# ARTICLE 8

RELATING TO MEDICAL ASSISTANCE

SECTION 1. Section 23-17-38.1 of the General Laws in Chapter 23-17 entitled "Licensing of Healthcare 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 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.~~

~~(b)~~(a) There is ~~also~~ imposed a hospital licensing fee described in subsections (c) through (f) 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.

(b) There is also imposed a hospital licensing fee described in subsections (c) through (f) for state fiscal year 2026 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, 2023. 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, 2025, and shall notify each hospital of its assigned tier by August 1, 2025.

(c) 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.

(d) 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 percent (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 hundredths percent (2.66%) of the outpatient net patient-services revenue derived from outpatient net patient-services revenue of every Tier 2 hospital.

(e) 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 percent (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 percent (1.33%) of the outpatient net patient-services revenue derived from outpatient net patient-services revenue of every Tier 3 hospital.

(f) 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 herein. 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. There is also imposed a hospital licensing fee for state fiscal ~~year~~ years 2025 and 2026 against state-government owned and operated hospitals in the state as defined herein 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, 2023.

(g) The hospital licensing fee described in subsections (b) through (f) is subject to U.S. Department of Health and Human Services approval of a request to waive the requirement that healthcare-related taxes be imposed uniformly as contained in 42 C.F.R. § 433.68(d).

(h) 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~~ June 25 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~~ of each fiscal year, 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~~ data referenced in subsection (a) and or (b), 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.

(i) For purposes of this section the following words and phrases have the following meanings:

(1) "Gross patient-services revenue" means the gross revenue related to patient care services.

(2) "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 six percent (6.0%) or greater.

(3) "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.

(4) "Independent hospitals" means a hospital not part of a multi-hospital system.

(5) "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.

(6) "Medicare-designated low-volume hospital" means a hospital that qualifies under 42 C.F.R. 412.101(b)(2) for additional Medicare payments to qualifying hospitals for the higher incremental costs associated with a low volume of discharges.

(7) "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.

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

(9) "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.

(10) "Rehabilitative hospital" means Rehabilitation Hospital Center licensed by the Rhode Island department of health.

(11) "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.

(j) 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.

(k) The licensing fee imposed by ~~subsection~~ subsections (a) through (f) shall apply to hospitals as defined herein that are duly licensed on July 1, ~~2022~~ 2024, 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.

~~(l) The licensing fees imposed by subsections (b) through (f) shall apply to hospitals as~~

~~defined herein that are duly licensed on July 1, 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 35-17-1 of the General Laws in Chapter 35-17 entitled "Medical Assistance and Public Assistance Caseload Estimating Conferences" is hereby amended to read as follows:

**35-17-1. Purpose and membership.**

(a) In order to provide for a more stable and accurate method of financial planning and budgeting, it is hereby declared the intention of the legislature that there be a procedure for the determination of official estimates of anticipated medical assistance expenditures and public assistance caseloads, upon which the executive budget shall be based and for which appropriations by the general assembly shall be made.

(b) The state budget officer, the house fiscal advisor, and the senate fiscal advisor shall meet in regularly scheduled caseload estimating conferences (C.E.C.). These conferences shall be open public meetings.

(c) The chairpersonship of each regularly scheduled C.E.C. will rotate among the state budget officer, the house fiscal advisor, and the senate fiscal advisor, hereinafter referred to as principals. The schedule shall be arranged so that no chairperson shall preside over two (2) successive regularly scheduled conferences on the same subject.

(d) Representatives of all state agencies are to participate in all conferences for which their input is germane.

(e) The department of human services shall provide monthly data to the members of the caseload estimating conference by the fifteenth day of the following month. Monthly data shall include, but is not limited to, actual caseloads and expenditures for the following case assistance programs: Rhode Island Works, SSI state program, general public assistance, and child care. For individuals eligible to receive the payment under § 40-6-27(a)(1)(vi) [repealed], the report shall include the number of individuals enrolled in a managed care plan receiving long-term care services and supports and the number receiving fee-for-service benefits. The executive office of health and human services shall report relevant caseload information and expenditures for the following medical assistance categories: hospitals, long-term care, managed care, pharmacy, and other medical services. In the category of managed care, caseload information and expenditures for the following populations shall be separately identified and reported: children with disabilities, children in foster care, and children receiving adoption assistance and RIte Share enrollees under § 40-8.4-12(j). The information shall include the number of Medicaid recipients whose estate may

be subject to a recovery and the anticipated amount to be collected from those subject to recovery, the total recoveries collected each month and number of estates attached to the collections and each month, the number of open cases and the number of cases that have been open longer than three months. The executive office will also report separately the amount that the Medicaid expenditures have been reduced by third-party liability payments to providers, supplemental income verification tools, the department of administration's office of internal audit and program integrity unit, and recoveries from ABLE accounts.

