the provider's responsibility to develop an appropriate care plan under state~~
13 ~~and federal regulations.~~

14 **40-8.13-10. Care transitions.**

15 ~~In the event that a beneficiary:~~

16 ~~(1) Has been determined to meet level of care requirements for nursing facility coverage~~
17 ~~as of the date of his or her enrollment in a managed care organization; or~~

18 ~~(2) Has been determined to meet level of care requirements for nursing facility coverage~~
19 ~~by a managed care organization after enrollment; and there is a change in condition whereby the~~
20 ~~managed care organization determines that the beneficiary no longer meets such level of care~~
21 ~~requirements, the nursing facility shall promptly arrange for an appropriate and safe discharge (with~~
22 ~~the assistance of the managed care organization if the facility requests it), and the managed care~~
23 ~~organization shall continue to pay for the beneficiary's nursing facility care at the same rate until~~
24 ~~the beneficiary is discharged.~~

25 **40-8.13-11. Reporting requirements.**

26 ~~EOHHS shall report to the general assembly and shall make available to interested persons~~
27 ~~a separate accounting of state expenditures for long term care supports and services under any~~
28 ~~managed long term care arrangement, specifically and separately identifying expenditures for~~
29 ~~home and community based services, assisted living services, hospice services within nursing~~
30 ~~facilities, hospice services outside of nursing facilities, and nursing facility services. Such reports~~
31 ~~shall be made twice annually, six (6) months apart, beginning six (6) months following the~~
32 ~~implementation of any managed long term care arrangement, and shall include a detailed report of~~
33 ~~utilization of each service. In order to facilitate reporting, any managed long term care arrangement~~
34 ~~shall include a requirement that a participating managed care organization make timely reports of~~

1 ~~the data necessary to compile the reports.~~

2 SECTION 14. Sections 42-7.2-10, 42-7.2-16 and 42-7.2-16.1 of the General Laws in
3 Chapter 42-7.2 entitled "Office of Health and Human Services" are hereby amended to read as
4 follows:

5 **42-7.2-10. Appropriations and disbursements.**

6 (a) The general assembly shall annually appropriate such sums as it may deem necessary
7 for the purpose of carrying out the provisions of this chapter. The state controller is hereby
8 authorized and directed to draw his or her orders upon the general treasurer for the payment of such
9 sum or sums, or so much thereof as may from time to time be required, upon receipt by him or her
10 of proper vouchers approved by the secretary of the executive office of health and human services,
11 or the secretary's designee.

12 (b) The general assembly shall, through the utilization of federal Medicaid reimbursement
13 for administrative costs, and additional funds, appropriate such funds as may be necessary to hire
14 additional personnel for the Medicaid office as follows: one hundred (100) outreach social workers
15 to encourage, assist and expedite individuals applying for Medicaid benefits; one hundred (100)
16 new programmers in order to build digital infrastructure for the Medicaid office; thirty (30) new
17 social workers and ten (10) new programmers to help increase spend down program utilization and
18 feasibility and examine possible legal changes necessary to increase spend down program
19 eligibility; and fifty (50) additional personnel for building administrative capacity. The Medicaid
20 office shall be exempt from any limitations placed on the number of full-time equivalent personnel
21 employed by the executive office of health and human services.

22 ~~(b)~~(c) For the purpose of recording federal financial participation associated with
23 qualifying healthcare workforce development activities at the state's public institutions of higher
24 education, and pursuant to the Rhode Island designated state health programs (DSHP), as approved
25 by the Centers for Medicare & Medicaid Services (CMC) October 20, 2016, in the 11-W-00242/1
26 amendment to Rhode Island's section 1115 Demonstration Waiver, there is hereby established a
27 restricted receipt account entitled "Health System Transformation Project" in the general fund of
28 the state and included in the budget of the office of health and human services. The office of health
29 and human services is forbidden from utilizing any funds within the health system transformation
30 project restricted receipts account for any imposition of downside risk for providers. No payment
31 models that impose downside risk or in any way deviate from fee-for-service shall be utilized for
32 the Medicaid program without explicit authorization by the general assembly.

33 ~~(c)~~(d) There are hereby created within the general fund of the state and housed within the
34 budget of the office of health and human services two restricted receipt accounts, respectively

1 entitled “HCBS Support-ARPA” and “HCBS Admin Support-ARPA”. Amounts deposited into
2 these accounts are equivalent to the general revenue savings generated by the enhanced federal
3 match received on eligible home and community-based services between April 1, 2021, and March
4 31, 2022, allowable under Section 9817 of the American Rescue Plan Act of 2021, Pub. L. No.
5 117-2. Funds deposited into the “HCBS Support-ARPA” account will be used to finance the state
6 share of newly eligible Medicaid expenditures by the office of health and human services and its
7 sister agencies, including the department of children, youth and families, the department of health,
8 and the department of behavioral healthcare, developmental disabilities and hospitals. Funds
9 deposited into the “HCBS Admin Support-ARPA” account will be used to finance the state share
10 of allowable administrative expenditures attendant to the implementation of these newly eligible
11 Medicaid expenditures. The accounts created under this subsection shall be exempt from the
12 indirect cost recovery provisions of § 35-4-27.

13 ~~(d)~~(e) There is hereby created within the general fund of the state and housed within the
14 budget of the office of health and human services a restricted receipt account entitled “Rhode Island
15 Statewide Opioid Abatement Account” for the purpose of receiving and expending monies from
16 settlement agreements with opioid manufacturers, pharmaceutical distributors, pharmacies, or their
17 affiliates, as well as monies resulting from bankruptcy proceedings of the same entities. The
18 executive office of health and human services shall deposit any revenues from such sources that
19 are designated for opioid abatement purposes into the restricted receipt account. Funds from this
20 account shall only be used for forward-looking opioid abatement efforts as defined and limited by
21 any settlement agreements, state-city and town agreements, or court orders pertaining to the use of
22 such funds. By January 1 of each calendar year, the secretary of health and human services shall
23 report to the governor, the speaker of the house of representatives, the president of the senate, and
24 the attorney general on the expenditures that were funded using monies from the Rhode Island
25 statewide opioid abatement account and the amount of funds spent. The account created under this
26 subsection shall be exempt from the indirect cost recovery provisions of § 35-4-27. No
27 governmental entity has the authority to assert a claim against the entities with which the attorney
28 general has entered into settlement agreements concerning the manufacturing, marketing,
29 distributing, or selling of opioids that are the subject of the Rhode Island Memorandum of
30 Understanding Between the State and Cities and Towns Receiving Opioid Settlement Funds
31 executed by every city and town and the attorney general and wherein every city and town agreed
32 to release all such claims against these settling entities, and any amendment thereto. Governmental
33 entity means any state or local governmental entity or sub-entity and includes, but is not limited to,
34 school districts, fire districts, and any other such districts. The claims that shall not be asserted are

1 the released claims, as that term is defined in the settlement agreements executed by the attorney
2 general, or, if not defined therein, the claims sought to be released in such settlement agreements.

3 (e) There is hereby created within the general fund of the state and housed within the budget
4 of the executive office of health and human services a restricted receipt account, respectively
5 entitled "Minimum Staffing Level Compliance and Enforcement". Funds deposited into the
6 account will be used for workforce development and compliance assistance programs as included
7 in § 23-17.5-33.

8 **42-7.2-16. ~~Medicaid System Reform 2008~~ Medicaid System Reform.**

9 (a) The executive office of health and human services, in conjunction with the department
10 of human services, the department of children, youth and families, the department of health, and
11 the department of behavioral healthcare, developmental disabilities and hospitals, is authorized to
12 design options that further ~~the reforms in Medicaid initiated in 2008~~ Medicaid reform to ensure that
13 the program: ~~utilizes competitive and value based purchasing to maximize the available service~~
14 ~~options, promotes accountability and transparency, and encourages and rewards healthy outcomes,~~
15 ~~independence, and responsible choices; promotes efficiencies and the coordination of services~~
16 ~~across all health and human services agencies; and ensures the state will have a fiscally sound~~
17 ~~source of publicly financed health care for Rhode Islanders in need~~ transitions to a Medicare level
18 of care as a first step in the transition to a state-level Medicare for All system; phases out the use
19 of intermediary privatized insurance companies such as managed care entities; transitions to the
20 management of health insurers acquired due to insolvency, smoothly integrating publicly owned
21 health insurers with the Medicaid system; utilizes payment models such as fee-for-service that
22 incentivize higher quality of care and more utilization of care; provides for the financial health of
23 Rhode Island healthcare providers; encourages fair wages and benefits for Rhode Island's
24 healthcare workforce; develops and builds out the Medicaid office's human capital, technological
25 infrastructure, expertise, and general ability to manage healthcare payments to prepare for the
26 transition to a single-payer Medicare-for-All system; and guides the transition of the Rhode Island
27 healthcare funding system to a state-level Medicare-for-All system.

