

ARTICLE 8 AS AMENDED

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:

(a) There is 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~~ years 2026 and 2027 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, annually 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 (1) The inpatient hospital licensing fee for Tier 2 is equal to two and sixty-three hundredths
2 percent (2.63%) of the inpatient net patient-services revenue derived from inpatient net patient-
3 services revenue of every Tier 2 hospital.

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

7 (e) Tier 3 is composed of hospitals that are Medicare-designated low-volume hospitals and
8 rehabilitative hospitals.

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

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

15 (f) There is also imposed a hospital licensing fee for state fiscal year 2024 against state-
16 government owned and operated hospitals in the state as defined herein. The hospital licensing fee
17 is equal to five and twenty-five hundredths percent (5.25%) of the net patient-services revenue of
18 every hospital for the hospital's first fiscal year ending on or after January 1, 2022. There is also
19 imposed a hospital licensing fee for state fiscal years 2025, ~~and 2026,~~ and 2027 against state-
20 government owned and operated hospitals in the state as defined herein equal to five and twenty-
21 five hundredths percent (5.25%) of the net patient-services revenue of every hospital for the
22 hospital's first fiscal year ending on or after January 1, 2023.

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

26 (h) This hospital licensing fee shall be administered and collected by the tax administrator,
27 division of taxation within the department of revenue, and all the administration, collection, and
28 other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to
29 the tax administrator before June 25 of each fiscal year, and payments shall be made by electronic
30 transfer of monies to the tax administrator and deposited to the general fund. Every hospital shall,
31 on or before August 1 of each fiscal year, make a return to the tax administrator containing the
32 correct computation of inpatient and outpatient net patient-services revenue for the hospital data
33 referenced in ~~subsection (a) and/or (b)~~ this section, and the licensing fee due upon that amount. All
34 returns shall be signed by the hospital's authorized representative, subject to the pains and penalties

1 of perjury.

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

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

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

9 (3) "Hospital" means the actual facilities and buildings in existence in Rhode Island,
10 licensed pursuant to § 23-17-1 et seq. on June 30, 2010, and thereafter any premises included on
11 that license, regardless of changes in licensure status pursuant to chapter 17.14 of this title (hospital
12 conversions) and § 23-17-6(b) (change in effective control), that provides short-term acute inpatient
13 and/or outpatient care to persons who require definitive diagnosis and treatment for injury, illness,
14 disabilities, or pregnancy. Notwithstanding the preceding language, the negotiated Medicaid
15 managed care payment rates for a court-approved purchaser that acquires a hospital through
16 receivership, special mastership, or other similar state insolvency proceedings (which court-
17 approved purchaser is issued a hospital license after January 1, 2013) shall be based upon the newly
18 negotiated rates between the court-approved purchaser and the health plan, and such rates shall be
19 effective as of the date that the court-approved purchaser and the health plan execute the initial
20 agreement containing the newly negotiated rate. The rate-setting methodology for inpatient hospital
21 payments and outpatient hospital payments set forth in §§ 40-8-13.4(b) and 40-8-13.4(b)(2),
22 respectively, shall thereafter apply to negotiated increases for each annual twelve-month (12)
23 period as of July 1 following the completion of the first full year of the court-approved purchaser's
24 initial Medicaid managed care contract.

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

26 (5) "Inpatient net patient-services revenue" means the charges related to inpatient care
27 services less (i) Charges attributable to charity care; (ii) Bad debt expenses; and (iii) Contractual
28 allowances.

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

32 (7) "Net patient-services revenue" means the charges related to patient care services less
33 (i) Charges attributable to charity care; (ii) Bad debt expenses; and (iii) Contractual allowances.

34 (8) "Non-government owned hospitals" means a hospital not owned and operated by the

1 state of Rhode Island.

2 (9) "Outpatient net patient-services revenue" means the charges related to outpatient care
3 services less (i) Charges attributable to charity care; (ii) Bad debt expenses; and (iii) Contractual
4 allowances.

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

7 (11) "State-government owned and operated hospitals" means a hospital facility licensed
8 by the Rhode Island department of health, owned and operated by the state of Rhode Island.

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

13 (k) The licensing fee imposed by subsections (a) through (f) shall apply to hospitals as
14 defined herein that are duly licensed on July 1, 2024, and shall be in addition to the inspection fee
15 imposed by § 23-17-38 and to any licensing fees previously imposed in accordance with this
16 section.

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

19 **40-8-3. Eligibility requirements.**

20 Medical care benefits shall be provided under this chapter to at least any person:

21 (1) Who has attained the age of sixty-five (65) years; or

22 (2) Who has no vision or whose vision is so defective as to prevent performance of ordinary
23 activities for which eyesight is essential; or

24 (3) Who is at least eighteen (18) years of age and who is permanently and totally disabled;
25 or

26 (4) Who is under the age of eighteen (18) years, and who has been deprived of parental
27 support or care by reason of the death, continued absence from the home, unemployment, or
28 physical or mental incapacity of a parent (called hereafter "dependent child") and who is living
29 with a relative in a place of residence maintained by one or more of these relatives as his or her or
30 their own home, or is in foster boarding care; or

31 (5) The relative as defined in subsection (8) of § 40-8-2, with whom the dependent child is
32 living; provided the person:

33 (i) Is a resident of this state; and

34 (ii) Is not receiving public assistance under the provisions of § 40-5.1-9(b) [repealed] or §

1 40-6-27; and

2 (iii) Is not an inmate of a public institution other than as a patient in a medical institution;
3 and

4 (iv) Is not a patient in an institution for tuberculosis or mental disease, unless the person
5 has attained the age of sixty-five (65) years; provided, however, that this clause shall become void
6 and of no effect if and when legislation enacted by the Congress of the United States shall become
7 effective providing for payments for medical care on behalf of persons who have not attained the
8 age of sixty-five (65) years who are patients in an institution for tuberculosis or mental disease; and

9 (v) Has insufficient income and resources. The department shall establish income and
10 resource rules, regulations, and limits in accordance with Title XIX of the federal Social Security
11 Act, 42 U.S.C. § 1396 et seq., as applicable to the medically needy only applicants and recipients.
12 The income limits established by the department must be more than the AFDC standard in effect
13 on July 16, 1996, under the Rhode Island state plan approved under part A of Title IV of the federal
14 Social Security Act, 42 U.S.C. § 601 et seq., but shall not be more than one hundred thirty-three
15 and one-third percent (133⅓%) of the AFDC standard in effect on July 16, 1996, under the Rhode
16 Island state plan approved under part A of Title IV of the federal Social Security Act; provided,
17 however, that subject to the maximum percentage increase allowable under § 1931(b)(2)(B), the
18 department shall increase the income limits on July 1, 1999, by six and six-tenths percent (6.6%),
19 and on January 1, of each year commencing in the year 2000 by a percentage equal to the annual
20 federal adjustment percentage as determined under the provisions of Title XVI of the federal Social
21 Security Act, 42 U.S.C. § 1381 et seq. The department shall establish resource limits equal to ~~two~~
22 ~~thousand dollars (\$2,000)~~ eight thousand dollars (\$8,000) for an individual and ~~three thousand~~
23 ~~dollars (\$3,000)~~ twelve thousand dollars (\$12,000) for a family. Provided, however, the department
24 shall apply to the United States Department of Health and Human Services for a waiver relating to
25 application of the reduced resource limit, and subject to the granting of the waiver by the Secretary
26 of the United States Department of Health and Human Services, the resource limit shall be applied
27 to all applicants who: (A) Become eligible for benefits under this chapter on or after the effective
28 date of this amendment and (B) Who were not receiving benefits under this chapter prior to July 1,
29 1993. In the event the secretary does not approve the waiver request, the current department
30 regulations relating to resource limits shall remain in effect for all eligible beneficiaries.

31 For the purposes of this subsection, a vehicle necessary to transport a family member with
32 a disability, where the vehicle is specially equipped to meet the specific needs of the person with a
33 disability or if the vehicle is a special type of vehicle that makes it possible to transport the person
34 with the disability, shall not be counted as resources of the applicants and recipients.

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

3 **40-8.3-2. Definitions.**

4 As used in this chapter:

5 (1) "Base year" means, for the purpose of calculating a disproportionate share payment for
6 any fiscal year ending after September 30, ~~2024~~2025, the period from October 1, ~~2022~~2023,
7 through September 30, ~~2023~~2024, and for any fiscal year ending after September 30, ~~2025~~2026,
8 the period from October 1, ~~2023~~2024, through September 30, ~~2024~~2025.

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

13 (3) "Participating hospital" means any nonpsychiatric hospital that:

14 (i) Was licensed as a hospital in accordance with chapter 17 of title 23 during the base year
15 and shall mean the actual facilities and buildings in existence in Rhode Island, licensed pursuant to
16 § 23-17-1 et seq. on June 30, 2010, and thereafter any premises included on that license, regardless
17 of changes in licensure status pursuant to chapter 17.14 of title 23 (hospital conversions) and § 23-
18 17-6(b) (change in effective control), that provides acute inpatient and/or outpatient care to persons
19 who require definitive diagnosis and treatment for injury, illness, disabilities, or pregnancy.
20 Notwithstanding the preceding language, the negotiated Medicaid managed care payment rates for
21 a court-approved purchaser that acquires a hospital through receivership, special mastership, or
22 other similar state insolvency proceedings (which court-approved purchaser is issued a hospital
23 license after January 1, 2013), shall be based upon the newly negotiated rates between the court-
24 approved purchaser and the health plan, and the rates shall be effective as of the date that the court-
25 approved purchaser and the health plan execute the initial agreement containing the newly
26 negotiated rate. The rate-setting methodology for inpatient hospital payments and outpatient
27 hospital payments set forth in §§ 40-8-13.4(b)(1)(ii)(C) and 40-8-13.4(b)(2), respectively, shall
28 thereafter apply to negotiated increases for each annual twelve-month (12) period as of July 1
29 following the completion of the first full year of the court-approved purchaser's initial Medicaid
30 managed care contract;

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

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

1 (4) "Uncompensated-care costs" means, as to any hospital, the sum of: (i) The cost incurred
2 by the hospital during the base year for inpatient or outpatient services attributable to charity care
3 (free care and bad debts) for which the patient has no health insurance or other third-party coverage
4 less payments, if any, received directly from such patients; (ii) The cost incurred by the hospital
5 during the base year for inpatient or outpatient services attributable to Medicaid beneficiaries less
6 any Medicaid reimbursement received therefor; and (iii) the sum of subsections (4)(i) and (4)(ii) of
7 this section shall be offset by the estimated hospital's commercial equivalent rates state directed
8 payment for the current SFY in which the disproportionate share hospital (DSH) payment is made.
9 The sum of subsections (4)(i), (4)(ii), and (4)(iii) of this section shall be multiplied by the
10 uncompensated care index.

