ARTICLE 9

RELATING TO HUMAN SERVICES

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

23-17-38.1. Hospitals -- Licensing fee.

~~(a) There is imposed a hospital licensing fee for state fiscal year 2021 against each hospital in the state. The hospital licensing fee is equal to five percent (5.0%) of the net patient-services revenue of every hospital for the hospital's first fiscal year ending on or after January 1, 2019, except that the license fee for all hospitals located in Washington County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for Washington County hospitals is subject to approval by the Secretary of the U.S. Department of Health and Human Services of a state plan amendment submitted by the executive office of health and human services for the purpose of pursuing a waiver of the uniformity requirement for the hospital license fee. This licensing fee shall be administered and collected by the tax administrator, division of taxation within the department of revenue, and all the administration, collection, and other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before July 13, 2021, and payments shall be made by electronic transfer of monies to the general treasurer and deposited to the general fund. Every hospital shall, on or before June 15, 2020, make a return to the tax administrator containing the correct computation of net patient services revenue for the hospital fiscal year ending September 30, 2019, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.~~

~~(b)~~(a) There is also imposed a hospital licensing fee for state fiscal year 2022 against each hospital in the state. The hospital licensing fee is equal to five and six hundred fifty-six thousandths percent (5.656%) of the net patient-services revenue of every hospital for the hospital's first fiscal year ending on or after January 1, 2020, except that the license fee for all hospitals located in Washington County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for Washington County hospitals is subject to approval by the Secretary of the U.S. Department of Health and Human Services of a state plan amendment submitted by the executive office of health and human services for the purpose of pursuing a waiver of the uniformity requirement for the

hospital license fee. This licensing fee shall be administered and collected by the tax administrator, division of taxation within the department of revenue, and all the administration, collection, and other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before July 13, 2022, and payments shall be made by electronic transfer of monies to the general treasurer and deposited to the general fund. Every hospital shall, on or before June 15, 2022, make a return to the tax administrator containing the correct computation of net patient-services revenue for the hospital fiscal year ending September 30, 2020, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.

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

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

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

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

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

(e) Tier 2 is composed of High Medicaid/Uninsured Cost Hospitals and Independent Hospitals.

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

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

(f) Tier 3 is composed of hospitals that are Medicare-designated Low Volume hospitals and rehabilitative hospitals.

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

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

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

(h) The hospital licensing fee described in subsections (c) through (g) is subject to U.S. Department of Health and Human Services approval of a request to waive the requirement that health care-related taxes be imposed uniformly as contained in 42 CFR 433.68(d).

(i) This hospital licensing fee shall be administered and collected by the tax administrator, division of taxation within the department of revenue, and all the administration, collection, and other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to

the tax administrator before June 30 of each fiscal year, and payments shall be made by electronic transfer of monies to the tax administrator and deposited to the general fund. Every hospital shall, on or before August 1, 2023, make a return to the tax administrator containing the correct computation of inpatient and outpatient net patient-services revenue for the hospital fiscal year ending in 2022, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.

~~(d)~~(j) For purposes of this section the following words and phrases have the following meanings:

(1) "Hospital" means 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 this title (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 such 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) 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.

(2) "Non-government owned hospitals" means a hospital not owned and operated by the state of Rhode Island.

(3) "State-government owned and operated hospitals" means a hospital facility licensed by the Rhode Island Department of Health, owned and operated by the state of Rhode Island.

(4) "Rehabilitative Hospital" means Rehabilitation Hospital Center licensed by the Rhode Island Department of Health.

(5) "Independent Hospitals" means a hospital not part of a multi-hospital system

(6) "High Medicaid/Uninsured Cost Hospital" means a hospital for which the hospital's total uncompensated care, as calculated pursuant to § 40-8.3-2(4), divided by the hospital's total net patient-services revenues, is equal to 6.0% or greater.

(7) “Medicare-designated Low Volume Hospital” means a hospital that qualifies under 42 CFR 412.101(b)(2) for additional Medicare payments to qualifying hospitals for the higher incremental costs associated with a low volume of discharges.

~~(2)~~(8) “Gross patient-services revenue” means the gross revenue related to patient care services.

~~(3)~~(9) “Net patient-services revenue” means the charges related to patient care services less (i) Charges attributable to charity care; (ii) Bad debt expenses; and (iii) Contractual allowances.

