ARTICLE 12

RELATING TO MEDICAL ASSISTANCE

SECTION 1. Sections 40-6-27 and 40-6-27.2 of the General Laws in Chapter 40-6 entitled "Public Assistance Act" is hereby amended to read as follows:

40-6-27. Supplemental Security Income.

(a)(1) The director of the department is hereby authorized to enter into agreements on behalf of the state with the secretary of the Department of Health and Human Services or other appropriate federal officials, under the Supplementary Security Income (SSI) program established by title XVI of the Social Security Act, 42 U.S.C. § 1381 et seq., concerning the administration and determination of eligibility for SSI benefits for residents of this state, except as otherwise provided in this section. The state's monthly share of supplementary assistance to the Supplementary Security Income program shall be as follows:

(i) Individual living alone: $39.92

(ii) Individual living with others: $51.92

(iii) Couple living alone: $79.38

(iv) Couple living with others: $97.30

(v) Individual living in state licensed assisted living residence: $332.00

~~(vi) Individual eligible to receive Medicaid-funded long-term services and supports and living in a Medicaid-certified state-licensed assisted living residence or adult supportive care residence, as defined in § 23-17.24-1, participating in the program authorized under § 40-8.13-12 or an alternative, successor, or substitute program or delivery option designated for such purposes by the secretary of the executive office of health and human services:~~

~~(A) With countable income above one hundred and twenty (120) percent of poverty: up to $465.00;~~

~~(B) With countable income at or below one hundred and twenty (120) percent of poverty: up to the total amount established in (v) and $465: $797~~

(vi~~i~~) Individual living in state-licensed supportive residential-care settings that, depending on the population served, meet the standards set by the department of human services in conjunction with the department(s) of children, youth and families, elderly affairs and/or behavioral healthcare, developmental disabilities and hospitals: $300.00.

Provided, however, that the department of human services shall by regulation reduce, effective January 1, 2009, the state's monthly share of supplementary assistance to the Supplementary Security Income (SSI) program for each of the above-listed payment levels, by the same value as the annual federal cost of living adjustment to be published by the federal Social Security Administration in October 2008 and becoming effective on January 1, 2009, as determined under the provisions of title XVI of the federal Social Security Act [42 U.S.C. § 1381 et seq.]; and provided further, that it is the intent of the general assembly that the January 1, 2009, reduction in the state's monthly share shall not cause a reduction in the combined federal and state payment level for each category of recipients in effect in the month of December 2008; provided further, that the department of human services is authorized and directed to provide for payments to recipients in accordance with the above directives.

(2) As of July 1, 2010, state supplement payments shall not be federally administered and shall be paid directly by the department of human services to the recipient.

(3) Individuals living in institutions shall receive a twenty dollar ($20.00) per month personal needs allowance from the state that shall be in addition to the personal needs allowance allowed by the Social Security Act, 42 U.S.C. § 301 et seq.

(4) Individuals living in state-licensed supportive residential-care settings and assisted-living residences who are receiving SSI supplemental payments under this section ~~who are participating in the program under § 40-8.13-12 or an alternative, successor, or substitute program or delivery option, or otherwise~~ shall be allowed to retain a minimum personal needs allowance of fifty-five dollars ($55.00) per month from their SSI monthly benefit prior to payment of any monthly fees in addition to any amounts established in an administrative rule promulgated by the secretary of the executive office of health and human services for persons eligible to receive Medicaid-funded long-term services and supports in the settings identified in subsections (a)(1)(v) ~~and (a)(1)(vi)~~.

(5) ~~Except as authorized for the program authorized under § 40-8.13-12 or an alternative, successor, or substitute program, or delivery option designated by the secretary to ensure that supportive residential care or an assisted living residence is a safe and appropriate service setting, the~~ The department is authorized and directed to make a determination of the medical need and whether a setting provides the appropriate services for those persons who:

(i) Have applied for or are receiving SSI, and who apply for admission to supportive residential care setting and assisted living residences on or after October 1, 1998; or

(ii) Who are residing in supportive residential care settings and assisted living residences, and who apply for or begin to receive SSI on or after October 1, 1998.

(6) The process for determining medical need required by subsection (a)(5) of this section shall be developed by the executive office of health and human services in collaboration with the departments of that office and shall be implemented in a manner that furthers the goals of establishing a statewide coordinated long-term care entry system as required pursuant to the Medicaid section 1115 waiver demonstration.

(7) To assure access to high quality coordinated services, the executive office of health and human services is further authorized and directed to establish certification or contract standards that must be met by those state-licensed supportive residential-care settings, including adult supportive-care homes and assisted-living residences admitting or serving any persons eligible for state-funded supplementary assistance under this section ~~or the program established under § 40-8.13-12~~. Such certification or contract standards shall define:

(i) The scope and frequency of resident assessments, the development and implementation of individualized service plans, staffing levels and qualifications, resident monitoring, service coordination, safety risk management and disclosure, and any other related areas;

(ii) The procedures for determining whether the certifications or contract standards have been met; and

(iii) The criteria and process for granting a one time, short-term good cause exemption from the certification or contract standards to a licensed supportive residential care setting or assisted living residence that provides documented evidence indicating that meeting or failing to meet said standards poses an undue hardship on any person eligible under this section who is a prospective or current resident.

(8) The certification or contract standards required by this section ~~or § 40-8.13-12 or an alternative, successor, or substitute program, or delivery option designated by the secretary~~ shall be developed in collaboration by the departments, under the direction of the executive office of health and human services, so as to ensure that they comply with applicable licensure regulations either in effect or in development.

(b) The department is authorized and directed to provide additional assistance to individuals eligible for SSI benefits for:

(1) Moving costs or other expenses as a result of an emergency of a catastrophic nature which is defined as a fire or natural disaster; and

(2) Lost or stolen SSI benefit checks or proceeds of them; and

(3) Assistance payments to SSI eligible individuals in need because of the application of federal SSI regulations regarding estranged spouses; and the department shall provide such assistance, in a form and amount, which the department shall by regulation determine.

40-6-27.2. Supplementary cash assistance payment for certain Supplemental Security Income recipients.

There is hereby established a $206 monthly payment for disabled and elderly individuals who, on or after July 1, 2012, receive the state supplementary assistance payment for an individual in a state-licensed assisted-living residence under § 40-6-27 and further reside in an assisted-living facility that is not eligible to receive funding under Title XIX of the Social Security Act, 42 U.S.C. § 1381 et seq.~~, or reside in any assisted-living facility financed by the Rhode Island housing and mortgage finance corporation prior to January 1, 2006, and receive a payment under § 40-6-27. The monthly payment shall not be made on behalf of persons participating in the program authorized under § 40-8.13-12 or an alternative, successor, or substitute program, or delivery option designated for such purposes by the secretary of the executive office of health and human services.~~

SECTION 2. Section 40-8-4 and 40-8-26 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is hereby amended to read as follows:

40-8-4. Direct vendor payment plan.