11 (5) "Uncompensated-care index" means the annual percentage increase for hospitals
12 established pursuant to § 27-19-14 [repealed] for each year after the base year, up to and including
13 the payment year; provided, however, that the uncompensated-care index for the payment year
14 ending September 30, 2007, shall be deemed to be five and thirty-eight hundredths percent (5.38%),
15 and that the uncompensated-care index for the payment year ending September 30, 2008, shall be
16 deemed to be five and forty-seven hundredths percent (5.47%), and that the uncompensated-care
17 index for the payment year ending September 30, 2009, shall be deemed to be five and thirty-eight
18 hundredths percent (5.38%), and that the uncompensated-care index for the payment years ending
19 September 30, 2010, September 30, 2011, September 30, 2012, September 30, 2013, September
20 30, 2014, September 30, 2015, September 30, 2016, September 30, 2017, September 30, 2018,
21 September 30, 2019, September 30, 2020, September 30, 2021, September 30, 2022, September
22 30, 2023, September 30, 2024, September 30, 2025, ~~and~~ September 30, 2026, [and September 30,](#)
23 [2027](#) shall be deemed to be five and thirty hundredths percent (5.30%).

24 **40-8.3-3. Implementation.**

25 ~~(a) For federal fiscal year 2024, commencing on October 1, 2023, and ending September~~
26 ~~30, 2024, the executive office of health and human services shall submit to the Secretary of the~~
27 ~~United States Department of Health and Human Services a state plan amendment to the Rhode~~
28 ~~Island Medicaid DSH Plan to provide:~~

29 ~~(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of~~
30 ~~\$14.8 million, shall be allocated by the executive office of health and human services to the Pool~~
31 ~~D component of the DSH Plan; and~~

32 ~~(2) That the Pool D allotment shall be distributed among the participating hospitals in direct~~
33 ~~proportion to the individual participating hospital's uncompensated care costs for the base year,~~
34 ~~inflated by the uncompensated care index to the total uncompensated care costs for the base year~~

1 ~~inflated by the uncompensated-care index for all participating hospitals. The disproportionate share~~
2 ~~payments shall be made on or before June 30, 2024, and are expressly conditioned upon approval~~
3 ~~on or before June 23, 2024, by the Secretary of the United States Department of Health and Human~~
4 ~~Services, or their authorized representative, of all Medicaid state plan amendments necessary to~~
5 ~~secure for the state the benefit of federal financial participation in federal fiscal year 2024 for the~~
6 ~~disproportionate share payments.~~

7 ~~(b)~~(a) For federal fiscal year 2025, commencing on October 1, 2024, and ending on
8 September 30, 2025, the executive office of health and human services shall submit to the Secretary
9 of the United States Department of Health and Human Services a state plan amendment to the
10 Rhode Island Medicaid DSH plan to provide:

11 (1) The creation of Pool C which allots no more than twelve million nine hundred thousand
12 dollars (\$12,900,000) to Medicaid eligible government-owned hospitals;

13 (2) That the DSH plan to all participating hospitals, not to exceed an aggregate limit of
14 \$27.7 million, shall be allocated by the executive office of health and human services to the Pool
15 C and D components of the DSH plan;

16 (3) That the Pool D allotment shall be distributed among the participating hospitals in direct
17 proportion to the individual participating hospital's uncompensated-care costs for the base year,
18 inflated by the uncompensated-care index to the total uncompensated-care costs for the base year
19 inflated by the uncompensated-care index of all participating hospitals. The disproportionate share
20 payments shall be made on or before June 30, 2025, and are expressly conditioned upon approval
21 on or before June 23, 2025, by the Secretary of the United States Department of Health and Human
22 Services, or their authorized representative, of all Medicaid state plan amendments necessary to
23 secure for the state the benefit of federal financial participation in federal fiscal year 2025 for the
24 disproportionate share payments; and

25 (4) That the Pool C allotment shall be distributed among the participating hospitals in direct
26 proportion to the individual participating hospital's uncompensated-care costs for the base year,
27 inflated by the uncompensated-care index to the total uncompensated-care cost for the base year
28 inflated by the uncompensated-care index of all participating hospitals. The disproportionate share
29 payments shall be made on or before June 30, 2025, and are expressly conditioned upon approval
30 on or before June 23, 2025, by the Secretary of the United States Department of Health and Human
31 Services, or their authorized representative, of all Medicaid state plan amendments necessary to
32 secure for the state the benefit of federal financial participation in federal fiscal year 2025 for the
33 disproportionate share payments.

