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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2024

A N A C T

RELATING TO HEALTH AND SAFETY -- THE RHODE ISLAND COMPREHENSIVE HEALTH INSURANCE PROGRAM

Introduced By: Representatives Morales, Potter, Handy, Stewart, Cruz, J. Lombardi, Batista, Tanzi, Cotter, and Giraldo
Date Introduced: May 03, 2024

Referred To: House Finance

It is enacted by the General Assembly as follows:

Title 23 of the General Laws entitled "HEALTH AND SAFETY" is hereby amended by adding thereto the following chapter:

CHAPTER 100

THE RHODE ISLAND COMPREHENSIVE HEALTH INSURANCE PROGRAM

23-100-1. Legislative findings.

(1) Health care is a human right, not a commodity available only to those who can afford it;

(2) Although the federal Affordable Care Act (ACA) allowed states to offer more people taxpayer subsidized private health insurance, the ACA has not provided universal, comprehensive, affordable coverage for all Rhode Islanders:

(i) In 2019, about four and three-tenths percent (4.3%) of Rhode Islanders had no health insurance, causing about forty-three (43) (1 per 1,000 uninsured) unnecessary deaths each year;

(ii) An estimated forty-five percent (45%) of Rhode Islanders are under-insured (e.g., not seeking health care because of high deductibles and co-pays);

(3) COVID-19 exacerbated and highlighted problems with the status quo health insurance system including:

(i) Coverage is too easily lost when health insurance is tied to jobs - between February and May, 2020, about twenty-one thousand (21,000) more Rhode Islanders lost their jobs and their

health insurance;

(ii) Systemic racism is reinforced - Black and Hispanic/Latinx Rhode Islanders, are more likely to be uninsured or underinsured, have suffered the highest rates of COVID-19 mortality and morbidity;

(iii) The fear of out-of-pocket costs for uninsured and underinsured puts everyone at risk because they avoid testing and treatment;

(4) In 2016, sixty million (60,000,000) people separated from their job at some point during the year (i.e., about forty-two percent (42%) of the American workforce) and although this act may cause some job loss, on balance, single payer would increase employment in Rhode Island by nearly three percent (3%);

(5) The existing US health insurance system has failed to control the cost of health care and to provide universal access to health care in a system which is widely accepted to waste thirty percent (30%) of its revenues on activities that do not improve the health of Americans;

(6) Every industrialized nation in the world, except the United States, offers universal health care to its citizens and enjoys better health outcomes for less than two thirds (2/3) to one-half (1/2) the cost;

(7) Health care is rationed under our current multi-payer system, despite the fact that Rhode Island patients, businesses and taxpayers already pay enough to have comprehensive and universal health insurance under a single-payer system;

(8) About one-third (1/3) of every "healthcare" dollar spent in the U.S. is wasted on unnecessary administrative costs and excessive pharmaceutical company profits due to laws preventing Medicare from negotiating prices and private health insurance companies lacking adequate market share to effectively negotiate prices;

(9) Private health insurance companies are incentivized to let the cost of health care rise because higher costs require health insurance companies to charge higher health insurance premiums, increasing companies' revenue and stock price;

(10) The healthcare marketplace is not an efficient market and because it represents only eighteen percent (18%) of the US domestic market, significantly restricts economic growth and thus the financial well-being of every American, including every Rhode Islander;

(11) Rhode Islanders cannot afford to keep the current multi-payer health insurance system:

(i) Between 1991 and 2014, healthcare spending in Rhode Island per person rose by over two hundred fifty percent (250%) rising much faster than income and greatly reducing disposable income;

(ii) It is estimated that by 2025, the cost of health insurance for an average family of four

(4) will equal about one-half (1/2) of their annual income;

(iii) In the U.S., about two-thirds (2/3) of personal bankruptcies are medical cost-related and of these, about three-fourths (3/4) had health insurance at the onset of their medical problems. In no other industrialized country do people worry about going bankrupt over medical costs;

(12) Rhode Island private businesses bear most of the costs of employee health insurance coverage and spend significant time and money choosing from a confusing array of increasingly expensive plans which do not provide comprehensive coverage;

(13) Rhode Island employees and retirees lose significant wages and pensions as they are forced to pay higher amounts of health insurance and healthcare costs;

(14) Rhode Island's hospitals are under increasing financial distress i.e., closing, sold to out-of-state entities, attempting mergers largely due to health insurance reimbursement problems that other nations do not face and are fixed by a single-payer system;

(15) The state and its municipalities face enormous other post-employment benefits (OPEB) unfunded liabilities due mostly to health insurance costs;

(16) An improved Medicare-for-all style single-payer program would, based on the performance of existing Medicare, eliminate fifty percent (50%) of the administrative waste in the current system of private insurance before other savings achieved through meaningful negotiation of prices and other savings are considered;

(17) The high costs of medical care could be lowered significantly if the state could negotiate on behalf of all its residents for bulk purchasing, as well as gain access to usage and price information currently kept confidential by private health insurers as "proprietary information;"

(18) Single payer health care would establish a true "free market" system where doctors compete for patients rather than health insurance companies dictating which patients are able to see which doctors and setting reimbursement rates;