(f) Beginning July 1, 2021, the department of behavioral healthcare, developmental disabilities and hospitals shall provide monthly data to the members of the caseload estimating conference by the twenty-fifth day of the following month. Monthly data shall include, but is not limited to, actual caseloads and expenditures for the private community developmental disabilities services program. Information shall include, but not be limited to: the number of cases and expenditures from the beginning of the fiscal year at the beginning of the prior month; cases added and denied during the prior month; expenditures made; and the number of cases and expenditures at the end of the month. The information concerning cases added and denied shall include summary information and profiles of the service-demand request for eligible adults meeting the state statutory definition for services from the division of developmental disabilities as determined by the division, including age, Medicaid eligibility and agency selection placement with a list of the services provided, and the reasons for the determinations of ineligibility for those cases denied. The department shall also provide, monthly, the number of individuals in a shared-living arrangement and how many may have returned to a twenty-four-hour (24) residential placement in that month. The department shall also report, monthly, any and all information for the consent decree that has been submitted to the federal court as well as the number of unduplicated individuals employed; the place of employment; and the number of hours working. The department shall also provide the amount of funding allocated to individuals above the assigned resource levels; the number of individuals and the assigned resource level; and the reasons for the approved additional resources. The department will also collect and forward to the house fiscal advisor, the senate fiscal advisor, and the state budget officer, by November 1 of each year, the annual cost reports for each community-based provider for the prior fiscal year. The department shall also provide the amount of patient liability to be collected and the amount collected as well as the number of individuals who have a financial obligation. The department will also provide a list of community-based providers awarded an advanced payment for residential and community-based day programs; the address for each property; and the value of the advancement. If the property is sold, the department must report the final sale, including the purchaser, the value of the sale, and the name of the agency

that operated the facility. If residential property, the department must provide the number of individuals residing in the home at the time of sale and identify the type of residential placement that the individual(s) will be moving to. The department must report if the property will continue to be licensed as a residential facility. The department will also report any newly licensed twenty-four-hour (24) group home; the provider operating the facility; and the number of individuals residing in the facility. Prior to December 1, 2017, the department will provide the authorizations for community-based and day programs, including the unique number of individuals eligible to receive the services and at the end of each month the unique number of individuals who participated in the programs and claims processed.

(g) The executive office of health and human services shall provide direct assistance to the department of behavioral healthcare, developmental disabilities and hospitals to facilitate compliance with the monthly reporting requirements in addition to preparation for the caseload estimating conferences.

SECTION 3. Section 40-6-9.1 of the General Laws in Chapter 40-6 entitled "Public Assistance Act" is hereby amended to read as follows:

**40-6-9.1. Data matching — Healthcare coverages.**

(a) For purposes of this section, the term “medical assistance program” shall mean medical assistance provided in whole or in part by the ~~department of human services~~ executive office of health and human services pursuant to chapters ~~5.1,~~ 8, 8.4 of this title, 12.3 of title 42 and/or Title XIX or XXI of the federal Social Security Act, as amended, 42 U.S.C. § 1396 et seq. and 42 U.S.C. § 1397aa et seq., respectively. Any references to the ~~department~~ office shall be to the ~~department of human services~~ executive office of health and human services.

(b) In furtherance of the assignment of rights to medical support to the ~~department of human services~~ executive office of health and human services under § 40-6-9(b), (c), (d), and (e), and in order to determine the availability of other sources of healthcare insurance or coverage for beneficiaries of the medical assistance program, and to determine potential third-party liability for medical assistance paid out by the ~~department~~ office, all health insurers, health-maintenance organizations, including managed care organizations, and third-party administrators, self-insured plans, pharmacy benefit managers (PBM), and other parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item of service doing business in the state of Rhode Island shall permit and participate in data matching with the ~~department of human services~~ executive office of health and human services, as provided in this section, to assist the ~~department~~ office to identify medical assistance program applicants, beneficiaries, and/or persons responsible for providing medical support for applicants and

beneficiaries who may also have healthcare insurance or coverage in addition to that provided, or to be provided, by the medical assistance program and to determine any third-party liability in accordance with this section.

The ~~department~~ office shall take all reasonable measures to determine the legal liability of all third parties (including health insurers, self-insured plans, group health plans (as defined in § 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1167(1)]), service benefit plans, health-maintenance organizations, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service), to pay for care and services on behalf of a medical assistance recipient, including collecting sufficient information to enable the ~~department~~ office to pursue claims against such third parties.

In any case where such a legal liability is found to exist and medical assistance has been made available on behalf of the individual (beneficiary), the ~~department~~ office shall seek reimbursement for the assistance to the extent of the legal liability and in accordance with the assignment described in § 40-6-9.

To the extent that payment has been made by the ~~department~~ office for medical assistance to a beneficiary in any case where a third party has a legal liability to make payment for the assistance, and to the extent that payment has been made by the ~~department~~ office for medical assistance for healthcare items or services furnished to an individual, the ~~department~~ office (state) is considered to have acquired the rights of the individual to payment by any other party for the healthcare items or services in accordance with § 40-6-9.

Any health insurer (including a group health plan, as defined in § 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1167(1)], a self-insured plan, a service-benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service), in enrolling an individual, or in making any payments for benefits to the individual or on the individual's behalf, is prohibited from taking into account that the individual is eligible for, or is provided, medical assistance under a plan under 42 U.S.C. § 1396 et seq. for this state, or any other state.

