ARTICLE 12 AS AMENDED

RELATING TO MEDICAL ASSISTANCE

SECTION 1. Sections 12-1.6-1 and 12-1.6-2 of the General Laws in Chapter 12-1.6 entitled "National Criminal Records Check System" are hereby amended to read as follows:

12-1.6-1. Automated fingerprint identification system database.

The department of attorney general may establish and maintain an automated fingerprint identification system database that would allow the department to store and maintain all fingerprints submitted in accordance with the national criminal records check system. The automated fingerprint identification system database would provide for an automatic notification if, and when, a subsequent criminal arrest fingerprint card is submitted to the system that matches a set of fingerprints previously submitted in accordance with a national criminal records check. If the aforementioned arrest results in a conviction, the department shall immediately notify those individuals and entities with which that individual is associated and who are required to be notified of disqualifying information concerning national criminal records checks as provided in chapters 17, 17.4, 17.7.1 of title 23 or § 23-1-52 and 42-7.2 of title 42 or §§ 42-7.2-18.2 and 42-7.2-18.4. The information in the database established under this section is confidential and not subject to disclosure under chapter 38-2.

12-1.6-2. ~~Long-term healthcare workers~~ Long-term healthcare workers -- High-risk Medicaid providers and personal care attendants.

The department of attorney general shall maintain an electronic, web-based system to assist facilities, licensed under chapters 17, 17.4, 17.7.1 of title 23 or § 23-1-52, and the executive office of health and human services under §§ 42-7.2-18.1 and 42-7.2-18.3, required to check relevant registries and conduct national criminal records checks of routine contact patient employees~~.~~, personal care attendants and high-risk providers. The department of attorney general shall provide for an automated notice, as authorized in § 12-1.6-1, to those facilities or to the executive office of health and human services if a routine-contact patient employee, personal care attendant or high-risk provider is subsequently convicted of a disqualifying offense, as described in the relevant licensing statute or in §§ 42-7.2-18.2 and 42-7.2-18.4. The department of attorney general may charge a facility a one-time, set-up fee of up to one hundred dollars ($100) for access to the electronic web-based system under this section.

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

40-8-13.4. Rate methodology for payment for in-state and out-of-state hospital services.

(a) The executive office of health and human services ("executive office") shall implement a new methodology for payment for in-state and out-of-state hospital services in order to ensure access to, and the provision of, high-quality and cost-effective hospital care to its eligible recipients.

(b) In order to improve efficiency and cost-effectiveness, the executive office shall:

(1)(i) With respect to inpatient services for persons in fee-for-service Medicaid, which is non-managed care, implement a new payment methodology for inpatient services utilizing the Diagnosis Related Groups (DRG) method of payment, which is, a patient-classification method that provides a means of relating payment to the hospitals to the type of patients cared for by the hospitals. It is understood that a payment method based on DRG may include cost outlier payments and other specific exceptions. The executive office will review the DRG-payment method and the DRG base price annually, making adjustments as appropriate in consideration of such elements as trends in hospital input costs; patterns in hospital coding; beneficiary access to care; and the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index. For the twelve-month (12) period beginning July 1, 2015, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of July 1, 2014. Beginning July 1, 2019, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall be 107.2% of the payment rates in effect as of July 1, 2018. Increases in the Medicaid fee-for-service DRG hospital payments for the twelve-month (12) period beginning July 1, 2020, shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national Prospective Payment System (IPPS) Hospital Input Price Index. Beginning July 1, 2022, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall be one hundred five percent (105%) of the payment rates in effect as of July 1, 2021. Increases in the Medicaid fee-for-service DRG hospital payments for each annual twelve-month (12) period beginning July 1, 2023, shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national Prospective Payment System (IPPS) Hospital Input Price Index.

(ii) With respect to inpatient services, (A) It is required as of January 1, 2011, until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not exceed ninety and one-tenth percent (90.1%) of the rate in effect as of June

30, 2010. Increases in inpatient hospital payments for each annual twelve-month (12) period beginning January 1, 2012, may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price index for the applicable period; (B) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the Medicaid managed care payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (C) Increases in inpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2017, shall be the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1; (D) Beginning July 1, 2019, the Medicaid managed care payment inpatient rates between each hospital and health plan shall be 107.2% of the payment rates in effect as of January 1, 2019, and shall be paid to each hospital retroactively to July 1; (E) Increases in inpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2020, shall be based on the payment rates in effect as of January 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1; the executive office will develop an audit methodology and process to assure that savings associated with the payment reductions will accrue directly to the Rhode Island Medicaid program through reduced managed care plan payments and shall not be retained by the managed care plans; (F) Beginning July 1, 2022, the Medicaid managed care payment inpatient rates between each hospital and health plan shall be one hundred five percent (105%) of the payment rates in effect as of January 1, 2022, and shall be paid to each hospital retroactively to July 1 within ninety days of passage; (G) Increases in inpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2023, shall be based on the payment rates in effect as of January 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1 within ninety days of passage; ~~(F)~~(H) All hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and ~~(G)~~(I) For all such hospitals, compliance with the provisions of this section shall be a condition of participation in the Rhode Island Medicaid program.