34 ~~(e)~~(b) For federal fiscal year 2026, commencing on October 1, 2025, and ending on

1 September 30, 2026, the executive office of health and human services shall submit to the Secretary
2 of the United States Department of Health and Human Services a state plan amendment to the
3 Rhode Island Medicaid DSH plan to provide:

4 (1) That the DSH plan to all participating hospitals, not to exceed an aggregate limit of
5 \$13.9 million, shall be allocated by the executive office of health and human services to the Pool
6 C and D components of the DSH plan. Pool C shall not exceed an aggregate limit of \$12.9 million.
7 Pool D shall not exceed an aggregate limit of \$1.0 million;

8 (2) That the Pool C allotment shall be distributed among the participating hospitals in direct
9 proportion to the individual participating hospital's uncompensated-care costs for the base year,
10 inflated by the uncompensated-care index to the total uncompensated-care cost for the base year
11 inflated by the uncompensated-care index of all participating hospitals. The disproportionate share
12 payments shall be made on or before June 30, 2026, and are expressly conditioned upon approval
13 on or before June 23, 2026, by the Secretary of the United States Department of Health and Human
14 Services, or their authorized representative, of all Medicaid state plan amendments necessary to
15 secure for the state the benefit of federal financial participation in federal fiscal year 2026 for the
16 disproportionate share payments; and

17 (3) That the Pool D allotment shall be distributed among the participating hospitals in direct
18 proportion to the individual participating hospital's uncompensated-care costs for the base year,
19 inflated by the uncompensated-care index to the total uncompensated-care costs for the base year
20 inflated by the uncompensated-care index of all participating hospitals. The disproportionate share
21 payments shall be made on or before June 30, 2026, and are expressly conditioned upon approval
22 on or before June 23, 2026, by the Secretary of the United States Department of Health and Human
23 Services, or their authorized representative, of all Medicaid state plan amendments necessary to
24 secure for the state the benefit of federal financial participation in federal fiscal year 2026 for the
25 disproportionate share payments.

26 (c) For federal fiscal year 2027, commencing on October 1, 2026, and ending on September
27 30, 2027, the DSH plan for all participating hospitals shall not exceed an aggregate limit of thirty-
28 eight million nine hundred thousand dollars (\$38,900,000) and shall be allocated by the executive
29 office of health and human services to the Pool C and D components of the DSH plan. The Pool C
30 component of the DSH plan shall not exceed an aggregate limit of twelve million nine hundred
31 thousand dollars (\$12,900,000). The Pool D component of the DSH plan shall not exceed an
32 aggregate limit of twenty-six million dollars (\$26,000,000).

33 (1) The Pool C allotment shall be distributed among the participating hospitals in direct
34 proportion to each individual participating hospital's uncompensated-care costs for the base year,

1 [inflated by the uncompensated-care index as described in § 40-8.3-2\(5\). The DSH payments shall](#)
2 [be made on or before June 30, 2027; and,](#)

3 [\(2\) The Pool D allotment shall be distributed among the participating hospitals in direct](#)
4 [proportion to the individual participating hospital's uncompensated-care costs for the base year,](#)
5 [inflated by the uncompensated-care index as described in § 40-8.3-2\(5\). The disproportionate share](#)
6 [payments shall be made on or before June 30, 2027.](#)

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

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

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

14 SECTION 4. Section 40-8.5-1 of the General Laws in Chapter 40-8.5 entitled "Health Care
15 for Elderly and Disabled Residents Act" is hereby amended to read as follows:

16 **40-8.5-1. Categorically needy medical assistance coverage.**

17 The department of human services is hereby authorized and directed to amend its Title XIX
18 state plan to provide for categorically needy medical assistance coverage as permitted pursuant to
19 Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as amended, to individuals who are
20 sixty-five (65) years or older or are disabled, as determined under § 1614(a)(3) of the Social
21 Security Act, 42 U.S.C. § 1382c(a)(3), as amended, whose income does not exceed one hundred
22 percent (100%) of the federal poverty level (as revised annually) applicable to the individual's
23 family size, and whose resources do not exceed ~~four thousand dollars (\$4,000)~~ [eight thousand](#)
24 [dollars \(\\$8,000\)](#) per individual, or ~~six thousand dollars (\$6,000)~~ [twelve thousand dollars \(\\$12,000\)](#)
25 per couple. The department shall provide medical assistance coverage to such elderly or disabled
26 persons in the same amount, duration, and scope as provided to other categorically needy persons
27 under the state's Title XIX state plan.

28 SECTION 5. Section 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical
29 Assistance — Long-Term Care Service and Finance Reform" is hereby amended to read as follows:

30 **40-8.9-9. Long-term-care rebalancing system reform goal.**

31 (a) Notwithstanding any other provision of state law, the executive office of health and
32 human services is authorized and directed to apply for, and obtain, any necessary waiver(s), waiver
33 amendment(s), and/or state-plan amendments from the Secretary of the United States Department
34 of Health and Human Services, and to promulgate rules necessary to adopt an affirmative plan of

1 program design and implementation that addresses the goal of allocating a minimum of fifty percent
2 (50%) of Medicaid long-term-care funding for persons aged sixty-five (65) and over and adults
3 with disabilities, in addition to services for persons with developmental disabilities, to home- and
4 community-based care; provided, further, the executive office shall report annually as part of its
5 budget submission, the percentage distribution between institutional care and home- and
6 community-based care by population and shall report current and projected waiting lists for long-
7 term-care and home- and community-based care services. The executive office is further authorized
8 and directed to prioritize investments in home- and community-based care and to maintain the
9 integrity and financial viability of all current long-term-care services while pursuing this goal.

