ARTICLE 8

RELATING TO MEDICAL ASSISTANCE

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

23-17-38.1. Hospitals – Licensing fee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

allowances.

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

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

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

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

SECTION 2. Sections 40-8-13.4 and 40-8-19 of the General Laws in Chapter 40-8 entitled “Medical Assistance” is hereby amended to read as follows:

40-8-13.4. Rate methodology for payment for in-state and out-of-state hospital services.

(a) The executive office of health and human services (“executive office”) shall implement a new methodology for payment for in-state and out-of-state hospital services in order to ensure access to, and the provision of, high-quality and cost-effective hospital care to its eligible recipients.

(b) In order to improve efficiency and cost-effectiveness, the executive office shall:

(1)(i) With respect to inpatient services for persons in fee-for-service Medicaid, which is non-managed care, implement a new payment methodology for inpatient services utilizing the Diagnosis Related Groups (DRG) method of payment, which is, a patient-classification method that provides a means of relating payment to the hospitals to the type of patients cared for by the hospitals. It is understood that a payment method based on DRG may include cost outlier payments and other specific exceptions. The executive office will review the DRG-payment method and the DRG base price annually, making adjustments as appropriate in consideration of such elements as trends in hospital input costs; patterns in hospital coding; beneficiary access to care; and the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index. For the twelve-month (12) period beginning July 1, 2015, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of July 1, 2014. Beginning July 1, 2019, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall be 107.2% of the payment

rates in effect as of July 1, 2018. Increases in the Medicaid fee-for-service DRG hospital payments for the twelve-month (12) period beginning July 1, 2020, shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national Prospective Payment System (IPPS) Hospital Input Price Index. Beginning July 1, 2022, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall be one hundred five percent (105%) of the payment rates in effect as of July 1, 2021. Beginning July 1, 2026, the DRG base rate for Medicaid fee-for-service inpatient hospital services shall be one hundred and two and five-tenths percent (102.5%) of the payment rates in effect as of July 1, 2025. Increases in the Medicaid fee-for-service DRG hospital payments for each annual twelve-month (12) period beginning July 1, 2023~~3~~7, shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national Prospective Payment System (IPPS) Hospital Input Price Index.

(ii) With respect to inpatient services, (A) It is required as of January 1, 2011, until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not exceed ninety and one-tenth percent (90.1%) of the rate in effect as of June 30, 2010. Increases in inpatient hospital payments for each annual twelve-month (12) period beginning January 1, 2012, may not exceed the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index for the applicable period; (B) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the Medicaid managed care payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1, 2015, the Medicaid managed care payment inpatient rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (C) Increases in inpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2017, shall be the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1; (D) Beginning July 1, 2019, the Medicaid managed care payment inpatient rates between each hospital and health plan shall be 107.2% of the payment rates in effect as of January 1, 2019, and shall be paid to each hospital retroactively to July 1; (E) Increases in inpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2020, shall be based on the payment rates in effect as of January 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital

retroactively to July 1; the executive office will develop an audit methodology and process to assure that savings associated with the payment reductions will accrue directly to the Rhode Island Medicaid program through reduced managed care plan payments and shall not be retained by the managed care plans; (F) Beginning July 1, 2022, the Medicaid managed care payment inpatient rates between each hospital and health plan shall be one hundred five percent (105%) of the payment rates in effect as of January 1, 2022, and shall be paid to each hospital retroactively to July 1 within ninety days of passage; (G) Beginning July 1, 2026, the Medicaid managed care payment inpatient rates between each hospital and health plan shall be one hundred and two and five-tenths percent (102.5%) of the payment rates in effect as of January 1, 2025; (H) Increases in inpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2023~~7~~, shall be based on the payment rates in effect as of January 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1 within ninety days of passage; (~~H~~I) All hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and (~~I~~J) For all such hospitals, compliance with the provisions of this section shall be a condition of participation in the Rhode Island Medicaid program.

