ARTICLE 12

RELATING TO MEDICAL ASSISTANCE

SECTION 1. Sections 12-1.6-1 and 12-1.6-2 of the General Laws in Chapter 12-1.6 entitled "National Criminal Records Check System" are hereby amended to read as follows:

12-1.6-1. Automated fingerprint identification system database.

The department of attorney general may establish and maintain an automated fingerprint identification system database that would allow the department to store and maintain all fingerprints submitted in accordance with the national criminal records check system. The automated fingerprint identification system database would provide for an automatic notification if, and when, a subsequent criminal arrest fingerprint card is submitted to the system that matches a set of fingerprints previously submitted in accordance with a national criminal records check. If the aforementioned arrest results in a conviction, the department shall immediately notify those individuals and entities with which that individual is associated and who are required to be notified of disqualifying information concerning national criminal records checks as provided in chapters 17, 17.4, 17.7.1 of title 23 or § 23-1-52 and 42-7.2 of title 42 or §§ 42-7.2-18.2 and 42-7.2-18.4. The information in the database established under this section is confidential and not subject to disclosure under chapter 38-2.

12-1.6-2. Long-term healthcare workers~~.~~, high-risk medicaid providers, and personal care attendants.

The department of attorney general shall maintain an electronic, web-based system to assist facilities, licensed under chapters 17, 17.4, 17.7.1 of title 23 or § 23-1-52, and the executive office of health and human services under §§ 42-7.2-18.1 and 42-7.2-18.3, required to check relevant registries and conduct national criminal records checks of routine contact patient employees~~.~~, personal care attendants and high-risk providers. The department of attorney general shall provide for an automated notice, as authorized in § 12-1.6-1, to those facilities or to the executive office of health and human services if a routine-contact patient employee, personal care attendant or high-risk provider is subsequently convicted of a disqualifying offense, as described in the relevant licensing statute or in §§ 42-7.2-18.2 and 42-7.2-18.4. The department of attorney general may charge a facility a one-time, set-up fee of up to one hundred dollars ($100) for access to the electronic web-based system under this section.

SECTION 2. Section 42-7.2-18 of Chapter 42-7.2 the General Laws entitled "Office of Health and Human Services" is hereby amended by adding thereto the following sections:

42-7.2-18.1. Professional responsibility – Criminal records check for high- risk providers.

(a) As a condition of enrollment and/or continued participation as a Medicaid provider, applicants to become and/or remain a provider shall be required to undergo criminal records checks including a national criminal records check supported by fingerprints by the level of screening based on risk of fraud, waste or abuse as determined by the executive office of health and human services for that category of Medicaid provider.

(b) Establishment of Risk Categories – The executive office of health and human services in consultation with the department of attorney general, shall establish through regulation, risk categories for Medicaid providers and provider categories who pose an increased financial risk of fraud, waste or abuse to the Medicaid/CHIP program, in accordance with § 42 CFR §§ 455.434 and 455.450.

(c) High risk categories, as determined by the executive office health and human services may include:

(1) Newly enrolled home health agencies that have not been medicare certified;

(2) Newly enrolled durable medical equipment providers;

(3) New or revalidating providers that have been categorized by the executive office of health and human services as high risk;

(4) New or revalidating providers with payment suspension histories;

(5) New or revalidating providers with office of inspector general exclusion histories;

(6) New or revalidating providers with qualified overpayment histories; and,

(7) New or revalidating providers applying for enrollment post debarment or moratorium (Federal or State-based)

(d) Upon the state Medicaid agency determination that a provider or an applicant to become a provider, or a person with a five percent (5%) or more direct or indirect ownership interest in the provider, meets the executive office of health and human services' criteria for criminal records checks as a "high" risk to the Medicaid program, the executive office of health and human services shall require that each such provider or applicant to become a provider undergo a national criminal records check supported by fingerprints.

(e) The executive office of health and human services shall require such a "high risk" Medicaid provider or applicant to become a provider, or any person with a five percent (5%) or more direct or indirect ownership interest in the provider, to submit to a national criminal records

check supported by fingerprints within thirty (30) days upon request from the Centers for Medicare and Medicaid or the executive office of health and human services.