(c) All health insurers or liable third parties, including, but not limited to, health-maintenance organizations, third-party administrators, nonprofit medical-service corporations, nonprofit hospital-service corporations, subject to the provisions of chapters 18, 19, 20, and 41 of title 27, as well as, self-insured plans, group health plans (as defined in § 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1167(1)]), service-benefit plans, managed

care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service) doing business in this state shall:

(1) Provide member information within fourteen (14) calendar days of the request to the ~~department~~ office to enable the medical assistance program to identify medical assistance program recipients, applicants and/or persons responsible for providing medical support for those recipients and applicants who are, or could be, enrollees or beneficiaries under any individual or group health insurance contract, plan, or policy available or in force and effect in the state;

(2) With respect to individuals who are eligible for, or are provided, medical assistance by the ~~department~~ office, upon the request of the ~~department~~ office, provide member information within fourteen (14) calendar days of the request to determine during what period the individual or his or her spouse or dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is, or was provided by the health insurer (including the name, address, and identifying number of the plan);

(3) Accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the party for an item or service for which payment has been made by the ~~department~~ office;

(4) Respond to any inquiry by the ~~department~~ office regarding a claim for payment for any healthcare item or service that is submitted not later than three (3) years after the date of the provision of the healthcare item or service; and

(5) Agree not to deny a claim submitted by the state based solely on procedural reasons, such as on the basis of the date of submission of the claim, the type or format of the claim form, failure to obtain a prior authorization, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if—

(i) The claim is submitted by the state within the three-year (3) period beginning on the date on which the item or service was furnished; and

(ii) Any action by the state to enforce its rights with respect to the claim is commenced within six (6) years of the state's submission of such claim.

(6) Agree to respond to any inquiry regarding claims within sixty (60) business days after receipt of the written documentation by the Medicaid recipient.

(7) Agree to not deny a claim for failure to obtain prior authorization for an item or service. In the case of a responsible third party that requires prior authorization for an item or service furnished to an individual eligible to receive medical assistance under the state Medicaid program, the third-party health insurer shall accept authorization provided by state medical assistance

program that the item or service is covered by Medicaid as if that authorization is a prior authorization made by the third-party health insurer for the item or service.

(d) This information shall be made available by these insurers and health-maintenance organizations and used by the ~~department of human services~~ executive office of health and human services only for the purposes of, and to the extent necessary for, identifying these persons, determining the scope and terms of coverage, and ascertaining third-party liability. The ~~department of human services~~ executive office of health and human services shall provide information to the health insurers, including health insurers, self-insured plans, group health plans (as defined in § 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1167(1)]), service-benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service) only for the purposes described herein.

(e) No health insurer, health-maintenance organization, or third-party administrator that provides, or makes arrangements to provide, information pursuant to this section shall be liable in any civil or criminal action or proceeding brought by beneficiaries or members on account of this action for the purposes of violating confidentiality obligations under the law.

(f) The ~~department~~ office shall submit any appropriate and necessary state plan provisions.

(g) The ~~department of human services~~ executive office of health and human services is authorized and directed to promulgate regulations necessary to ensure the effectiveness of this section.

SECTION 4. Section 40-8-19 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is hereby amended to read as follows:

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

(a) **Rate reform.**

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

(2) The executive office shall review the current methodology for providing Medicaid payments to nursing facilities, including other long-term care services providers, and is authorized

to modify the principles of reimbursement to replace the current cost-based methodology rates with rates based on a price-based methodology to be paid to all facilities with recognition of the acuity of patients and the relative Medicaid occupancy, and to include the following elements to be developed by the executive office:

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

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

(iii) Revision of rates as necessary based on increases in direct and indirect costs beginning October 2024 utilizing data from the most recent finalized year of facility cost report. The per diem rate components deferred in subsections (a)(2)(i) and (a)(2)(ii) of this section shall be adjusted accordingly to reflect changes in direct and indirect care costs since the previous rate review;

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

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

(vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be applied on October 1 of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013, October 1, 2014, or October 1, 2015, but will occur on April 1, 2015. The adjustment of rates will also not occur on October 1, 2017, October 1, 2018, October 1, 2019, and October 2022. Effective July 1, 2018, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2017, both fee-for-service and managed care, will be increased by one and one-half percent (1.5%) and further increased by one percent (1%) on October 1, 2018, and further increased by one percent (1%) on October 1, 2019. Effective October 1, 2022, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2021, both fee-for-service and managed care, will be increased by three percent (3%). In addition to the annual nursing home inflation index adjustment, there shall be a base rate staffing adjustment of one-half percent (0.5%) on October 1, 2021, one percent (1.0%) on October 1, 2022, and one and one-half percent (1.5%) on October 1, 2023. For the twelve (12) month period beginning October 1, 2025, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2024, both fee-for-service and managed care, will be increased by two and three-tenths percent (2.3%) There shall also be a base rate staffing adjustment of three percent (3%) effective October 1, 2025. Not less than one hundred percent (100%) of this base-rate staffing adjustment shall be expended by each nursing facility to increase compensation, wages, benefits, and related employer costs, for eligible direct-care staff, including the cost of hiring additional eligible direct-care positions, as defined in subsection (a)(2)(vi). The inflation index shall be applied without regard for the transition factors in subsections (b)(1) and (b)(2). For purposes of