(a) The department shall furnish medical care benefits to eligible beneficiaries through a direct vendor payment plan. The plan shall include, but need not be limited to, any or all of the following benefits, which benefits shall be contracted for by the director:

(1) Inpatient hospital services, other than services in a hospital, institution, or facility for tuberculosis or mental diseases;

(2) Nursing services for the period of time as the director shall authorize;

(3) Visiting nurse service;

(4) Drugs for consumption either by inpatients or by other persons for whom they are prescribed by a licensed physician;

(5) Dental services; and

(6) Hospice care up to a maximum of two hundred and ten (210) days as a lifetime benefit.

(b) For purposes of this chapter, the payment of federal Medicare premiums or other health insurance premiums by the department on behalf of eligible beneficiaries in accordance with the provisions of Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et seq., shall be deemed to be a direct vendor payment.

~~(c) With respect to medical care benefits furnished to eligible individuals under this chapter or Title XIX of the federal Social Security Act, the department is authorized and directed to impose:~~

~~(1) Nominal co-payments or similar charges upon eligible individuals for non-emergency services provided in a hospital emergency room; and~~

~~(2) Co-payments for prescription drugs in the amount of one dollar ($1.00) for generic drug~~

~~prescriptions and three dollars ($3.00) for brand name drug prescriptions in accordance with the provisions of 42 U.S.C. § 1396 et seq.~~

~~(d) The department is authorized and directed to promulgate rules and regulations to impose co-payments or charges and to provide that, with respect to subsection (c)(2), those regulations shall be effective upon filing.~~

~~(e)~~(c) No state agency shall pay a vendor for medical benefits provided to a recipient of assistance under this chapter until and unless the vendor has submitted a claim for payment to a commercial insurance plan, Medicare, and/or a Medicaid managed care plan, if applicable for that recipient, in that order. This includes payments for skilled nursing and therapy services specifically outlined in Chapters 7, 8, and 15 of the Medicare Benefit Policy Manual.

40-8-26. Community health centers.

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

(b) To support the ability of community health centers to provide high-quality medical care to patients, the executive office of health and human services ("executive office") ~~shall~~ may adopt and implement an alternative payment methodology (APM) for determining a Medicaid per-visit reimbursement for community health centers that is compliant with the prospective payment system (PPS) provided for in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000~~1~~. The following principles are to ensure that the APM PPS ~~prospective payment~~ rate determination methodology is part of the executive office overall value purchasing approach. For community health centers that do not agree to the Principles of Reimbursement that reflects the APM PPS, EOHHS shall reimburse such community health centers at the federal PPS rate, as required per 1902(bb)(3) of the Social Security Act. For community health centers that are reimbursed at the federal PPS rate, RIGL Sections 40-8-26(d) through (f) apply.

(c) The APM PPS rate determination methodology will (i) Fairly recognize the reasonable costs of providing services. Recognized reasonable costs will be those appropriate for the organization, management, and direct provision of services and (ii) Provide assurances to the executive office that services are provided in an effective and efficient manner, consistent with industry standards. Except for demonstrated cause and at the discretion of the executive office, the maximum reimbursement rate for a service (e.g., medical, dental) provided by an individual community health center shall not exceed one hundred twenty-five percent (125%) of the median rate for all community health centers within Rhode Island.

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

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

(f) Reimbursement rates established through this methodology shall be incorporated into the actuarially certified capitation rates paid to a health plan. The health plan shall be responsible for paying the full amount of the reimbursement rate to the community health center for each service eligible for reimbursement under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 20001. If the health plan has an alternative payment arrangement with the community health center the health plan may establish a PPS reconciliation process for eligible services and make monthly payments related to PPS for persons enrolled in the health plan on the date of service. The executive office will review, at least annually, the Medicaid reimbursement rates and reconciliation methodology used by the health plans for community health centers to ensure payments to each are made in compliance with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 20001.

SECTION 3. Sections 40-8.3-2, 40-8.3-3 and 40-8.3-10 of the General Laws in Chapter 40-8.3 entitled “Uncompensated Care” are hereby amended to read as follows:

40-8.3-2. Definitions.

As used in this chapter:

(1) "Base year" means, for the purpose of calculating a disproportionate share payment for any fiscal year ending after September 30, 2018 2020, the period from October 1, 2016 2018, through September 30, 2017 2019, and for any fiscal year ending after September 30, 2019 2021, the period from October 1, 2016 2019, through September 30, 2017 2020.

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

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

(i) Was licensed as a hospital in accordance with chapter 17 of title 23 during the base year and shall mean the actual facilities and buildings in existence in Rhode Island, licensed pursuant to § 23-17-1 et seq. on June 30, 2010, and thereafter any premises included on that license, regardless of changes in licensure status pursuant to chapter 17.14 of title 23 (hospital conversions) and § 23-17-6(b) (change in effective control), that provides short-term, acute inpatient and/or outpatient care to persons who require definitive diagnosis and treatment for injury, illness, disabilities, or

pregnancy. Notwithstanding the preceding language, the negotiated Medicaid managed-care payment rates for a court-approved purchaser that acquires a hospital through receivership, special mastership, or other similar state insolvency proceedings (which court-approved purchaser is issued a hospital license after January 1, 2013), shall be based upon the newly negotiated rates between the court-approved purchaser and the health plan, and the rates shall be effective as of the date that the court-approved purchaser and the health plan execute the initial agreement containing the newly negotiated rate. The rate-setting methodology for inpatient hospital payments and outpatient hospital payments set forth in §§ 40-8-13.4(b)(1)(ii)(C) and 40-8-13.4(b)(2), respectively, shall thereafter apply to negotiated increases for each annual twelve-month (12) period as of July 1 following the completion of the first full year of the court-approved purchaser's initial Medicaid managed-care contract;

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

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

(4) "Uncompensated-care costs" means, as to any hospital, the sum of: (i) The cost incurred by such hospital during the base year for inpatient or outpatient services attributable to charity care (free care and bad debts) for which the patient has no health insurance or other third-party coverage less payments, if any, received directly from such patients; and (ii) The cost incurred by such hospital during the base year for inpatient or out-patient services attributable to Medicaid beneficiaries less any Medicaid reimbursement received therefor; multiplied by the uncompensated-care index.