(2) With respect to outpatient services and notwithstanding any provisions of the law to the contrary, for persons enrolled in fee-for-service Medicaid, the executive office will reimburse hospitals for outpatient services using a rate methodology determined by the executive office and in accordance with federal regulations. Fee-for-service outpatient rates shall align with Medicare payments for similar services. Notwithstanding the above, there shall be no increase in the Medicaid fee-for-service outpatient rates effective on July 1, 2013, July 1, 2014, or July 1, 2015. For the twelve-month (12) period beginning July 1, 2015, Medicaid fee-for-service outpatient rates shall not exceed ninety-seven and one-half percent (97.5%) of the rates in effect as of July 1, 2014. Increases in the outpatient hospital payments for the twelve-month (12) period beginning July 1, 2016, may not exceed the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. Beginning July 1, 2019, the Medicaid fee-for-service outpatient rates shall be 107.2% of the payment rates in effect as of July 1, 2018. Increases in the outpatient hospital payments for the twelve-month (12) period beginning July 1, 2020, shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. Beginning July 1, 2022, the Medicaid fee-for-service outpatient rates shall be one hundred five percent (105%) of the payment rates in effect as of July 1. 2021. Increases in the outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2023, shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. With respect to the outpatient rate, (i) It is required as of January 1, 2011, until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010; (ii) Increases in hospital outpatient payments for each annual twelve-month (12) period beginning January 1, 2012, until July 1, 2017, may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment System OPPS hospital price index for the applicable period; (iii) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the Medicaid managed care outpatient payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (iv) Increases in outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2017, shall be the Centers for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively

to July 1; (v) Beginning July 1, 2019, the Medicaid managed care outpatient payment rates between each hospital and health plan shall be one hundred seven and two-tenths percent (107.2%) of the payment rates in effect as of January 1, 2019 and shall be paid to each hospital retroactively to July 1; (vi) Increases in outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2020, shall be based on the payment rates in effect as of January 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1; (vii) Beginning July 1. 2022. the Medicaid managed care outpatient payment rates between each hospital and health plan shall be one hundred five percent (105%) of the payment rates in effect as of January 1, 2022 and shall be paid to each hospital retroactively to July 1 within ninety days of passage; (viii) Increases in outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2020. shall be based on the payment rates in effect as of January 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1.

(3) "Hospital," as used in this section, 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 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 new rates between the court-approved purchaser and the health plan, and such rates shall be effective as of the date that the court-approved purchaser and the health plan execute the initial agreement containing the new rates. The rate-setting methodology for inpatient-hospital payments and outpatient-hospital payments set forth in subsections (b)(1)(ii)(C) and (b)(2), respectively, shall thereafter apply to 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.

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

(d) The secretary of the executive office is hereby authorized to promulgate such rules and regulations consistent with this chapter, and to establish fiscal procedures he or she deems necessary, for the proper implementation and administration of this chapter in order to provide payment to hospitals using the DRG-payment methodology. Furthermore, amendment of the Rhode Island state plan for Medicaid, pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et seq., is hereby authorized to provide for payment to hospitals for services provided to eligible recipients in accordance with this chapter.

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

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

(g) The provisions of this section shall be effective upon implementation of the new payment methodology set forth in this section and § 40-8-13.3, which shall in any event be no later than March 30, 2010, at which time the provisions of §§ 40-8-13.2, 27-19-14, 27-19-15, and 27-19-16 shall be repealed in their entirety.

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

(a) **Rate reform.**

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

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

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

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

(iii) ~~A rearray of costs for all facilities every three (3) years beginning October, 2015, that may or may not result in automatic per diem revisions~~ Revise rates as necessary based on increases in direct and indirect costs beginning October 2024 utilizing data from the most recent finalized year of facility cost report. The per diem rate components deferred in subsections (a)(2)(i) and (a)(2)(ii) of this section shall be adjusted accordingly to reflect changes in direct and indirect care costs since the previous rate review;

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

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

(vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be applied on October 1 of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013, October 1, 2014, or October 1, 2015, but will occur on April 1, 2015. The adjustment of rates will also not occur on October 1, 2017, October 1, 2018, ~~and~~ October 1, 2019~~.~~, and October 2022. Effective July 1, 2018, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2017, both fee-for-service and managed care, will be increased by one and one-half percent (1.5%) and further increased by one percent (1%) on October 1, 2018, and further increased by one percent (1%) on October 1, 2019. Effective October 1, 2022, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2021, both fee-for-service and managed care, will be increased by three percent (3%). In addition to the annual nursing home inflation index adjustment, there shall be a base rate staffing adjustment of one-half percent (0.5%) on October 1, 2021, one percent (1.0%) on October 1, 2022, and one and one-half percent (1.5%) on October 1, 2023. The inflation index shall be applied without regard for the transition factors in subsections (b)(1) and (b)(2). For purposes of October 1, 2016, adjustment only, any rate increase that results from application of the inflation index to subsections (a)(2)(i) and (a)(2)(ii) shall be dedicated to increase compensation for direct-care workers in the following manner: Not less than 85% of this aggregate amount shall be expended to fund an increase in wages,

benefits, or related employer costs of direct-care staff of nursing homes. For purposes of this section, direct-care staff shall include registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), certified medical technicians, housekeeping staff, laundry staff, dietary staff, or other similar employees providing direct-care services; provided, however, that this definition of direct-care staff shall not include: (i) RNs and LPNs who are classified as "exempt employees" under the federal Fair Labor Standards Act (29 U.S.C. § 201 et seq.); or (ii) CNAs, certified medical technicians, RNs, or LPNs who are contracted, or subcontracted, through a third-party vendor or staffing agency. By July 31, 2017, nursing facilities shall submit to the secretary, or designee, a certification that they have complied with the provisions of this subsection (a)(2)(vi) with respect to the inflation index applied on October 1, 2016. Any facility that does not comply with terms of such certification shall be subjected to a clawback, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification.

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

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

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

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

(4) (i) By July 31, 2021, and July 31 of each year thereafter, nursing facilities shall submit to the secretary or designee a certification that they have complied with the provisions of subsection (a)(3) of this section with respect to the inflation index applied on October 1. The executive office

of health and human services (EOHHS) shall create the certification form nursing facilities must complete with information on how each individual eligible employee's compensation increased, including information regarding hourly wages prior to the increase and after the compensation increase, hours paid after the compensation increase, and associated increased payroll taxes. A collective bargaining agreement can be used in lieu of the certification form for represented employees. All data reported on the compliance form is subject to review and audit by EOHHS. The audits may include field or desk audits, and facilities may be required to provide additional supporting documents including, but not limited to, payroll records.