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

(11) “Outpatient net patient-services revenue” means the charges related to outpatient care services less (i) Charges attributable to charity care; (ii) Bad debt expenses; and (iii) Contractual allowances.

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

~~(f)~~(l) The licensing fee imposed by subsection (a) shall apply to hospitals as defined herein that are duly licensed on July 1, ~~2020~~ 2021, and shall be in addition to the inspection fee imposed by § 23-17-38 and to any licensing fees previously imposed in accordance with this section.

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

~~(h)~~(n) The licensing ~~fee~~ fees imposed by ~~subsection~~ subsections (c) through (g) shall apply to hospitals as defined herein that are duly licensed on July 1, ~~2022~~ 2023, and shall be in addition to the inspection fee imposed by § 23-17-38 and to any licensing fees previously imposed in accordance with this section.

SECTION 2. Section 40-6-27 of the General Laws in Chapter 40-6 entitled "Public Assistance Act" is hereby amended to read as follows:

40-6-27. Supplemental Security Income.

(a)(1) The director of the department is hereby authorized to enter into agreements on behalf of the state with the Secretary of the Department of Health and Human Services or other appropriate federal officials, under the Supplemental Security Income (SSI) program established

by Title XVI of the Social Security Act, 42 U.S.C. § 1381 et seq., concerning the administration and determination of eligibility for SSI benefits for residents of this state, except as otherwise provided in this section. The state's monthly share of supplementary assistance to the Supplemental Security Income program shall be as follows:

(i) Individual living alone: $39.92

(ii) Individual living with others: $51.92

(iii) Couple living alone: $79.38

(iv) Couple living with others: $97.30

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

(vi) [Deleted by P.L. 2021, ch. 162, art. 12, § 1.]

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

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

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

(3) Individuals living in institutions shall receive a ~~twenty dollar ($20.00)~~ forty-five dollar ($45.00) per-month personal needs allowance from the state that shall be in addition to the personal needs allowance allowed by the Social Security Act, 42 U.S.C. § 301 et seq.

(4) Individuals living in state-licensed supportive residential-care settings and assisted-living residences who are receiving SSI supplemental payments under this section shall be allowed to retain a minimum personal needs allowance of fifty-five dollars ($55.00) per month from their SSI monthly benefit prior to payment of any monthly fees in addition to any amounts established

in an administrative rule promulgated by the secretary of the executive office of health and human services for persons eligible to receive Medicaid-funded long-term services and supports in the settings identified in subsection (a)(1)(v).

(5) The department is authorized and directed to make a determination of the medical need and whether a setting provides the appropriate services for those persons who:

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

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

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

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

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

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

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

(8) The certification or contract standards required by this section shall be developed in collaboration by the departments, under the direction of the executive office of health and human services, so as to ensure that they comply with applicable licensure regulations either in effect or in development.

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

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

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

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

SECTION 3. Section 40-8-2 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is hereby amended to read as follows:

40-8-2. Definitions.

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

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

(2) “Department” means the department of human services.

(3) “Director” means the director of human services.

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

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

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

(i) Bed and board;

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

(iii)(A) Other diagnostic or therapeutic items or services, including, but not limited to, pathology, radiology, and anesthesiology furnished by the hospital or by others under arrangements made by the hospital, as are customarily furnished to inpatients either by the hospital or by others under such arrangements, and services as are customarily provided to inpatients in the hospital by

an intern or resident-in-training under a teaching program having the approval of the Council on Medical Education and Hospitals of the American Medical Association or of any other recognized medical society approved by the director.

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

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

(7) "Nursing services" means the following items and services furnished to an inpatient in a nursing facility:

(i) Bed and board;

(ii) Nursing care and other related services as are customarily furnished to inpatients admitted to the nursing facility, and drugs, biologicals, supplies, appliances, and equipment for use in the facility, as are customarily furnished in the facility for the care and treatment of patients;

(iii) Other diagnostic or therapeutic items or services, legally furnished by the facility or by others under arrangements made by the facility, as are customarily furnished to inpatients either by the facility or by others under such arrangement;

(iv) Medical services provided in the facility by the inpatient's physician, or by an intern or resident-in-training of a hospital with which the facility is affiliated or that is under the same control, under a teaching program of the hospital approved as provided in subsection (6); and

(v) A personal-needs allowance of ~~fifty dollars ($50.00)~~ seventy-five dollars ($75.00) per month.