(5) "Uncompensated-care index" means the annual percentage increase for hospitals established pursuant to § 27-19-14 for each year after the base year, up to and including the payment year; provided, however, that the uncompensated-care index for the payment year ending September 30, 2007, shall be deemed to be five and thirty-eight hundredths percent (5.38%), and that the uncompensated-care index for the payment year ending September 30, 2008, shall be deemed to be five and forty-seven hundredths percent (5.47%), and that the uncompensated-care index for the payment year ending September 30, 2009, shall be deemed to be five and thirty-eight hundredths percent (5.38%), and that the uncompensated-care index for the payment years ending September 30, 2010, September 30, 2011, September 30, 2012, September 30, 2013, September 30, 2014, September 30, 2015, September 30, 2016, September 30, 2017, September 30, 2018, September 30, 2019, ~~and~~ September 30, 2020, September 30, 2021, and September 30, 2022 shall be deemed to be five and thirty hundredths percent (5.30%).

40-8.3-3. Implementation.

(~~a) For federal fiscal year 2018, commencing on October 1, 2017, and ending September 30, 2018, the executive office of health and human services shall submit to the Secretary of the United States Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:~~

~~(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $138.6 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and~~

~~(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year inflated by uncompensated care index for all participating hospitals. The disproportionate share payments shall be made on or before July 10, 2018, and are expressly conditioned upon approval on or before July 5, 2018, by the Secretary of the United States. Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2018 for the disproportionate share payments.~~

~~(b) For federal fiscal year 2019, commencing on October 1, 2018, and ending September 30, 2019, the executive office of health and human services shall submit to the Secretary of the United States Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:~~

~~(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $142.4 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and~~

~~(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year inflated by uncompensated care index for all participating hospitals. The disproportionate share payments shall be made on or before July 10, 2019, and are expressly conditioned upon approval on or before July 5, 2019, by the Secretary of the United States Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2019 for the disproportionate share payments.~~

~~(c)~~ (a) For federal fiscal year 2020, commencing on October 1, 2019, and ending September

30, 2020, the executive office of health and human services shall submit to the Secretary of the United States Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $142.4 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated-care costs for the base year, inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before July 13, 2020, and are expressly conditioned upon approval on or before July 6, 2020, by the Secretary of the United States Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2020 for the disproportionate share payments.

(b) For federal fiscal year 2021, commencing on October 1, 2020, and ending September 30, 2021, the executive office of health and human services shall submit to the Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $142.5 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year inflated by uncompensated care index for all participating hospitals. The disproportionate share payments shall be made on or before July 12, 2021, and are expressly conditioned upon approval on or before July 5, 2021, by the Secretary of the U.S. Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2021 for the disproportionate share payments.

(c) For federal fiscal year 2022, commencing on October 1, 2021, and ending September 30, 2022, the executive office of health and human services shall submit to the Secretary of the U.S. Department of Health and Human Services a state plan amendment to the Rhode Island

Medicaid DSH Plan to provide:

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $143.8 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year inflated by uncompensated care index for all participating hospitals. The disproportionate share payments shall be made on or before July 12, 2022, and are expressly conditioned upon approval on or before July 5, 2022, by the Secretary of the U.S. Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2022 for the disproportionate share payments.

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

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

40-8.3-10. Hospital adjustment payments.

Effective July 1, ~~2012~~ 2021, and for each subsequent year, the executive office of health and human services is hereby authorized and directed to amend its regulations for reimbursement to hospitals for inpatient and outpatient services as follows:

(a) Each hospital in the state of Rhode Island, as defined in § 23-17-38.1, shall receive a quarterly outpatient adjustment payment each state fiscal year of an amount determined as follows:

(1) Determine the percent of the state's total Medicaid outpatient and emergency department services (exclusive of physician services) provided by each hospital during each hospital's prior fiscal year;

(2) Determine the sum of all Medicaid payments to hospitals made for outpatient and emergency department services (exclusive of physician services) provided during each hospital's prior fiscal year;

(3) Multiply the sum of all Medicaid payments as determined in subsection (a)(2) by a percentage defined as the total identified upper payment limit for all hospitals divided by the sum of all Medicaid payments as determined in subsection (a)(2); and then multiply that result by each

hospital's percentage of the state's total Medicaid outpatient and emergency department services as determined in subsection (a)(1) to obtain the total outpatient adjustment for each hospital to be paid each year;

(4) Pay each hospital on or before July 20, October 20, January 20, and April 20 one quarter (1/4) of its total outpatient adjustment as determined in subsection (a)(3).

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

(c) Each hospital in the state of Rhode Island, as defined in subdivision 3-17-38.19(b)(1), shall receive a quarterly inpatient adjustment payment each state fiscal year of an amount determined as follows:

(1) Determine the percent of the state's total Medicaid inpatient services (exclusive of physician services) provided by each hospital during each hospital's prior fiscal year;

(2) Determine the sum of all Medicaid payments to hospitals made for inpatient services (exclusive of physician services) provided during each hospital's prior fiscal year;

(3) Multiply the sum of all Medicaid payments as determined in subdivision (2) by a percentage defined as the total identified upper payment limit for all hospitals divided by the sum of all Medicaid payments as determined in subdivision (2); and then multiply that result by each hospital's percentage of the state's total Medicaid inpatient services as determined in subdivision (1) to obtain the total inpatient adjustment for each hospital to be paid each year;

(4) Pay each hospital on or before July 20, October 20, January 20, and April 20 one quarter (1/4) of its total inpatient adjustment as determined in subdivision (3) above.

~~(c)~~(d) The amounts determined in ~~subsection~~ subsections (a) and (c) are in addition to Medicaid inpatient and outpatient payments and emergency services payments (exclusive of physician services) paid to hospitals in accordance with current state regulation and the Rhode Island Plan for Medicaid Assistance pursuant to Title XIX of the Social Security Act and are not subject to recoupment or settlement.

SECTION 4. Section 15 of Article 5 of Chapter 141 of the Public Laws of 2015 is hereby repealed.

~~A pool is hereby established of up to $4.0 million to support Medicaid Graduate Education funding for Academic Medical Centers who provide care to the state's critically ill and indigent populations. The office of Health and Human Services shall utilize this pool to provide up to $5 million per year in additional Medicaid payments to support Graduate Medical Education programs to hospitals meeting all of the following criteria:~~

~~(a) Hospital must have a minimum of 25,000 inpatient discharges per year for all patients regardless of coverage.~~

~~(b) Hospital must be designated as Level I Trauma Center.~~

~~(c) Hospital must provide graduate medical education training for at least 250 interns and residents per year.~~

~~The Secretary of the Executive Office of Health and Human Services shall determine the appropriate Medicaid payment mechanism to implement this program and amend any state plan documents required to implement the payments.~~

~~Payments for Graduate Medical Education programs shall be made annually.~~

SECTION 5. Section 40-8.4-12 of the General Laws in Chapter 40-8.4 entitled "Health Care for Families" is hereby amended to read as follows:

40-8.4-12. RIte Share health insurance premium assistance program.