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

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

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

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

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

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

(4) Notwithstanding any law to the contrary, for the twelve-month (12) period beginning

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

SECTION 3. Sections 40-8.3-2 and 40-8.3-3 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, ~~2020~~ 2021, the period from October 1, ~~2018~~ 2019, through September 30, ~~2019~~ 2020, and for any fiscal year ending after September 30, ~~2021~~ 2022, the period from October 1, 2019, through September 30, 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 the 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 the hospital during the base year for inpatient or outpatient 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 [repealed] 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, September 30, 2020, September 30, 2021, ~~and~~ September 30, 2022, and September 30, 2023 shall be deemed to be five and thirty hundredths percent (5.30%).

40-8.3-3. Implementation.

~~(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 the 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)~~ (a) 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 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 $142.5 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 the 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 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 2021 for the disproportionate share payments.

~~(c)~~(b) 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 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 ~~$143.8~~ $145.1 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated-care costs for the base year, inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by the uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before ~~July 12, 2022~~ June 30, 2022, and are expressly conditioned upon approval on or before July 5, 2022, by the Secretary of the United States Department of Health

and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2022 for the disproportionate share payments.

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

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

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

(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.

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

SECTION 4. Chapter 40.1-8.5 of the General Laws entitled "Community Mental Health Services" is hereby amended by adding thereto the following section:

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

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

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

pursuant to Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI [42 U.S.C § 1397 et seq.] of the Social Security Act as necessary to cover all required services for persons with mental health and substance use disorders at a certified community behavioral health clinic through a daily or monthly bundled payment methodology that is specific to each organization's anticipated costs and inclusive of all required services within Section 223 of the federal Protecting Access to Medicare Act of 2014. Such certified community behavioral health clinics shall adhere to the federal model, including payment structures and rates.

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

(1) Outpatient mental health and substance use services;

(2) Twenty-four (24) hour mobile crisis response and hotline services;

(3) Screening, assessment, and diagnosis, including risk assessments;

(4) Person-centered treatment planning;

(5) Primary care screening and monitoring of key indicators of health risks;

(6) Targeted case management;

(7) Psychiatric rehabilitation services;

(8) Peer support and family supports;

(9) Medication-assisted treatment;

(10) Assertive community treatment; and

(11) Community-based mental health care for military service members and veterans.

(d) Subject to the approval from the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services, the certified community behavioral health clinic model pursuant to this chapter, shall be established by July 1, 2023, and include any enhanced Medicaid match for required services or populations served.

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

(f) By December 1, 2022, the organizations will submit a detailed cost report developed by the department of behavioral healthcare, developmental disabilities and hospitals with approval from the executive office of health and human services, that includes the cost for the organization to provide the required services.

(g) By January 15, 2023, the department of behavioral healthcare, developmental disabilities and hospitals, in coordination with the executive office of health and human services, will prepare an analysis of proposals, determine how many behavioral health clinics can be certified in FY 2024 and the costs for each one. Funding for the Certified Behavioral Health Clinics will be included in the FY 2024 budget recommended by the Governor.

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

SECTION 5. Section 42-7.2-18 of Chapter 42-7.2 the General Laws entitled "Office of Health and Human Services" is hereby amended by adding thereto the following sections:

42-7.2-18.1. Professional responsibility -- Criminal records check for high- risk providers.

(a) As a condition of enrollment and/or continued participation as a Medicaid provider, applicants to become and/or remain a provider shall be required to undergo criminal records checks including a national criminal records check supported by fingerprints by the level of screening based on risk of fraud, waste or abuse as determined by the executive office of health and human services for that category of Medicaid provider.

(b) Establishment of Risk Categories – The executive office of health and human services in consultation with the department of attorney general, shall establish through regulation, risk categories for Medicaid providers and provider categories who pose an increased financial risk of fraud, waste or abuse to the Medicaid/CHIP program, in accordance with § 42 CFR §§ 455.434 and 455.450.

(c) High risk categories, as determined by the executive office health and human services may include:

(1) Newly enrolled home health agencies that have not been medicare certified;

(2) Newly enrolled durable medical equipment providers;

(3) New or revalidating providers that have been categorized by the executive office of health and human services as high risk;

(4) New or revalidating providers with payment suspension histories;

(5) New or revalidating providers with office of inspector general exclusion histories;

(6) New or revalidating providers with qualified overpayment histories; and,

(7) New or revalidating providers applying for enrollment post debarment or moratorium (Federal or State-based)

(d) Upon the state Medicaid agency determination that a provider or an applicant to become

a provider, or a person with a five percent (5%) or more direct or indirect ownership interest in the provider, meets the executive office of health and human services' criteria for criminal records checks as a "high" risk to the Medicaid program, the executive office of health and human services shall require that each such provider or applicant to become a provider undergo a national criminal records check supported by fingerprints.

(e) The executive office of health and human services shall require such a "high risk" Medicaid provider or applicant to become a provider, or any person with a five percent (5%) or more direct or indirect ownership interest in the provider, to submit to a national criminal records check supported by fingerprints within thirty (30) days upon request from the Centers for Medicare and Medicaid Services or the executive office of health and human services.

(f) The Medicaid providers requiring the national criminal records check shall apply to the department of attorney general, bureau of criminal identification (BCI) to be fingerprinted. The fingerprints will subsequently be transmitted to the federal bureau of investigation for a national criminal records check. The results of the national criminal records check shall be made available to the applicant undergoing a record check and submitting fingerprints.