(8) "Relative with whom the dependent child is living" means and includes the father,

mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece of any dependent child who maintains a home for the dependent child.

(9) “Visiting nurse service” means part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse other than in a hospital or nursing home.

SECTION 4. Sections 40-8.3-2 and 40-8.3-3 of the General Laws in Chapter 40-8 entitled “Uncompensated Care” is 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, ~~2021~~ 2022, the period from October 1, ~~2019~~ 2020, through September 30, ~~2020~~ 2021, and for any fiscal year ending after September 30, ~~2022~~ 2023, the period from October 1, ~~2019~~ 2021, through September 30, ~~2020~~ 2022.

(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, September 30, 2022, September 30, 2023, and September 30, 2024 shall be deemed to be five and thirty hundredths percent (5.30%).

40-8.3-3. Implementation.

~~(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.~~

~~(b)~~(a) 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 $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 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)~~(b) 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~~ $159.0 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated-care costs for the base year, inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by the uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before June 15, 2023, and are expressly conditioned upon approval

on or before June 23, 2023, by the Secretary of the United States Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2023 for the disproportionate share payments.

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

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

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated-care costs for the base year, inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by the uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before June 15, 2024, and are expressly conditioned upon approval on or before June 23, 2024, 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 2024 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 5. Sections 40-8.7-1, 40-8.7-2 and 40-8.7-6 of the General Laws in Chapter 40-8.7 entitled "Healthcare Assistance for Working People with Disabilities" are hereby amended to read as follows:

40-8.7-1. Short title.

This chapter shall be known and may be cited as "The Sherlock Act." or "The Ticket to Work Program."

40-8.7-2. Medicaid buy-in program.

The ~~department of human services~~ Executive Office of Health and Human Services is hereby authorized and directed to ~~establish~~ maintain a Medicaid buy-in program pursuant to the "Balanced Budget Act of 1997," 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII) and the federal Ticket to Work and Incentives Improvement Act of 1999 (TWWIIA), Public Law 106-170.

40-8.7-6. Eligibility.

(a) To be eligible for benefits under the Medicaid buy-in program:

(1) The person shall be an individual with disabilities as defined in § 40-8.7-4, but without regard to his or her ability to engage in substantial gainful activity, as specified in the Social Security Act, 42 U.S.C. § 423(d)(4);

(2) The person shall be employed as defined in § 40-8.7-4;

(3) For the Sherlock Act Medicaid buy in program the ~~The~~ person's net accountable income shall either not exceed two hundred fifty percent (250%) of the federal poverty level, taking into account the SSI program disregards and impairment-related work expenses as defined in 42 U.S.C. § 1396a(r)(2) or for the Ticket to Work Program buy in program there are no income or asset limits to be considered as part of the eligibility determination;

(4) A maximum of ten thousand dollars ($10,000) of available resources for an individual and twenty thousand dollars ($20,000) for a couple shall be disregarded as shall any additional resources held in a retirement account, in a medical savings account, or any other account, related to enhancing the independence of the individual and approved under rules to be adopted by the ~~department~~ executive office for the Sherlock Act; there are no income or asset limits for the Ticket to Work Program; and

(5) The person shall be a current medical assistance recipient under § 40-8.5-1 [CNIL] or § 40-8-3(5)(v) [MNIL]; or shall meet income, assets, (except as modified by subsection (a)(4) of this section) and eligibility requirements for the medical assistance program under § 40-8.5-1 [CNIL] or § 40-8-3(5)(v) [MNIL], as such requirements are modified and extended by this chapter.

(b) Appeals Process. The director or designee shall review each application filed in accordance with regulations, and shall make a determination of whether the application will be approved and the extent of the benefits to be made available to the applicant, and shall, within thirty (30) days after the filing, notify the applicant, in writing, of the determination. If the application is rejected, the applicant shall be notified the reason for the denial. The director may at any time reconsider any determination. Any applicant for or recipient of benefits aggrieved because of a decision, or delay in making a decision, shall be entitled to an appeal and shall be afforded reasonable notice and opportunity for a fair hearing conducted by the director, pursuant to chapter 8 of this title.