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

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

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

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

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

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

(5) "Policy holder" means the person in the household with access to ESI, typically the

employee.

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

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

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

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

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

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

(c) RIte Share populations. Medicaid beneficiaries subject to RIte Share include: children, families, parent and caretakers eligible for Medicaid or the children's health insurance program (CHIP) under this chapter or chapter 12.3 of title 42; and adults between the ages of nineteen (19) and sixty-four (64) who are eligible under chapter 8.12 of this title, not receiving or eligible to receive Medicare, and are enrolled in managed care delivery systems. The following conditions apply:

(1) The income of Medicaid beneficiaries shall affect whether and in what manner they must participate in RIte Share as follows:

(i) Income at or below one hundred fifty percent (150%) of FPL -- Persons and families determined to have household income at or below one hundred fifty percent (150%) of the federal poverty level (FPL) guidelines based on the modified adjusted gross income (MAGI) standard or

other standard approved by the secretary are required to participate in RIte Share if a Medicaid-eligible adult or parent/caretaker has access to cost-effective ESI. Enrolling in ESI through RIte Share shall be a condition of maintaining Medicaid health coverage for any eligible adult with access to such coverage.

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

(d) RIte Share enrollment as a condition of eligibility. For Medicaid beneficiaries over the age of nineteen (19), enrollment in RIte Share shall be a condition of eligibility except as exempted below and by regulations promulgated by the executive office.

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

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

(e) Approval of health insurance plans for premium assistance. The executive office of health and human services shall adopt regulations providing for the approval of employer-based health insurance plans for premium assistance and shall approve employer-based health insurance plans based on these regulations. In order for an employer-based health insurance plan to gain approval, the executive office must determine that the benefits offered by the employer-based health insurance plan are substantially similar in amount, scope, and duration to the benefits provided to Medicaid-eligible persons enrolled in a Medicaid managed care plan, when the plan is evaluated in conjunction with available supplemental benefits provided by the office. The office shall obtain and make available to persons otherwise eligible for Medicaid identified in this section as supplemental benefits those benefits not reasonably available under employer-based health insurance plans that are required for Medicaid beneficiaries by state law or federal law or

regulation. Once it has been determined by the Medicaid agency that the ESI offered by a particular employer is RIte Share-approved, all Medicaid members with access to that employer's plan are required to participate in RIte Share. Failure to meet the mandatory enrollment requirement shall result in the termination of the Medicaid eligibility of the policy holder and other Medicaid members nineteen (19) or older in the household who could be covered under the ESI until the policy holder complies with the RIte Share enrollment procedures established by the executive office.

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

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

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

(i) Implementation by regulation. The executive office of health and human services is authorized and directed to adopt regulations to ensure the establishment and implementation of the premium assistance program in accordance with the intent and purpose of this section, the requirements of Title XIX, Title XXI, and any approved federal waivers.

(j) Outreach and reporting. The executive office of health and human services shall develop a plan to identify Medicaid-eligible individuals who have access to employer-sponsored insurance and increase the use of RIte Share benefits. Beginning October 1, 2019, the executive office shall submit the plan to be included as part of the reporting requirements under § 35-17-1. Starting January 1, 2020, the executive office of health and human services shall include the number of Medicaid recipients with access to employer-sponsored insurance, the number of plans that did not

meet the cost-effectiveness criteria for RIte Share, and enrollment in the premium assistance program as part of the reporting requirements under § 35-17-1.

(k) Employer Sponsored Insurance. The Executive Office of Health and Human Services shall dedicate staff and resources to reporting monthly as part of the requirements under § 35-17-1 which employer sponsored insurance plans meet the cost effectiveness criteria for RIte Share. Information in the report shall be used for screening for Medicaid enrollment to encourage Rite Share participation. By October 1, 2021, the report shall include any employers with 300 or more employees. By January 1, 2022, the report shall include employers with 100 or more employees. The January report shall also be provided to the chairperson of the house finance committee; the chairperson of the senate finance committee; the house fiscal advisor; the senate fiscal advisor; and the state budget officer..

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

40-8.9-9. Long-term-care rebalancing system reform goal.

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

(b) The reformed long-term-care system rebalancing goal is person-centered and encourages individual self-determination, family involvement, interagency collaboration, and individual choice through the provision of highly specialized and individually tailored home-based services. Additionally, individuals with severe behavioral, physical, or developmental disabilities must have the opportunity to live safe and healthful lives through access to a wide range of supportive services in an array of community-based settings, regardless of the complexity of their medical condition, the severity of their disability, or the challenges of their behavior. Delivery of

services and supports in less-costly and less-restrictive community settings will enable children, adolescents, and adults to be able to curtail, delay, or avoid lengthy stays in long-term-care institutions, such as behavioral health residential-treatment facilities, long-term-care hospitals, intermediate-care facilities, and/or skilled nursing facilities.

(c) Pursuant to federal authority procured under § 42-7.2-16, the executive office of health and human services is directed and authorized to adopt a tiered set of criteria to be used to determine eligibility for services. The criteria shall be developed in collaboration with the state's health and human services departments and, to the extent feasible, any consumer group, advisory board, or other entity designated for these purposes, and shall encompass eligibility determinations for long-term-care services in nursing facilities, hospitals, and intermediate-care facilities for persons with intellectual disabilities, as well as home- and community-based alternatives, and shall provide a common standard of income eligibility for both institutional and home- and community-based care. The executive office is authorized to adopt clinical and/or functional criteria for admission to a nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities that are more stringent than those employed for access to home- and community-based services. The executive office is also authorized to promulgate rules that define the frequency of re-assessments for services provided for under this section. Levels of care may be applied in accordance with the following:

(1) The executive office shall continue to apply the level-of-care criteria in effect on June 30, 2015, for any recipient determined eligible for and receiving Medicaid-funded long-term services in supports in a nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities on or before that date, unless:

(i) The recipient transitions to home- and community-based services because he or she would no longer meet the level-of-care criteria in effect on June 30, 2015; or

(ii) The recipient chooses home- and community-based services over the nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities. For the purposes of this section, a failed community placement, as defined in regulations promulgated by the executive office, shall be considered a condition of clinical eligibility for the highest level of care. The executive office shall confer with the long-term-care ombudsperson with respect to the determination of a failed placement under the ombudsperson's jurisdiction. Should any Medicaid recipient eligible for a nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities as of June 30, 2015, receive a determination of a failed community placement, the recipient shall have access to the highest level of care; furthermore, a recipient who has experienced a failed community placement shall be transitioned back into his or her former

nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities whenever possible. Additionally, residents shall only be moved from a nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities in a manner consistent with applicable state and federal laws.

