

## 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:

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

19 **40-8.3-2. Definitions.**

20 As used in this chapter:

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

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

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

30 (i) Was licensed as a hospital in accordance with chapter 17 of title 23 during the base year  
31 and shall mean the actual facilities and buildings in existence in Rhode Island, licensed pursuant to  
32 § 23-17-1 et seq. on June 30, 2010, and thereafter any premises included on that license, regardless  
33 of changes in licensure status pursuant to chapter 17.14 of title 23 (hospital conversions) and § 23-  
34 17-6(b) (change in effective control), that provides acute inpatient and/or outpatient care to persons

1 who require definitive diagnosis and treatment for injury, illness, disabilities, or pregnancy.  
2 Notwithstanding the preceding language, the negotiated Medicaid managed care payment rates for  
3 a court-approved purchaser that acquires a hospital through receivership, special mastership, or  
4 other similar state insolvency proceedings (which court-approved purchaser is issued a hospital  
5 license after January 1, 2013), shall be based upon the newly negotiated rates between the court-  
6 approved purchaser and the health plan, and the rates shall be effective as of the date that the court-  
7 approved purchaser and the health plan execute the initial agreement containing the newly  
8 negotiated rate. The rate-setting methodology for inpatient hospital payments and outpatient  
9 hospital payments set forth in §§ 40-8-13.4(b)(1)(ii)(C) and 40-8-13.4(b)(2), respectively, shall  
10 thereafter apply to negotiated increases for each annual twelve-month (12) period as of July 1  
11 following the completion of the first full year of the court-approved purchaser's initial Medicaid  
12 managed care contract;

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

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

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

27 (5) "Uncompensated-care index" means the annual percentage increase for hospitals  
28 established pursuant to § 27-19-14 [repealed] for each year after the base year, up to and including  
29 the payment year; provided, however, that the uncompensated-care index for the payment year  
30 ending September 30, 2007, shall be deemed to be five and thirty-eight hundredths percent (5.38%),  
31 and that the uncompensated-care index for the payment year ending September 30, 2008, shall be  
32 deemed to be five and forty-seven hundredths percent (5.47%), and that the uncompensated-care  
33 index for the payment year ending September 30, 2009, shall be deemed to be five and thirty-eight  
34 hundredths percent (5.38%), and that the uncompensated-care index for the payment years ending

1 September 30, 2010, September 30, 2011, September 30, 2012, September 30, 2013, September  
2 30, 2014, September 30, 2015, September 30, 2016, September 30, 2017, September 30, 2018,  
3 September 30, 2019, September 30, 2020, September 30, 2021, September 30, 2022, September  
4 30, 2023, September 30, 2024, September 30, 2025, ~~and~~ September 30, 2026, and September 30,  
5 2027 shall be deemed to be five and thirty hundredths percent (5.30%).

6 **40-8.3-3. Implementation.**

7 ~~(a) For federal fiscal year 2024, commencing on October 1, 2023, and ending September~~  
8 ~~30, 2024, the executive office of health and human services shall submit to the Secretary of the~~  
9 ~~United States Department of Health and Human Services a state plan amendment to the Rhode~~  
10 ~~Island Medicaid DSH Plan to provide:~~

11 ~~(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of~~  
12 ~~\$14.8 million, shall be allocated by the executive office of health and human services to the Pool~~  
13 ~~D component of the DSH Plan; and~~

14 ~~(2) That the Pool D allotment shall be distributed among the participating hospitals in direct~~  
15 ~~proportion to the individual participating hospital's uncompensated care costs for the base year,~~  
16 ~~inflated by the uncompensated care index to the total uncompensated care costs for the base year~~  
17 ~~inflated by the uncompensated care index for all participating hospitals. The disproportionate share~~  
18 ~~payments shall be made on or before June 30, 2024, and are expressly conditioned upon approval~~  
19 ~~on or before June 23, 2024, by the Secretary of the United States Department of Health and Human~~  
20 ~~Services, or their authorized representative, of all Medicaid state plan amendments necessary to~~  
21 ~~secure for the state the benefit of federal financial participation in federal fiscal year 2024 for the~~  
22 ~~disproportionate share payments.~~