(2) With respect to outpatient services and notwithstanding any provisions of the law to the contrary, for persons enrolled in fee-for-service Medicaid, the executive office will reimburse hospitals for outpatient services using a rate methodology determined by the executive office and in accordance with federal regulations. Fee-for-service outpatient rates shall align with Medicare payments for similar services. Notwithstanding the above, there shall be no increase in the Medicaid fee-for-service outpatient rates effective on July 1, 2013, July 1, 2014, or July 1, 2015. For the twelve-month (12) period beginning July 1, 2015, Medicaid fee-for-service outpatient rates shall not exceed ninety-seven and one-half percent (97.5%) of the rates in effect as of July 1, 2014. Increases in the outpatient hospital payments for the twelve-month (12) period beginning July 1, 2016, may not exceed the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. Beginning July 1, 2019, the Medicaid fee-for-service outpatient rates shall be 107.2% of the payment rates in effect as of July 1, 2018. Increases in the outpatient hospital payments for the twelve-month (12) period beginning July 1, 2020, shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. Beginning July 1, 2022, the Medicaid fee-for-service outpatient rates shall be one hundred five percent (105%) of the payment rates in effect as of July 1, 2021. Beginning July 1, 2026, the Medicaid fee-for-service outpatient

rates shall be one hundred and two and five-tenths percent (102.5%) of the payment rates in effect as of July 1, 2025. Increases in the outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2023~~3~~7, shall be based on the payment rates in effect as of July 1 of the preceding fiscal year, and shall be the CMS national Outpatient Prospective Payment System (OPPS) Hospital Input Price Index. With respect to the outpatient rate, (i) It is required as of January 1, 2011, until December 31, 2011, that the Medicaid managed care payment rates between each hospital and health plan shall not exceed one hundred percent (100%) of the rate in effect as of June 30, 2010; (ii) Increases in hospital outpatient payments for each annual twelve-month (12) period beginning January 1, 2012, until July 1, 2017, may not exceed the Centers for Medicare and Medicaid Services national CMS Outpatient Prospective Payment System OPPS Hospital Price Index for the applicable period; (iii) Provided, however, for the twenty-four-month (24) period beginning July 1, 2013, the Medicaid managed care outpatient payment rates between each hospital and health plan shall not exceed the payment rates in effect as of January 1, 2013, and for the twelve-month (12) period beginning July 1, 2015, the Medicaid managed care outpatient payment rates between each hospital and health plan shall not exceed ninety-seven and one-half percent (97.5%) of the payment rates in effect as of January 1, 2013; (iv) Increases in outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2017, shall be the Centers for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1; (v) Beginning July 1, 2019, the Medicaid managed care outpatient payment rates between each hospital and health plan shall be one hundred seven and two-tenths percent (107.2%) of the payment rates in effect as of January 1, 2019, and shall be paid to each hospital retroactively to July 1; (vi) Increases in outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2020, shall be based on the payment rates in effect as of January 1 of the preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1; (vii) Beginning July 1, 2022, the Medicaid managed care outpatient payment rates between each hospital and health plan shall be one hundred five percent (105%) of the payment rates in effect as of January 1, 2022, and shall be paid to each hospital retroactively to July 1 within ninety days of passage; (viii) Beginning July 1, 2026, the Medicaid managed care outpatient payment rates between each hospital and health plan shall be one hundred and two and five-tenths percent (102.5%) of the payment rates in effect as of January 1, 2025; (ix) Increases in outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2020~~0~~7, shall be based on the payment rates in effect as of January 1 of the

preceding fiscal year, and shall be the Centers for Medicare and Medicaid Services national CMS OPPS Hospital Input Price Index, less Productivity Adjustment, for the applicable period and shall be paid to each hospital retroactively to July 1.

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

(c) It is intended that payment utilizing the DRG method shall reward hospitals for providing the most efficient care, and provide the executive office the opportunity to conduct value-based purchasing of inpatient care.

(d) The secretary of the executive office is hereby authorized to promulgate such rules and regulations consistent with this chapter, and to establish fiscal procedures he or she deems necessary, for the proper implementation and administration of this chapter in order to provide payment to hospitals using the DRG-payment methodology. Furthermore, amendment of the Rhode Island state plan for Medicaid, pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et seq., is hereby authorized to provide for payment to hospitals for services provided to eligible recipients in accordance with this chapter.

(e) The executive office shall comply with all public notice requirements necessary to implement these rate changes.

(f) As a condition of participation in the DRG methodology for payment of hospital services, every hospital shall submit year-end settlement reports to the executive office within one year from the close of a hospital's fiscal year. Should a participating hospital fail to timely submit

a year-end settlement report as required by this section, the executive office shall withhold financial-cycle payments due by any state agency with respect to this hospital by not more than ten percent (10%) until the report is submitted. For hospital fiscal year 2010 and all subsequent fiscal years, hospitals will not be required to submit year-end settlement reports on payments for outpatient services. For hospital fiscal year 2011 and all subsequent fiscal years, hospitals will not be required to submit year-end settlement reports on claims for hospital inpatient services. Further, for hospital fiscal year 2010, hospital inpatient claims subject to settlement shall include only those claims received between October 1, 2009, and June 30, 2010.