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

(3) No nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities shall be denied payment for services rendered to a Medicaid recipient on the grounds that the recipient does not meet level-of-care criteria unless and until the executive office has:

(i) Performed an individual assessment of the recipient at issue and provided written notice to the nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities that the recipient does not meet level-of-care criteria; and

(ii) The recipient has either appealed that level-of-care determination and been unsuccessful, or any appeal period available to the recipient regarding that level-of-care determination has expired.

(d) The executive office is further authorized to consolidate all home- and community-based services currently provided pursuant to 42 U.S.C. § 1396n into a single system of home- and community-based services that include options for consumer direction and shared living. The resulting single home- and community-based services system shall replace and supersede all 42 U.S.C. § 1396n programs when fully implemented. Notwithstanding the foregoing, the resulting single program home- and community-based services system shall include the continued funding of assisted-living services at any assisted-living facility financed by the Rhode Island housing and mortgage finance corporation prior to January 1, 2006, and shall be in accordance with chapter 66.8 of title 42 as long as assisted-living services are a covered Medicaid benefit.

(e) The executive office is authorized to promulgate rules that permit certain optional services including, but not limited to, homemaker services, home modifications, respite, and physical therapy evaluations to be offered to persons at risk for Medicaid-funded long-term care subject to availability of state-appropriated funding for these purposes.

(f) To promote the expansion of home- and community-based service capacity, the executive office is authorized to pursue payment methodology reforms that increase access to homemaker, personal care (home health aide), assisted living, adult supportive-care homes, and adult day services, as follows:

(1) Development of revised or new Medicaid certification standards that increase access to

service specialization and scheduling accommodations by using payment strategies designed to achieve specific quality and health outcomes.

(2) Development of Medicaid certification standards for state-authorized providers of adult day services, excluding providers of services authorized under § 40.1-24-1(3), assisted living, and adult supportive care (as defined under chapter 17.24 of title 23) that establish for each, an acuity-based, tiered service and payment methodology tied to: licensure authority; level of beneficiary needs; the scope of services and supports provided; and specific quality and outcome measures.

The standards for adult day services for persons eligible for Medicaid-funded long-term services may differ from those who do not meet the clinical/functional criteria set forth in § 40-8.10-3.

(3) As the state's Medicaid program seeks to assist more beneficiaries requiring long-term services and supports in home- and community-based settings, the demand for home-care workers has increased, and wages for these workers has not kept pace with neighboring states, leading to high turnover and vacancy rates in the state's home-care industry, the executive office shall institute a one-time increase in the base-payment rates for FY 2019, as described below, for home-care service providers to promote increased access to and an adequate supply of highly trained home-healthcare professionals, in amount to be determined by the appropriations process, for the purpose of raising wages for personal care attendants and home health aides to be implemented by such providers.

~~(4)~~(i) A prospective base adjustment, effective not later than July 1, 2018, of ten percent (10%) of the current base rate for home-care providers, home nursing care providers, and hospice providers contracted with the executive office of health and human services and its subordinate agencies to deliver Medicaid fee-for-service personal care attendant services.

~~(5)~~(ii) A prospective base adjustment, effective not later than July 1, 2018, of twenty percent (20%) of the current base rate for home-care providers, home nursing care providers, and hospice providers contracted with the executive office of health and human services and its subordinate agencies to deliver Medicaid fee-for-service skilled nursing and therapeutic services and hospice care.

~~(6)~~(iii) Effective upon passage of this section, hospice provider reimbursement, exclusively for room and board expenses for individuals residing in a skilled nursing facility, shall revert to the rate methodology in effect on June 30, 2018, and these room and board expenses shall be exempted from any and all annual rate increases to hospice providers as provided for in this section.

~~(7)~~(iv) On the first of July in each year, beginning on July 1, 2019, the executive office of health and human services will initiate an annual inflation increase to the base rate for home-care

providers, home nursing care providers, and hospice providers contracted with the executive office and its subordinate agencies to deliver Medicaid fee-for-service personal care attendant services, skilled nursing and therapeutic services and hospice care. The base rate increase shall be a percentage amount equal to the New England Consumer Price Index card as determined by the United States Department of Labor for medical care and for compliance with all federal and state laws, regulations, and rules, and all national accreditation program requirements.

(g) As the state's Medicaid program seeks to assist more beneficiaries requiring long-term services and supports in home- and community-based settings, the demand for home-care workers has increased, and wages for these workers has not kept pace with neighboring states, leading to high turnover and vacancy rates in the state's home-care industry, to promote increased access to and an adequate supply of direct care workers the executive office shall institute a payment methodology change, in Medicaid fee-for-service and managed care, for FY 2022, which shall be passed through directly to the direct care workers' wages that are employed by home nursing care and home care providers licensed by Rhode Island Department of Health, as described below:

(1) Effective July 1, 2021, increase the existing shift differential modifier by $0.19 per fifteen (15) minutes for Personal Care and Combined Personal Care/Homemaker.

(i) Employers must pass on one-hundred percent (100%) of the shift differential modifier increase per fifteen (15) minute unit of service to the CNAs that rendered such services. This compensation shall be provided in addition to the rate of compensation that the employee was receiving as of June 30, 2021. For an employee hired after June 30, 2021, the agency shall use not less than the lowest compensation paid to an employee of similar functions and duties as of June 30, 2021 as the base compensation to which the increase is applied.

(ii) Employers must provide to EOHHS an annual compliance statement showing wages as of June 30, 2021, amounts received from the increases outlined herein, and compliance with this section by July 1, 2022. EOHHS may adopt any additional necessary regulations and processes to oversee this section.

(2) Effective January 1, 2022, establish a new behavioral healthcare enhancement of $0.39 per fifteen (15) minutes for Personal Care, Combined Personal Care/Homemaker, and Homemaker only for providers who have at least thirty percent (30%) of their direct care workers (which includes Certified Nursing Assistants (CNA) and Homemakers) certified in behavioral healthcare training.

(i) Employers must pass on one-hundred percent (100%) of the behavioral healthcare enhancement per fifteen (15) minute unit of service rendered by only those CNAs and Homemakers who have completed the thirty (30) hour behavioral health certificate training program offered by

Rhode Island College, or a training program that is prospectively determined to be compliant per EOHHS, to those CNAs and Homemakers. This compensation shall be provided in addition to the rate of compensation that the employee was receiving as of December 31, 2021. For an employee hired after December 31, 2021, the agency shall use not less than the lowest compensation paid to an employee of similar functions and duties as of December 31, 2021 as the base compensation to which the increase is applied.