October 1, 2016, adjustment only, any rate increase that results from application of the inflation index to subsections (a)(2)(i) and (a)(2)(ii) shall be dedicated to increase compensation for direct-care workers in the following manner: Not less than 85% of this aggregate amount shall be expended to fund an increase in wages, benefits, or related employer costs of direct-care staff of nursing homes. For purposes of this section, direct-care staff shall include registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), certified medical technicians, housekeeping staff, laundry staff, dietary staff, or other similar employees providing direct-care services; provided, however, that this definition of direct-care staff shall not include: (i) RNs and LPNs who are classified as "exempt employees" under the federal Fair Labor Standards Act (29 U.S.C. § 201 et seq.); or (ii) CNAs, certified medical technicians, RNs, or LPNs who are contracted, or subcontracted, through a third-party vendor or staffing agency. By July 31, 2017, nursing facilities shall submit to the secretary, or designee, a certification that they have complied with the provisions of this subsection (a)(2)(vi) with respect to the inflation index applied on October 1, 2016. Any facility that does not comply with the terms of such certification shall be subjected to a clawback, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification.

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

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

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

(B) CNAs, certified medication technicians, RNs, or LPNs who are contracted or

subcontracted through a third-party vendor or staffing agency.

(4)(i) By July 31, 2021, and July 31 of each year thereafter, nursing facilities shall submit to the secretary or designee a certification that they have complied with the provisions of subsection (a)(3) of this section with respect to the inflation index applied on October 1. The executive office of health and human services (EOHHS) shall create the certification form nursing facilities must complete with information on how each individual eligible employee's compensation increased, including information regarding hourly wages prior to the increase and after the compensation increase, hours paid after the compensation increase, and associated increased payroll taxes. A collective bargaining agreement can be used in lieu of the certification form for represented employees. All data reported on the compliance form is subject to review and audit by EOHHS. The audits may include field or desk audits, and facilities may be required to provide additional supporting documents including, but not limited to, payroll records.

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

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

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

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

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

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

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

SECTION 5. Sections 40-8.3-2 and 40-8.3-3 of the General Laws in Chapter 40-8.3 entitled "Uncompensated Care" are hereby amended to read as follows:

**40-8.3-2. Definitions.**

As used in this chapter:

(1) "Base year" means, for the purpose of calculating a disproportionate share payment for any fiscal year ending after September 30, ~~2023~~ 2024, the period from October 1, ~~2021~~ 2022, through September 30, ~~2022~~ 2023, and for any fiscal year ending after September 30, ~~2024~~ 2025, the period from October 1, ~~2022~~ 2023, through September 30, ~~2023~~ 2024.

(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; (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; and (iii) the sum of subsections (4)(i) and (4)(ii) of this section shall be offset by the estimated hospital's commercial equivalent rates state directed payment for the current SFY in which the disproportionate share hospital (DSH) payment is made. The sum of subsections (4)(i), (4)(ii), and (4)(iii) of this section shall be 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, September 30, 2024, ~~and~~ September 30, 2025, and September 30, 2026, shall be deemed to be five and thirty hundredths percent (5.30%).

**40-8.3-3. Implementation.**

~~(a) 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 $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.~~

~~(b)~~(a) 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 30, 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.

~~(c)~~(b) For federal fiscal year 2025, commencing on October 1, 2024, and ending September 30, 2025, 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) The creation of Pool C which allots no more than ~~nineteen million nine hundred thousand dollars ($19,900,000)~~ twelve million nine hundred thousand dollars ($12,900,000) to Medicaid eligible government-owned hospitals;

(2) That the DSH plan to all participating hospitals, not to exceed an aggregate limit of ~~$34.7~~ $27.7 million, shall be allocated by the executive office of health and human services to the Pool C and D components of the DSH plan;

(3) 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 of all participating hospitals. The disproportionate share payments shall be made on or before June 30, 2025, and are expressly conditioned upon approval on or before June 23, 2025, by the Secretary of the United States Department of Health and Human Services, or their authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2025 for the disproportionate share payments; and

(4) That the Pool C 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 cost for the base year inflated by the uncompensated-care index of all participating hospitals. The disproportionate share payments shall be made on or before June 30, 2025, and are expressly conditioned upon approval on or before June 23, 2025, by the Secretary of the United States Department of Health and Human Services, or their authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2025 for the disproportionate share payments.

(c) For federal fiscal year 2026, commencing on October 1, 2025, and ending September 30, 2026, 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 $13.9 million, shall be allocated by the executive office of health and human services to the Pool C and D components of the DSH plan. Pool C shall not exceed an aggregate limit of $12.9 million. Pool D shall not exceed an aggregate limit of $1.0 million.

(2) That the Pool C 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 cost for the base year inflated by the uncompensated-care index of all participating hospitals. The disproportionate share payments shall be made on or before June 30, 2026, and are expressly conditioned upon approval on or before June 23, 2026, by the Secretary of the United States Department of Health and Human Services, or their authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2026 for the disproportionate share payments; and

(3) 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 of all participating hospitals. The disproportionate share payments shall be made on or before June 30, 2026, and are expressly conditioned upon approval on or before June 23, 2026, by the Secretary of the United States Department of Health and Human Services, or their authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2026 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 6. Section 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical Assistance — Long-Term Care Service and Finance Reform" is hereby amended to read as follows:

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

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

budget submission, the percentage distribution between institutional care and home- and community-based care by population and shall report current and projected waiting lists for long-term-care and home- and community-based care services. The executive office is further authorized and directed to prioritize investments in home- and community-based care and to maintain the integrity and financial viability of all current long-term-care services while pursuing this goal.