(g) The provisions of this section shall be effective upon implementation of the new payment methodology set forth in this section and § 40-8-13.3, which shall in any event be no later than March 30, 2010, at which time the provisions of §§ 40-8-13.2, 27-19-14, 27-19-15, and 27-19-16 shall be repealed in their entirety.

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

(a) Rate reform.

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

(2) The executive office shall review the current methodology for providing Medicaid payments to nursing facilities, including other long-term care services providers, and is authorized to modify the principles of reimbursement to replace the current cost-based methodology rates with rates based on a price-based methodology to be paid to all facilities with recognition of the acuity of patients and the relative Medicaid occupancy, and to include the following elements to be developed by the executive office:

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

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

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

accordingly to reflect changes in direct and indirect care costs since the previous rate review;

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

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

(vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be applied on October 1 of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013, October 1, 2014, or October 1, 2015, but will occur on April 1, 2015. The adjustment of rates will also not occur on October 1, 2017, October 1, 2018, October 1, 2019, and October 2022. Effective July 1, 2018, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2017, both fee-for-service and managed care, will be increased by one and one-half percent (1.5%) and further increased by one percent (1%) on October 1, 2018, and further increased by one percent (1%) on October 1, 2019. Effective October 1, 2022, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2021, both fee-for-service and managed care, will be increased by three percent (3%). In addition to the annual nursing home inflation index adjustment, there shall be a base rate staffing adjustment of one-half percent (0.5%) on October 1, 2021, one percent (1.0%) on October 1, 2022, and one and one-half percent (1.5%) on October 1, 2023. For the twelve-month (12) period beginning October 1, 2025, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2024, both fee-for-service and managed care, will be increased by two and three-tenths percent (2.3%). There shall also be a base rate staffing adjustment of three percent (3%) effective October 1, 2025. Not less than one hundred percent (100%) of this base-rate staffing adjustment shall be expended by each nursing facility to increase compensation, wages, benefits, and related employer costs, for eligible direct-care staff, including the cost of hiring additional eligible direct-care positions, as defined in this subsection (a)(2)(vi). The inflation index shall be applied without regard for the transition factors in subsections (b)(1) and (b)(2). Effective October 1, 2026, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2025, both fee-for-service and managed care, shall be increased by two and five-tenths percent (2.5%). For purposes of October 1, 2016, adjustment only, any rate increase that results from application of the inflation index to subsections (a)(2)(i) and (a)(2)(ii) shall be dedicated to increase compensation for direct-care workers in the following manner: Not less than eighty-five percent (85%) of this aggregate amount shall be expended to fund an increase in wages, benefits, or related employer costs of direct-care staff of nursing homes. For purposes of this section, direct-care staff shall include registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), certified medical technicians,

housekeeping staff, laundry staff, dietary staff, or other similar employees providing direct-care services; provided, however, that this definition of direct-care staff shall not include: (i) RNs and LPNs who are classified as "exempt employees" under the federal Fair Labor Standards Act (29 U.S.C. § 201 et seq.); or (ii) CNAs, certified medical technicians, RNs, or LPNs who are contracted, or subcontracted, through a third-party vendor or staffing agency. By July 31, 2017, nursing facilities shall submit to the secretary, or designee, a certification that they have complied with the provisions of this subsection (a)(2)(vi) with respect to the inflation index applied on October 1, 2016. Any facility that does not comply with the terms of such certification shall be subjected to a clawback, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification.

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

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

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

(B) CNAs, certified medication technicians, RNs, or LPNs who are contracted or subcontracted through a third-party vendor or staffing agency.

(4)(i) By July 31, 2021, and July 31 of each year thereafter, nursing facilities shall submit to the secretary or designee a certification that they have complied with the provisions of subsection (a)(3) of this section with respect to the inflation index applied on October 1. The executive office of health and human services (EOHHS) shall create the certification form nursing facilities must complete with information on how each individual eligible employee's compensation increased,

including information regarding hourly wages prior to the increase and after the compensation increase, hours paid after the compensation increase, and associated increased payroll taxes. A collective bargaining agreement can be used in lieu of the certification form for represented employees. All data reported on the compliance form is subject to review and audit by EOHHS. The audits may include field or desk audits, and facilities may be required to provide additional supporting documents including, but not limited to, payroll records.