(g) Upon the discovery of any disqualifying information, as defined in § 42-7.2-18.2 and as in accordance with the regulations promulgated by the executive office of health and human services, the bureau of criminal identification of the department of the attorney general will inform the applicant, in writing, of the nature of the disqualifying information; and, without disclosing the nature of the disqualifying information, will notify the executive office of health and human services, in writing, that disqualifying information has been discovered.

(h) In those situations, in which no disqualifying information has been found, the bureau of criminal identification of the department of the attorney general shall inform the applicant and the executive office of health and human services, in writing, of this fact.

(i) The applicant shall be responsible for the cost of conducting the national criminal records check through the bureau of criminal identification of the department of attorney general.

42-7.2-18.2. Professional responsibility -- Criminal records check disqualifying information for high-risk providers.

(a) Information produced by a national criminal records check pertaining to conviction, for the following crimes will result in a letter to the executive office of health and human services , disqualifying the applicant from being a medicaid provider: murder, voluntary manslaughter, involuntary manslaughter, first degree sexual assault, second degree sexual assault, third degree sexual assault, assault on persons sixty (60) years of age or older, assault with intent to commit specified felonies (murder, robbery, rape, burglary, or the abominable and detestable crime against

nature) felony assault, patient abuse, neglect or mistreatment of patients, burglary, first degree arson, robbery, felony drug offenses, felony larceny, or felony banking law violations, felony obtaining money under false pretenses, felony embezzlement, abuse, neglect and/or exploitation of adults with severe impairments, exploitation of elders, or a crime under section 1128 (a) of the Social Security Act (42 U.S.C. 1320a-7(a)). An applicant against whom disqualifying information has been found, for purposes of appeal, may provide a copy of the national criminal records check to the executive office of health and human services, who shall make a judgment regarding the approval of or the continued status of that person as a provider.

(b) For purposes of this section, "conviction" means, in addition to judgments of conviction entered by a court subsequent to a finding of guilty or a plea of guilty, those instances where the defendant has entered a plea of nolo contendere and has received a sentence of probation and those instances where a defendant has entered into a deferred sentence agreement with the attorney general.

42-7.2-18.3. Professional responsibility -- Criminal records check for personal care aides.

(a) Any person seeking employment to provide care to elderly or individuals with disabilities who is, or may be required to be, licensed, registered, trained or certified with the office of medicaid if that employment involves routine contact with elderly or individuals with disabilities without the presence of other employees, shall undergo a national criminal records check supported by fingerprints. The applicant will report to the office of attorney general, bureau of criminal identification to submit their fingerprints. The fingerprints will subsequently be submitted to the federal bureau of investigation (FBI) by the bureau of criminal identification of the office of attorney general. The national criminal records check shall be initiated prior to, or within one week of, employment.

(b) The director of the office of medicaid may, by rule, identify those positions requiring criminal records checks. The identified employee, through the executive office of health and human services, shall apply to the bureau of criminal identification of the department of attorney general for a national criminal records check. Upon the discovery of any disqualifying information, as defined in § 42-7.2-18.4 and in accordance with the rule promulgated by the secretary of the executive office of health and human services, the bureau of criminal identification of the department of the attorney general will inform the applicant, in writing, of the nature of the disqualifying information; and, without disclosing the nature of the disqualifying information, will notify the executive office of health and human services executive office of health and human services in writing, that disqualifying information has been discovered.

(c) An applicant against whom disqualifying information has been found, for purposes of appeal, may provide a copy of the national criminal history check to the executive office of health and human services, who shall make a judgment regarding the approval of the applicant.

(d) In those situations, in which no disqualifying information has been found, the bureau of criminal identification of the department of the attorney general shall inform the applicant and the executive office health and human services, in writing, of this fact.

(e) The executive office of health and human services shall maintain on file evidence that criminal records checks have been initiated on all applicants subsequent to July 1, 2022.

(f) The applicant shall be responsible for the cost of conducting the national criminal records check through the bureau of criminal identification of the department of the attorney general.

42-7.2-18.4. Professional responsibility -- Criminal records check disqualifying information for personal care aides.

(a) Information produced by a national criminal records check pertaining to conviction, for the following crimes will result in a letter to the applicant and the executive office of health and human services, disqualifying the applicant: murder, voluntary manslaughter, involuntary manslaughter, first degree sexual assault, second degree sexual assault, third degree sexual assault, assault on persons sixty (60) years of age or older, assault with intent to commit specified felonies (murder, robbery, rape, burglary, or the abominable and detestable crime against nature) felony assault, patient abuse, neglect or mistreatment of patients, burglary, first degree arson, robbery, felony drug offenses, felony larceny, or felony banking law violations, felony obtaining money under false pretenses, felony embezzlement, abuse, neglect and/or exploitation of adults with severe impairments, exploitation of elders, or a crime under section 1128(a) of the Social Security Act (42 U.S.C. 1320a-7(a)).

(b) For purposes of this section, "conviction" means, in addition to judgments of conviction entered by a court subsequent to a finding of guilty or a plea of guilty, those instances where the defendant has entered a plea of nolo contendere and has received a sentence of probation and those instances where a defendant has entered into a deferred sentence agreement with the attorney general.

SECTION 6. Sections 42-12.3-3, 42-12.3-4 and 42-12.3-15 of the General Laws in Chapter 42-12.3 "Health Care for Children and Pregnant Women" are hereby amended to read as follows:

42-12.3-3. Medical assistance expansion for pregnant women/RIte Start.