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

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

29 (2) That the DSH plan to all participating hospitals, not to exceed an aggregate limit of  
30 \$27.7 million, shall be allocated by the executive office of health and human services to the Pool  
31 C and D components of the DSH plan;

32 (3) 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 of all participating hospitals. The disproportionate share  
2 payments shall be made on or before June 30, 2025, and are expressly conditioned upon approval  
3 on or before June 23, 2025, 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 2025 for the  
6 disproportionate share payments; and

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

16 ~~(e)~~(b) For federal fiscal year 2026, commencing on October 1, 2025, and ending on  
17 September 30, 2026, the executive office of health and human services shall submit to the Secretary  
18 of the United States Department of Health and Human Services a state plan amendment to the  
19 Rhode Island Medicaid DSH plan to provide:

20 (1) That the DSH plan to all participating hospitals, not to exceed an aggregate limit of  
21 \$13.9 million, shall be allocated by the executive office of health and human services to the Pool  
22 C and D components of the DSH plan. Pool C shall not exceed an aggregate limit of \$12.9 million.  
23 Pool D shall not exceed an aggregate limit of \$1.0 million;

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

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

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

8 (c) For federal fiscal year 2027, commencing on October 1, 2026, and ending on September  
9 30, 2027, the DSH plan for all participating hospitals shall not exceed an aggregate limit of thirty-  
10 eight million nine hundred thousand dollars (\$38,900,000) and shall be allocated by the executive  
11 office of health and human services to the Pool C and D components of the DSH plan. The Pool C  
12 component of the DSH plan shall not exceed an aggregate limit of twelve million nine hundred  
13 thousand dollars (\$12,900,000). The Pool D component of the DSH plan shall not exceed an  
14 aggregate limit of twenty-six million dollars (\$26,000,000).

15 (1) The Pool C allotment shall be distributed among the participating hospitals in direct  
16 proportion to each individual participating hospital's uncompensated-care costs for the base year,  
17 inflated by the uncompensated-care index as described in § 40-8.3-2(5). The DSH payments shall  
18 be made on or before June 30, 2027; and,

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

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

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

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

30 SECTION 3. Section 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical  
31 Assistance — Long-Term Care Service and Finance Reform" is hereby amended to read as follows:

32 **40-8.9-9. Long-term-care rebalancing system reform goal.**

33 (a) Notwithstanding any other provision of state law, the executive office of health and  
34 human services is authorized and directed to apply for, and obtain, any necessary waiver(s), waiver

1 amendment(s), and/or state-plan amendments from the Secretary of the United States Department  
2 of Health and Human Services, and to promulgate rules necessary to adopt an affirmative plan of  
3 program design and implementation that addresses the goal of allocating a minimum of fifty percent  
4 (50%) of Medicaid long-term-care funding for persons aged sixty-five (65) and over and adults  
5 with disabilities, in addition to services for persons with developmental disabilities, to home- and  
6 community-based care; provided, further, the executive office shall report annually as part of its  
7 budget submission, the percentage distribution between institutional care and home- and  
8 community-based care by population and shall report current and projected waiting lists for long-  
9 term-care and home- and community-based care services. The executive office is further authorized  
10 and directed to prioritize investments in home- and community-based care and to maintain the  
11 integrity and financial viability of all current long-term-care services while pursuing this goal.

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

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

1 for services provided for under this section. Levels of care may be applied in accordance with the  
2 following:

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

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

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

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

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

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

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

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

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

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

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

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

26 The standards for adult day services for persons eligible for Medicaid-funded long-term  
27 services may differ from those who do not meet the clinical/functional criteria set forth in § 40-  
28 8.10-3.

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

1 healthcare professionals, in amount to be determined by the appropriations process, for the purpose  
2 of raising wages for personal care attendants and home health aides to be implemented by such  
3 providers.