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

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

(1) The executive office shall continue to apply the level-of-care criteria in effect on 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 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 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~~.~~, except as of July 1, 2025, and thereafter, when no annual inflation increase shall occur for these rates.

(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, title 40.1, title 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 § 42-7.2-1 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.

(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.

(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.

(*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.

(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. Sections 40-8.10-2, 40-8.10-3 and 40-8.10-4 of the General Laws in Chapter 40-8.10 entitled "Long-Term Care Service Reform for Medicaid Eligible Individuals" are hereby amended to read as follows:

**40-8.10-2. Definitions.**

As used in this chapter:

(1) “Core services” mean homemaker services, environmental modifications (home accessibility adaptations, special medical equipment (minor assistive devices), meals on wheels (home delivered meals), personal emergency response (PERS), licensed practical nurse services, community transition services, residential supports, day supports, supported employment, supported living arrangements, private duty nursing, supports for consumer direction (supports facilitation), participant directed goods and services, case management, senior companion services, assisted living, personal care assistance services and respite.

~~(2) “Preventive services” mean homemaker services, minor environmental modifications, physical therapy evaluation and services, and respite services.~~

**40-8.10-3. Levels of care.**

(a) The secretary of the executive office of health and human services shall coordinate responsibilities for long-term-care assessment in accordance with the provisions of this chapter. Importance shall be placed upon the proper and consistent determination of levels of care across the state departments for each long-term-care setting, including behavioral health residential treatment facilities, long-term-care hospitals, intermediate-care facilities, and/or skilled nursing facilities. Specialized plans of care that meet the needs of the individual Medicaid recipients shall be coordinated and consistent across all state departments. The development of care plans shall be

person-centered and shall support individual self-determination, family involvement, when appropriate, individual choice, and interdepartmental collaboration.

(b) Levels of care for long-term-care institutions (behavioral health residential treatment facilities, long-term-care hospitals, intermediate-care facilities and/or skilled nursing facilities), for which alternative community-based services and supports are available, shall be established pursuant to § 40-8.9-9. The structure of the ~~three (3)~~ two (2) levels of care is as follows:

(1) Highest level of care. Individuals who are determined, based on medical need, to require the institutional level of care will have the choice to receive services in a long-term-care institution or in a home- and community-based setting.

(2) High level of care. Individuals who are determined, based on medical need, to benefit from home- and community-based services.

~~(3) Preventive level of care. Individuals who do not presently need an institutional level of care but who need services targeted at preventing admission, re-admissions, or reducing lengths of stay in an institution.~~

(c) Determinations of levels of care and the provision of long-term-care health services shall be determined in accordance with this section and shall be in accordance with the applicable provisions of § 40-8.9-9.

**40-8.10-4. Long-term care assessment and coordination.**

(a) The executive office of health and human services shall implement a long-term-care-options counseling program to provide individuals or their representative, 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; information on caregiver support services, including respite care; 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 a long-term-care-options consultation, if he or she so requests. Each individual who applies for Medicaid long-term-care services shall be provided with a long-term-care consultation.

(b) Core ~~and preventative~~ home- and community-based services defined and delineated in § 40-8.10-2 shall be provided only to those individuals who meet one of the levels of care provided for in this chapter. Other long-term-care services authorized by the federal government, such as medication management, may also be provided to Medicaid-eligible recipients who have established the requisite need.

(c) The assessments for individuals conducted in accordance with this section shall serve as the basis for individual budgets for those medical assistance recipients eligible to receive services utilizing a self-directed delivery system.

(d) Nothing in this section shall prohibit the secretary of the executive office of health and human services, or the directors of that office's departments from utilizing community agencies or contractors when appropriate to perform assessment functions outlined in this chapter.

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;

(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 & 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, Pub. L. No. 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, childcare assistance, and food assistance.

(16) The secretary shall convene, in consultation with the governor, an advisory working group to assist in the review and analysis of potential impacts of any adopted federal actions related to Medicaid programs. The working group shall develop options for administrative action or general assembly consideration that may be needed to address any federal funding changes that impact Rhode Island's Medicaid programs.

(i) The advisory working group may include, but not be limited to, the secretary of health and human services, director of management and budget, and designees from the following: state agencies, businesses, healthcare, public sector unions, and advocates.

(ii) As soon as practicable after the enactment federal budget for fiscal year 2026, but no later than October 31, 2025, the advisory working group shall forward a report to the governor, speaker of the house, and president of the senate containing the findings, recommendations and options for consideration to become compliant with federal changes prior to the governor's budget submission pursuant to § 35-3-7.