(a) The ~~director of the department of human services~~ secretary of the executive office of health and human services is authorized to amend its Title XIX state plan pursuant to Title XIX of

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

(b) The ~~director of the department of human services~~ secretary of health and human services is authorized and directed to establish a payor of last resort program to cover prenatal, delivery and postpartum care. The program shall cover the cost of maternity care for any woman who lacks health insurance coverage for maternity care and who is not eligible for medical assistance under Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security Act including, but not limited to, a noncitizen pregnant woman lawfully admitted for permanent residence on or after August 22, 1996, without regard to the availability of federal financial participation, provided such pregnant woman satisfies all other eligibility requirements. The ~~director~~ secretary shall promulgate regulations to implement this program. Such regulations shall include specific eligibility criteria; the scope of services to be covered; procedures for administration and service delivery; referrals for non-covered services; outreach; and public education. Excluded services under this subsection will include, but not be limited to, induced abortion except in cases of rape or incest or to save the life of the pregnant individual.

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

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

(1) Ante-partum and postpartum care;

(2) Delivery;

(3) Cesarean section;

(4) Newborn hospital care;

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

(6) Prescription medications and laboratory tests.

(e) The ~~department of human services~~ secretary of health and human services shall provide

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

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

(g) Effective October 1, 2022, individuals eligible for RIte Start pursuant to this section or for medical assistance under Title XIX or Title XXI of the Social Security Act while pregnant (including during a period of retroactive eligibility), are eligible for full Medicaid benefits through the last day of the month in which their twelve (12) month postpartum period ends. This benefit will be provided to eligible Rhode Island residents without regard to the availability of federal financial participation. The executive office of health and human services is directed to ensure that federal financial participation is used to the maximum extent allowable to provide coverage pursuant to this section, and that state-only funds will be used only if federal financial participation is not available.

42-12.3-4. "RIte track" program.

(a) There is hereby established a payor of last resort program for comprehensive health care for children until they reach nineteen (19) years of age, to be known as "RIte track." The ~~department of human services~~ executive office of health and human services is hereby authorized to amend its Title XIX state plan pursuant to Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security Act as necessary to provide for expanded Medicaid coverage through expanded family income disregards for children, until they reach nineteen (19) years of age, whose family income levels are up to two hundred fifty percent (250%) of the federal poverty level. Provided, however, that healthcare coverage provided under this section shall also be provided without regard to the availability of federal financial participation ~~in accordance to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.,~~ to a noncitizen child who is a resident of Rhode Island ~~lawfully residing in the United States~~, and who is otherwise

eligible for such assistance. The department is further authorized to promulgate any regulations necessary, and in accord with Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security Act as necessary in order to implement the state plan amendment. For those children who lack health insurance, and whose family incomes are in excess of two hundred fifty percent (250%) of the federal poverty level, the department of human services shall promulgate necessary regulations to implement the program. The department of human services is further directed to ascertain and promulgate the scope of services that will be available to those children whose family income exceeds the maximum family income specified in the approved Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI [42 U.S.C. § 1397aa et seq.] state plan amendment.

(b) The executive office of health and human services is directed to ensure that federal financial participation is used to the maximum extent allowable to provide coverage pursuant to this section, and that state-only funds will be used only if federal financial participation is not available.

42-12.3-15. Expansion of RIte track program.

(a) The ~~Department of Human Services~~ executive office of health and human services is hereby authorized and directed to submit to the United States Department of Health and Human Services an amendment to the "RIte Care" waiver project number 11-W-0004/1-01 to provide for expanded Medicaid coverage for children until they reach eight (8) years of age, whose family income levels are to two hundred fifty percent (250%) of the federal poverty level. Expansion of the RIte track program from the age of six (6) until they reach eighteen (18) years of age in accordance with this chapter shall be subject to the approval of the amended waiver by the United States Department of Health and Human Services. Healthcare coverage under this section shall also be provided to a noncitizen child ~~lawfully residing in the United States~~ who is a resident of Rhode Island, and who is otherwise eligible for such assistance under Title XIX [42 U.S.C. § 1396 et seq.] or Title XXI [42 U.S.C. § 1397aa et seq.]

(b) The executive office of health and human services is directed to ensure that federal financial participation is used to the maximum extent allowable to provide coverage pursuant to this section, and that state-only funds will be used only if federal financial participation is not available.

SECTION 7. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended to read as follows:

42-14.5-3. Powers and duties.

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

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

(b) To make recommendations to the governor and the house of representatives and senate finance committees regarding healthcare insurance and the regulations, rates, services, administrative expenses, reserve requirements, and operations of insurers providing health insurance in the state, and to prepare or comment on, upon the request of the governor or chairpersons of the house or senate finance committees, draft legislation to improve the regulation of health insurance. In making the recommendations, the commissioner shall recognize that it is the intent of the legislature that the maximum disclosure be provided regarding the reasonableness of individual administrative expenditures as well as total administrative costs. The commissioner shall make recommendations on the levels of reserves, including consideration of: targeted reserve levels; trends in the increase or decrease of reserve levels; and insurer plans for distributing excess reserves.

(c) To establish a consumer/business/labor/medical advisory council to obtain information and present concerns of consumers, business, and medical providers affected by health insurance decisions. The council shall develop proposals to allow the market for small business health insurance to be affordable and fairer. The council shall be involved in the planning and conduct of the quarterly public meetings in accordance with subsection (a). The advisory council shall develop measures to inform small businesses of an insurance complaint process to ensure that small businesses that experience rate increases in a given year may request and receive a formal review by the department. The advisory council shall assess views of the health provider community relative to insurance rates of reimbursement, billing, and reimbursement procedures, and the insurers' role in promoting efficient and high-quality health care. The advisory council shall issue an annual report of findings and recommendations to the governor and the general assembly and present its findings at hearings before the house and senate finance committees. The advisory council is to be diverse in interests and shall include representatives of community consumer

organizations; small businesses, other than those involved in the sale of insurance products; and hospital, medical, and other health provider organizations. Such representatives shall be nominated by their respective organizations. The advisory council shall be co-chaired by the health insurance commissioner and a community consumer organization or small business member to be elected by the full advisory council.