(ii) Any facility that does not comply with the terms of certification shall be subjected to a clawback and twenty-five percent (25%) penalty of the unspent or impermissibly spent funds, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification. There shall be created within the general fund of the state and housed within the budget of the executive office of health and human services a restricted receipt account entitled "Nursing Facility Rate Adjustment Wage Pass-through Compliance" for the express purpose of recording receipts and expenditures of the aforementioned penalty. Funds deposited into the account shall be used for workforce development and compliance assistance programs.

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

(b) Transition to full implementation of rate reform.

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

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

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

(3) The transition plan and/or period may be modified upon full implementation of facility

per diem rate increases for quality of care-related measures. Said modifications shall be submitted in a report to the general assembly at least six (6) months prior to implementation.

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

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

40-8.3-2. Definitions.

As used in this chapter:

(1) "Base year" means, for the purpose of calculating a disproportionate share payment for any fiscal year ending after September 30, 2024~~4~~5, the period from October 1, 2022~~2~~3, through September 30, 2023~~3~~4, and for any fiscal year ending after September 30, 2025~~5~~6, the period from October 1, 2023~~3~~4, through September 30, 2024~~4~~5.

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

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

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

thereafter apply to negotiated increases for each annual twelve-month (12) period as of July 1 following the completion of the first full year of the court-approved purchaser's initial Medicaid managed care contract;

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

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

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

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

40-8.3-3. Implementation.

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

~~Island Medicaid DSH Plan to provide:~~

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

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

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

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

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

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

(4) That the Pool C allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated-care costs for the base year, inflated by the uncompensated-care index to the total uncompensated-care cost for the base year

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

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

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

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

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

(c) For federal fiscal year 2027, commencing on October 1, 2026, and ending on September 30, 2027, the DSH plan for all participating hospitals shall not exceed an aggregate limit of $23.9

million and shall be allocated by the executive office of health and human services to the Pool C and D components of the DSH plan. The Pool C component of the DSH plan shall not exceed an aggregate limit of $12.9 million. The Pool D component of the DSH plan shall not exceed an aggregate limit of $11.0 million.

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

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

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

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

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

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

42-7.2-5. Duties of the secretary.

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

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

amendments, or authorized federal waiver applications, once approved by the secretary.

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

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

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

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

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

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

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

(ii) Expenditures, outcomes, and utilization rates by population and sub-population served (e.g., families with children, persons with disabilities, children in foster care, children receiving

adoption assistance, adults ages nineteen (19) to sixty-four (64), and elders);

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

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

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

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

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

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

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

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

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

(iii) Develop all opportunities to maximize resources by leveraging the state's purchasing power, centralizing fiscal service functions related to budget, finance, and procurement, centralizing communication, policy analysis and planning, and information systems and data

management, pursuing alternative funding sources through grants, awards, and partnerships and securing all available federal financial participation for programs and services provided EOHHS-wide;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) As soon as practicable after the enactment federal budget for fiscal year 2026, but no later than October 31, 2025, the advisory working group shall forward a report to the governor,

speaker of the house, and president of the senate containing the findings, recommendations and options for consideration to become compliant with federal changes prior to the governor's budget submission pursuant to § 35-3-7.

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

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

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

(ii) stakeholder interest and participation in the model; and

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

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

42-72-37. Family Care Community Partnerships.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Inpatient and Outpatient Hospital Rate Increase Alignment with State Revenue Growth. The executive office of health and human services will pursue and implement any state plan amendments needed to limit rate increases for inpatient and outpatient hospital services in SFY 2027 to the anticipated rate of growth of state tax revenue, 2.5 percent.

(b) Nursing Facility Rate Increase Alignment with State Revenue Growth. The executive office of health and human services will pursue and implement any state plan amendments needed to align rate increases for nursing facilities in SFY 2027 to the anticipated rate of growth of state tax revenue, 2.5 percent.

(c) Federally Qualified Health Center Rate Increase Alignment with State Revenue Growth. The secretary of the executive office of health and human services will pursue and implement any amendments needed to the Principles of Reimbursement for Federally Qualified Health Centers (FQHC) needed to align rate increases for FQHC services in SFY 2027 to the anticipated rate of growth of state tax revenue, 2.5 percent.

(d) Substance Abuse Residential Services Rates. The secretary of the executive office of health and human services will pursue and implement any state plan amendments needed to

eliminate annual rate increases for substance abuse residential services.

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

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

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

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

Now, therefore, be it:

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

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

RESOLVED, that this Joint Resolution shall take effect on July 1, 2026.

SECTION 7. This article shall take effect upon passage, except section 6 which shall take effect on July 1, 2026.