SECTION 9. Sections 42-14.5-2.1 and 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The Rhode Island Health Care Reform Act of 2004 — Health Insurance Oversight" are hereby amended to read as follows:

**42-14.5-2.1. Definitions.**

As used in this chapter:

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

(2) “Executive Office of Health and Human Services (EOHHS)” means the department that serves as “principal agency of the executive branch of state government” (§ 42-7.2-2) responsible for managing the departments and offices of: health (RIDOH), human services (DHS),

healthy aging (OHA), veterans services (VETS), children, youth and families (DCYF), and behavioral healthcare, developmental disabilities and hospitals (BHDDH). EOHHS is also designated as the single state agency with authority to administer the Medicaid program in Rhode Island.

(3) "Primary care services" means, for the purposes of the biennial review required under § 42-14.5-3(t), professional services rendered by primary care providers at a primary care site of care, including care management services performed in the context of team-based primary care.

~~(3)~~(4) "Rate review" means the process of reviewing and reporting of specific trending factors that influence the cost of service that informs rate setting.

~~(4)~~(5) "Rate setting" means the process of establishing rates for social and human service programs that are based on a thorough rate review process.

~~(5)~~(6) "Social and human service program" means a social, mental health, developmental disability, child welfare, juvenile justice, prevention services, habilitative, rehabilitative, substance use disorder treatment, residential care, adult or adolescent day services, vocational, employment and training, or aging service program or accommodations purchased by the state.

~~(6)~~(7) "Social and human service provider" means a provider of social and human service programs pursuant to a contract with the state or any subdivision or agency to include, but not be limited to, the department of children, youth and families (DCYF), the department of behavioral healthcare, developmental disabilities and hospitals (BHDDH), the department of human services (DHS), the department of health (DOH), and Medicaid.

~~(7)~~(8) "State government and the provider network" refers to the contractual relationship between a state agency or subdivision of a state agency and private companies the state contracts with to provide the network of mandated and discretionary social and human services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

that the workgroup meets and submits recommendations to the office of the health insurance commissioner, the office of the health insurance commissioner shall submit such recommendations to the health and human services committees of the Rhode Island house of representatives and the Rhode Island senate prior to the implementation of any such recommendations and subsequently shall submit a report to the general assembly by June 30, 2024. The report shall include the recommendations the commissioner may implement, with supporting rationale. The workgroup shall consider and make recommendations for:

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

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

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

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

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

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

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

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

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

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

(iv) Uniformity in the processing of claims by payors; and the processing of corrections to claims by providers and payors;

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

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

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

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

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

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

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

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

(v) Develop and implement the use of programs that implement selective prior authorization requirements, based on stratification of healthcare providers' performance and adherence to evidence-based medicine with the input of contracted healthcare providers and/or provider organizations. Such criteria shall be transparent and easily accessible to contracted

providers. Such selective prior authorization programs shall be available when healthcare providers participate directly with the insurer in risk-based payment contracts and may be available to providers who do not participate in risk-based contracts;

(vi) Require the review of medical services, including behavioral health services, and prescription drugs, subject to prior authorization on at least an annual basis, with the input of contracted healthcare providers and/or provider organizations. Any changes to the list of medical services, including behavioral health services, and prescription drugs requiring prior authorization, shall be shared via provider-accessible websites;

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

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

(B) Supporting:

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

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

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

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

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

(C) Requiring communication between healthcare providers, health plans, and patients to

facilitate continuity of care and minimize disruptions in needed treatment which may be satisfied by posting to provider-accessible websites or similar electronic portals or services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Utilization review;

(2) Contracting; and

(3) Licensing and regulation.

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

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

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

(r) To direct insurers toward policies and practices that address the behavioral health needs

of the public and greater integration of physical and behavioral healthcare delivery.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(x) Completion of the development of an assessment and review process that includes the following components: eligibility; scope of services; relationship of social and human service provider and the state; national and regional rate comparisons and accountability standards that result in recommended rate adjustments; and this process shall be completed by September 1, 2023, and conducted biennially hereafter. The biennial rate setting shall be consistent with payment requirements established in § 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. § 1396a(a)(30)(A), and all federal and state law, regulations, and quality and safety standards. The results and findings of this process shall be transparent, and public meetings shall be conducted to allow providers, recipients, and other interested parties an opportunity to ask questions and provide comment beginning in September 2023 and biennially thereafter; and

(xi) On or before September 1, 2026, the office shall publish and submit to the general assembly and the governor a one-time report making and justifying recommendations for adjustments to primary care services reimbursement and ..

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

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

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

SECTION 10. Rhode Island Medicaid Reform Act of 2008 Resolution.

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

WHEREAS, A legislative enactment is required pursuant to Rhode Island General Laws section 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 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) Nursing Facility Rate Increase Alignment with State Revenue Growth. The executive office of health and human services will pursue and implement any state plan amendments needed to limit rate increases for nursing facilities in SFY 2026 to the anticipated rate of growth of state tax revenue, estimated to be 2.3 percent.

(b) Home Care Rates. The secretary of the executive office of health and human services will pursue and implement any state plan amendments needed to eliminate annual rate increases for home care services.

(c) Establishment of interprofessional consultation program. The secretary of the executive office of health and human services will pursue and implement any state plan amendments needed to establish an interprofessional consultation program in Medicaid effective October 1, 2025.

(d) Long-term Behavioral Healthcare Beds. The secretary of the executive office of health and human services will pursue and implement any state plan amendments needed to establish a rate methodology in support of long-term care behavioral health inpatient units for non-governmental owned hospitals.