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

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

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

17 (iv) On the first of July in each year, beginning on July 1, 2019, the executive office of  
18 health and human services will initiate an annual inflation increase to the base rate for home-care  
19 providers, home nursing care providers, and hospice providers contracted with the executive office  
20 and its subordinate agencies to deliver Medicaid fee-for-service personal care attendant services,  
21 skilled nursing and therapeutic services and hospice care. The base rate increase shall be a  
22 percentage amount equal to the New England Consumer Price Index card as determined by the  
23 United States Department of Labor for medical care and for compliance with all federal and state  
24 laws, regulations, and rules, and all national accreditation program requirements, except as of July  
25 1, 2025, and thereafter, when no annual inflation increase shall occur for these rates.

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

34 (1) Effective July 1, 2021, increase the existing shift differential modifier by \$0.19 per

1 fifteen (15) minutes for personal care and combined personal care/homemaker.

2 (i) Employers must pass on one hundred percent (100%) of the shift differential modifier  
3 increase per fifteen-minute (15) unit of service to the CNAs who rendered such services. This  
4 compensation shall be provided in addition to the rate of compensation that the employee was  
5 receiving as of June 30, 2021. For an employee hired after June 30, 2021, the agency shall use not  
6 less than the lowest compensation paid to an employee of similar functions and duties as of June  
7 30, 2021, as the base compensation to which the increase is applied.

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

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

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

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

31 (h) The executive office shall implement a long-term-care-options counseling program to  
32 provide individuals, or their representatives, or both, with long-term-care consultations that shall  
33 include, at a minimum, information about: long-term-care options, sources, and methods of both  
34 public and private payment for long-term-care services and an assessment of an individual's

1 functional capabilities and opportunities for maximizing independence. Each individual admitted  
2 to, or seeking admission to, a long-term-care facility, regardless of the payment source, shall be  
3 informed by the facility of the availability of the long-term-care-options counseling program and  
4 shall be provided with long-term-care-options consultation if they so request. Each individual who  
5 applies for Medicaid long-term-care services shall be provided with a long-term-care consultation.

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

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

33 (k) To ensure persons with long-term-care needs who remain living at home have adequate  
34 resources to deal with housing maintenance and unanticipated housing-related costs, the secretary

1 is authorized to ~~develop higher~~ implement resource eligibility limits of eight thousand dollars  
2 (\$8,000) for single persons ~~or~~ and twelve thousand dollars (\$12,000) for couples and obtain any  
3 state plan or waiver authorities necessary to change the financial eligibility criteria for long-term  
4 services and supports to enable beneficiaries receiving home and community waiver services to  
5 have the resources to continue living in their own homes or rental units or other home-based  
6 settings.

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

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

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

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

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

21 SECTION 4. Section 42-7.2-5 of the General Laws in Chapter 42-7.2 entitled "Office of  
22 Health and Human Services" is hereby amended to read as follows:

23 **42-7.2-5. Duties of the secretary.**

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

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

1 the administrative responsibility for the preparation and submission of any state plans, state plan  
2 amendments, or authorized federal waiver applications, once approved by the secretary.

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

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

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

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

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

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

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

34 (ii) Expenditures, outcomes, and utilization rates by population and sub-population served

1 (e.g., families with children, persons with disabilities, children in foster care, children receiving  
2 adoption assistance, adults ages nineteen (19) to sixty-four (64), and elders);

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

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

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

11 (vi) Information submitted to the Centers for Medicare & Medicaid Services for the  
12 mandatory annual state reporting of the Core Set of Children's Health Care Quality Measures for  
13 Medicaid and Children's Health Insurance Program, behavioral health measures on the Core Set of  
14 Adult Health Care Quality Measures for Medicaid and the Core Sets of Health Home Quality  
15 Measures for Medicaid to ensure compliance with the Bipartisan Budget Act of 2018, Pub. L. No.  
16 115-123.