SECTION 6. Sections 40-8.9-1 and 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Long-Term Care Service and Finance Reform" are hereby amended to read as follows:

40-8.9-1. Findings.

(a) The number of Rhode Islanders in need of long-term-care services continues to rise substantially, and the quality of life of these Rhode Islanders is determined by the capacity of the ~~long-term-care system~~ state to ~~provide~~ ensure equitable access to the full array of services and supports required to meet their healthcare needs and maintain their independence.

(b) It is in the interest of all Rhode Islanders to endorse and fund statewide efforts to build a fiscally sound, dynamic and resilient long-term-care system that ~~supports~~ fosters: consumer independence and choice; the delivery of high-quality, coordinated services; the financial integrity of all participants-purchasers, payers, providers, and consumers; and the responsible and efficient allocation of all available public and private resources, including preservation of federal financial participation.

(c) It is in the interest of all Rhode Islanders to assure that rates paid for community-based long-term-care services are adequate to assure high quality ~~as well as~~ and ~~supportive of~~ support workforce recruitment and retention.

(d) It is in the interest of all Rhode Islanders to improve consumers' access information regarding community-based alternatives to institutional settings of care.

(e) It is in the best interest of all Rhode Islanders to maintain a person-centered, quality driven, and conflict-free system of publicly financed long-term services and supports that is responsive to the goals and preferences of those served.

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

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

integrity and financial viability of all current long-term-care services while pursuing this goal.

(b) The reformed long-term-care system rebalancing goal is person-centered and encourages individual self-determination, family involvement, interagency collaboration, and individual choice through the provision of highly specialized and individually tailored home-based services. Additionally, individuals with severe behavioral, physical, or developmental disabilities must have the opportunity to live safe and healthful lives through access to a wide range of supportive services in an array of community-based settings, regardless of the complexity of their medical condition, the severity of their disability, or the challenges of their behavior. Delivery of services and supports in less-costly and less-restrictive community settings will enable children, adolescents, and adults to be able to curtail, delay, or avoid lengthy stays in long-term-care institutions, such as behavioral health residential-treatment facilities, long-term-care hospitals, intermediate-care facilities, and/or skilled nursing facilities.

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

(1) The executive office shall continue to apply the level-of-care criteria in effect on ~~June 30, 2015~~ April 1, 2021, for any recipient determined eligible for and receiving Medicaid-funded long-term services and supports in a nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities on or before that date, unless:

(i) The recipient transitions to home- and community-based services because he or she would no longer meet the level-of-care criteria in effect on ~~June 30, 2015~~ April 1, 2021; or

(ii) The recipient chooses home- and community-based services over the nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities. For the purposes of

this section, a failed community placement, as defined in regulations promulgated by the executive office, shall be considered a condition of clinical eligibility for the highest level of care. The executive office shall confer with the long-term-care ombudsperson with respect to the determination of a failed placement under the ombudsperson's jurisdiction. Should any Medicaid recipient eligible for a nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities as of ~~June 30, 2015~~ April 1, 2021, receive a determination of a failed community placement, the recipient shall have access to the highest level of care; furthermore, a recipient who has experienced a failed community placement shall be transitioned back into his or her former nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities whenever possible. Additionally, residents shall only be moved from a nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities in a manner consistent with applicable state and federal laws.

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

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

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

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

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

(e) The executive office is authorized to promulgate rules that permit certain optional

services including, but not limited to, homemaker services, home modifications, respite, and physical therapy evaluations to be offered to persons at risk for Medicaid-funded long-term care subject to availability of state-appropriated funding for these purposes.

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

(1) Development of revised or new Medicaid certification standards that increase access to service specialization and scheduling accommodations by using payment strategies designed to achieve specific quality and health outcomes.

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

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

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

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

(ii) A prospective base adjustment, effective not later than July 1, 2018, of twenty percent (20%) of the current base rate for home-care providers, home nursing care providers, and hospice providers contracted with the executive office of health and human services and its subordinate

agencies to deliver Medicaid fee-for-service skilled nursing and therapeutic services and hospice care.