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

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

1 (1) The executive office shall continue to apply the level-of-care criteria in effect on April
2 1, 2021, for any recipient determined eligible for and receiving Medicaid-funded long-term services
3 and supports in a nursing facility, hospital, or intermediate-care facility for persons with intellectual
4 disabilities on or before that date, unless:

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

7 (ii) The recipient chooses home- and community-based services over the nursing facility,
8 hospital, or intermediate-care facility for persons with intellectual disabilities. For the purposes of
9 this section, a failed community placement, as defined in regulations promulgated by the executive
10 office, shall be considered a condition of clinical eligibility for the highest level of care. The
11 executive office shall confer with the long-term-care ombudsperson with respect to the
12 determination of a failed placement under the ombudsperson's jurisdiction. Should any Medicaid
13 recipient eligible for a nursing facility, hospital, or intermediate-care facility for persons with
14 intellectual disabilities as of April 1, 2021, receive a determination of a failed community
15 placement, the recipient shall have access to the highest level of care; furthermore, a recipient who
16 has experienced a failed community placement shall be transitioned back into their former nursing
17 home, hospital, or intermediate-care facility for persons with intellectual disabilities whenever
18 possible. Additionally, residents shall only be moved from a nursing home, hospital, or
19 intermediate-care facility for persons with intellectual disabilities in a manner consistent with
20 applicable state and federal laws.

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

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

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

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

33 (d) The executive office is further authorized to consolidate all home- and community-
34 based services currently provided pursuant to 42 U.S.C. § 1396n into a single system of home- and

1 community-based services that include options for consumer direction and shared living. The
2 resulting single home- and community-based services system shall replace and supersede all 42
3 U.S.C. § 1396n programs when fully implemented. Notwithstanding the foregoing, the resulting
4 single program home- and community-based services system shall include the continued funding
5 of assisted-living services at any assisted-living facility financed by the Rhode Island housing and
6 mortgage finance corporation prior to January 1, 2006, and shall be in accordance with chapter 66.8
7 of title 42 as long as assisted-living services are a covered Medicaid benefit.

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

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

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

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

24 The standards for adult day services for persons eligible for Medicaid-funded long-term
25 services may differ from those who do not meet the clinical/functional criteria set forth in § 40-
26 8.10-3.

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

1 providers.

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

6 (ii) A prospective base adjustment, effective not later than July 1, 2018, of twenty percent
7 (20%) of the current base rate for home-care providers, home nursing care providers, and hospice
8 providers contracted with the executive office of health and human services and its subordinate
9 agencies to deliver Medicaid fee-for-service skilled nursing and therapeutic services and hospice
10 care.

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

15 (iv) On the first of July in each year, beginning on July 1, 2019, the executive office of
16 health and human services will initiate an annual inflation increase to the base rate for home-care
17 providers, home nursing care providers, and hospice providers contracted with the executive office
18 and its subordinate agencies to deliver Medicaid fee-for-service personal care attendant services,
19 skilled nursing and therapeutic services and hospice care. The base rate increase shall be a
20 percentage amount equal to the New England Consumer Price Index card as determined by the
21 United States Department of Labor for medical care and for compliance with all federal and state
22 laws, regulations, and rules, and all national accreditation program requirements, except as of July
23 1, 2025, and thereafter, when no annual inflation increase shall occur for these rates.

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

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

34 (i) Employers must pass on one hundred percent (100%) of the shift differential modifier

1 increase per fifteen-minute (15) unit of service to the CNAs who rendered such services. This
2 compensation shall be provided in addition to the rate of compensation that the employee was
3 receiving as of June 30, 2021. For an employee hired after June 30, 2021, the agency shall use not
4 less than the lowest compensation paid to an employee of similar functions and duties as of June
5 30, 2021, as the base compensation to which the increase is applied.

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

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

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

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

29 (h) The executive office shall implement a long-term-care-options counseling program to
30 provide individuals, or their representatives, or both, with long-term-care consultations that shall
31 include, at a minimum, information about: long-term-care options, sources, and methods of both
32 public and private payment for long-term-care services and an assessment of an individual's
33 functional capabilities and opportunities for maximizing independence. Each individual admitted
34 to, or seeking admission to, a long-term-care facility, regardless of the payment source, shall be

1 informed by the facility of the availability of the long-term-care-options counseling program and
2 shall be provided with long-term-care-options consultation if they so request. Each individual who
3 applies for Medicaid long-term-care services shall be provided with a long-term-care consultation.

4 (i) The executive office shall implement, no later than January 1, 2024, a statewide network
5 and rate methodology for conflict-free case management for individuals receiving Medicaid-funded
6 home and community-based services. The executive office shall coordinate implementation with
7 the state's health and human services departments and divisions authorized to deliver Medicaid-
8 funded home and community-based service programs, including the department of behavioral
9 healthcare, developmental disabilities and hospitals; the department of human services; and the
10 office of healthy aging. It is in the best interest of the Rhode Islanders eligible to receive Medicaid
11 home and community-based services under this chapter, title 40.1, title 42, or any other general
12 laws to provide equitable access to conflict-free case management that shall include person-
13 centered planning, service arranging, and quality monitoring in the amount, duration, and scope
14 required by federal law and regulations. It is necessary to ensure that there is a robust network of
15 qualified conflict-free case management entities with the capacity to serve all participants on a
16 statewide basis and in a manner that promotes choice, self-reliance, and community integration.
17 The executive office, as the designated single state Medicaid authority and agency responsible for
18 coordinating policy and planning for health and human services under § 42-7.2-1 et seq., is directed
19 to establish a statewide conflict-free case management network under the management of the
20 executive office and to seek any Medicaid waivers, state plan amendments, and changes in rules,
21 regulations, and procedures that may be necessary to ensure that recipients of Medicaid home and
22 community-based services have access to conflict-free case management in a timely manner and in
23 accordance with the federal requirements that must be met to preserve financial participation.