(f) The Medicaid providers requiring the national criminal records check shall apply to the department of attorney general, bureau of criminal dentification (BCI) to be fingerprinted. The fingerprints will subsequently be transmitted to the federal bureau of investigation for a national criminal records check. The results of the national criminal records check shall be made available to the applicant undergoing a record check and submitting fingerprints.

(g) Upon the discovery of any disqualifying information, as defined in § 42-7.2-18.2 and as in accordance with the regulations promulgated by the executive office of health and human services, the bureau of criminal identification of the department of the attorney general will inform the applicant, in writing, of the nature of the disqualifying information; and, without disclosing the nature of the disqualifying information, will notify the executive office of health and human services, in writing, that disqualifying information has been discovered.

(h) In those situations, in which no disqualifying information has been found, the bureau of criminal identification of the department of the attorney general shall inform the applicant and the executive office of health and human services, in writing, of this fact.

(i) The applicant shall be responsible for the cost of conducting the national criminal records check through the bureau of criminal identification of the department of attorney general.

42-7.2-18.2. Professional responsibility – Criminal records check disqualifying information for high-risk providers.

(a) Information produced by a national criminal records check pertaining to conviction, for the following crimes will result in a letter to the executive office of health and human services , disqualifying the applicant from being a medicaid provider: murder, voluntary manslaughter, involuntary manslaughter, first degree sexual assault, second degree sexual assault, third degree sexual assault, assault on persons sixty (60) years of age or older, assault with intent to commit specified felonies (murder, robbery, rape, burglary, or the abominable and detestable crime against nature) felony assault, patient abuse, neglect or mistreatment of patients, burglary, first degree arson, robbery, felony drug offenses, felony larceny, or felony banking law violations, felony obtaining money under false pretenses, felony embezzlement, abuse, neglect and/or exploitation of adults with severe impairments, exploitation of elders, or a crime under section 1128 (a) of the Social Security Act (42 U.S.C. 1320a-7(a)). An applicant against whom disqualifying information has been found, for purposes of appeal, may provide a copy of the national criminal records check to the executive office of health and human services, who shall make a judgment regarding the approval of or the continued status of that person as a provider.

(b) For purposes of this section, "conviction" means, in addition to judgments of conviction entered by a court subsequent to a finding of guilty or a plea of guilty, those instances where the defendant has entered a plea of nolo contendere and has received a sentence of probation and those instances where a defendant has entered into a deferred sentence agreement with the attorney general.

42-7.2-18.3. Professional responsibility – Criminal records check for personal care aides.

(a) Any person seeking employment to provide care to elderly or individuals with disabilities who is, or may be required to be, licensed, registered, trained or certified with the office of medicaid if that employment involves routine contact with elderly or individuals with disabilities without the presence of other employees, shall undergo a national criminal records check supported by fingerprints. The applicant will report to the office of attorney general, bureau of criminal identification to submit their fingerprints. The fingerprints will subsequently be submitted to the federal bureau of investigation (FBI) by the bureau of criminal identification of the office of attorney general. The national criminal records check shall be initiated prior to, or within one week of, employment.

(b) The director of the office of medicaid may, by rule, identify those positions requiring criminal records checks. The identified employee, through the executive office of health and human services, shall apply to the bureau of criminal identification of the department of attorney general for a national criminal records check. Upon the discovery of any disqualifying information, as defined in § 42-7.2-18.4 and in accordance with the rule promulgated by the secretary of the executive office of health and human services, the bureau of criminal identification of the department of the attorney general will inform the applicant, in writing, of the nature of the disqualifying information; and, without disclosing the nature of the disqualifying information, will notify the executive office of health and human services executive office of health and human services in writing, that disqualifying information has been discovered.

(c) An applicant against whom disqualifying information has been found, for purposes of appeal, may provide a copy of the national criminal history check to the executive office of health and human services, who shall make a judgment regarding the approval of the applicant.

(d) In those situations, in which no disqualifying information has been found, the bureau of criminal identification of the department of the attorney general shall inform the applicant and the executive office health and human services, in writing, of this fact.

(e) The executive office of health and human services shall maintain on file evidence that criminal records checks have been initiated on all applicants subsequent to July 1, 2022.