28 (b) Principles and goals. In developing and implementing this system of reform, the
29 executive office of health and human services and the four (4) health and human services
30 departments shall pursue the following principles and goals:

31 (1) Empower consumers to make reasoned and cost-effective choices about their health by
32 providing them with the information and array of service options they need and offering rewards
33 for healthy decisions;

34 (2) Encourage personal responsibility by assuring the information available to beneficiaries

1 is easy to understand and accurate, provide that a fiscal intermediary is provided when necessary,
2 and adequate access to needed services;

3 (3) When appropriate, promote community-based care solutions by transitioning
4 beneficiaries from institutional settings back into the community and by providing the needed
5 assistance and supports to beneficiaries requiring long-term care or residential services who wish
6 to remain, or are better served in the community;

7 (4) Enable consumers to receive individualized health care that is outcome-oriented,
8 focused on prevention, disease management, recovery, and maintaining independence;

9 (5) Promote competition between healthcare providers to ensure best value purchasing, to
10 leverage resources, and to create opportunities for improving service quality and performance;

11 (6) Redesign purchasing and payment methods to ~~assure fiscal accountability and~~
12 ~~encourage and to reward service quality and cost effectiveness by tying reimbursements to~~
13 ~~evidence-based performance measures and standards, including those related to patient satisfaction~~
14 promote payment models such as fee-for-service that incentivize higher quality of care and phase
15 out the use of payment models that shift risk to providers including, but not limited to, capitation,
16 episode-based payments, global budgets, and similar models; and

17 (7) Continually improve technology to take advantage of recent innovations and advances
18 that help decision makers, consumers, and providers to make informed and cost-effective decisions
19 regarding health care.

20 (c) The executive office of health and human services shall annually submit a report to the
21 governor and the general assembly describing the status of the administration and implementation
22 of the Medicaid Section 1115 demonstration waiver.

23 **42-7.2-16.1. Reinventing Medicaid Act of 2015.**

24 ~~(a) Findings.~~ The Rhode Island Medicaid program is an integral component of the state's
25 healthcare system that provides crucial services and supports to many Rhode Islanders. ~~As the~~
26 ~~program's reach has expanded, the costs of the program have continued to rise and the delivery of~~
27 ~~care has become more fragmented and uncoordinated. Given the crucial role of the Medicaid~~
28 ~~program to the state, it is of compelling importance that the state conduct a fundamental~~
29 ~~restructuring of its Medicaid program that achieves measurable improvement in health outcomes~~
30 ~~for the people and transforms the healthcare system to one that pays for the outcomes and quality~~
31 ~~they deserve at a sustainable, predictable, and affordable cost.~~ The Reinventing Medicaid Act of
32 2015, as implemented in the budget for FY2016, involved drastic cuts to the Medicaid program,
33 along with policies that shifted risk to providers away from intermediary insurers. Since the passage
34 of that act, the finances of healthcare providers in Rhode Island have deteriorated significantly, and

1 it is therefore the duty of the general assembly to seek corrective action to restore critical
2 investments in the Medicaid system and redesign payment models to remove risk from providers
3 and concentrate risk in private insurance companies during their phase-out period along the
4 transition to Medicare-for-All.

5 ~~(b) The Working Group to Reinvent Medicaid, which was established to refine the~~
6 ~~principles and goals of the Medicaid reforms begun in 2008, was directed to present to the general~~
7 ~~assembly and the governor initiatives to improve the value, quality, and outcomes of the health care~~
8 ~~funded by the Medicaid program.~~

9 SECTION 15. Chapter 42-12.1 of the General Laws entitled "Department of Behavioral
10 Healthcare, Developmental Disabilities and Hospitals" is hereby amended by adding thereto the
11 following section:

12 **42-12.1-11. The Rhode Island mental health nursing facility.**

13 There is hereby established a state nursing facility for the care of Rhode Islanders in need
14 of nursing facility-level inpatient behavioral healthcare known as the Rhode Island mental health
15 nursing facility. The Rhode Island mental health nursing facility shall fall within the purview of the
16 department, and the chief executive officer, chief financial officer, and chief medical officer shall
17 be appointed by the governor with the advice and consent of the senate.

18 SECTION 16. Sections 42-12.3-3, 42-12.3-5, 42-12.3-7 and 42-12.3-9 of the General Laws
19 in Chapter 42-12.3 entitled "Health Care for Children and Pregnant Women" are hereby amended
20 to read as follows:

21 **42-12.3-3. Medical assistance expansion for pregnancy/Rite Start.**

22 (a) The secretary of the executive office of health and human services is authorized to
23 amend its Title XIX state plan pursuant to Title XIX of the Social Security Act to provide Medicaid
24 coverage and to amend its Title XXI state plan pursuant to Title XXI of the Social Security Act to
25 provide medical assistance coverage through expanded family income disregards for pregnant
26 persons whose family income levels are between one hundred eighty-five percent (185%) and two
27 hundred fifty percent (250%) of the federal poverty level. The department is further authorized to
28 promulgate any regulations necessary and in accord with Title XIX [42 U.S.C. § 1396 et seq.] and
29 Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security Act necessary in order to implement
30 said state plan amendment. The services provided shall be in accord with Title XIX [42 U.S.C. §
31 1396 et seq.] and Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security Act.

32 (b) The secretary of health and human services is authorized and directed to establish a
33 payor of last resort program to cover prenatal, delivery, and postpartum care. The program shall
34 cover the cost of maternity care for any person who lacks health insurance coverage for maternity

1 care and who is not eligible for medical assistance under Title XIX [42 U.S.C. § 1396 et seq.] and
2 Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security Act including, but not limited to, a
3 noncitizen pregnant person ~~lawfully admitted for permanent residence on or after August 22, 1996,~~
4 without regard to the availability of federal financial participation, provided such pregnant person
5 satisfies all other eligibility requirements. The secretary shall promulgate regulations to implement
6 this program. Such regulations shall include specific eligibility criteria; the scope of services to be
7 covered; procedures for administration and service delivery; referrals for non-covered services;
8 outreach; and public education.

9 (c) The secretary of health and human services may enter into cooperative agreements with
10 the department of health and/or other state agencies to provide services to individuals eligible for
11 services under subsections (a) and (b) above.

12 (d) The following services shall be provided through the program:

13 (1) Ante-partum and postpartum care;

14 (2) Delivery;

15 (3) Cesarean section;

16 (4) Newborn hospital care;

17 (5) Inpatient transportation from one hospital to another when authorized by a medical
18 provider; and

19 (6) Prescription medications and laboratory tests.

20 (e) The secretary of health and human services shall provide enhanced services, as
21 appropriate, to pregnant persons as defined in subsections (a) and (b), as well as to other pregnant
22 persons eligible for medical assistance. These services shall include: care coordination; nutrition
23 and social service counseling; high-risk obstetrical care; childbirth and parenting preparation
24 programs; smoking cessation programs; outpatient counseling for drug-alcohol use; interpreter
25 services; mental health services; and home visitation. The provision of enhanced services is subject
26 to available appropriations. In the event that appropriations are not adequate for the provision of
27 these services, the executive office has the authority to limit the amount, scope, and duration of
28 these enhanced services.

29 (f) The executive office of health and human services shall provide for extended family
30 planning services for up to twenty-four (24) months postpartum. These services shall be available
31 to persons who have been determined eligible for RItE Start or for medical assistance under Title
32 XIX [42 U.S.C. § 1396 et seq.] or Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security
33 Act.

34 (g) Effective October 1, 2022, individuals eligible for RItE Start pursuant to this section or

1 for medical assistance under Title XIX or Title XXI of the Social Security Act while pregnant
2 (including during a period of retroactive eligibility), are eligible for full Medicaid benefits through
3 the last day of the month in which their twelve-month (12) postpartum period ends. This benefit
4 will be provided to eligible Rhode Island residents without regard to the availability of federal
5 financial participation. The executive office of health and human services is directed to ensure that
6 federal financial participation is used to the maximum extent allowable to provide coverage
7 pursuant to this section, and that state-only funds will be used only if federal financial participation
8 is not available.

9 (h) Any person eligible for services under subsections (a) and (b) of this section, or
10 otherwise eligible for medical assistance under Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI
11 [42 U.S.C. § 1397aa et seq.] of the Social Security Act, shall also be entitled to services for any
12 termination of pregnancy permitted under § 23-4.13-2; provided, however, that no federal funds
13 shall be used to pay for such services, except as authorized under federal law.

14 **42-12.3-5. Managed care.**

15 The delivery and financing of the healthcare services provided pursuant to §§ 42-12.3-3
16 and 42-12.3-4 ~~shall~~ may be provided through a system of managed care. The delivery and financing
17 of the healthcare services provided under this chapter may be provided through a system of
18 managed care. Beginning July 1, 2030, all payments shall be provided directly by the state without
19 an intermediate payment to a managed care entity or other form of health insurance company,
20 unless the intermediate payor is owned by the Medicaid office or another branch of state
21 government. Beginning July 1, 2026, no new contracts may be entered into between the Medicaid
22 office and an intermediate payor such as a managed care entity or other form of health insurance
23 company for the payment of healthcare services pursuant to this chapter, unless the intermediate
24 payor is owned by the Medicaid office or another branch of state government.

25 ~~A managed care system integrates an efficient financing mechanism with quality service~~
26 ~~delivery, provides a “medical home” to assure appropriate care and deter unnecessary and~~
27 ~~inappropriate care, and places emphasis on preventive and primary health care. In developing a~~
28 ~~managed care system the department of human services shall consider managed care models~~
29 ~~recognized by the health care financing administration. The department of human services is hereby~~
30 ~~authorized and directed to seek any necessary approvals or waivers from the U.S. Department of~~
31 ~~Health and Human Services, Health Care Financing Administration, needed to assure that services~~
32 ~~are provided through a mandatory managed care system. Certain health services may be provided~~
33 ~~on an interim basis through a fee for service arrangement upon a finding that there are temporary~~
34 ~~barriers to implementation of mandatory managed care for a particular population or particular~~

1 ~~geographic area. Nothing in this section shall prohibit the department of human services from~~
2 ~~providing enhanced services to medical assistance recipients within existing appropriations.~~

3 **42-12.3-7. Financial contributions.**

4 The department of human services may not require the payment of enrollment fees, sliding
5 fees, deductibles, copayments, and/or other contributions based on ability to pay. ~~These fees shall~~
6 ~~be established by rules and regulations to be promulgated by the department of human services or~~
7 ~~the department of health, as appropriate.~~

8 **42-12.3-9. Insurance coverage — Third-party insurance.**

9 (a) ~~No payment will be made nor service provided in the RItE Start or RItE Track program~~
10 ~~with respect to any health care that is covered or would be covered, by any employee welfare benefit~~
11 ~~plan under which a woman or child is either covered or eligible to be covered either as an employee~~
12 ~~or dependent, whether or not coverage under such plan is elected.~~

13 ~~(b)~~ A premium may be charged for participation in the RItE Track or RItE Start programs
14 for eligible individuals whose family incomes are in excess of two hundred fifty percent (250%) of
15 the federal poverty level and who have voluntarily terminated healthcare insurance within one year
16 of the date of application for benefits under this chapter.