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

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

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

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

(4) Methods for health maintenance organizations, as defined by § 27-41-2, and nonprofit hospital or medical-service corporations, as defined by chapters 19 and 20 of title 27, to make facility-specific data and other medical service-specific data available in reasonably consistent formats to patients regarding quality and costs. This information would help consumers make informed choices regarding the facilities and clinicians or physician practices at which to seek care. Among the items considered would be the unique health services and other public goods provided by facilities and clinicians or physician practices in establishing the most appropriate cost comparisons;

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

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

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

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

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

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

(f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The

fund shall be used to effectuate the provisions of §§ 27-18.5-9 and 27-50-17.

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

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

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

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

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

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

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

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

(8) The task force shall meet as necessary and include its findings in the annual report, and the commissioner shall include the information in the annual presentation before the house and

senate finance committees.

(h) To establish and convene a workgroup representing healthcare providers and health insurers for the purpose of coordinating the development of processes, guidelines, and standards to streamline healthcare administration that are to be adopted by payors and providers of healthcare services operating in the state. This workgroup shall include representatives with expertise who would contribute to the streamlining of healthcare administration and who are selected from hospitals, physician practices, community behavioral health organizations, each health insurer, and other affected entities. The workgroup shall also include at least one designee each from the Rhode Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the Rhode Island Health Center Association, and the Hospital Association of Rhode Island. The workgroup shall consider and make recommendations for:

(1) Establishing a consistent standard for electronic eligibility and coverage verification. Such standard shall:

(i) Include standards for eligibility inquiry and response and, wherever possible, be consistent with the standards adopted by nationally recognized organizations, such as the Centers for Medicare and Medicaid Services;

(ii) Enable providers and payors to exchange eligibility requests and responses on a system-to-system basis or using a payor-supported web browser;

(iii) Provide reasonably detailed information on a consumer's eligibility for healthcare coverage; scope of benefits; limitations and exclusions provided under that coverage; cost-sharing requirements for specific services at the specific time of the inquiry; current deductible amounts; accumulated or limited benefits; out-of-pocket maximums; any maximum policy amounts; and other information required for the provider to collect the patient's portion of the bill;

(iv) Reflect the necessary limitations imposed on payors by the originator of the eligibility and benefits information;

(v) Recommend a standard or common process to protect all providers from the costs of services to patients who are ineligible for insurance coverage in circumstances where a payor provides eligibility verification based on best information available to the payor at the date of the request of eligibility.

(2) Developing implementation guidelines and promoting adoption of the guidelines for:

(i) The use of the National Correct Coding Initiative code-edit policy by payors and providers in the state;

(ii) Publishing any variations from codes and mutually exclusive codes by payors in a manner that makes for simple retrieval and implementation by providers;

(iii) Use of Health Insurance Portability and Accountability Act standard group codes, reason codes, and remark codes by payors in electronic remittances sent to providers;

(iv) The processing of corrections to claims by providers and payors.

(v) A standard payor-denial review process for providers when they request a reconsideration of a denial of a claim that results from differences in clinical edits where no single, common-standards body or process exists and multiple conflicting sources are in use by payors and providers.

(vi) Nothing in this section, nor in the guidelines developed, shall inhibit an individual payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of detecting and deterring fraudulent billing activities. The guidelines shall require that each payor disclose to the provider its adjudication decision on a claim that was denied or adjusted based on the application of such edits and that the provider have access to the payor's review and appeal process to challenge the payor's adjudication decision.

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

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

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

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

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

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

(4) To provide a report to the house and senate, on or before January 1, 2017, with

recommendations for establishing guidelines and regulations for systems that give patients electronic access to their claims information, particularly to information regarding their obligations to pay for received medical services, pursuant to 45 C.F.R. 164.524.

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

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

(k) To monitor the transition from fee-for-service and toward global and other alternative payment methodologies for the payment for healthcare services. Alternative payment methodologies should be assessed for their likelihood to promote access to affordable health insurance, health outcomes, and performance.

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

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

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

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

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

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

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

(1) Utilization review;

(2) Contracting; and

(3) Licensing and regulation.

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

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

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

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

(s) The office of the health insurance commissioner shall conduct an analysis of the impact of the provisions of § 27-38.2-1(i) on health insurance premiums and access in Rhode Island and submit a report of its findings to the general assembly on or before June 1, 2023.

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

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

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

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

(B) Establishing a baseline of the service offering through each agency for those

determined eligible;

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

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

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

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

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

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

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

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

(ii) An assessment and detailed reporting on eligibility standards and processes of all mandatory and discretionary social and human service programs to be completed by January 1, 2023;

(iii) An assessment and detailed reporting on utilization trends from the period of January 1, 2017 through December 31, 2021 for social and human service programs to be completed by January 1, 2023;

(iv) An assessment and detailed reporting on the structure of the state government as it relates to the provision of services by social and human service providers including eligibility and functions of the provider network to be completed by January 1, 2023;

(v) An assessment and detailed reporting on accountability standards for services for social and human service programs to be completed by January 1, 2023;

(vi) An assessment and detailed reporting by April 1, 2023 on all professional licensed and unlicensed personnel requirements for established rates for social and human service programs pursuant to a contract or established fee schedule;

(vii) An assessment and reporting on access to social and human service programs, to include any wait lists and length of time on wait lists, in each service category by April 1, 2023;

(viii) An assessment and reporting of national and regional Medicaid rates in comparison to Rhode Island social and human service provider rates by April 1, 2023; and

(ix) An assessment and reporting on usual and customary rates paid by private insurers and private pay for similar social and human service providers, both nationally and regionally, by April 1, 2023;

(x) Completion of the development of an assessment and review process that includes the following components: eligibility, scope of services, relationship of social and human service provider and the state, national and regional rate comparisons and accountability standards that result in recommended rate adjustments, and this process shall be completed by September 1, 2023 and conducted biennially hereafter. The biennial rate setting shall be consistent with payment requirements established in §1902(a)(30)(A) of the Social Security Act and all federal, and state law, regulations and quality and safety standards. The results and findings of this process shall be transparent, and public meetings shall be conducted to allow providers, recipients and other interested parties an opportunity to ask questions and provide comment beginning in September 2023 and biennially thereafter. (3) In fulfillment of the responsibilities defined in section (t), the office of the health insurance commissioner shall consult with the Executive Office of Health and Human Services.