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

(iv) On the first of July in each year, beginning on July 1, 2019, the executive office of health and human services will initiate an annual inflation increase to the base rate for home-care providers, home nursing care providers, and hospice providers contracted with the executive office and its subordinate agencies to deliver Medicaid fee-for-service personal care attendant services, skilled nursing and therapeutic services and hospice care. The base rate increase shall be a percentage amount equal to the New England Consumer Price Index card as determined by the United States Department of Labor for medical care and for compliance with all federal and state laws, regulations, and rules, and all national accreditation program requirements.

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

(1) Effective July 1, 2021, increase the existing shift differential modifier by $0.19 per fifteen (15) minutes for personal care and combined personal care/homemaker.

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

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

(2) Effective January 1, 2022, establish a new behavioral healthcare enhancement of $0.39 per fifteen (15) minutes for personal care, combined personal care/homemaker, and homemaker only for providers who have at least thirty percent (30%) of their direct-care workers (which includes certified nursing assistants (CNA) and homemakers) certified in behavioral healthcare training.

(i) Employers must pass on one hundred percent (100%) of the behavioral healthcare enhancement per fifteen (15) minute unit of service rendered by only those CNAs and homemakers who have completed the thirty (30) hour behavioral health certificate training program offered by Rhode Island College, or a training program that is prospectively determined to be compliant per EOHHS, to those CNAs and homemakers. This compensation shall be provided in addition to the rate of compensation that the employee was receiving as of December 31, 2021. For an employee hired after December 31, 2021, the agency shall use not less than the lowest compensation paid to an employee of similar functions and duties as of December 31, 2021, as the base compensation to which the increase is applied.

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

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

(i) The executive office shall implement, no later than January 1, 2024, a statewide network and rate methodology for conflict-free case management for individuals receiving Medicaid-funded home and community-based services. The executive office shall coordinate implementation with the state's health and human services departments and divisions authorized to deliver Medicaid-funded home and community-based service programs, including the department of behavioral healthcare, developmental disabilities and hospitals; the department of human services; and the

office of healthy aging. It is in the best interest of the Rhode Islanders eligible to receive Medicaid home and community-based services under this chapter, chapter 40.1, chapter 42 or any other general laws to provide equitable access to conflict-free case management that shall include person-centered planning, service arranging and quality monitoring in the amount, duration and scope required by federal law and regulations. It is necessary to ensure that there is a robust network of qualified conflict-free case management entities with the capacity to serve all participants on a statewide basis and in a manner that promotes choice, self-reliance, and community integration. The executive office, as the designated single state Medicaid authority and agency responsible for coordinating policy and planning for health and human services under § 42-7.2 et seq., is directed to establish a statewide conflict-free case management network under the management of the executive office and to seek any Medicaid waivers, state plan amendments and changes in rules, regulations and procedures that may be necessary to ensure that recipients of Medicaid home and community-based services have access to conflict-free case management in a timely manner and in accordance with the federal requirements that must be met to preserve financial participation.

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

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

(~~k~~)(l) The executive office shall implement, no later than January 1, 2016, the following home- and community-based service and payment reforms:

(1) [Deleted by P.L. 2021, ch. 162, art. 12, § 6.]

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

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

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

SECTION 7. Section 40.1-8.5-8 of the General Laws in Chapter 40 entitled "General Provisions" is hereby amended to read as follows:

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~~ February 1, 2024, 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~~ 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~~ 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 8. Section 42-7.2-5 of the General Laws in Chapter 42-7.2 entitled "Office of Health and Human Services" is hereby amended to read as follows:

42-7.2-5. Duties of the secretary.

The secretary shall be subject to the direction and supervision of the governor for the oversight, coordination, and cohesive direction of state-administered health and human services and in ensuring the laws are faithfully executed, notwithstanding any law to the contrary. In this capacity, the secretary of the executive office of health and human services (EOHHS) shall be authorized to:

(1) Coordinate the administration and financing of healthcare benefits, human services, and programs including those authorized by the state's Medicaid section 1115 demonstration waiver and, as applicable, the Medicaid state plan under Title XIX of the U.S. Social Security Act.

However, nothing in this section shall be construed as transferring to the secretary the powers, duties, or functions conferred upon the departments by Rhode Island public and general laws for the administration of federal/state programs financed in whole or in part with Medicaid funds or the administrative responsibility for the preparation and submission of any state plans, state plan amendments, or authorized federal waiver applications, once approved by the secretary.