17 ~~(e)~~(b) Every family who is eligible to participate in the RItE Track program, who has an
18 additional child who because of age is not eligible for RItE Track, or whose child becomes ineligible
19 for RItE Track because of the child's age, may be offered by the managed care provider with whom
20 the family is enrolled, the opportunity to enroll such ineligible child or children in the same
21 managed care program on a self-pay basis at the same cost, charge, or premium as is being charged
22 to the state under the provisions of this chapter for other covered children within the managed care
23 program. The family may also purchase a package of enhanced services at the same cost or charge
24 to the department.

25 SECTION 17. Section 42-12.3-14 of the General Laws in Chapter 42-12.3 entitled "Health
26 Care for Children and Pregnant Women" is hereby repealed.

27 **42-12.3-14. Benefits and coverage — Exclusion.**

28 ~~For as long as the United States Department of Health and Human Services, Health Care~~
29 ~~Financing Administration Project No. 11-W-0004/1-01 entitled "RItE Care" remains in effect, any~~
30 ~~healthcare services provided pursuant to this chapter shall be exempt from all mandatory benefits~~
31 ~~and coverage as may otherwise be provided for in the general laws.~~

32 SECTION 18. Sections 42-14.5-2 and 42-14.5-3 of the General Laws in Chapter 42-14.5
33 entitled "The Rhode Island Health Care Reform Act of 2004 — Health Insurance Oversight" are
34 hereby amended to read as follows:

1 **42-14.5-2. Purpose.**

2 With respect to health insurance as defined in § 42-14-5, the health insurance commissioner
3 shall discharge the powers and duties of office to:

4 (1) ~~Guard the solvency of health insurers~~ Claw back excessive profits, reserves charges,
5 and other monies that health insurers may have accumulated against the public interest of the people
6 of Rhode Island;

7 (2) Protect the interests of consumers;

8 (3) Encourage fair treatment of healthcare providers;

9 (4) Encourage policies and developments that improve the quality and efficiency of
10 healthcare service delivery and outcomes; ~~and~~

11 (5) View the healthcare system as a comprehensive entity and encourage and direct insurers
12 towards policies that advance the welfare of the public through overall efficiency, improved
13 healthcare quality, and appropriate access; and

14 (6) Facilitate the transformation of the healthcare payments system to a state-level
15 Medicare-for-All system.

16 **42-14.5-3. Powers and duties.**

17 The health insurance commissioner shall have the following powers and duties:

18 (a) To conduct quarterly public meetings throughout the state, separate and distinct from
19 rate hearings pursuant to § 42-62-13, regarding the rates, services, and operations of insurers
20 licensed to provide health insurance in the state; the effects of such rates, services, and operations
21 on consumers, medical care providers, patients, and the market environment in which the insurers
22 operate; and efforts to bring new health insurers into the Rhode Island market. Notice of not less
23 than ten (10) days of the hearing(s) shall go to the general assembly, the governor, the Rhode Island
24 Medical Society, the Hospital Association of Rhode Island, the director of health, the attorney
25 general, and the chambers of commerce. Public notice shall be posted on the department's website
26 and given in the newspaper of general circulation, and to any entity in writing requesting notice.

27 (b) To make recommendations to the governor and the house of representatives and senate
28 finance committees regarding healthcare insurance and the regulations, rates, services,
29 administrative expenses, reserve requirements, and operations of insurers providing health
30 insurance in the state, and to prepare or comment on, upon the request of the governor or
31 chairpersons of the house or senate finance committees, draft legislation to improve the regulation
32 of health insurance. In making the recommendations, the commissioner shall recognize that it is
33 the intent of the legislature that the maximum disclosure be provided regarding the reasonableness
34 of individual administrative expenditures as well as total administrative costs. The commissioner

1 shall make recommendations on the levels of reserves, including consideration of: targeted reserve
2 levels; trends in the increase or decrease of reserve levels; and insurer plans for distributing excess
3 reserves.

4 (c) To establish a consumer/business/labor/medical advisory council to obtain information
5 and present concerns of consumers, business, and medical providers affected by health insurance
6 decisions. The council shall develop proposals to allow the market for small business health
7 insurance to be affordable and fairer. The council shall be involved in the planning and conduct of
8 the quarterly public meetings in accordance with subsection (a). The advisory council shall develop
9 measures to inform small businesses of an insurance complaint process to ensure that small
10 businesses that experience rate increases in a given year may request and receive a formal review
11 by the department. The advisory council shall assess views of the health provider community
12 relative to insurance rates of reimbursement, billing, and reimbursement procedures, and the
13 insurers' role in promoting efficient and high-quality health care. The advisory council shall issue
14 an annual report of findings and recommendations to the governor and the general assembly and
15 present its findings at hearings before the house and senate finance committees. The advisory
16 council is to be diverse in interests and shall include representatives of community consumer
17 organizations; small businesses, other than those involved in the sale of insurance products; and
18 hospital, medical, and other health provider organizations. Such representatives shall be nominated
19 by their respective organizations. The advisory council shall be co-chaired by the health insurance
20 commissioner and a community consumer organization or small business member to be elected by
21 the full advisory council.

22 (d) ~~To establish and provide guidance and assistance to a subcommittee ("the professional-~~
23 ~~provider health plan work group") of the advisory council created pursuant to subsection (c),~~
24 ~~composed of healthcare providers and Rhode Island licensed health plans. This subcommittee~~ The
25 health commissioner shall ~~include~~ provide in its annual report and presentation before the house
26 and senate finance committees the following information:

27 (1) A method whereby health plans shall disclose to contracted providers the fee schedules
28 used to provide payment to those providers for services rendered to covered patients;

29 (2) A standardized provider application and credentials verification process, for the
30 purpose of verifying professional qualifications of participating healthcare providers;

31 (3) The uniform health plan claim form utilized by participating providers;

32 (4) Methods for health maintenance organizations, as defined by § 27-41-2, and nonprofit
33 hospital or medical service corporations, as defined by chapters 19 and 20 of title 27, to make
34 facility-specific data and other medical service-specific data available in reasonably consistent

1 formats to patients regarding quality and costs. This information would help consumers make
2 informed choices regarding the facilities and clinicians or physician practices at which to seek care.
3 Among the items considered would be the unique health services and other public goods provided
4 by facilities and clinicians or physician practices in establishing the most appropriate cost
5 comparisons;

6 (5) All activities related to contractual disclosure to participating providers of the
7 mechanisms for resolving health plan/provider disputes;

8 (6) The uniform process being utilized for confirming, in real time, patient insurance
9 enrollment status, benefits coverage, including copays and deductibles;

10 (7) Information related to temporary credentialing of providers seeking to participate in the
11 plan's network and the impact of the activity on health plan accreditation;

12 (8) The feasibility of regular contract renegotiations between plans and the providers in
13 their networks; and

14 (9) Efforts conducted related to reviewing impact of silent PPOs on physician practices.

15 (e) To enforce the provisions of title 27 and this title as set forth in § 42-14-5(d).

16 (f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The
17 fund shall be used to effectuate the provisions of §§ 27-18.5-9 and 27-50-17.

18 (g) To analyze the impact of changing the rating guidelines and/or merging the individual
19 health insurance market, as defined in chapter 18.5 of title 27, and the small-employer health
20 insurance market, as defined in chapter 50 of title 27, in accordance with the following:

21 (1) The analysis shall forecast the likely rate increases required to effect the changes
22 recommended pursuant to the preceding subsection (g) in the direct-pay market and small-employer
23 health insurance market over the next five (5) years, based on the current rating structure and
24 current products.

25 (2) The analysis shall include examining the impact of merging the individual and small-
26 employer markets on premiums charged to individuals and small-employer groups.

27 (3) The analysis shall include examining the impact on rates in each of the individual and
28 small-employer health insurance markets and the number of insureds in the context of possible
29 changes to the rating guidelines used for small-employer groups, including: community rating
30 principles; expanding small-employer rate bonds beyond the current range; increasing the employer
31 group size in the small-group market; and/or adding rating factors for broker and/or tobacco use.

32 (4) The analysis shall include examining the adequacy of current statutory and regulatory
33 oversight of the rating process and factors employed by the participants in the proposed, new
34 merged market.

1 (5) The analysis shall include assessment of possible reinsurance mechanisms and/or
2 federal high-risk pool structures and funding to support the health insurance market in Rhode Island
3 by reducing the risk of adverse selection and the incremental insurance premiums charged for this
4 risk, and/or by making health insurance affordable for a selected at-risk population.