(e) Mobile Response and Stabilization Services (MRSS). The secretary of the executive office of health and human services will pursue and implement any state plan amendments needed to establish a rate of methodology for twenty-four-hour mobile response and stabilization services for children and youth ages two through twenty-one. This program shall convert the existing pilot Mobile Response and Stabilization Services program into a Medicaid-covered benefit to establish MRSS as the state-sanctioned crisis system for children's behavioral health that adheres to nationally recognized fidelity standard. The request for a state plan amendment shall be submitted no later than October 1, 2025, for a start date no later than October 1, 2026.

(f) 340 B Program. The secretary of the executive office of health and human services will pursue and implement any state plan or 1115 waiver amendments needed to effectuate a 340 B program.

The following terms have the following meanings:

(1) "340B drug" means a drug that has been subject to any offer for reduced prices by a manufacturer pursuant to 42 U.S.C. § 256b and is purchased by a covered entity as defined in 42 U.S.C. § 256b(a)(4);

(2) “340B-contract pharmacy” means a pharmacy, as defined in § 5-19.1-2, that dispenses 340B drugs on behalf of a 340B-covered entity;

(3) "340B covered entity" means an entity participating or authorized to participate in the

federal 340B drug discount program on behalf of a 340B-covered entity under contract;

(4) "Medicaid" means the Rhode Island Medicaid program;

(5) "Pharmaceutical manufacturer" means any person or entity that manufactures, distributes, or sells prescription drugs, directly or through another person or entity, in this state;

(6) "Pharmacy benefit manager" or "PBMs" means an entity doing business in the state that contracts to administer or manage prescription-drug benefits on behalf of Medicaid that provides prescription-drug benefits to Medicaid members;

The executive office will prohibit certain discriminatory actions related to reimbursement of 340B covered entities and 340B contract pharmacies as follows:

(a) With respect to reimbursement to a 340B covered entity for 340B drugs, a health insurer, pharmacy benefit manager, manufacturer, other third-party payor, or its agent shall not do any of the following:

(1) Reimburse a 340B covered entity or contract pharmacy for 340B drugs at a rate lower than that paid for the same drug or service to a non- 340B pharmacy;

(2) Impose fees, chargebacks, adjustments, or conditions on reimbursement to 340B covered entity, that differs from such terms or conditions applied to a non-340B entity, based on 340B status and participation in the federal 340B drug discount program set forth in 42 U.S.C. § 256b including, without limitation, any of the following:

(3) Deny or limit participation in standard or preferred pharmacy networks based on 340B status;

(4) Impose requirements relating to the frequency or scope of audits of inventory management systems inconsistent with the federal 340B drug pricing program;

(5) Require submission of claims-level data or documentation that identifies 340B drugs as a condition of reimbursement or pricing, unless it is required by the Centers for Medicare and Medicaid Services;

(6) Require a 340B covered entity to reverse, resubmit, or clarify a claim after the initial adjudication unless these actions are in the normal course of pharmacy business and not related to 340B drug pricing;

(7) Interfere with, or limit, a 340B covered entity's choice to use a contract pharmacy for drug distribution or dispensing;

(8) Include any other provision in a contract between a health insurer, pharmacy benefit manager, manufacturer, or other third-party payor and a 340B covered entity that differ from the terms and conditions applied to entities that are not 340B covered entities, that discriminates against the 340B covered entity or prevents or interferes with an individual's choice to receive a

prescription drug from a 340B covered entity, including the administration of such drugs in person or via direct delivery, mail, or other form of shipment, or create a restriction or additional charge on a patient who chooses to receive drugs from a 340B covered entity;

(9) Place a restriction or additional charge on a patient who chooses to receive 340B drugs from a 340B covered entity if such restriction or additional charge differs from the terms and conditions applied where patients choose to receive drugs that are not 340B drugs from an entity that is not a 340B covered entity or from a pharmacy that is not a 340B contract pharmacy;

(10) Exclude any 340B covered entity from a health insurer, pharmacy benefit manager, or other third-party payor network or refuse to contract with a 340B covered entity for reasons other than those that apply equally to a non-340B entity;

(11) Impose any other restrictions, requirements, practices, or policies that are not imposed on a non- 340B entity;

(b) Nothing in this section is intended to limit Medicaid fee-for-service or managed care program's or pharmacy benefit manager’s ability to use preferred pharmacies or develop preferred networks so long as participation is not based on an entity’s status as a 340B covered entity and participation in the network is subject to the same terms and conditions as a non-340B covered entity;

(c) Annually on or before April 1, each 340B covered entity participating in the federal 340B drug pricing program established by 42 U.S.C. §256b shall submit to the office of the Governor, the Speaker of the House of Representatives, the President of the Senate, and Auditor General a report detailing the 340B covered entity’s participation in the program during the previous calendar year, which report shall be posted on the state Auditor General’s website and which shall contain at least the following information:

(1) the aggregated acquisition cost for all prescription drugs that the 340B covered entity obtained through the 340B program during the previous calendar year;

(2) the aggregated payment amount that the 340B covered entity received for drugs, under the 340B program and dispensed or administered to patients enrolled in commercial and Medicare Supplemental plans;

