ARTICLE 9

RELATING TO MEDICAL ASSISTANCE

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 year 2024 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 fifty-four hundredths percent (13.54%) 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 seventy-three hundredths percent (13.73%) 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 seventy-one hundredths (2.71%) 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 seven-five one hundredths (2.75%) 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-five hundredths (1.35%) 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-seven hundredths (1.37%) 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 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, 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 on a quarterly basis and fully before June 30, 2024, 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 fees imposed by 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. 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 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 $15.2 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 3. 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 4. 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 5. 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.

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 6. This article shall take effect upon passage, except for Section 5 which shall take effect as of July 1, 2023.