5 (6) The health insurance commissioner shall work with an insurance market merger task
6 force to assist with the analysis. The task force shall be chaired by the health insurance
7 commissioner and shall include, but not be limited to, representatives of the general assembly, the
8 business community, small-employer carriers as defined in § 27-50-3, carriers offering coverage in
9 the individual market in Rhode Island, health insurance brokers, and members of the general public.

10 (7) For the purposes of conducting this analysis, the commissioner may contract with an
11 outside organization with expertise in fiscal analysis of the private insurance market. In conducting
12 its study, the organization shall, to the extent possible, obtain and use actual health plan data. Said
13 data shall be subject to state and federal laws and regulations governing confidentiality of health
14 care and proprietary information.

15 (8) The task force shall meet as necessary and include its findings in the annual report, and
16 the commissioner shall include the information in the annual presentation before the house and
17 senate finance committees.

18 (h) To establish and convene a workgroup representing healthcare providers and health
19 insurers for the purpose of coordinating the development of processes, guidelines, and standards to
20 streamline healthcare administration that are to be adopted by payors and providers of healthcare
21 services operating in the state. This workgroup shall include representatives with expertise who
22 would contribute to the streamlining of healthcare administration and who are selected from
23 hospitals, physician practices, community behavioral health organizations, ~~each health insurer~~
24 [labor union representing healthcare workers](#), and other affected entities. The workgroup shall also
25 include at least one designee each from the Rhode Island Medical Society, Rhode Island Council
26 of Community Mental Health Organizations, the Rhode Island Health Center Association, and the
27 Hospital Association of Rhode Island. In any year that the workgroup meets and submits
28 recommendations to the office of the health insurance commissioner, the office of the health
29 insurance commissioner shall submit such recommendations to the health and human services
30 committees of the Rhode Island house of representatives and the Rhode Island senate prior to the
31 implementation of any such recommendations and subsequently shall submit a report to the general
32 assembly by June 30, 2024. The report shall include the recommendations the commissioner may
33 implement, with supporting rationale. The workgroup shall consider and make recommendations
34 for:

- 1 (1) Establishing a consistent standard for electronic eligibility and coverage verification.
- 2 Such standard shall:
- 3 (i) Include standards for eligibility inquiry and response and, wherever possible, be
- 4 consistent with the standards adopted by nationally recognized organizations, such as the Centers
- 5 for Medicare & Medicaid Services;
- 6 (ii) Enable providers and payors to exchange eligibility requests and responses on a system-
- 7 to-system basis or using a payor-supported web browser;
- 8 (iii) Provide reasonably detailed information on a consumer's eligibility for healthcare
- 9 coverage; scope of benefits; limitations and exclusions provided under that coverage; cost-sharing
- 10 requirements for specific services at the specific time of the inquiry; current deductible amounts;
- 11 accumulated or limited benefits; out-of-pocket maximums; any maximum policy amounts; and
- 12 other information required for the provider to collect the patient's portion of the bill;
- 13 (iv) Reflect the necessary limitations imposed on payors by the originator of the eligibility
- 14 and benefits information;
- 15 (v) Recommend a standard or common process to protect all providers from the costs of
- 16 services to patients who are ineligible for insurance coverage in circumstances where a payor
- 17 provides eligibility verification based on best information available to the payor at the date of the
- 18 request of eligibility.
- 19 (2) Developing implementation guidelines and promoting adoption of the guidelines for:
- 20 (i) The use of the National Correct Coding Initiative code-edit policy by payors and
- 21 providers in the state;
- 22 (ii) Publishing any variations from codes and mutually exclusive codes by payors in a
- 23 manner that makes for simple retrieval and implementation by providers;
- 24 (iii) Use of Health Insurance Portability and Accountability Act standard group codes,
- 25 reason codes, and remark codes by payors in electronic remittances sent to providers;
- 26 (iv) Uniformity in the processing of claims by payors; and the processing of corrections to
- 27 claims by providers and payors;
- 28 (v) A standard payor-denial review process for providers when they request a
- 29 reconsideration of a denial of a claim that results from differences in clinical edits where no single,
- 30 common-standards body or process exists and multiple conflicting sources are in use by payors and
- 31 providers.
- 32 (vi) Nothing in this section, nor in the guidelines developed, shall inhibit an individual
- 33 payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of
- 34 detecting and deterring fraudulent billing activities. The guidelines shall require that each payor

1 disclose to the provider its adjudication decision on a claim that was denied or adjusted based on
2 the application of such edits and that the provider have access to the payor's review and appeal
3 process to challenge the payor's adjudication decision.

4 (vii) Nothing in this subsection shall be construed to modify the rights or obligations of
5 payors or providers with respect to procedures relating to the investigation, reporting, appeal, or
6 prosecution under applicable law of potentially fraudulent billing activities.

7 (3) Developing and promoting widespread adoption by payors and providers of guidelines
8 to:

9 (i) Ensure payors do not automatically deny claims for services when extenuating
10 circumstances make it impossible for the provider to obtain a preauthorization before services are
11 performed or notify a payor within an appropriate standardized timeline of a patient's admission;

12 (ii) Require payors to use common and consistent processes and time frames when
13 responding to provider requests for medical management approvals. Whenever possible, such time
14 frames shall be consistent with those established by leading national organizations and be based
15 upon the acuity of the patient's need for care or treatment. For the purposes of this section, medical
16 management includes prior authorization of services, preauthorization of services, precertification
17 of services, post-service review, medical-necessity review, and benefits advisory;

18 (iii) Develop, maintain, and promote widespread adoption of a single, common website
19 where providers can obtain payors' preauthorization, benefits advisory, and preadmission
20 requirements;

21 (iv) Establish guidelines for payors to develop and maintain a website that providers can
22 use to request a preauthorization, including a prospective clinical necessity review; receive an
23 authorization number; and transmit an admission notification;

24 (v) Develop and implement the use of programs that implement selective prior
25 authorization requirements, based on stratification of healthcare providers' performance and
26 adherence to evidence-based medicine with the input of contracted healthcare providers and/or
27 provider organizations. Such criteria shall be transparent and easily accessible to contracted
28 providers. Such selective prior authorization programs shall be available when healthcare providers
29 participate directly with the insurer in risk-based payment contracts and may be available to
30 providers who do not participate in risk-based contracts;

31 (vi) Require the review of medical services, including behavioral health services, and
32 prescription drugs, subject to prior authorization on at least an annual basis, with the input of
33 contracted healthcare providers and/or provider organizations. Any changes to the list of medical
34 services, including behavioral health services, and prescription drugs requiring prior authorization,

1 shall be shared via provider-accessible websites;

2 (vii) Improve communication channels between health plans, healthcare providers, and
3 patients by:

4 (A) Requiring transparency and easy accessibility of prior authorization requirements,
5 criteria, rationale, and program changes to contracted healthcare providers and patients/health plan
6 enrollees which may be satisfied by posting to provider-accessible and member-accessible
7 websites; and

8 (B) Supporting:

9 (I) Timely submission by healthcare providers of the complete information necessary to
10 make a prior authorization determination, as early in the process as possible; and

11 (II) Timely notification of prior authorization determinations by health plans to impacted
12 health plan enrollees, and healthcare providers, including, but not limited to, ordering providers,
13 and/or rendering providers, and dispensing pharmacists which may be satisfied by posting to
14 provider-accessible websites or similar electronic portals or services;

15 (viii) Increase and strengthen continuity of patient care by:

16 (A) Defining protections for continuity of care during a transition period for patients
17 undergoing an active course of treatment, when there is a formulary or treatment coverage change
18 or change of health plan that may disrupt their current course of treatment and when the treating
19 physician determines that a transition may place the patient at risk; and for prescription medication
20 by allowing a grace period of coverage to allow consideration of referred health plan options or
21 establishment of medical necessity of the current course of treatment;

22 (B) Requiring continuity of care for medical services, including behavioral health services,
23 and prescription medications for patients on appropriate, chronic, stable therapy through
24 minimizing repetitive prior authorization requirements; and which for prescription medication shall
25 be allowed only on an annual review, with exception for labeled limitation, to establish continued
26 benefit of treatment; and

27 (C) Requiring communication between healthcare providers, health plans, and patients to
28 facilitate continuity of care and minimize disruptions in needed treatment which may be satisfied
29 by posting to provider-accessible websites or similar electronic portals or services;

30 (D) Continuity of care for formulary or drug coverage shall distinguish between FDA
31 designated interchangeable products and proprietary or marketed versions of a medication;

32 (ix) Encourage healthcare providers and/or provider organizations and health plans to
33 accelerate use of electronic prior authorization technology, including adoption of national standards
34 where applicable; and

1 (x) For the purposes of subsections (h)(3)(v) through (h)(3)(x) of this section, the
2 workgroup meeting may be conducted in part or whole through electronic methods.

3 (4) To provide a report to the house and senate, on or before January 1, 2017, with
4 recommendations for establishing guidelines and regulations for systems that give patients
5 electronic access to their claims information, particularly to information regarding their obligations
6 to pay for received medical services, pursuant to 45 C.F.R. § 164.524.

7 (5) No provision of this subsection (h) shall preclude the ongoing work of the office of
8 health insurance commissioner's administrative simplification task force, which includes meetings
9 with key stakeholders in order to improve, and provide recommendations regarding, the prior
10 authorization process.

11 (i) To issue an anti-cancer medication report. Not later than June 30, 2014, and annually
12 thereafter, the office of the health insurance commissioner (OHIC) shall provide the senate
13 committee on health and human services, and the house committee on corporations, with: (1)
14 Information on the availability in the commercial market of coverage for anti-cancer medication
15 options; (2) For the state employee's health benefit plan, the costs of various cancer-treatment
16 options; (3) The changes in drug prices over the prior thirty-six (36) months; and (4) Member
17 utilization and cost-sharing expense.