(f) The applicant shall be responsible for the cost of conducting the national criminal records check through the bureau of criminal identification of the department of the attorney general.

42-7.2-18.4. Professional responsibility – Criminal records check disqualifying information for personal care aides.

(a) Information produced by a national criminal records check pertaining to conviction, for the following crimes will result in a letter to the applicant and the executive office of health and human services , disqualifying the applicant: murder, voluntary manslaughter, involuntary manslaughter, first degree sexual assault, second degree sexual assault, third degree sexual assault, assault on persons sixty (60) years of age or older, assault with intent to commit specified felonies (murder, robbery, rape, burglary, or the abominable and detestable crime against nature) felony assault, patient abuse, neglect or mistreatment of patients, burglary, first degree arson, robbery, felony drug offenses, felony larceny, or felony banking law violations, felony obtaining money under false pretenses, felony embezzlement, abuse, neglect and/or exploitation of adults with severe impairments, exploitation of elders, or a crime under section 1128(a) of the Social Security Act (42 U.S.C. 1320a-7(a)).

(b) For purposes of this section, "conviction" means, in addition to judgments of conviction entered by a court subsequent to a finding of guilty or a plea of guilty, those instances where the defendant has entered a plea of nolo contendere and has received a sentence of probation and those instances where a defendant has entered into a deferred sentence agreement with the attorney general.

SECTION 3. Section 23-17-38.1 of the General Laws in Chapter 23-17 entitled "Licensing of Health Care Facilities" is hereby amended to read as follows:

23-17-38.1. Hospitals — Licensing fee. ~~(a) There is imposed a hospital licensing fee at the rate of six percent (6%) upon the net patient services revenue of every hospital for the hospital's first fiscal year ending on or after January 1, 2018, except that the license fee for all hospitals located in Washington County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for Washington County hospitals is subject to approval by the Secretary of the U.S. Department of Health and Human Services of a state plan amendment submitted by the executive office of health and human services for the purpose of pursuing a waiver of the uniformity requirement for the hospital license fee. This licensing fee shall be administered and collected by~~

~~the tax administrator, division of taxation within the department of revenue, and all the administration, collection, and other provisions of Chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before July 13, 2020, and payments shall be made by electronic transfer of monies to the general treasurer and deposited to the general fund. Every hospital shall, on or before June 15, 2020, make a return to the tax administrator containing the correct computation of net patient services revenue for the hospital fiscal year ending September 30, 2018, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.~~

~~(b)~~ (a) There is also imposed a hospital licensing fee for state fiscal year 2021 against each hospital in the state. The hospital licensing fee is equal to five percent (5.0%) of the net patient-services revenue of every hospital for the hospital's first fiscal year ending on or after January 1, 2019, except that the license fee for all hospitals located in Washington County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for Washington County hospitals is subject to approval by the Secretary of the U.S. Department of Health and Human Services of a state plan amendment submitted by the executive office of health and human services for the purpose of pursuing a waiver of the uniformity requirement for the hospital license fee. This licensing fee shall be administered and collected by the tax administrator, division of taxation within the department of revenue, and all the administration, collection, and other provisions of Chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before July 13, 2021, and payments shall be made by electronic transfer of monies to the general treasurer and deposited to the general fund. Every hospital shall, on or before June 15, 2020, make a return to the tax administrator containing the correct computation of net patient-services revenue for the hospital fiscal year ending September 30, 2019, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.

~~(c)~~ (b) There is also imposed a hospital licensing fee for state fiscal year 2022 against each hospital in the state. The hospital licensing fee is equal to five and seven hundred twenty-five thousandths percent (5.725%) of the net patient-services revenue of every hospital for the hospital's first fiscal year ending on or after January 1, 2020, except that the license fee for all hospitals located in Washington County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for Washington County hospitals is subject to approval by the Secretary of the U.S. Department of Health and Human Services of a state plan amendment submitted by the executive office of health and human services for the purpose of pursuing a waiver of the uniformity requirement for the hospital license fee. This licensing fee shall be administered and collected by

the tax administrator, division of taxation within the department of revenue, and all the administration, collection, and other provisions of Chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before July 13, 2022, and payments shall be made by electronic transfer of monies to the general treasurer and deposited to the general fund. Every hospital shall, on or before June 15, 2022, make a return to the tax administrator containing the correct computation of net patient-services revenue for the hospital fiscal year ending September 30, 2020, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.