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

31 (k) To ensure persons with long-term-care needs who remain living at home have adequate
32 resources to deal with housing maintenance and unanticipated housing-related costs, the secretary
33 is authorized to ~~develop higher~~ implement resource eligibility limits of eight thousand dollars
34 (\$8,000) for single persons ~~or~~ and twelve thousand dollars (\$12,000) for couples and obtain any

1 state plan or waiver authorities necessary to change the financial eligibility criteria for long-term
2 services and supports to enable beneficiaries receiving home and community waiver services to
3 have the resources to continue living in their own homes or rental units or other home-based
4 settings.

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

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

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

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

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

19 SECTION 6. Section 42-7.2-5 of the General Laws in Chapter 42-7.2 entitled "Office of
20 Health and Human Services" is hereby amended to read as follows:

21 **42-7.2-5. Duties of the secretary.**

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

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

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

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

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

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

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

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

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

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

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

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

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

9 (vi) Information submitted to the Centers for Medicare & Medicaid Services for the
10 mandatory annual state reporting of the Core Set of Children's Health Care Quality Measures for
11 Medicaid and Children's Health Insurance Program, behavioral health measures on the Core Set of
12 Adult Health Care Quality Measures for Medicaid and the Core Sets of Health Home Quality
13 Measures for Medicaid to ensure compliance with the Bipartisan Budget Act of 2018, Pub. L. No.
14 115-123.

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

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

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

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

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

31 (iii) Develop all opportunities to maximize resources by leveraging the state's purchasing
32 power, centralizing fiscal service functions related to budget, finance, and procurement,
33 centralizing communication, policy analysis and planning, and information systems and data
34 management, pursuing alternative funding sources through grants, awards, and partnerships and

1 securing all available federal financial participation for programs and services provided EOHHS-
2 wide;

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

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

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

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

18 (7) Prepare and integrate comprehensive budgets for the health and human services
19 departments and any other functions and duties assigned to the office. The budgets shall be
20 submitted to the state budget office by the secretary, for consideration by the governor, on behalf
21 of the state's health and human services agencies in accordance with the provisions set forth in §
22 35-3-4.

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

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

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

34 (11) Provide regular and timely reports to the governor and make recommendations with

1 respect to the state's health and human services agenda.

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

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

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

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

17 (16) Ensure that insurers minimize administrative burdens on providers that may delay
18 medically necessary care, including requiring that insurers do not impose a prior authorization
19 requirement for any admission, item, service, treatment, or procedure ordered by an in-network
20 primary care provider. Provided, the prohibition shall not be construed to prohibit prior
21 authorization requirements for prescription drugs. Provided further, that as used in this subsection
22 (16) of this section, the terms "insurer," "primary care provider," and "prior authorization" means
23 the same as those terms are defined in § 27-18.9-2.

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

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

32 (ii) As soon as practicable after the enactment federal budget for fiscal year 2026, but no
33 later than October 31, 2025, the advisory working group shall forward a report to the governor,
34 speaker of the house, and president of the senate containing the findings, recommendations and

1 options for consideration to become compliant with federal changes prior to the governor's budget
2 submission pursuant to § 35-3-7.

3 (18) The secretary shall implement, in coordination with the health insurance
4 commissioner, the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model
5 Grant Program and produce a report to the governor and the general assembly outlining the
6 program's activities. The report, due no later than October 31, 2026, and annually thereafter by
7 October 31 for the duration of the state's participation in the grant, should address, at minimum:

8 (i) A description of activities and funding uses during the grant year;

9 (ii) The legislative authority, including budgetary authority, required to implement changes
10 to the Rhode Island Medical Assistance program;

11 (ii) Stakeholder interest and participation in the model; and

12 (iv) Overall long-term value of implementing the alternative payment models required by
13 the AHEAD model.

14 SECTION 7. Chapter 42-72 of the General Laws entitled "Department of Children, Youth
15 and Families" is hereby amended by adding thereto the following section:

16 **42-72-37. Family care community partnerships.**

17 (a) As used in this section, "family care community partnership" (FCCP) means a specific,
18 community-based child abuse and neglect prevention service that an agency or entity provides to
19 children and families through a Medicaid certification, department license, or contract with the
20 department.

21 (b) There are hereby established five (5) FCCP catchment regions to serve residents of a
22 specific area within the state, as follows:

23 (1) West Urban Core: The cities of Providence and Cranston;

24 (2) East Urban Core: The cities of East Providence, Central Falls, and Pawtucket;

25 (3) East Bay: The towns of Barrington, Bristol, Jamestown, Little Compton, Middletown,
26 Portsmouth, Tiverton, and Warren, and the city of Newport;

27 (4) Washington and Kent Counties: The towns of Charlestown, Coventry, East Greenwich,
28 Exeter, Hopkinton, Narragansett, New Shoreham, North Kingstown, Richmond, South Kingstown,
29 West Greenwich, West Warwick, and Westerly, and the city of Warwick; and

30 (5) Northern Rhode Island: The towns of Burrillville, Cumberland, Foster, Gloucester,
31 Johnston, Lincoln, North Providence, North Smithfield, Scituate, Smithfield, and the city of
32 Woonsocket.