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

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

SECTION 8. Chapter 42-14.5 of the General Laws entitled "The Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended by adding thereto the following sections:

42-14.5-2.1. Definitions.

As used in this chapter:

(1) "Accountability standards" means measures including service processes, client and population outcomes, practice standard compliance and fiscal integrity of social and human service providers on the individual contractual level and service type for all state contacts of the state or any subdivision or agency to include, but not limited to, the department of children, youth and families (DCYF), the department of behavioral healthcare, developmental disabilities and hospitals (BHDDH), the department of human services (DHS), the department of health (DOH), and Medicaid. This may include mandatory reporting, consolidated, standardized reporting, audits regardless of organizational tax status and accountability dashboards of aforementioned state departments or subdivisions that are regularly shared with public.

(2) "Executive Office of Health and Human Services (EOHHS)" means the department that serves as "principal agency of the executive branch of state government" (RIGL § 42-7.2-2) responsible for managing the departments and offices of: health (RIDOH); human services (DHS); healthy aging (OHA); veterans services (VETS); children, youth and families (DCYF); and behavioral healthcare, developmental disabilities and hospitals (BHDDH). EOHHS is also designated at the single state agency with authority to administer the Medicaid program in Rhode Island.

(3) "Rate review" means the process of reviewing and reporting of specific trending factors that influence the cost of service that informs rate setting.

(4) "Rate setting" means the process of establishing rates for social and human service programs that are based on a thorough rate review process.

(5) "Social and human service program" means a social, mental health, developmental disability, child welfare, juvenile justice, prevention services, habilitative, rehabilitative, substance use disorder treatment, residential care, adult or adolescent day services, vocational, employment and training, or aging service program or accommodations purchased by the state.

(6) "Social and human service provider" means a provider of social and human service programs pursuant to a contract with the state or any subdivision or agency to include, but not be limited to, the department of children, youth and families (DCYF), the department of behavioral healthcare, developmental disabilities and hospitals (BHDDH), the department of human services (DHS), the department of health (DOH), and Medicaid.

(7) "State government and the provider network" refers to the contractual relationship between a state agency or subdivision of state agency and private companies the state contracts with to provide the network of mandated and discretionary social and human services.

42-14.5-5. Severability.

If any provision of this chapter or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the chapter, which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared to be severable.

SECTION 9. Section 42-66.3-4 of the General Laws in Chapter 42-66.3 entitled "Home and Community Care Services to the Elderly" is hereby amended to read as follows:

42-66.3-4. Persons eligible.

(a) To be eligible for this program the client must be determined, through a functional assessment, to be in need of assistance with activities of daily living or and/or must meet a required level of care as defined in rules and regulations promulgated by the department;

(b) Medicaid eligible individuals age sixty-five (65) or older of the state who meet the financial guidelines of the Rhode Island medical assistance program, as defined in rules and regulations promulgated by the department, shall be provided the services without charge; or

(c) Persons eligible for assistance under the provisions of this section, subject to the annual appropriations deemed necessary by the general assembly to carry out the provisions of this chapter, include: (1) any homebound unmarried resident or homebound married resident of the state living separate and apart, who is ineligible for Medicaid, at least sixty-five (65) years of age or, if under sixty-five (65) years of age, has a diagnosis of Alzheimer's disease or a related dementia, confirmed by a licensed physician, ~~ineligible for Medicaid,~~ and whose income does not exceed ~~the income eligibility limits as defined by rules and regulations promulgated by the department~~ two hundred fifty percent (250%) of the federal poverty level; and (2) any married resident of the state who is ineligible for Medicaid, at least sixty-five (65) years of age, ~~ineligible for Medicaid,~~ or, if under sixty-five (65) years of age, has a diagnosis of Alzheimer's disease or a related dementia confirmed by a licensed physician and whose income when combined with any income of that person's spouse does not exceed two hundred fifty percent (250%) of the federal poverty level ~~the income eligibility limits as defined in rules and regulations promulgated by the department~~. Persons who meet the eligibility requirement of this subsection shall be eligible for the co-payment portion as set forth in § 42-66.3-5.

SECTION 10. 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 Laws section 42-7.2-5(3)(i) provides that the 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 category II or III 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; and

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

(a) Section 1115 Demonstration Waiver – Extension Request. The Executive Office proposes to seek approval from the federal centers for Medicare and Medicaid services ("CMS") to extend the Medicaid section 1115 demonstration waiver as authorized in Rhode Island General Laws § 42-12.4. In the Medicaid section 1115 demonstration waiver extension request due to CMS by December 31, 2022, in addition to maintaining existing Medicaid section 1115 demonstration waiver authorities, the Executive Office proposes to seek additional federal authorities including but not limited to promoting choice and community integration.

(b) Meals on Wheels. The Executive Office proposes an increase to existing fee-for-service and managed care rates to account for growing utilization and rising food and delivery costs. Additionally, the Executive Office of Health and Human Services will offer new Medicaid reimbursement for therapeutic and cultural meals that are specifically tailored to improve health through nutrition, provide post discharge support, and bolster complex care management for those with chronic health conditions. To ensure the continued adequacy of rates, effective July 1, 2022, and annually thereafter, the Executive Office proposes an annual rate increase based on the CPI-U for New England: Food at Home, March release (containing the February data).