18 (j) To monitor the adequacy of each health plan's compliance with the provisions of the
19 federal Mental Health Parity Act, including a review of related claims processing and
20 reimbursement procedures. Findings, recommendations, and assessments shall be made available
21 to the public.

22 (k) To ~~monitor the~~ prevent by regulation transition from fee-for-service and toward global
23 and other alternative payment methodologies for the payment for healthcare services that the health
24 insurance commissioner shall deem against the interest of public health. The health insurance
25 commissioner shall have no power to impose, encourage, or in any way incentivize any rate caps,
26 global budgets, episode-based payments, or capitation structures in the payment models utilized in
27 contracts between health insurers and providers. Alternative payment methodologies should be
28 assessed for their likelihood to ~~promote~~ damage access to affordable health ~~insurance~~ care, health
29 outcomes, and performance.

30 (l) To report annually, no later than July 1, 2014, then biannually thereafter, on hospital
31 payment variation, including findings and recommendations, subject to available resources.

32 (m) Notwithstanding any provision of the general or public laws or regulation to the
33 contrary, provide a report with findings and recommendations to the president of the senate and the
34 speaker of the house, on or before April 1, 2014, including, but not limited to, the following

1 information:

2 (1) The impact of the current, mandated healthcare benefits as defined in §§ 27-18-48.1,
3 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20, and 41 of title 27, and §§ 27-
4 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health
5 insurance for fully insured employers, subject to available resources;

6 (2) Current provider and insurer mandates that are unnecessary and/or duplicative due to
7 the existing standards of care and/or delivery of services in the healthcare system;

8 (3) A state-by-state comparison of health insurance mandates and the extent to which
9 Rhode Island mandates exceed other states benefits; and

10 (4) Recommendations for amendments to existing mandated benefits based on the findings
11 in subsections (m)(1), (m)(2), and (m)(3) above.

12 (n) On or before July 1, 2014, the office of the health insurance commissioner, in
13 collaboration with the director of health and lieutenant governor's office, shall submit a report to
14 the general assembly and the governor to inform the design of accountable care organizations
15 (ACOs) in Rhode Island as unique structures for comprehensive healthcare delivery and value-
16 based payment arrangements, that shall include, but not be limited to:

17 (1) Utilization review;

18 (2) Contracting; and

19 (3) Licensing and regulation.

20 (o) On or before February 3, 2015, the office of the health insurance commissioner shall
21 submit a report to the general assembly and the governor that describes, analyzes, and proposes
22 recommendations to improve compliance of insurers with the provisions of § 27-18-76 with regard
23 to patients with mental health and substance use disorders.

24 (p) To work to ensure the health insurance coverage of behavioral health care under the
25 same terms and conditions as other health care, and to integrate behavioral health parity
26 requirements into the office of the health insurance commissioner insurance oversight and
27 healthcare transformation efforts.

28 (q) To work with other state agencies to seek delivery system improvements that enhance
29 access to a continuum of mental health and substance use disorder treatment in the state; and
30 integrate that treatment with primary and other medical care to the fullest extent possible.

31 (r) To direct insurers toward policies and practices that address the behavioral health needs
32 of the public and greater integration of physical and behavioral healthcare delivery.

33 (s) The office of the health insurance commissioner shall conduct an analysis of the impact
34 of the provisions of § 27-38.2-1(i) on health insurance premiums and access in Rhode Island and

1 submit a report of its findings to the general assembly on or before June 1, 2023.

2 (t) To undertake the analyses, reports, and studies contained in this section:

3 (1) The office shall hire the necessary staff and prepare a request for proposal for a qualified
4 and competent firm or firms to undertake the following analyses, reports, and studies:

5 (i) The firm shall undertake a comprehensive review of all social and human service
6 programs having a contract with or licensed by the state or any subdivision of the department of
7 children, youth and families (DCYF), the department of behavioral healthcare, developmental
8 disabilities and hospitals (BHDDH), the department of human services (DHS), the department of
9 health (DOH), and Medicaid for the purposes of:

10 (A) Establishing a baseline of the eligibility factors for receiving services;

11 (B) Establishing a baseline of the service offering through each agency for those
12 determined eligible;

13 (C) Establishing a baseline understanding of reimbursement rates for all social and human
14 service programs including rates currently being paid, the date of the last increase, and a proposed
15 model that the state may use to conduct future studies and analyses;

16 (D) Ensuring accurate and adequate reimbursement to social and human service providers
17 that facilitate the availability of high-quality services to individuals receiving home and
18 community-based long-term services and supports provided by social and human service providers;

19 (E) Ensuring the general assembly is provided accurate financial projections on social and
20 human service program costs, demand for services, and workforce needs to ensure access to entitled
21 beneficiaries and services;

22 (F) Establishing a baseline and determining the relationship between state government and
23 the provider network including functions, responsibilities, and duties;

24 (G) Determining a set of measures and accountability standards to be used by EOHHS and
25 the general assembly to measure the outcomes of the provision of services including budgetary
26 reporting requirements, transparency portals, and other methods; and

27 (H) Reporting the findings of human services analyses and reports to the speaker of the
28 house, senate president, chairs of the house and senate finance committees, chairs of the house and
29 senate health and human services committees, and the governor.

30 (2) The analyses, reports, and studies required pursuant to this section shall be
31 accomplished and published as follows and shall provide:

32 (i) An assessment and detailed reporting on all social and human service program rates to
33 be completed by January 1, 2023, including rates currently being paid and the date of the last
34 increase;

- 1 (ii) An assessment and detailed reporting on eligibility standards and processes of all
2 mandatory and discretionary social and human service programs to be completed by January 1,
3 2023;
- 4 (iii) An assessment and detailed reporting on utilization trends from the period of January
5 1, 2017, through December 31, 2021, for social and human service programs to be completed by
6 January 1, 2023;
- 7 (iv) An assessment and detailed reporting on the structure of the state government as it
8 relates to the provision of services by social and human service providers including eligibility and
9 functions of the provider network to be completed by January 1, 2023;
- 10 (v) An assessment and detailed reporting on accountability standards for services for social
11 and human service programs to be completed by January 1, 2023;
- 12 (vi) An assessment and detailed reporting by April 1, 2023, on all professional licensed
13 and unlicensed personnel requirements for established rates for social and human service programs
14 pursuant to a contract or established fee schedule;
- 15 (vii) An assessment and reporting on access to social and human service programs, to
16 include any wait lists and length of time on wait lists, in each service category by April 1, 2023;
- 17 (viii) An assessment and reporting of national and regional Medicaid rates in comparison
18 to Rhode Island social and human service provider rates by April 1, 2023;
- 19 (ix) An assessment and reporting on usual and customary rates paid by private insurers and
20 private pay for similar social and human service providers, both nationally and regionally, by April
21 1, 2023;
- 22 (x) Completion of the development of an assessment and review process that includes the
23 following components: eligibility; scope of services; relationship of social and human service
24 provider and the state; national and regional rate comparisons and accountability standards that
25 result in recommended rate adjustments; and this process shall be completed by September 1, 2023,
26 and conducted biennially hereafter. The biennial rate setting shall be consistent with payment
27 requirements established in section 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. §
28 1396a(a)(30)(A), and all federal and state law, regulations, and quality and safety standards. The
29 results and findings of this process shall be transparent, and public meetings shall be conducted to
30 allow providers, recipients, and other interested parties an opportunity to ask questions and provide
31 comment beginning in September 2023 and biennially thereafter; and
- 32 (xi) On or before September 1, 2026, the office shall publish and submit to the general
33 assembly and the governor a one-time report making and justifying recommendations for
34 adjustments to primary care services reimbursement and financing. The report shall include

1 consideration of Medicaid, Medicare, commercial, and alternative contracted payments.

2 (3) In fulfillment of the responsibilities defined in subsection (t), the office of the health
3 insurance commissioner shall consult with the Executive Office of Health and Human Services.

4 (u) Annually, each department (namely, EOHHS, DCYF, DOH, DHS, and BHDDH) shall
5 include the corresponding components of the assessment and review (i.e., eligibility; scope of
6 services; relationship of social and human service provider and the state; and national and regional
7 rate comparisons and accountability standards including any changes or substantive issues between
8 biennial reviews) including the recommended rates from the most recent assessment and review
9 with their annual budget submission to the office of management and budget and provide a detailed
10 explanation and impact statement if any rate variances exist between submitted recommended
11 budget and the corresponding recommended rate from the most recent assessment and review
12 process starting October 1, 2023, and biennially thereafter.

13 (v) The general assembly shall appropriate adequate funding as it deems necessary to
14 undertake the analyses, reports, and studies contained in this section relating to the powers and
15 duties of the office of the health insurance commissioner.

16 (w) The office of the health insurance commissioner shall:

17 (1) Ensure that insurers minimize administrative burdens that may delay medically
18 necessary care, by promulgating rules and regulations and taking enforcement actions to implement
19 § 27-18.9-16; and

20 (2) Convene the payor/provider workgroup described in subsection (h) of this section, or a
21 similar taskforce, comprised of members with relevant experience and expertise, to serve as a
22 standing advisory steering committee (“committee”) to review and make recommendations
23 regarding:

24 (i) The continuous improvement and simplification of the prior authorization processes for
25 medical services and prescription drugs;

26 (ii) The facilitation of communication and collaboration related to volume reduction;

27 (iii) The establishment of a tracking method to improve the collection of baseline data from
28 commercial health insurers that does not create an administrative burden;

29 (iv) The assessment of prior authorizations that have been approved, those that have been
30 approved with modifications, and the utilization of MRI services in the emergency department; and

31 (v) The assessment of improvements to the access of primary care services and other
32 quality care measures related to the elimination of prior authorizations during this program,
33 including increase in staff availability to perform other office functions; increase in patient
34 appointments; and reduction in care delay.