33 (c) Exactly one FCCP Lead Agency shall be permitted to operate in each region set forth
34 in subsection (b) of this section.

1 SECTION 8. Rhode Island Medicaid Reform Act of 2008 Resolution.

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

4 WHEREAS, A legislative enactment is required pursuant to Rhode Island general laws §
5 42-12.4-1, et seq.; and

6 WHEREAS, Rhode Island general laws § 42-7.2-5(3)(i) provides that the secretary of the
7 executive office of health and human services is responsible for the review and coordination of any
8 Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives and
9 proposals requiring amendments to the Medicaid state plan or category II or III changes as
10 described in the demonstration, "with potential to affect the scope, amount, or duration of publicly-
11 funded health care services, provider payments or reimbursements, or access to or the availability
12 of benefits and services provided by Rhode Island general and public laws"; and

13 WHEREAS, In pursuit of a more cost-effective consumer choice system of care that is
14 fiscally sound and sustainable, the secretary requests legislative approval of the following proposals
15 to amend the demonstration; and

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

20 (a) Substance Abuse Residential Services Rates. The secretary of the executive office of
21 health and human services will pursue and implement any state plan amendments needed to
22 eliminate annual rate increases for substance abuse residential services.

23 (b) Assisted Living Tier C Rates. The secretary of the executive office of health and human
24 services is authorized to pursue and implement any waiver amendments, state plan amendments,
25 and/or changes to the applicable department's rules, regulations, and procedures required to
26 increase Tier C Assisted Living reimbursement rates by 13 percent starting January 1, 2027

27 (c) Children's Services Rate Setting. The secretary of the executive office of health and
28 human services is authorized to pursue and implement any waiver amendments, state plan
29 amendments, and/or changes to the applicable department's rules, regulations, and procedures
30 required to implement reimbursement rates resulting from the Children's Services Rate Setting
31 project.

32 (d) Provider Reimbursement Rates. The secretary of the executive office of health and
33 human services is authorized to pursue and implement any waiver amendments, state plan
34 amendments, and/or changes to the applicable department's rules, regulations, and procedures

1 required to implement updates to Medicaid provider reimbursement rates consisting of rate
2 increases limited to the lower amount of the increases recommended or one hundred percent
3 (100%) of the Medicare rates identified in the Social and Human Service Programs Review Final
4 Report produced by the office of the health insurance commissioner pursuant to Rhode Island
5 general laws § 42-14.5-3(t)(2)(x), effective October 1, 2026.

6 (e) Change to Rates for Nursing Facility Services. The secretary of the executive office of
7 health and human services is authorized to pursue and implement any waiver amendments, state
8 plan amendments, and/or changes to the applicable department's rules, regulations, and procedures
9 required to update the behavioral health per-diem add-on program for particularly complex patients
10 [starting April 1, 2027](#), to include, but not limited to, those who:

11 (1) Require nursing home level of care and have complex needs that are barriers to
12 placement in a traditional nursing home, and have a history of persistent, disruptive behaviors
13 requiring moderate-to-frequent intervention;

14 (2) Admission to a specialized nursing home is consistent with the least restrictive setting
15 requirement enunciated in the landmark U.S. Supreme Court case, *Olmstead v. L.C.* (1999); and

16 (3) The individual must meet nursing facility level of care criteria and has been approved
17 by BHDDH for specialized services through the BHDDH Level II PASRR determination process
18 prior to admission to a specialized nursing home.

19 (f) Glucagon-like Peptide-1 (GLP-1) Coverage. The secretary of the executive office of
20 health and human services is authorized to pursue and implement any waiver amendments, state
21 plan amendments, and/or changes to the applicable department's rules, regulations, and procedures
22 required to remove coverage for GLP-1 medications, except if prescribed to treat type 2 diabetes.

23 (g) Targeted Case Management. The secretary of the executive office of health and human
24 services is authorized to pursue and implement any waiver amendments, state plan amendments,
25 and/or changes to the applicable department's rules, regulations, and procedures required to
26 implement updates to Medicaid's authority to reimburse for the governmental provision of targeted
27 case management to Medicaid enrolled children and youth (up to 21 years old) by qualified staff at
28 the Department of Children, Youth and Families.

29 (h) Graduate Medical Education for Federally Qualified Health Centers. The executive
30 office of health and human services shall review and assess any Medicaid waiver or state plan
31 opportunities that support Rhode Island Federally Qualified Health Centers that operate, or
32 participate in the operation of, accredited primary care-focused physician residency programs. The
33 Secretary shall provide a report with options, recommendations, and estimated fiscal impact to the
34 General Assembly and Governor by November 1, 2026, for consideration in the FY 2028 enacted

1 budget.