(c) There is also imposed a hospital licensing fee for state fiscal year 2023 against each hospital in the state. The hospital licensing fee is equal to five and seven hundred twenty-five thousandths percent (5.725%) of the net patient-services revenue of every hospital for the hospital's first fiscal year ending on or after January 1, 2020, except that the license fee for all hospitals located in Washington County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for Washington County hospitals is subject to approval by the Secretary of the U.S. Department of Health and Human Services of a state plan amendment submitted by the executive office of health and human services for the purpose of pursuing a waiver of the uniformity requirement for the hospital license fee. This licensing fee shall be administered and collected by the tax administrator, division of taxation within the department of revenue, and all the administration, collection, and other provisions of Chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before July 13, 2023, and payments shall be made by electronic transfer of monies to the general treasurer and deposited to the general fund. Every hospital shall, on or before June 15, 2023, make a return to the tax administrator containing the correct computation of net patient-services revenue for the hospital fiscal year ending September 30, 2020, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.

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

(1) "Hospital" means the actual facilities and buildings in existence in Rhode Island, licensed pursuant to § 23-17-1 et seq. on June 30, 2010, and thereafter any premises included on that license, regardless of changes in licensure status pursuant to chapter 17.14 of title 23 (hospital conversions) and § 23-17-6(b) (change in effective control), that provides short-term acute inpatient and/or outpatient care to persons who require definitive diagnosis and treatment for injury, illness, disabilities, or pregnancy. Notwithstanding the preceding language, the negotiated Medicaid managed care payment rates for a court-approved purchaser that acquires a hospital through

receivership, special mastership, or other similar state insolvency proceedings (which court-approved purchaser is issued a hospital license after January 1, 2013) shall be based upon the newly negotiated rates between the court-approved purchaser and the health plan, and such rates shall be effective as of the date that the court-approved purchaser and the health plan execute the initial agreement containing the newly negotiated rate. The rate-setting methodology for inpatient hospital payments and outpatient hospital payments set forth in §§ 40-8-13.4(b) and 40-8-13.4(b)(2), respectively, shall thereafter apply to negotiated increases for each annual twelve-month (12) period as of July 1 following the completion of the first full year of the court-approved purchaser's initial Medicaid managed care contract.

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

(3) "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.

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

(f) The licensing fee imposed by subsection ~~(b)~~ (a) shall apply to hospitals as defined herein that are duly licensed on July 1, 2020, and shall be in addition to the inspection fee imposed by § 23-17-38 and to any licensing fees previously imposed in accordance with this section.

(g) The licensing fee imposed by subsection ~~(c)~~ (b) shall apply to hospitals as defined herein that are duly licensed on July 1, 2021, and shall be in addition to the inspection fee imposed by § 23-17-38 and to any licensing fees previously imposed in accordance with this section.

(e) The licensing fee imposed by subsection (c) shall apply to hospitals as defined herein that are duly licensed on July 1, 2022, and shall be in addition to the inspection fee imposed by § 23-17-38 and to any licensing fees previously imposed in accordance with this section.

SECTION 4. 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, ~~2020~~ 2021, the period from October 1, ~~2018~~ 2019, through September 30, ~~2019~~ 2020, and for any fiscal year ending after September 30, ~~2021~~ 2022, the period from October 1, 2019, through September 30, 2020.

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

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

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

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

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

(4) "Uncompensated-care costs" means, as to any hospital, the sum of: (i) The cost incurred by the hospital during the base year for inpatient or outpatient services attributable to charity care (free care and bad debts) for which the patient has no health insurance or other third-party coverage less payments, if any, received directly from such patients; and (ii) The cost incurred by the hospital during the base year for inpatient or outpatient services attributable to Medicaid beneficiaries less any Medicaid reimbursement received therefor; multiplied by the uncompensated-care index.