1 (x) To approve or deny any compensation of employees of health insurers subject to the
2 laws of the State of Rhode Island in excess of one million dollars (\$1,000,000) per employee.

3 (y) To approve or deny dividends of stock buybacks of health insurers subject to the laws
4 of the State of Rhode Island.

5 (3) Submit such recommendations of the committee with a rationale, to the governor's
6 office, speaker of the house of representatives, and the president of the senate, prior to the
7 implementation of any such recommendations and subsequently shall submit a full report to the
8 general assembly by July 1 of each year of the pilot program.

9 SECTION 19. Section 44-17-1 of the General Laws in Chapter 44-17 entitled "Taxation of
10 Insurance Companies" is hereby amended to read as follows:

11 **44-17-1. Companies required to file — Payment of tax — Retaliatory rates.**

12 (a) Every domestic, foreign, or alien insurance company, mutual association, organization,
13 or other insurer, including any health maintenance organization as defined in § 27-41-2, any
14 medical malpractice insurance joint underwriters association as defined in § 42-14.1-1, any
15 nonprofit dental service corporation as defined in § 27-20.1-2 and any nonprofit hospital or medical
16 service corporation as defined in chapters 19 and 20 of title 27, except companies mentioned in §
17 44-17-6 and organizations defined in § 27-25-1, transacting business in this state, shall, on or before
18 April 15 in each year, file with the tax administrator, in the form that he or she may prescribe, a
19 return under oath or affirmation signed by a duly authorized officer or agent of the company,
20 containing information that may be deemed necessary for the determination of the tax imposed by
21 this chapter, and shall at the same time pay an annual tax to the tax administrator of two percent
22 (2%) of the gross premiums on contracts of insurance, except for ocean marine insurance as referred
23 to in § 44-17-6, covering property and risks within the state, written during the calendar year ending
24 December 31st next preceding. For tax year 2028 and thereafter, this rate shall be increased to four
25 percent (4%).

26 (b) Qualifying insurers for purposes of this section means every domestic, foreign, or alien
27 insurance company, mutual association, organization, or other insurer and excludes:

28 (1) Health maintenance organizations, as defined in § 27-41-2;

29 (2) Nonprofit dental service corporations, as defined in § 27-20.1-2; and

30 (3) Nonprofit hospital or medical service corporations, as defined in §§ 27-19-1 and 27-
31 20-1.

32 (c) For tax years 2018 and thereafter, the rate of taxation may be reduced as set forth below
33 and, if so reduced, shall be fully applicable to qualifying insurers instead of the two percent (2%)
34 rate listed in subsection (a). In the case of foreign or alien companies, except as provided in § 27-

1 2-17(d), the tax shall not be less in amount than is imposed by the laws of the state or country under
2 which the companies are organized upon like companies incorporated in this state or upon its
3 agents, if doing business to the same extent in the state or country. The tax rate shall not be reduced
4 for gross premiums written on contracts of health insurance as defined in § 42-14-5(c) but shall
5 remain at ~~two percent (2%)~~ the rate in subsection (a) or the appropriate retaliatory tax rate,
6 whichever is higher.

7 ~~(d) For qualifying insurers, the premium tax rate may be decreased based upon Rhode
8 Island jobs added by the industry as detailed below:~~

9 ~~(1) A committee shall be established for the purpose of implementing tax rates using the
10 framework established herein. The committee shall be comprised of the following persons or their
11 designees: the secretary of commerce, the director of the department of business regulation, the
12 director of the department of revenue, and the director of the office of management and budget. No
13 rule may be issued pursuant to this section without the prior, unanimous approval of the committee;~~

14 ~~(2) On the timetable listed below, the committee shall determine whether qualifying
15 insurers have added new qualifying jobs in this state in the preceding calendar year. A qualifying
16 job for purposes of this section is any employee with total annual wages equal to or greater than
17 forty percent (40%) of the average annual wages of the Rhode Island insurance industry, as
18 published by the annual employment and wages report of the Rhode Island department of labor and
19 training, in NAICS code 5241;~~

20 ~~(3) If the committee determines that there has been a sufficient net increase in qualifying
21 jobs in the preceding calendar year(s) to offset a material reduction in the premium tax, it shall
22 calculate a reduced premium tax rate. Such rate shall be determined via a method selected by the
23 committee and designed such that the estimated personal income tax generated by the increase in
24 qualifying jobs is at least one hundred and twenty-five percent (125%) of the anticipated reduction
25 in premium tax receipts resulting from the new rate. For purposes of this calculation, the committee
26 may consider personal income tax withholdings or receipts, but in no event may the committee
27 include for the purposes of determining revenue neutrality income taxes that are subject to
28 segregation pursuant to § 44-48.3-8(f) or that are otherwise available to the general fund;~~

29 ~~(4) Any reduced rate established pursuant to this section must be established in a
30 rulemaking proceeding pursuant to chapter 35 of title 42, subject to the following conditions:~~

31 ~~(i) Any net increase in qualifying jobs and the resultant premium tax reduction and revenue
32 impact shall be determined in any rulemaking proceeding conducted under this section and shall
33 be set forth in a report included in the rulemaking record, which report shall also include a
34 description of the data sources and calculation methods used. The first such report shall also include~~

1 a calculation of the baseline level of employment of qualifying insurers for the calendar year 2015;
2 and

3 (ii) ~~Notwithstanding any provision of the law to the contrary, no rule changing the tax rate~~
4 ~~shall take effect until one hundred and twenty (120) days after notice of the rate change is provided~~
5 ~~to the speaker of the house, the president of the senate, the house and senate fiscal advisors, and~~
6 ~~the auditor general, which notice shall include the report required under the preceding provision.~~

7 (5) ~~For each of the first three (3) rulemaking proceedings required under this section, the~~
8 ~~tax rate may remain unchanged or be decreased consistent with the requirements of this section,~~
9 ~~but may not be increased. These first three (3) rulemaking proceedings shall be conducted by the~~
10 ~~division of taxation and occur in the following manner:~~

11 (i) ~~The first rulemaking proceeding shall take place in calendar year 2017. This proceeding~~
12 ~~shall establish a rule that sets forth: (A) A new premium tax rate, if allowed under the requirements~~
13 ~~of this section, which rate shall take effect in 2018, and (B) A method for calculating the number~~
14 ~~of jobs at qualifying insurers;~~

15 (ii) ~~The second rulemaking proceeding shall take place in calendar year 2018. This~~
16 ~~proceeding shall establish a rule that sets forth: (A) A new premium tax rate, if allowed under the~~
17 ~~requirements of this section, which rate shall take effect in 2019, and (B) The changes, if any, to~~
18 ~~the method for calculating the number of jobs at qualifying insurers; and~~

19 (iii) ~~The third rulemaking proceeding shall take place in calendar year 2019. This~~
20 ~~proceeding shall establish a rule that sets forth: (A) A new premium tax rate, if allowed under the~~
21 ~~requirements of this section, which rate shall take effect in 2020, and (B) The changes, if any, to~~
22 ~~the method for calculating the number of jobs at qualifying insurers.~~

23 (6) ~~The tax rate established in the regulation following regulatory proceedings that take~~
24 ~~place in 2019 shall remain in effect through and including 2023. In calendar year 2023, the~~
25 ~~department of business regulation will conduct a rulemaking proceeding and issue a rule that sets~~
26 ~~forth: (A) A new premium tax rate, if allowed under the requirements of this section, which rate~~
27 ~~shall take effect in 2024, and (B) The changes, if any, to the method for calculating the number of~~
28 ~~jobs at qualifying insurers. A rule issued by the department of business regulation may decrease~~
29 ~~the tax rate if the requirements for a rate reduction contained in this section are met, or it may~~
30 ~~increase the tax rate to the extent necessary to achieve the overall revenue level sought when the~~
31 ~~then existing tax rate was established. Any rate established shall be no lower than one percent (1%)~~
32 ~~and no higher than two percent (2%). This proceeding shall be repeated every three (3) calendar~~
33 ~~years thereafter, however, the base for determination of job increases or decreases shall remain the~~
34 ~~number of jobs existing during calendar year 2022;~~

1 ~~(7) No reduction in the premium tax rate pursuant to this section shall be allowed absent a~~
2 ~~determination that qualifying insurers have added in this state at least three hundred fifty (350)~~
3 ~~new, full-time, qualifying jobs above the baseline level of employment of qualifying insurers for~~
4 ~~the calendar year 2015;~~

5 ~~(8) Notwithstanding any provision of this section to the contrary, the premium tax rate shall~~
6 ~~never be set lower than one percent (1%);~~

7 ~~(9) The division of taxation may adopt implementation guidelines, directives, criteria, rules~~
8 ~~and regulations pursuant to chapter 35 of title 42 as are necessary to implement this section; and~~

9 ~~(10) The calculation of revenue impacts under this section is at the sole discretion of the~~
10 ~~committee established under subsection (d)(1). Notwithstanding any provision of law to the~~
11 ~~contrary, any administrative action or rule setting a tax rate pursuant to this section or failing or~~
12 ~~declining to alter a tax rate pursuant to this section shall not be subject to judicial review under~~
13 ~~chapter 35 of title 42.~~

14 SECTION 20. Relating to Capital Development Programs - Statewide Referendum.

15 Section 1. Proposition to be submitted to the people. -- At the general election to be held
16 on the Tuesday next after the first Monday in November, 2026, there shall be submitted to the
17 people of the State of Rhode Island, for their approval or rejection, the following proposition:

18 "Shall the action of the general assembly, by an act passed at the January 2026 session,
19 authorizing the issuance of a bond, refunding bond, and/or temporary note of the State of Rhode
20 Island for the local capital projects and in the total amount with respect to the projects listed below
21 be approved, and the issuance of a bond, refunding bond, and/or temporary note authorized in
22 accordance with the provisions of said act?