(ii) By January 1, 2023, employers must provide to EOHHS an annual compliance statement showing wages as of December 31, 2021, amounts received from the increases outlined herein, and compliance with this section, including which behavioral healthcare training programs were utilized. EOHHS may adopt any additional necessary regulations and processes to oversee this section.

~~(g)~~(h) The executive office shall implement a long-term-care-options counseling program to provide individuals, or their representatives, or both, with long-term-care consultations that shall include, at a minimum, information about: long-term-care options, sources, and methods of both public and private payment for long-term-care services and an assessment of an individual's functional capabilities and opportunities for maximizing independence. Each individual admitted to, or seeking admission to, a long-term-care facility, regardless of the payment source, shall be informed by the facility of the availability of the long-term-care-options counseling program and shall be provided with long-term-care-options consultation if they so request. Each individual who applies for Medicaid long-term-care services shall be provided with a long-term-care consultation.

~~(h)~~(i) The executive office is also authorized, subject to availability of appropriation of funding, and federal, Medicaid-matching funds, to pay for certain services and supports necessary to transition or divert beneficiaries from institutional or restrictive settings and optimize their health and safety when receiving care in a home or the community. The secretary is authorized to obtain any state plan or waiver authorities required to maximize the federal funds available to support expanded access to home- and community-transition and stabilization services; provided, however, payments shall not exceed an annual or per-person amount.

~~(i)~~(j) To ensure persons with long-term-care needs who remain living at home have adequate resources to deal with housing maintenance and unanticipated housing-related costs, the secretary is authorized to develop higher resource eligibility limits for persons or obtain any state plan or waiver authorities necessary to change the financial eligibility criteria for long-term services and supports to enable beneficiaries receiving home and community waiver services to have the resources to continue living in their own homes or rental units or other home-based settings.

~~(j)~~(k) The executive office shall implement, no later than January 1, 2016, the following

home- and community-based service and payment reforms:

~~(1) Community-based, supportive-living program established in § 40-8.13-12 or an alternative, successor, or substitute program, or delivery option designated for these purposes by the secretary of the executive office of health and human services;~~

~~(2)~~ (1) Adult day services level of need criteria and acuity-based, tiered-payment methodology; and

~~(3)~~ (2) Payment reforms that encourage home- and community-based providers to provide the specialized services and accommodations beneficiaries need to avoid or delay institutional care.

~~(k)~~(l) The secretary is authorized to seek any Medicaid section 1115 waiver or state-plan amendments and take any administrative actions necessary to ensure timely adoption of any new or amended rules, regulations, policies, or procedures and any system enhancements or changes, for which appropriations have been authorized, that are necessary to facilitate implementation of the requirements of this section by the dates established. The secretary shall reserve the discretion to exercise the authority established under §§ 42-7.2-5(6)(v) and 42-7.2-6.1, in consultation with the governor, to meet the legislative directives established herein.

SECTION 7. Section 40-8.13-12 of the General Laws in Chapter 40-8.13 entitled "Long-Term Managed Care Arrangements" is hereby repealed in its entirety.

~~**40-8.13-12. Community-based supportive living program.**~~

~~(a) To expand the number of community-based service options, the executive office of health and human services shall establish a program for beneficiaries opting to participate in managed care long-term care arrangements under this chapter who choose to receive Medicaid-funded assisted living, adult supportive-care home, or shared living long-term-care services and supports. As part of the program, the executive office shall implement Medicaid certification or, as appropriate, managed care contract standards for state-authorized providers of these services that establish an acuity-based, tiered service and payment system that ties reimbursements to: a beneficiary's clinical/functional level of need; the scope of services and supports provided; and specific quality and outcome measures. These standards shall set the base level of Medicaid state-plan and waiver services that each type of provider must deliver, the range of acuity-based service enhancements that must be made available to beneficiaries with more intensive care needs, and the minimum state licensure and/or certification requirements a provider must meet to participate in the pilot at each service/payment level. The standards shall also establish any additional requirements, terms, or conditions a provider must meet to ensure beneficiaries have access to high-quality, cost-effective care.~~

~~(b) Room and board. The executive office shall raise the cap on the amount Medicaid-~~

~~certified assisted living and adult supportive home care providers are permitted to charge participating beneficiaries for room and board. In the first year of the program, the monthly charges for a beneficiary living in a single room who has income at or below three hundred percent (300%) of the Supplemental Security Income (SSI) level shall not exceed the total of both the maximum monthly federal SSI payment and the monthly state supplement authorized for persons requiring long-term services under § 40-6-27(a)(1)(vi), less the specified personal needs allowance. For a beneficiary living in a double room, the room and board cap shall be set at eighty-five percent (85%) of the monthly charge allowed for a beneficiary living in a single room.~~

~~(c) Program cost-effectiveness. The total cost to the state for providing the state supplement and Medicaid-funded services and supports to beneficiaries participating in the program in the initial year of implementation shall not exceed the cost for providing Medicaid-funded services to the same number of beneficiaries with similar acuity needs in an institutional setting in the initial year of the operations. The program shall be terminated if the executive office determines that the program has not met this target. The state shall expand access to the program to qualified beneficiaries who opt out of a long-term services and support (LTSS) arrangement, in accordance with § 40-8.13-2, or are required to enroll in an alternative, successor, or substitute program, or delivery option designated for these purposes by the secretary of the executive office of health and human services if the enrollment in an LTSS plan is no longer an option.~~

SECTION 8. Section 42-7.2-5 of the General Laws in Chapter 42-7.2 entitled "Office of Health and Human Services" is hereby amended to read as follows:

42-7.2-5. Duties of the secretary.

The secretary shall be subject to the direction and supervision of the governor for the oversight, coordination, and cohesive direction of state-administered health and human services and in ensuring the laws are faithfully executed, not withstanding any law to the contrary. In this capacity, the secretary of the executive office of health and human services (EOHHS) shall be authorized to:

(1) Coordinate the administration and financing of healthcare benefits, human services, and programs including those authorized by the state's Medicaid section 1115 demonstration waiver and, as applicable, the Medicaid State Plan under Title XIX of the U.S. Social Security Act. However, nothing in this section shall be construed as transferring to the secretary the powers, duties, or functions conferred upon the departments by Rhode Island public and general laws for the administration of federal/state programs financed in whole or in part with Medicaid funds or the administrative responsibility for the preparation and submission of any state plans, state plan amendments, or authorized federal waiver applications, once approved by the secretary.

(2) Serve as the governor's chief advisor and liaison to federal policymakers on Medicaid reform issues as well as the principal point of contact in the state on any such related matters.