(5) "Uncompensated-care index" means the annual percentage increase for hospitals established pursuant to § 27-19-14 [repealed] for each year after the base year, up to and including

the payment year; provided, however, that the uncompensated-care index for the payment year ending September 30, 2007, shall be deemed to be five and thirty-eight hundredths percent (5.38%), and that the uncompensated-care index for the payment year ending September 30, 2008, shall be deemed to be five and forty-seven hundredths percent (5.47%), and that the uncompensated-care index for the payment year ending September 30, 2009, shall be deemed to be five and thirty-eight hundredths percent (5.38%), and that the uncompensated-care index for the payment years ending September 30, 2010, September 30, 2011, September 30, 2012, September 30, 2013, September 30, 2014, September 30, 2015, September 30, 2016, September 30, 2017, September 30, 2018, September 30, 2019, September 30, 2020, September 30, 2021, ~~and~~ September 30, 2022, and September 30, 2023 shall be deemed to be five and thirty hundredths percent (5.30%).

40-8.3-3. Implementation.

~~(a) For federal fiscal year 2020, commencing on October 1, 2019, and ending September 30, 2020, the executive office of health and human services shall submit to the Secretary of the United States Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:~~

~~(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $142.4 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and~~

~~(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year inflated by the uncompensated care index for all participating hospitals. The disproportionate share payments shall be made on or before July 13, 2020, and are expressly conditioned upon approval on or before July 6, 2020, by the Secretary of the United States Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2020 for the disproportionate share payments.~~

~~(b)~~ (a) For federal fiscal year 2021, commencing on October 1, 2020, and ending September 30, 2021, the executive office of health and human services shall submit to the Secretary of the United States Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $142.5 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated-care costs for the base year, inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by the uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before July 12, 2021, and are expressly conditioned upon approval on or before July 5, 2021, by the Secretary of the United States department of health and human services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2021 for the disproportionate share payments.

~~(c)~~ (b) For federal fiscal year 2022, commencing on October 1, 2021, and ending September 30, 2022, the executive office of health and human services shall submit to the Secretary of the United States Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of ~~$143.8~~ $142.5 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated-care costs for the base year, inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by the uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before July 12, 2022, and are expressly conditioned upon approval on or before July 5, 2022, by the Secretary of the United States Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2022 for the disproportionate share payments.

(c) For federal fiscal year 2023, commencing on October 1, 2022, and ending September 30, 2023, the executive office of health and human services shall submit to the Secretary of the United States Department of Health and Human Services a state plan amendment to the Rhode Island Medicaid DSH Plan to provide:

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $142.5 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and

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

inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by the uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before July 12, 2023, and are expressly conditioned upon approval on or before July 5, 2023, by the Secretary of the United States Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2023 for the disproportionate share payments.

(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 5. Section 40-8.19 of the General Laws in Chapter 40-8 entitled “Medical Assistance” is hereby amended to read as follows:

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

(a) **Rate reform.**

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

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

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

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

(iii) A rearray of costs for all facilities every three (3) years beginning October, 2015, that may or may not result in automatic per diem revisions;

(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, ~~and~~ 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. The inflation index shall be applied without regard for the transition factors in subsections (b)(1) and (b)(2). For purposes of October 1, 2016, adjustment only, any rate increase that results from application of the inflation index to subsections (a)(2)(i) and (a)(2)(ii) shall be dedicated to increase compensation for direct-care workers in the following manner: Not less than 85% of this aggregate amount shall be expended to fund an increase in wages, benefits, or related employer costs of direct-care staff of nursing homes. For purposes of this section, direct-care staff shall include registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), certified medical technicians, housekeeping staff, laundry staff, dietary staff, or other similar employees providing direct-care services; provided, however, that this definition of direct-care staff shall not include: (i) RNs and LPNs who are classified as "exempt employees" under the federal Fair Labor Standards Act (29 U.S.C. § 201 et seq.); or (ii) CNAs, certified medical technicians, RNs, or LPNs who are contracted, or subcontracted, through a third-party vendor or staffing agency. By July 31, 2017, nursing facilities shall submit to the secretary, or designee, a certification that they have complied with the provisions of this subsection (a)(2)(vi) with respect to the inflation index applied on October 1, 2016. Any facility that does not comply with 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, housekeeping staff, laundry staff, dietary staff or other similar employees providing direct-care services; provided, however that this definition of direct-care staff shall not include:

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

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

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

(ii) Any facility that does not comply with the terms of certification shall be subjected to a clawback and twenty-five percent (25%) penalty of the unspent or impermissibly spent funds, paid

by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification.