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

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

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

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

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

(4) Beginning in 2020, prepare and submit to the governor, the chairpersons of the house and senate finance committees, the caseload estimating conference, and to the joint legislative committee for health-care oversight, by no later than September 15 of each year, a comprehensive overview of all Medicaid expenditures outcomes, administrative costs, and utilization rates. The

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

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

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

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

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

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

(vi) Information submitted to the Centers for Medicare and Medicaid Services for the mandatory annual state reporting of the Core Set of Children's Health Care Quality Measures for Medicaid and Children's Health Insurance Program, behavioral health measures on the Core Set of Adult Health Care Quality Measures for Medicaid and the Core Sets of Health Home Quality Measures for Medicaid to ensure compliance with the Bipartisan Budget Act of 2018, Public Law 115-123.

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

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

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

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

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

of the people and communities they serve;

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

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

(v) Facilitate the rebalancing of the long term system by creating an assessment and coordination organization or unit for the expressed purpose of developing and implementing procedures EOHHS-wide that ensure that the appropriate publicly funded health services are provided at the right time and in the most appropriate and least restrictive setting;

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

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

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

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

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

(10) At the direction of the governor or the general assembly, conduct independent reviews

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

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

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

(13) Assume responsibility for complying with the provisions of any general or public law or regulation related to the disclosure, confidentiality and privacy of any information or records, in the possession or under the control of the executive office or the departments assigned to the executive office, that may be developed or acquired or transferred at the direction of the governor or the secretary for purposes directly connected with the secretary's duties set forth herein.

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

(15) Identify opportunities for inclusion with the EOHHS' October 1, 2023 budget submission, to remove fixed eligibility thresholds for programs under its purview by establishing sliding scale decreases in benefits commensurate with income increases up to four hundred fifty percent (450%) of the federal poverty level. These shall include but not be limited to medical assistance, child care assistance, and food assistance.

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

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

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

WHEREAS, Rhode Island General 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) *Cedar Rate Increase.* The Secretary of the Executive Office is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the applicable department's rules, regulations and procedures required to implement an increase to existing fee-for-service and managed care rates and an updated code structure for the Cedar Family Centers.

(b) *Hospital State Directed Managed Care Payment.* The Secretary of the Executive Office is hereby authorized and directed to amend its regulations for reimbursement to Medicaid Managed Care Organizations (MMCO) and authorized to direct MMCO's to make quarterly state directed payments to hospitals for inpatient and outpatient services in accordance with the payment methodology contained in the approved CMS preprint for hospital state directed payments.

(c) *Hospital Licensing Fee.* The Secretary of the Executive Office is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the applicable department's rules, regulations and procedures required to implement a hospital licensing rate, including but not limited to, a three-tiered hospital licensing rate for non-government owned hospitals and one rate for government-owned and operated hospitals.

(d) *Permanent Appendix K Authority for Parents and Other Relatives to Provide Day and Community- Based Services Through Self-Directed HCBS Programs*. The Secretary of the Executive Office is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the applicable department's rules, regulations and procedures required to implement permanent current 1115 Global Waiver Appendix K Authority to allow parents and other relatives of adult members with disabilities to be reimbursed for day and community-based services provided to adults with disabilities who participate in Self-Directed Home and Community-Based Services Programs. The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals will include the necessary information for the expenses and number of participants in the monthly reported required under § 35-17-1.

(e) *Authority for Personal Care Attendant Service Delivery to HCBS Recipients in Acute Care Settings*. The Secretary of the Executive Office is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the applicable department's rules,

regulations and procedures required to allow Medicaid reimbursement of direct support professionals to assist Medicaid Long-Term Services and Supports Home and Community-Based Services beneficiaries while such individuals are receiving care in hospital acute care settings. Approval of the waiver does not create an obligation for any hospital to staff home and community-based service providers and those providers may not interfere with hospital clinical activities or engage in activities beyond the scope of the services prior to hospitalization.

Now, therefore, be it

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 amendment, 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 on July 1, 2023.

SECTION 10. This article shall take effect upon passage, except for Section 9 which shall take effect as of July 1, 2023.