(3)(i) Review and ensure the coordination of the state's Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or formal amendment changes, as described in the special terms and conditions of the state's Medicaid section 1115 demonstration waiver with the potential to affect the scope, amount or duration of publicly funded healthcare services, provider payments or reimbursements, or access to or the availability of benefits and services as provided by Rhode Island general and public laws. The secretary shall consider whether any such changes are legally and fiscally sound and consistent with the state's policy and budget priorities. The secretary shall also assess whether a proposed change is capable of obtaining the necessary approvals from federal officials and achieving the expected positive consumer outcomes. Department directors shall, within the timelines specified, provide any information and resources the secretary deems necessary in order to perform the reviews authorized in this section.

(ii) Direct the development and implementation of any Medicaid policies, procedures, or systems that may be required to assure successful operation of the state's health and human services integrated eligibility system and coordination with HealthSource RI, the state's health insurance marketplace.

(iii) Beginning in 2015, conduct on a biennial basis a comprehensive review of the Medicaid eligibility criteria for one or more of the populations covered under the state plan or a waiver to ensure consistency with federal and state laws and policies, coordinate and align systems, and identify areas for improving quality assurance, fair and equitable access to services, and opportunities for additional financial participation.

(iv) Implement service organization and delivery reforms that facilitate service integration, increase value, and improve quality and health outcomes.

(4) Beginning in 2020, prepare and submit to the governor, the chairpersons of the house and senate finance committees, the caseload estimating conference, and to the joint legislative committee for health-care oversight, by no later than ~~March~~ September 15 of each year, a comprehensive overview of all Medicaid expenditures outcomes, administrative costs, and utilization rates. The overview shall include, but not be limited to, the following information:

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

(ii) Expenditures, outcomes and utilization rates by population and sub-population served (e.g. families with children, persons with disabilities, children in foster care, children receiving adoption assistance, adults ages nineteen (19) to sixty-four (64), and elders);

(iii) Expenditures, outcomes and utilization rates by each state department or other municipal or public entity receiving federal reimbursement under Titles XIX and XXI of the Social Security Act, as amended;

(iv) Expenditures, outcomes and utilization rates by type of service and/or service provider; and

(v) Expenditures by mandatory population receiving mandatory services and, reported separately, optional services, as well as optional populations receiving mandatory services and, reported separately, optional services for each state agency receiving Title XIX and XXI funds.

The directors of the departments, as well as local governments and school departments, shall assist and cooperate with the secretary in fulfilling this responsibility by providing whatever resources, information and support shall be necessary.

(5) Resolve administrative, jurisdictional, operational, program, or policy conflicts among departments and their executive staffs and make necessary recommendations to the governor.

(6) Ensure continued progress toward improving the quality, the economy, the accountability and the efficiency of state-administered health and human services. In this capacity, the secretary shall:

(i) Direct implementation of reforms in the human resources practices of the executive office and the departments that streamline and upgrade services, achieve greater economies of scale and establish the coordinated system of the staff education, cross-training, and career development services necessary to recruit and retain a highly-skilled, responsive, and engaged health and human services workforce;

(ii) Encourage EOHHS-wide consumer-centered approaches to service design and delivery that expand their capacity to respond efficiently and responsibly to the diverse and changing needs of the people and communities they serve;

(iii) Develop all opportunities to maximize resources by leveraging the state's purchasing power, centralizing fiscal service functions related to budget, finance, and procurement, centralizing communication, policy analysis and planning, and information systems and data management, pursuing alternative funding sources through grants, awards and partnerships and securing all available federal financial participation for programs and services provided EOHHS-wide;

(iv) Improve the coordination and efficiency of health and human services legal functions by centralizing adjudicative and legal services and overseeing their timely and judicious administration;

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

coordination organization or unit for the expressed purpose of developing and implementing procedures EOHHS-wide that ensure that the appropriate publicly funded health services are provided at the right time and in the most appropriate and least restrictive setting;

(vi) Strengthen health and human services program integrity, quality control and collections, and recovery activities by consolidating functions within the office in a single unit that ensures all affected parties pay their fair share of the cost of services and are aware of alternative financing;

(vii) Assure protective services are available to vulnerable elders and adults with developmental and other disabilities by reorganizing existing services, establishing new services where gaps exist and centralizing administrative responsibility for oversight of all related initiatives and programs.

(7) Prepare and integrate comprehensive budgets for the health and human services departments and any other functions and duties assigned to the office. The budgets shall be submitted to the state budget office by the secretary, for consideration by the governor, on behalf of the state's health and human services agencies in accordance with the provisions set forth in § 35-3-4.

(8) Utilize objective data to evaluate health and human services policy goals, resource use and outcome evaluation and to perform short and long-term policy planning and development.

(9) Establishment of an integrated approach to interdepartmental information and data management that complements and furthers the goals of the unified health infrastructure project initiative and that will facilitate the transition to a consumer-centered integrated system of state administered health and human services.

(10) At the direction of the governor or the general assembly, conduct independent reviews of state-administered health and human services programs, policies and related agency actions and activities and assist the department directors in identifying strategies to address any issues or areas of concern that may emerge thereof. The department directors shall provide any information and assistance deemed necessary by the secretary when undertaking such independent reviews.

(11) Provide regular and timely reports to the governor and make recommendations with respect to the state's health and human services agenda.

(12) Employ such personnel and contract for such consulting services as may be required to perform the powers and duties lawfully conferred upon the secretary.

(13) Assume responsibility for complying with the provisions of any general or public law or regulation related to the disclosure, confidentiality and privacy of any information or records, in the possession or under the control of the executive office or the departments assigned to the

executive office, that may be developed or acquired or transferred at the direction of the governor or the secretary for purposes directly connected with the secretary's duties set forth herein.

(14) Hold the director of each health and human services department accountable for their administrative, fiscal and program actions in the conduct of the respective powers and duties of their agencies.

SECTION 9. Rhode Island Medicaid Reform Act of 2008 Resolution.

WHEREAS, the General Assembly enacted Chapter 12.4 of Title 42 entitled "The Rhode Island Medicaid Reform Act of 2008"; and

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

WHEREAS, Rhode Island General Law Section 42-7.2-5(3)(a) provides that the Secretary of Health and Human Services ("Secretary"), of the Executive Office of Health and Human Services ("Executive Office"), is responsible for the review and coordination of any Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or changes as described in the demonstration, "with potential to affect the scope, amount, or duration of publicly-funded health care services, provider payments or reimbursements, or access to or the availability of benefits and services provided by Rhode Island general and public laws"; and

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

(a) Update dental benefits for children. The Executive Office proposes to allow coverage for dental caries arresting treatments using Silver Diamine Fluoride when necessary. Implementation of this initiative requires amendments to the Medicaid State Plan.