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

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

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

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

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

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

SECTION 6. Section 40-8.9-4 of the General Laws in Chapter 40-8.9 entitled “Medical Assistance — Long-Term Care Service and Finance Reform” is hereby amended to read as follows:

40-8.9-4. Unified long-term care budget.

Beginning on July 1, 2007, but not including state fiscal year 2023, a unified long-term-care budget shall combine in a single, line-item appropriation within the executive office of health and human services (executive office), annual executive office Medicaid appropriations for nursing

facility and community-based, long-term-care services for elderly sixty-five (65) years and older and younger persons at risk of nursing home admissions (including adult day care, home health, PACE, and personal care in assisted-living settings). Beginning on July 1, 2007, but not including state fiscal year 2023, the total system savings attributable to the value of the reduction in nursing home days including hospice nursing home days paid for by Medicaid shall be allocated in the budget enacted by the general assembly for the ensuing fiscal year for the express purpose of promoting and strengthening community-based alternatives; provided, further, beginning July 1, 2009, but not including state fiscal year 2023, said savings shall be allocated within the budgets of the executive office and, as appropriate, the department of human services, office of healthy aging. The allocation shall include, but not be limited to, funds to support an ongoing, statewide community education and outreach program to provide the public with information on home and community services and the establishment of presumptive eligibility criteria for the purposes of accessing home and community care. Notwithstanding the foregoing, for state fiscal year 2023, enhanced federal medical assistance percentage funding provided through the American Rescue Plan Act (ARPA) specifically for enhancement and expansion of home and community-based (HCBS) services, may be used to satisfy the total system savings reallocation to strengthening community-based alternatives and funding requirements of this section. The home- and community-care service presumptive eligibility criteria shall be developed through rule or regulation on or before September 30, 2007. The allocation may also be used to fund home and community services provided by the office of healthy aging for persons eligible for Medicaid long-term care, and the co-pay program administered pursuant to chapter 66.3 of title 42. Any monies in the allocation that remain unexpended in a fiscal year shall be carried forward to the next fiscal year for the express purpose of strengthening community-based alternatives.

The caseload estimating conference pursuant to § 35-17-1 shall determine the amount of general revenues to be added to the current service estimate of community-based, long-term-care services for elderly sixty-five (65) and older and younger persons at risk of nursing home admissions for the ensuing budget year by multiplying the combined, cost per day of nursing home and hospice nursing home days estimated at the caseload conference for that year by the reduction in nursing home and hospice nursing home days from those in the second fiscal year prior to the current fiscal year to those in the first fiscal year prior to the current fiscal year.

SECTION 7. Sections 42-12.3-3, 42-12.3-4 and 42-12.3-15 of the General Laws in Chapter 42-12.3 “Health Care for Children and Pregnant Women” are hereby amended to read as follows:

42-12.3-3. Medical assistance expansion for pregnant women/RIte Start.

(a) The ~~director of the department of human services~~ secretary of the executive office of health and human services is authorized to amend its Title XIX state plan pursuant to Title XIX of the Social Security Act to provide Medicaid coverage and to amend its Title XXI state plan pursuant to Title XXI of the Social Security Act to provide medical assistance coverage through expanded family income disregards for pregnant women whose family income levels are between one hundred eighty-five percent (185%) and two hundred fifty percent (250%) of the federal poverty level. The department is further authorized to promulgate any regulations necessary and in accord with Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security Act necessary in order to implement said state plan amendment. The services provided shall be in accord with Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security Act.

(b) The ~~director of the department of human services~~ secretary of health and human services is authorized and directed to establish a payor of last resort program to cover prenatal, delivery and postpartum care. The program shall cover the cost of maternity care for any woman who lacks health insurance coverage for maternity care and who is not eligible for medical assistance under Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security Act including, but not limited to, a noncitizen pregnant woman lawfully admitted for permanent residence on or after August 22, 1996, without regard to the availability of federal financial participation, provided such pregnant woman satisfies all other eligibility requirements. The ~~director~~ secretary shall promulgate regulations to implement this program. Such regulations shall include specific eligibility criteria; the scope of services to be covered; procedures for administration and service delivery; referrals for non-covered services; outreach; and public education. Excluded services under this subsection will include, but not be limited to, induced abortion except in cases of rape or incest or to save the life of the pregnant individual.