23 Funding

24 The bond, refunding bond and/or temporary note shall be allocated to the Medicaid office
25 for oversight of the funds.

26 Project

27 (1) Group homes, assisted living facilities, and recovery beds \$300,000,000

28 Approval of this question will allow the State of Rhode Island to issue general obligation
29 bonds, refunding bonds, and/or temporary notes in an amount not to exceed three hundred million
30 dollars (\$300,000,000) for expansion of and investment in Rhode Island Community Living and
31 Supports. One hundred million dollars (\$100,000,000) shall be allocated for investment in and
32 expansion of state group homes operated by Rhode Island Community Living and Supports. One
33 hundred million dollars (\$100,000,000) shall be allocated for the construction of assisted living-
34 level care facilities for people with mental illnesses and developmental disabilities operated by

1 Rhode Island Community Living and Supports for persons who are eligible for Medicaid. One
2 hundred million dollars (\$100,000,000) shall be allocated for the construction of inpatient recovery
3 facilities operated by Rhode Island Community Living and Supports for persons who are eligible
4 for Medicaid and suffering from substance abuse issues in need of inpatient recovery services.
5 None of these funds may be allocated to private facilities.

6 (2) Hospital facilities expansion \$50,000,000

7 Approval of this question will allow the State of Rhode Island to issue general obligation
8 bonds, refunding bonds, and/or temporary notes in an amount not to exceed fifty million dollars
9 (\$50,000,000) for the improvement of state operated hospital facilities.

10 (3) University of Rhode Island Medical School \$500,000,000

11 Approval of this question will allow the State of Rhode Island to issue a general obligation
12 bond, refunding bond, and/or temporary note in an amount not to exceed five hundred million
13 dollars (\$500,000,000) for the construction of a medical school at the University of Rhode Island.
14 The Medicaid office shall work with the University of Rhode Island Medical School to establish a
15 reasonable annual contribution to fund the debt service on this bond from tuition revenue. While
16 these contributions shall continue until the entire debt service costs are paid, the Medicaid office
17 may allow for an amortization schedule that lasts for up to fifty (50) years."

18 Section 2. Ballot labels and applicability of general election laws. -- The secretary of state
19 shall prepare and deliver to the state board of elections ballot labels for each of the projects provided
20 for in Section 1 hereof with the designations "approve" or "reject" provided next to the description
21 of each such project to enable voters to approve or reject each such proposition. The general
22 election laws, so far as consistent herewith, shall apply to this proposition.

23 Section 3. Approval of projects by people. -- If a majority of the people voting on the
24 proposition in Section 1 hereof shall vote to approve any project stated therein, said project shall
25 be deemed to be approved by the people. The authority to issue bonds, refunding bonds and/or
26 temporary notes of the state shall be limited to the aggregate amount for all such projects as set
27 forth in the proposition, which have been approved by the people.

28 Section 4. Bonds for capital development program. -- The general treasurer is hereby
29 authorized and empowered, with the approval of the governor, and in accordance with the
30 provisions of this act to issue capital development bonds in serial form, in the name of and on behalf
31 of the State of Rhode Island, in amounts as may be specified by the governor in an aggregate
32 principal amount not to exceed the total amount for all projects approved by the people and
33 designated as "capital development loan of 2026 bonds." Provided, however, that the aggregate
34 principal amount of such capital development bonds and of any temporary notes outstanding at any

1 one time issued in anticipation thereof pursuant to Section 7 hereof shall not exceed the total amount
2 for all such projects approved by the people. All provisions in this act relating to "bonds" shall also
3 be deemed to apply to "refunding bonds."

4 Capital development bonds issued under this act shall be in denominations of one thousand
5 dollars (\$1,000) each, or multiples thereof, and shall be payable in any coin or currency of the
6 United States which at the time of payment shall be legal tender for public and private debts.

7 These capital development bonds shall bear such date or dates, mature at specified time or
8 times, but not mature beyond the end of the twentieth state fiscal year following the fiscal year in
9 which they are issued; bear interest payable semi-annually at a specified rate or different or varying
10 rates; be payable at designated time or times at specified place or places; be subject to express terms
11 of redemption or recall, with or without premium; be in a form, with or without interest coupons
12 attached; carry such registration, conversion, reconversion, transfer, debt retirement, acceleration
13 and other provisions as may be fixed by the general treasurer, with the approval of the governor,
14 upon each issue of such capital development bonds at the time of each issue. Whenever the
15 governor shall approve the issuance of such capital development bonds, the governor's approval
16 shall be certified to the secretary of state; the bonds shall be signed by the general treasurer and
17 countersigned by the secretary of state and shall bear the seal of the state. The signature approval
18 of the governor shall be endorsed on each bond.

19 Section 5. Refunding bonds for 2026 capital development program. -- The general treasurer
20 is hereby authorized and empowered, with the approval of the governor, and in accordance with
21 the provisions of this act, to issue bonds to refund the 2026 capital development program bonds, in
22 the name of and on behalf of the state, in amounts as may be specified by the governor in an
23 aggregate principal amount not to exceed the total amount approved by the people, to be designated
24 as "capital development program loan of 2026 refunding bonds" (hereinafter "refunding bonds").
25 The general treasurer with the approval of the governor shall fix the terms and form of any
26 refunding bonds issued under this act in the same manner as the capital development bonds issued
27 under this act, except that the refunding bonds may not mature more than twenty (20) years from
28 the date of original issue of the capital development bonds being refunded. The proceeds of the
29 refunding bonds, exclusive of any premium and accrual interest and net the underwriters' cost, and
30 cost of bond insurance, shall, upon their receipt, be paid by the general treasurer immediately to
31 the paying agent for the capital development bonds which are to be called and prepaid. The paying
32 agent shall hold the refunding bond proceeds in trust until they are applied to prepay the capital
33 development bonds. While the proceeds are held in trust, the proceeds may be invested for the
34 benefit of the state in obligations of the United States of America or the State of Rhode Island.

1 If the general treasurer shall deposit with the paying agent for the capital development
2 bonds the proceeds of the refunding bonds, or proceeds from other sources, amounts that, when
3 invested in obligations of the United States or the State of Rhode Island, are sufficient to pay all
4 principal, interest, and premium, if any, on the capital development bonds until these bonds are
5 called for prepayment, then such capital development bonds shall not be considered debts of the
6 State of Rhode Island for any purpose starting from the date of deposit of such monies with the
7 paying agent. The refunding bonds shall continue to be a debt of the state until paid.

8 The term "bond" shall include "note," and the term "refunding bonds" shall include
9 "refunding notes" when used in this act.

10 Section 6. Proceeds of capital development program. -- The general treasurer is directed to
11 deposit the proceeds from the sale of capital development bonds issued under this act, exclusive of
12 premiums and accrued interest and net the underwriters' cost, and cost of bond insurance, in one or
13 more of the depositories in which the funds of the state may be lawfully kept in special accounts
14 (hereinafter cumulatively referred to as "such capital development bond fund") appropriately
15 designated for each of the projects set forth in Section 1 hereof which shall have been approved by
16 the people to be used for the purpose of paying the cost of all such projects so approved.

17 All monies in the capital development bond fund shall be expended for the purposes
18 specified in the proposition provided for in Section 1 hereof under the direction and supervision of
19 the director of administration (hereinafter referred to as "director"). The director, or designee, shall
20 be vested with all power and authority necessary or incidental to the purposes of this act, including,
21 but not limited to, the following authority:

22 (1) To acquire land or other real property or any interest, estate, or right therein as may be
23 necessary or advantageous to accomplish the purposes of this act;

24 (2) To direct payment for the preparation of any reports, plans and specifications, and
25 relocation expenses and other costs such as for furnishings, equipment designing, inspecting, and
26 engineering, required in connection with the implementation of any projects set forth in Section 1
27 hereof;

28 (3) To direct payment for the costs of construction, rehabilitation, enlargement, provision
29 of service utilities, and razing of facilities, and other improvements to land in connection with the
30 implementation of any projects set forth in Section 1 hereof; and

31 (4) To direct payment for the cost of equipment, supplies, devices, materials, and labor for
32 repair, renovation, or conversion of systems and structures as necessary for the 2026 capital
33 development program bonds or notes hereunder from the proceeds thereof. No funds shall be
34 expended in excess of the amount of the capital development bond fund designated for each project

1 authorized in Section 1 hereof.

2 Section 7. Sale of bonds and notes. --Any bonds or notes issued under the authority of this
3 act shall be sold at not less than the principal amount thereof, in such mode and on such terms and
4 conditions as the general treasurer, with the approval of the governor, shall deem to be in the best
5 interests of the state.

6 Any bonds or notes issued under the provisions of this act and coupons on any capital
7 development bonds, if properly executed by the manual or electronic signatures of officers of the
8 state in office on the date of execution, shall be valid and binding according to their tenor,
9 notwithstanding that before the delivery thereof and payment therefor, any or all such officers shall
10 for any reason have ceased to hold office.