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

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

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

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

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

33 (iii) Develop all opportunities to maximize resources by leveraging the state's purchasing  
34 power, centralizing fiscal service functions related to budget, finance, and procurement,

1 centralizing communication, policy analysis and planning, and information systems and data  
2 management, pursuing alternative funding sources through grants, awards, and partnerships and  
3 securing all available federal financial participation for programs and services provided EOHHS-  
4 wide;

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

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

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

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

20 (7) Prepare and integrate comprehensive budgets for the health and human services  
21 departments and any other functions and duties assigned to the office. The budgets shall be  
22 submitted to the state budget office by the secretary, for consideration by the governor, on behalf  
23 of the state's health and human services agencies in accordance with the provisions set forth in §  
24 35-3-4.

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

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

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

1 assistance deemed necessary by the secretary when undertaking such independent reviews.

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

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

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

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

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

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

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

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

34 (ii) As soon as practicable after the enactment federal budget for fiscal year 2026, but no

1 later than October 31, 2025, the advisory working group shall forward a report to the governor,  
2 speaker of the house, and president of the senate containing the findings, recommendations and  
3 options for consideration to become compliant with federal changes prior to the governor's budget  
4 submission pursuant to § 35-3-7.

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

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

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

13 (iii) Stakeholder interest and participation in the model; and

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

16 SECTION 5. Chapter 42-72 of the General Laws entitled "Department of Children, Youth  
17 and Families" is hereby amended by adding thereto the following section:

18 **42-72-37. Family care community partnerships.**

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

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

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

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

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

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

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

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

3           SECTION 6. Rhode Island Medicaid Reform Act of 2008 Resolution.

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

6           WHEREAS, A legislative enactment is required pursuant to Rhode Island general laws §  
7 42-12.4-1, et seq.; and

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

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

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

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

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

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

34           (d) Provider Reimbursement Rates. The secretary of the executive office of health and

1 human services is authorized to pursue and implement any waiver amendments, state plan  
2 amendments, and/or changes to the applicable department's rules, regulations, and procedures  
3 required to implement updates to Medicaid provider reimbursement rates consisting of rate  
4 increases limited to the lower amount of the increases recommended or one hundred percent  
5 (100%) of the Medicare rates identified in the Social and Human Service Programs Review Final  
6 Report produced by the office of the health insurance commissioner pursuant to Rhode Island  
7 general laws § 42-14.5-3(t)(2)(x), effective October 1, 2026.

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

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

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

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

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

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

31 (h) Graduate Medical Education for Federally Qualified Health Centers. The executive  
32 office of health and human services shall review and assess any Medicaid waiver or state plan  
33 opportunities that support Rhode Island Federally Qualified Health Centers that operate, or  
34 participate in the operation of, accredited primary care-focused physician residency programs. The

1 Secretary shall provide a report with options, recommendations, and estimated fiscal impact to the  
2 General Assembly and Governor by November 1, 2026, for consideration in the FY 2028 enacted  
3 budget.

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

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

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

19 SECTION 7. Joint Resolution. AUTHORIZING THE SECRETARY OF THE  
20 EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES TO CONTINUE AND  
21 EXPAND AN ACUTE HOSPITAL CARE AT HOME PROGRAM

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

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

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

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

34 WHEREAS, The Centers for Medicare and Medicaid Services has extended the Acute

1 Hospital Care at Home initiative through September 30, 2030, via the Consolidated Appropriations  
2 Act; and

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

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

7 NOW, THEREFORE BE IT RESOLVED,

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

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

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

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

29 (5) The Secretary of the Executive Office of Health and Human Services shall apply for  
30 any State plan amendments or waivers as may be necessary to implement the provisions of this  
31 resolution and to secure federal financial participation for State Medicaid expenditures under the  
32 federal Medicaid program.

33 (6) The Secretary of the Executive Office of Health and Human Services shall adopt rules  
34 and regulations, in accordance with the Administrative Procedure Act, if necessary, to effectuate

1 the provisions of this resolution; and be it further

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

4           SECTION 8. This article shall take effect upon passage, except sections 6 and 7 which  
5 shall take effect on July 1, 2026.