2 (i) The secretary of the executive office of health and human services is authorized to
3 pursue and implement any waiver amendments, state plan amendments, and/or changes to the
4 applicable department's rules, regulations, and procedures required to increase resource limits
5 effective January 1, 2027, for Community Medicaid, long-term services and supports, and
6 medically needy beneficiaries to eight thousand dollars (\$8,000) for an individual and twelve
7 thousand dollars (\$12,000) for a couple.

8 ~~(i)~~ Federal Financing Opportunities. The executive office of health and human services
9 proposes that it shall review Medicaid requirements and opportunities under the U.S. Patient
10 Protection and Affordable Care Act of 2010 (PPACA) and various other recently enacted federal
11 laws and pursue any changes in the Rhode Island Medicaid program that promote, increase and
12 enhance service quality, access and cost-effectiveness that may require a Medicaid state plan
13 amendment or amendment under the terms and conditions of Rhode Island's section 1115 waiver,
14 its successor, or any extension thereof. Any such actions by the executive office of health and
15 human services shall not have an adverse impact on beneficiaries or cause there to be an increase
16 in expenditures beyond the amount appropriated for state fiscal year 2027; now, therefore be it

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

19 RESOLVED, That the secretary of the executive office of health and human services is
20 authorized to pursue and implement any waiver amendments, state plan amendments, and/or
21 changes to the applicable department's rules, regulations and procedures approved herein and as
22 authorized by chapter 12.4 of title 42; and be it further

23 SECTION 9. Joint Resolution. AUTHORIZING THE SECRETARY OF THE
24 EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES TO CONTINUE AND
25 EXPAND AN ACUTE HOSPITAL CARE AT HOME PROGRAM

26 WHEREAS, The State of Rhode Island has received a multi-hundred-million-dollar,
27 multiyear award from the Centers for Medicare and Medicaid Services called The Rural Health
28 Transformation Program (RHTP); and

29 WHEREAS, RHTP strongly favors and funds states that have hospitals that participate in
30 the Centers for Medicare and Medicaid Services Acute Hospital Care at Home initiative, the
31 services of which are often called hospital at home programs; and

32 WHEREAS, Hospital at home models have shown over decades that advanced care at
33 home can be a safe, effective way to provide care to patients that is associated with lower costs and
34 better patient outcomes and satisfaction compared with inpatient hospitalization; and

1 WHEREAS, The hospital at home model is an important component of the shift away from
2 institutionalized care and has been successful in allowing patients with particular conditions to
3 remain in their homes and avoid risks associated with inpatient admission and care; and

4 WHEREAS, The Centers for Medicare and Medicaid Services has extended the Acute
5 Hospital Care at Home initiative through September 30, 2030, via the Consolidated Appropriations
6 Act; and

7 WHEREAS, The Acute Hospital Care at Home initiative applies to Medicare beneficiaries,
8 but can be extended to Medicaid beneficiaries if states choose to cover such services; and

9 WHEREAS, The State of Rhode Island wishes to extend the Acute Hospital Care at Home
10 initiative benefits to both traditional and managed Medicaid enrollees;

11 NOW, THEREFORE BE IT RESOLVED,

12 (1) Notwithstanding any provision of law to the contrary, the Executive Office of Health
13 and Human Services shall establish and maintain a program to cover hospital at home services for
14 all eligible medical assistance enrollees and managed Medicaid enrollees. The program shall be
15 established and maintained in a manner that is consistent with the provisions of the Acute Hospital
16 Care at Home initiative, as authorized by the federal Centers for Medicare and Medicaid Services.

17 (2) Any Rhode Island licensed hospital in receipt of a waiver to operate, or otherwise
18 approved to participate in the Centers for Medicare and Medicaid Services Acute Hospital Care at
19 Home initiative, shall be permitted to operate or to continue to operate its program in the manner
20 permitted under federal law.

21 (3) For as long the Acute Hospital Care at Home initiative, or a successor, remains in effect,
22 the Rhode Island Medical Assistance program, including managed Medicaid plans, shall provide
23 coverage and payment for acute hospital care services delivered to a covered person through the
24 program established pursuant to this resolution, on the same basis as when services are delivered
25 within the facilities of a hospital. Reimbursement payments under this section shall be provided to
26 the hospital, facility, or organization providing the services or the individual practitioner who
27 delivered the reimbursable services, or to the agency, facility, or organization that employs or
28 contracts with the individual practitioner who delivered the reimbursable services, as appropriate,
29 at a rate no higher than the payer's then applicable reimbursement rates for the same service in the
30 same hospital.

31 (4) The program shall not utilize more stringent utilization management criteria than apply
32 when those services are provided within the facilities of a hospital.

33 (5) The Secretary of the Executive Office of Health and Human Services shall apply for
34 any State plan amendments or waivers as may be necessary to implement the provisions of this

1 resolution and to secure federal financial participation for State Medicaid expenditures under the
2 federal Medicaid program.

3 (6) The Secretary of the Executive Office of Health and Human Services shall adopt rules
4 and regulations, in accordance with the Administrative Procedure Act, if necessary, to effectuate
5 the provisions of this resolution; and be it further

6 RESOLVED, The Secretary of the Executive Office of Health and Human Services shall
7 provide a report to the Governor and the General Assembly regarding the cost of the program.

8 SECTION 10. Sections 8 and 9 of this article shall take effect on July 1, 2026. Sections 2,
9 4 and 5 shall take effect on January 1, 2027. The remainder of the article shall take effect upon
10 passage