(b) Perinatal Doula Services. The Executive Office proposes to establish medical assistance coverage and reimbursement rates for perinatal doula services, a practice to provide non-clinical emotional, physical and informational support before, during and after birth for expectant mothers, in order to reduce maternal health disparities, reduce the likelihood of costly interventions during births, such as cesarean birth and epidural pain relief, while increasing the likelihood of a shorter labor, a spontaneous vaginal birth, and a positive childbirth experience.

(c) Community Health Workers. To improve health outcomes, increase access to care, and reduce healthcare costs, the Executive Office proposes to provide medical assistance coverage and reimbursement to community health workers.

(d) HCBS Maintenance of Need Allowance Increase. The Executive Office proposes to

increase the Home and Community Based Services (HCBS) Maintenance of Need Allowance from 100% of the Federal Poverty Limit (FPL) plus twenty dollars to 300% of the Federal Social Security Income (SSI) standard to enable the Executive Office to provide sufficient support for individuals who are able to, and wish to, receive services in their homes.

(e) Change to Rates for Nursing Facility Services. To more effectively compensate the nursing facilities for the costs of providing care to members who require behavioral healthcare or ventilators, the Executive Office proposes to revise the fee-for-service Medicaid payment rate for nursing facility residents in the following ways:

(i) Re-weighting towards behavioral health care, such that the average Resource Utilization Group (RUG) weight is not increased as follows:

1. Increase the RUG weights related to behavioral healthcare; and

2. Decrease all other RUG weights

(ii) Increase the RUG weight related to ventilators; and

(iii) Implement a behavioral health per-diem add-on for particularly complex patients, who have been hospitalized for six months or more, are clinically appropriate for discharge to a nursing facility, and where the nursing facility is Medicaid certified to provide or facilitate enhanced levels of behavioral healthcare.

(f) Increase Shared Living Rates. In order to better incentivize the utilization of home- and community-based care for individuals that wish to receive their care in the community, the Executive Office proposes a ten percent (10%) increase to shared living caregiver stipend rates that are paid to providers through Medicaid fee-for-service and managed care.

(g) Increase rates for home nursing care and home care providers licensed by Rhode Island Department of Health. To ensure better access to home- and community-based services, the Executive Office proposes, for both fee-for-service and managed care, to increase the existing shift differential modifier by $0.19 per fifteen (15) minutes for Personal Care and Combined Personal Care/Homemaker effective July 1, 2021, and to establish a new behavioral healthcare enhancement of $0.39 per fifteen (15) minutes for Personal Care, Combined Personal Care/Homemaker, and Homemaker only for providers who have at least thirty percent (30%) of their direct care workers (which includes Certified Nursing Assistants (CNA) and Homemakers) certified in behavioral healthcare training effective January 1, 2022.

(h) Expansion of First Connections Program. In collaboration with the Rhode Island Department of Health (RIDOH), the Executive Office proposes to seek federal matching funds for the expansion of the First Connections Program, a risk assessment and response home visiting program designed to ensure that families are connected to appropriate services such as food

assistance, mental health, child care, long term family home visiting, Early Intervention (EI) and other programs, to prenatal women. The Executive Office would establish medical assistance coverage and reimbursement rates for such First Connection services provided to prenatal women.

(i) Parents as Teachers Program. In collaboration with RIDOH, the Executive Office proposes to seek federal matching funds for the coverage of the Parents as Teachers Program, to ensure that parents of young children are connected with the medical and social supports necessary to support their families.

(j) Increase Assisted Living rates. To ensure better access to home- and community-based services, the Executive Office proposes to increase the rates for Assisted Living providers in both fee-for-service and managed care.

(k) Elimination of Category F State Supplemental Payments. To ensure better access to home- and community-based services, the Executive Office proposes to eliminate the State Supplemental Payment for Category F individuals.

(l) Establish an intensive, expanded Mental Health Psychiatric Rehabilitative Residential ("MHPRR"). In collaboration with BHDDH, the Executive Office proposes to establish a MHPRR to provide discharge planning, medical and/or psychiatric treatment, and identification and amelioration of barriers to transition to less restrictive settings.

(m) Hospice and Home Care Annual Rate Increase Language. The Executive Office proposes amending the language in the Medicaid State Plan detailing the annual inflationary adjustments to hospice rates to utilize the New England Consumer Price Index card as determined by the United States Department of Labor for medical care data that is released in March, containing the February data. Additionally, the Executive Office proposes to add language to the Medicaid State Plan regarding the annual inflationary adjustments to home care rates to clarify that the Executive Office will utilize the New England Consumer Price Index card as determined by the United States Department of Labor for medical care data that is released in March, containing the February data.

(n) Non-Emergency Transportation Services. The Executive Office of Health and Human Services shall, as part of its payments through the transportation broker model, reimburse for basic life-support services at a rate no less than $147.67 and for advanced life-support services at no less than $177.20.

(o) Expansion of Home and Community Co-Pay Programs. The Executive Office, in conjunction with the Office of Healthy Aging, proposes to implement the authorities approved under the section 1115 demonstration waiver to increase the maximum income limit for all co-pay program eligibility from two hundred percent (200%) to two hundred fifty percent (250%) of the

federal poverty level. This includes implementing programs for adults, age 19 through 64, diagnosed with Alzheimer's or a related dementia. Implementation of these waiver authorities requires adoption of new or amended rules, regulations and procedures..

(p) Federal Financing Opportunities. The Executive Office proposes to review Medicaid requirements and opportunities under the U.S. Patient Protection and Affordable Care Act of 2010 (PPACA) and various other recently enacted federal laws and pursue any changes in the Rhode Island Medicaid program that promote service quality, access and cost-effectiveness that may warrant a Medicaid state plan amendment or amendment under the terms and conditions of Rhode Island's section 1115 waiver, its successor, or any extension thereof. Any such actions by the Executive Office shall not have an adverse impact on beneficiaries or cause there to be an increase in expenditures beyond the amount appropriated for state fiscal year 2022.

Now, therefore, be it

RESOLVED, the General Assembly hereby approves the proposals stated in (a) through (p) above; and be it further;

RESOLVED, the Secretary of the Executive Office is authorized to pursue and implement any 1115 demonstration waiver amendments, Medicaid state plan amendments, and/or changes to the applicable department's rules, regulations and procedures approved herein and as authorized by Chapter 42-12.4; and be it further;

RESOLVED, that this Joint Resolution shall take effect upon passage.

SECTION 10. This article shall take effect as of July 1, 2021.