(c) The ~~department of human services~~ secretary of health and human services may enter into cooperative agreements with the department of health and/or other state agencies to provide services to individuals eligible for services under subsections (a) and (b) above.

(d) The following services shall be provided through the program:

(1) Ante-partum and postpartum care;

(2) Delivery;

(3) Cesarean section;

(4) Newborn hospital care;

(5) Inpatient transportation from one hospital to another when authorized by a medical provider; and

(6) Prescription medications and laboratory tests.

(e) The ~~department of human services~~ secretary of health and human services shall provide enhanced services, as appropriate, to pregnant women as defined in subsections (a) and (b), as well as to other pregnant women eligible for medical assistance. These services shall include: care coordination, nutrition and social service counseling, high risk obstetrical care, childbirth and parenting preparation programs, smoking cessation programs, outpatient counseling for drug-alcohol use, interpreter services, mental health services, and home visitation. The provision of enhanced services is subject to available appropriations. In the event that appropriations are not adequate for the provision of these services, the ~~department~~ executive office has the authority to limit the amount, scope and duration of these enhanced services.

(f) The ~~department of human services~~ executive office of health and human services shall provide for extended family planning services for up to twenty-four (24) months postpartum. These services shall be available to women who have been determined eligible for RIte Start or for medical assistance under Title XIX [42 U.S.C. § 1396 et seq.] or Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security Act.

(g) Effective October 1, 2022, individuals eligible for RIte Start pursuant to this section or for medical assistance under Title XIX or Title XXI of the Social Security Act while pregnant (including during a period of retroactive eligibility), are eligible for full Medicaid benefits through the last day of the month in which their twelve (12) month postpartum period ends. This benefit will be provided to eligible Rhode Island residents without regard to the availability of federal financial participation. The executive office of health and human services is directed to ensure that federal financial participation is used to the maximum extent allowable to provide coverage pursuant to this section, and that state-only funds will be used only if federal financial participation is not available.

42-12.3-4. "RIte track" program.

(a) There is hereby established a payor of last resort program for comprehensive health care for children until they reach nineteen (19) years of age, to be known as "RIte track." The ~~department of human services~~ executive office of health and human services is hereby authorized to amend its Title XIX state plan pursuant to Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security Act as necessary to provide for expanded Medicaid coverage through expanded family income disregards for children, until they reach nineteen (19) years of age, whose family income levels are up to two hundred fifty percent (250%) of the federal poverty level. Provided, however, that healthcare coverage provided under this section shall also be provided without regard to the availability of federal financial participation ~~in~~

~~accordance to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.,~~ to a noncitizen child who is a resident of Rhode Island ~~lawfully residing in the United States~~, and who is otherwise eligible for such assistance. The department is further authorized to promulgate any regulations necessary, and in accord with Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI [42 U.S.C. § 1397aa et seq.] of the Social Security Act as necessary in order to implement the state plan amendment. For those children who lack health insurance, and whose family incomes are in excess of two hundred fifty percent (250%) of the federal poverty level, the department of human services shall promulgate necessary regulations to implement the program. The department of human services is further directed to ascertain and promulgate the scope of services that will be available to those children whose family income exceeds the maximum family income specified in the approved Title XIX [42 U.S.C. § 1396 et seq.] and Title XXI [42 U.S.C. § 1397aa et seq.] state plan amendment.

(b) The executive office of health and human services is directed to ensure that federal financial participation is used to the maximum extent allowable to provide coverage pursuant to this section, and that state-only funds will be used only if federal financial participation is not available.

42-12.3-15. Expansion of RIte track program.