(c) American Rescue Plan Act. The Executive Office proposes to seek approval from CMS

for any necessary amendments to the Rhode Island State Plan or the 1115 Demonstration Waiver to implement the spending plan approved by CMS under section 9817 of the American Rescue Plan Act of 2021.

(d) HealthSource RI automatic enrollment: The Executive Office shall work with HealthSource RI to establish a program for automatically enrolling qualified individuals who lose Medicaid coverage at the end of the COVID-19 Public Health Emergency into Qualified Health Plans ("QHP"). HealthSource RI may use funds available through the American Rescue Plan Act to pay the first two (2) month's premium for individuals who qualify for this program. HealthSource RI may promulgate regulations establishing the scope and parameters of this program.

(e) Increase Nursing Facility Rates. The Executive Office proposes to increase rates, both fee-for-service and managed care, paid to nursing facilities by three percent (3.0%) on October 1, 2022, in lieu of the adjustment of rates by the change in a recognized national home inflation index as defined in § 40-8-19 (2)(vi) and in addition to the one percent (1.0%) increase required for the minimum wage pass through as defined in § 40-8-19 (2)(vi).

(f) Extend Post-Partum Medicaid Coverage. The Executive Office proposes extending the continuous coverage of full benefit medical assistance from sixty (60) days to twelve (12) months postpartum to women who are (1) not eligible for Medicaid under another Medicaid eligibility category, or (2) do not have qualified immigrant status for Medicaid whose births are financed by Medicaid through coverage of the child and currently only receive state-only extended family planning benefits postpartum.

(g) Extending Medical Coverage to Children Previously Ineligible. The executive office of health and human services will maximize federal financial participation if and when available, though state-only funds will be used if federal financial participation is not available.

(h) 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 2023.

(i) Increase Adult Dental Rates. To ensure better access to dental care for adults, the Executive Office proposes to increase rates in ~~both~~ fee-for-service ~~and managed care~~.

(j) Increase Pediatric Provider Rates. To ensure better access to pediatric providers, the Executive Office proposes to increase rates in both fee-for-service and managed care to be equal to Medicare primary care rates.

(k) Increase Early Intervention Rates. To ensure better access to Early Intervention Services, the Executive Office proposes to increase rates in both fee-for-service and managed care by forty-five percent (45%).

(l) Increase Hospital Rates. The Executive Office proposes to increase inpatient and outpatient rates, both fee-for-service and managed care, paid to hospitals by five percent (5%) on July 1, 2022, in lieu of the adjustment of rates by the change in the recognized inflation index as defined in § 40-8-13.4(1)(i). The Executive Office proposes amendments, as needed, to the inpatient and outpatient supplemental payment methodology to incorporate the five percent (5%) rate increase into the upper payment limit demonstration modeling.

(m) Nursing Facility Rate Setting. The Executive Office proposes to seek approval from the federal Centers for Medicare and Medicaid Services ("CMS") for amendments to the Rhode Island State Plan to eliminate references to the rate review process and audit requirements for nursing facilities.

(n) Public Health Emergency Unwinding. The Executive Office proposes to seek approval from the federal Centers for Medicare and Medicaid Services ("CMS") for section 1115 demonstration waivers and State Plan Amendments as necessary to: (1) continue some of the temporary federal authorities granted during the Public Health Emergency ("PHE") for a period not to extend 14 months beyond the termination of the PHE; and (2) ensure minimum adverse impact on beneficiaries and state operations at the end of the PHE, including temporary authorities where applicable, provided that such temporary authorities shall not extend beyond 14 months following the termination of the PHE.

~~*(o) Labor and Delivery Rates.* The Executive Office proposes to increase rates paid for labor and delivery services by 20 percent.~~

(o) Managed Care Payment for Antepartum, Delivery, and Postpartum Care. The Executive Office proposes to increase the payment it makes to the managed care plans by twenty percent (20%) to reimburse hospitals that provide antepartum, delivery, postpartum, newborn care, and to pay for other authorized services.

(p) Increase Rates for Home Based Services. To ensure better access to home care services for children, the elderly and disabled adults, the Executive Office proposes to increase reimbursement rates in both fee-for-service and managed care to a minimum of $15 an hour for direct care workers.

(q) Certified Behavioral Healthcare Clinics. The Executive Office proposes to seek approval from the federal Centers for Medicare and Medicaid Service for any necessary amendments to the Rhode Island State Plan or 1115 Demonstration Waiver to implement the Certified Behavioral Health Clinics federal model.

Now, therefore, be it:

(r) Palliative Care. The Executive Office of Health and Human Services proposes to seek approval from the federal Centers for Medicare and Medicaid Services for an amendment to the Rhode Island State Plan that ensures palliative care coverage to those age nineteen (19) to under twenty-six (26) who are either covered by an individual or family health insurance plan but have aged out of the option to receive services through the Katie Beckett coverage category. The services offered shall be determined by the Executive Office and may include, but are not limited to, consultations for pain and symptom management, case management and assessment, social services, counseling, volunteer support services, and respite services.

(s) Biomarker Testing. The Executive Office of Health and Human Services proposes to seek approval from the federal Centers for Medicare and Medicaid Services for an amendment to the Rhode Island State Plan to provide coverage for biomarker testing that must be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Medicaid beneficiary's disease or condition when the test is supported by medical and scientific evidence.

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

RESOLVED, that the Secretary of the Executive Office of Health and Human Services is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the applicable department’s rules, regulations and procedures approved herein and as authorized by 42-12.4; and be it further;

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

SECTION 11. Sections 1 through 6 and 9 of this Article shall take effect as of July 1, 2022. Sections 7, 8 and 10 shall take effect upon passage.