(3) the aggregated payment amount that the 340B covered entity made:

(i) to contract pharmacies to dispense drugs to its patients under the 340B program during the previous calendar year;

(ii) to any other outside vendor for managing, administering, or facilitating any aspect of the 340B covered entity’s drug program during the previous calendar year; and

(iii) for all other expenses related to administering the 340B program, including staffing,

operational, and administrative expenses, during the previous calendar year;

(4) The names of all vendors, including split billing vendors, and contract pharmacies, with which the 340B covered entity contracted to provide services associated with the covered entity's 340B program participation during the previous calendar year;

(5) The number of claims for all prescription drugs the 340B covered entity obtained through the 340B program during the previous calendar year, including the total number of claims and the number of claims reported by commercial and Medicare Supplemental plans; and be it further

(g) Primary Care Rates. The secretary of the executive office of health and human services is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the department's rules, regulations, and procedures to set Medicaid reimbursement rates for primary care services, as defined by the executive office, equal to one hundred percent (100%) of the Medicare reimbursement rates for primary care services. The reimbursement rates will be annually updated to reflect one hundred percent (100%) of the Medicare reimbursement rates for primary care.

(h) Medicare Savings Programs. The secretary of the executive office of health and human services is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the applicable department's rules, regulations, and procedures required to implement income disregards for the Qualified Medicare Savings Program to increase eligibility up to one hundred and twenty-five percent (125%) of federal poverty and the Qualified Individual Medicare Savings Program up to one hundred and sixty-eight percent (168%) of federal poverty effective January 1, 2026. Premium payments for the Qualified Individuals will be one hundred percent (100%) federally funded up to the amount of the federal allotment and the Secretary shall discontinue enrollment in the Qualified Individual program when the Part B premiums meet the federal allotment.

(i) Prior Authorization Pilot Program. The secretary of the executive office of health and human services will pursue and implement any state plan or 1115 waiver amendments needed to effectuate a prior authorization pilot program. The executive office of health and human services will conduct a three-year pilot within Medicaid fee-for-service and managed care program, that eliminates prior authorization requirements for any service, treatment, or procedure ordered by a primary care provider in the normal course of providing primary care treatment, which shall take effect on October 1, 2025, and sunset on October 1, 2028.

For purposes of the pilot program, a primary care provider means a provider within the practice type of family medicine, geriatric medicine, internal medicine, obstetrics and gynecology,

or pediatrics with the following professional credentials: a doctor of medicine or doctor of osteopathic medicine, a nurse practitioner, or a physician assistant, and who is credentialed with Medicaid fee-for-service or managed care organization. Prior authorization means the pre-service assessment for purposes of utilization review that a Primary Care Provider is required by Medicaid fee-for-service or managed care organization to undergo before a covered healthcare service is approved for a patient.

The executive office of health and human services will provide an annual report to the Speaker of the House, the Senate President, the Office of the Governor and the Office of the Health Insurance Commissioner that includes recommendations on the further simplification and reduction of administrative burdens related to the utilization of prior authorizations in primary care and data and analytics demonstrating the impact the pilot program is having on utilization and patient care.

RESOLVED, That EOHHS will conduct a three (3) year pilot within Medicaid fee-for-service and managed care program, that eliminates Prior Authorization requirements for any service, treatment, or procedure ordered by a Primary Care Provider in the normal course of providing primary care treatment, which shall take effect on October I, 2025, and sunset on October 1, 2028; and be it further

RESOLVED, That for purposes of this pilot a "Primary Care Provider" means a provider within the practice type of family medicine, geriatric medicine, internal medicine, obstetrics and gynecology, or pediatrics with the following professional credentials: a doctor of medicine or doctor of osteopathic medicine, a nurse practitioner, or a physician assistant, and who is credentialed with Medicaid fee-for-service or managed care organization; and be it further

RESOLVED, That for purposes of this pilot "Prior Authorization" means the pre-service assessment for purposes of utilization review that a Primary Care Provider is required by Medicaid fee-for-service or managed care organization to undergo before a covered healthcare service is approved for a patient; and be it further

RESOLVED, That EOHHS will provide an annual report to the Speaker of the House, the Senate President, the Office of the Governor and the Office of the Health Insurance Commissioner that includes recommendations on the further simplification and reduction of administrative burdens related to the utilization of prior authorizations in primary care and data and analytics demonstrating the impact the pilot program is having on utilization and patient care; and be it further

RESOLVED, That the General Assembly hereby approves the above-referenced Medicaid pilot proposals; and be it further

RESOLVED, That the Secretary of the EOHHS is hereby ordered and directed to pursue

and implement any state plan or 1115 waiver amendments needed to effectuate this pilot program.

Now, therefore, be it:

RESOLVED, That the General Assembly hereby approves the above-referenced proposals; and be it further;

RESOLVED, That the secretary of the executive office of health and human services is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the applicable department's rules, regulations and procedures approved herein and as authorized by Rhode Island General Laws section 42-12.4; and be it further;

RESOLVED, That this Joint Resolution shall take effect on July 1, 2025.

SECTION 11. This article shall take effect upon passage, except Section 10 which shall take effect as of July 1, 2025.