(a) The ~~Department of Human Services~~ executive office of health and human services is hereby authorized and directed to submit to the United States Department of Health and Human Services an amendment to the "RIte Care" waiver project number 11-W-0004/1-01 to provide for expanded Medicaid coverage for children until they reach eight (8) years of age, whose family income levels are to two hundred fifty percent (250%) of the federal poverty level. Expansion of the RIte track program from the age of six (6) until they reach eighteen (18) years of age in accordance with this chapter shall be subject to the approval of the amended waiver by the United States Department of Health and Human Services. Healthcare coverage under this section shall also be provided to a noncitizen child ~~lawfully residing in the United States~~ who is a resident of Rhode Island, and who is otherwise eligible for such assistance under Title XIX [42 U.S.C. § 1396 et seq.] or Title XXI [42 U.S.C. § 1397aa et seq.]

(b) The executive office of health and human services is directed to ensure that federal financial participation is used to the maximum extent allowable to provide coverage pursuant to this section, and that state-only funds will be used only if federal financial participation is not available.

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

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

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

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

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

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

(a) Section 1115 Demonstration Waiver – Extension Request. The Executive Office proposes to seek approval from the federal centers for Medicare and Medicaid services ("CMS") to extend the Medicaid section 1115 demonstration waiver as authorized in Rhode Island General Laws § 42-12.4. In the Medicaid section 1115 demonstration waiver extension request due to CMS by December 31, 2022, in addition to maintaining existing Medicaid section 1115 demonstration waiver authorities, the Executive Office proposes to seek additional federal authorities including but not limited to promoting choice and community integration.

(b) Meals on Wheels. The Executive Office proposes an increase to existing fee-for-service and managed care rates to account for growing utilization and rising food and delivery costs. Additionally, the Executive Office of Health and Human Services will offer new Medicaid reimbursement for therapeutic and cultural meals that are specifically tailored to improve health through nutrition, provide post discharge support, and bolster complex care management for those with chronic health conditions. To ensure the continued adequacy of rates, effective July 1, 2022, and annually thereafter, the Executive Office proposes an annual rate increase based on the CPI-U for New England: Food at Home, March release (containing the February data).

(c) American Rescue Act. The Executive Office proposes to seek approval from CMS for any necessary amendments to the Rhode Island State Plan or the 1115 Demonstration Waiver to implement the spending plan approved by CMS under section 9817 of the American Rescue Plan Act of 2021.

(d) HealthSource RI automatic enrollment: The Executive Office shall work with HealthSource RI to establish a program for automatically enrolling qualified individuals who lose Medicaid coverage at the end of the COVID-19 Public Health Emergency into Qualified Health Plans ("QHP"). HealthSource RI may use funds available through the American Rescue Plan Act to pay the first month's premium for individuals who qualify for this program. HealthSource RI may promulgate regulations establishing the scope and parameters of this program.

(e) Increase Nursing Facility Rates. The Executive Office proposes to increase rates, both fee-for-service and managed care, paid to nursing facilities by three percent (3.0%) on October 1, 2022, in lieu of the adjustment of rates by the change in a recognized national home inflation index as defined in § 40-8-19 (2)(vi) and in addition to the one percent (1.0%) increase required for the minimum wage pass through as defined in § 40-8-19 (2)(vi).

(f) Extend Post-Partum Medicaid Coverage. The Executive Office proposes extending the continuous coverage of full benefit medical assistance from sixty (60) days to twelve (12) months postpartum to women who are (1) not eligible for Medicaid under another Medicaid eligibility category, or (2) do not have qualified immigrant status for Medicaid whose births are financed by Medicaid through coverage of the child and currently only receive state-only extended family planning benefits postpartum.

(g) Extending Medical Coverage to Children Previously Ineligible. The executive office of health and human services will maximize federal financial participation if and when available, though state-only funds will be used if federal financial participation is not available.

(h) Federal Financing Opportunities. The Executive Office proposes to 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 service quality, access and cost-effectiveness that may warrant 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 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 2021.

Now, therefore, be it:

RESOLVED, that the General Assembly hereby approves the proposals stated above in the recitals; and be it further;

RESOLVED, that the Secretary of the Executive Office of Health and Human Services is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the applicable department's rules, regulations and procedures approved herein and as authorized by 42-12.4; and be it further;

RESOLVED, that this Joint Resolution shall take effect upon passage.

SECTION 9. Sections 1 – 7 of this Article shall take effect as of July 1, 2022. Section 8 shall take effect upon passage.