11 Section 8. Bonds and notes to be tax exempt and general obligations of the state. -- All
12 bonds and notes issued under the authority of this act shall be exempt from taxation in the state and
13 shall be general obligations of the state, and the full faith and credit of the state is hereby pledged
14 for the due payment of the principal and interest on each of such bonds and notes as the same shall
15 become due.

16 Section 9. Investment of monies in fund. -- All monies in the capital development fund not
17 immediately required for payment pursuant to the provisions of this act may be invested by the
18 investment commission, as established by chapter 10 of title 35, entitled "state investment
19 commission," pursuant to the provisions of such chapter; provided, however, that the securities in
20 which the capital development fund is invested shall remain a part of the capital development fund
21 until exchanged for other securities; and provided further, that the income from investments of the
22 capital development fund shall become a part of the general fund of the state and shall be applied
23 to the payment of debt service charges of the state, unless directed by federal law or regulation to
24 be used for some other purpose, or to the extent necessary, to rebate to the United States treasury
25 any income from investments (including gains from the disposition of investments) of proceeds of
26 bonds or notes to the extent deemed necessary to exempt (in whole or in part) the interest paid on
27 such bonds or notes from federal income taxation.

28 Section 10. Appropriation. -- To the extent the debt service on these bonds is not otherwise
29 provided, a sum sufficient to pay the interest and principal due each year on bonds and notes
30 hereunder is hereby annually appropriated out of any money in the treasury not otherwise
31 appropriated.

32 Section 11. Advances from general fund. -- The general treasurer is authorized, with the
33 approval of the director and the governor, in anticipation of the issuance of bonds or notes under
34 the authority of this act, to advance to the capital development bond fund for the purposes specified

1 in Section 1 hereof, any funds of the state not specifically held for any particular purpose; provided,
2 however, that all advances made to the capital development bond fund shall be returned to the
3 general fund from the capital development bond fund forthwith upon the receipt by the capital
4 development fund of proceeds resulting from the issue of bonds or notes to the extent of such
5 advances.

6 Section 12. Federal assistance and private funds. -- In carrying out this act, the director, or
7 designee, is authorized on behalf of the state, with the approval of the governor, to apply for and
8 accept any federal assistance which may become available for the purpose of this act, whether in
9 the form of a loan or grant or otherwise, to accept the provision of any federal legislation therefor,
10 to enter into, act and carry out contracts in connection therewith, to act as agent for the federal
11 government in connection therewith, or to designate a subordinate so to act. Where federal
12 assistance is made available, the project shall be carried out in accordance with applicable federal
13 law, the rules and regulations thereunder and the contract or contracts providing for federal
14 assistance, notwithstanding any contrary provisions of state law. Subject to the foregoing, any
15 federal funds received for the purposes of this act shall be deposited in the capital development
16 bond fund and expended as a part thereof. The director or designee may also utilize any private
17 funds that may be made available for the purposes of this act.

18 Section 13. Effective Date. -- Sections 1, 2, 3, 10, 11 and 12 of this act shall take effect
19 upon passage. The remaining sections of this act shall take effect when and if the state board of
20 elections shall certify to the secretary of state that a majority of the qualified electors voting on the
21 proposition contained in Section 1 hereof have indicated their approval of all or any projects
22 thereunder.

23 SECTION 21. Rhode Island Medicaid Reform Act of 2008 Joint Resolution.

24 WHEREAS, The General Assembly enacted chapter 12.4 of title 42 entitled "The Rhode
25 Island Medicaid Reform Act of 2008"; and

26 WHEREAS, A legislative enactment is required pursuant to Rhode Island General Laws
27 chapter 12.4 of title 42; and

28 WHEREAS, Rhode Island General Laws § 42-7.2-5(3)(i) provides that the Secretary of the
29 Executive Office of Health and Human Services ("Executive Office") is responsible for the
30 implementation of Medicaid policies; and

31 WHEREAS, In pursuit of a higher quality system of care, the General Assembly grants
32 legislative approval of the following proposals and directs the Secretary to implement them; and

33 WHEREAS, If implementation requires changes to rules, regulations, procedures, the
34 Medicaid state plan, and/or the section 1115 waiver, the General Assembly directs and empowers

1 the Secretary to make said changes; further, adoption of new or amended rules, regulations and
2 procedures may also be required:

3 (a) Raising Nursing Facility Personal Needs Allowance. The Executive Office will raise
4 the personal needs allowance for nursing facility residents to two hundred dollars (\$200).

5 (b) Medicare Equivalent Rate. The Executive Office will raise all Medicaid rates, except
6 for hospital rates, dental rates, and outpatient behavioral health rates to equal the Medicare
7 equivalent rate. Specific to early intervention services, a payment of fifty dollars (\$50.00) per
8 member per month payment shall be established in addition to these rates, and a floor of fifty
9 percent (50%) rate increase shall be established within the calculation of the Medicare equivalent
10 rate.

11 (c) Setting Outpatient Behavioral Healthcare Rates at one hundred fifty percent (150%) of
12 Medicare Equivalent Rates. The Executive Office will set outpatient behavioral health rates at one
13 hundred fifty percent (150%) of the Medicare equivalent rate. The Executive Office will maximize
14 federal financial participation if and when available, though state-only funds will be used if federal
15 financial participation is not available.

16 (d) FQHC APM Modernization. The Executive Office will make certain modifications to
17 modernize and standardize the alternative payment methodology option for federally qualified
18 health centers.

19 (e) RItShare Freedom of Choice. The Executive Office will make employee participation
20 in the RItShare program voluntary.

21 (f) Elderly and Disabled Eligibility Expansion. The Executive Office will expand Medicaid
22 eligibility for elderly and disabled residents to one hundred thirty-three percent (133%) of the
23 federal poverty level.

24 (g) Payments Streamlining. The Executive Office will conduct a multifaceted initiative to
25 begin the phase-out of intermediary payers such as managed care entities, streamlining payments
26 and reducing wasteful expenditures on intermediary payers.

27 (h) End to Health System Transformation Project. The Executive Office will end the Health
28 System Transformation Project to reduce risk exposure to providers and increase the efficiency of
29 the payments system.

30 (i) Rhode Island Mental Health Nursing Facility. The Executive Office will open a state
31 nursing facility to serve patients with significant mental health needs.

32 (j) Dental Optimization. The Executive Office will make an array of changes to dental
33 benefits offered under Medicaid. Rates will be the rates utilized in § 27-18-54; § 27-19-30.1 § 27-
34 20-25.2; and § 27-41-27.2; billing will be extended to teledentistry services, Silver Diamine

1 Fluoride (code D1354), and denture billing (codes D5130, D5140, D5221, D5222, D5213, and
2 D5214); the mobile dentistry encounter rate will be raised to the FQHC rate; and a fifty percent
3 (50%) payment shall be established for undeliverable dentures.

4 (k) Transition to State-Level Medicare for All. The Executive Office is empowered to
5 begin the process of negotiating the necessary waivers for a transition to a state-level Medicare for
6 All health care payments system for Rhode Island. These waivers shall include the combining of
7 all federal health care funding streams into the system financing including, but not limited to,
8 Medicaid, Medicare, federal health care tax exemptions, and exchange subsidies established
9 pursuant to the U.S. Patient Protection and Affordable Care Act of 2010. The Executive Office
10 plans to begin the transition process after the completion of the raising of the Medicaid system to
11 a Medicare standard of care and the associated stabilization of the Rhode Island health care
12 workforce and provider network; provided, however, that the Executive Office, understanding the
13 complexity of the proposed waiver application, reserves the right to begin the waiver negotiation
14 process before the transition of Medicaid to a Medicare standard is complete. The Executive Office
15 shall only proceed with the waiver and transition should waiver conditions be favorable to the state
16 as a whole, in the judgment of the Executive Office. In the event that a full waiver cannot be
17 complete, and health insurers have been acquired by the Medicaid Office due to insolvency and the
18 Medicaid Office's goal of payer system stabilization, the Executive Office is empowered to seek
19 limited waivers for the streamlining and integration of acquired health insurers with the Medicaid
20 system. The Executive Office shall submit the final approved waiver and transition plan to the
21 general assembly for final approval; now, therefore be it

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

24 RESOLVED, That the Secretary of the Executive Office of Health and Human Services is
25 authorized to pursue and implement any waiver amendments, state plan amendments, and/or
26 changes to the applicable department's rules, regulations and procedures approved herein and as
27 authorized by chapter 12.4 of title 42; and be it further

28 RESOLVED, That this Joint Resolution shall take effect upon passage.

29 SECTION 22. This act shall take effect upon passage; provided, however, the RICHIP
30 program shall not come into operation until the necessary waivers are obtained, and the final
31 financing proposal is approved by the general assembly.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO HEALTH AND SAFETY -- THE RHODE ISLAND COMPREHENSIVE
HEALTH INSURANCE PROGRAM

1 This act would establish a universal, comprehensive, affordable single-payer health care
2 insurance program and help control health care costs, which would be referred to as, "the Rhode
3 Island Comprehensive Health Insurance Program" (RICHIP). The program would be paid for by
4 consolidating government and private payments to multiple insurance carriers into a more
5 economical and efficient improved Medicare-for-all style single-payer program and substituting
6 lower progressive taxes for higher health insurance premiums, co-pays, deductibles and costs due
7 to caps. This program would save Rhode Islanders from the current overly expensive, inefficient
8 and unsustainable multi-payer health insurance system that unnecessarily prevents access to
9 medically necessary health care.

10 This act would take effect upon passage; provided, however, the RICHIP program would
11 not come into operation until the necessary waivers are obtained, and the final financing proposal
12 is approved by the general assembly.

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