(19) Healthcare providers would spend significantly less time with administrative work caused by multiple health insurance company requirements and barriers to care delivery and would spend significantly less for overhead costs because of streamlined billing;

(20) Rhode Island must act because there are currently no effective state or federal laws that can provide universal coverage and adequately control rising premiums, co-pays, deductibles and medical costs, or prevent private insurance companies from continuing to limit available providers and coverage;

(21) In 1962, Canada's successful single-payer program began in the province of Saskatchewan (with approximately the same population as Rhode Island) and became a national program within ten (10) years; and

(22) The proposed Rhode Island single payer program was studied by Professor Gerald Friedman at UMass Amherst in 2015 and he concluded that:

"Single-payer in Rhode Island will finance medical care with substantial savings compared with the existing multi-payer system of public and private insurers and would improve access to health care by extending coverage to the four percent (4%) of Rhode Island residents still without insurance under the Affordable Care Act and expanding coverage for the growing number with inadequate healthcare coverage. Single-payer would improve the economic health of Rhode Island by: increasing real disposable income for most residents; reducing the burden of health care on businesses and promoting increased employment; and shifting the costs of health care away from working and middle-class residents."

23-100-2. Legislative purpose.

It is the intent of the general assembly that this chapter establish a universal, comprehensive, affordable single-payer healthcare insurance program that will help control healthcare costs which shall be referred to as, "the Rhode Island comprehensive health insurance program" (RICHIP). The program will be paid for by consolidating government and private payments to multiple insurance carriers into a more economical and efficient improved Medicare-for-all style single-payer program and substituting lower progressive taxes for higher health insurance premiums, co-pays, deductibles and costs in excess of caps. This program will save Rhode Islanders from the current overly expensive, inefficient and unsustainable multi-payer health insurance system that unnecessarily prevents access to medically necessary health care. The program will be established after the standard of care funded by Medicaid has been raised to a Medicare standard.

23-100-3. Definitions.

As used in this chapter:

(1) "Affordable Care Act" or "ACA" means the Federal Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(2) "Carrier" means either a private health insurer authorized to sell health insurance in Rhode Island or a healthcare service plan, i.e., any person who undertakes to arrange for the provision of healthcare services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees, or any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost

of, or who undertakes to arrange or arranges for, the provision of healthcare services that are to be provided, wholly or in part, in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(3) "Dependent" has the same definition as set forth in federal tax law (26 U.S.C. § 152).

(4) "Emergency and urgently needed services" has the same definition as set forth in the federal Medicare law (42 CFR 422.113).

(5) "Federally matched public health program" means the state's Medicaid program under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.) and the state's Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(6) "For-profit provider" means any healthcare professional or healthcare institution that provides payments, profits or dividends to investors or owners who do not directly provide health care.

(7) "Health insurance" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the health insurance commissioner, that contracts or offers to contract, to provide and/or insuring health services on a prepaid basis, including, but not limited to, policies of accident and sickness insurance, as defined by chapter 18 of title 27, nonprofit hospital service corporation as defined by chapter 19 of title 27, and nonprofit medical service corporation as defined in chapter 20 of title 27, a health maintenance organizations, as defined in chapter 41 of title 27 and also includes a nonprofit dental service corporation, as defined in chapter 20.1 of title 27, all nonprofit optometric service corporations, as defined in chapter 20.2 of title 27, a domestic insurance company subject to chapter 1 of title 27 that offers or provides health insurance coverage in the state, and a foreign insurance company, subject to chapter 2 of title 27, all pharmacy benefit managers (PBMs) that contracts to administer or manage prescription drug benefits, any plan preempted by ERISA, but subject to state control (specifically state government, local government, and quasi-public agency ERISA plans).

(8) "Medicaid" or "medical assistance" means a program that is one of the following:

(i) The state's Medicaid program under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.); or

(ii) The state's Children's Health Insurance Program under Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(9) "Medically necessary" means medical, surgical or other services or goods (including prescription drugs) required for the prevention, diagnosis, cure, or treatment of a health-related condition including any such services that are necessary to prevent a detrimental change in either

medical or mental health status. Medically necessary services shall be provided in a cost-effective and appropriate setting and shall not be provided solely for the convenience of the patient or service provider. "Medically necessary" does not include services or goods that are primarily for cosmetic purposes; and does not include services or goods that are experimental, unless approved pursuant to § 23-100-6(b).

(10) "Medicare" means Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.) and the programs thereunder.

(11) "Qualified healthcare provider" means any individual who meets requirements set forth in § 23-100-7(a)(1).

(12) "Qualified Rhode Island resident" means any individual who is a "resident" as defined by §§ 44-30-5(a)(1) and (a)(2) or a dependent of that resident.

(13) "Rhode Island comprehensive health insurance program" or ("RICHIP") means the affordable, comprehensive and effective health insurance program as set forth in this chapter.

(14) "RICHIP participant" means a qualified Rhode Island resident who is enrolled in RICHIP (and not disenrolled or disqualified) at the time they seek health care.

23-100-4. Rhode Island health insurance program.

(a) Organization. This chapter creates the Rhode Island comprehensive health insurance program (RICHIP), as an independent state government agency.

(b) Director. A director shall be appointed by the governor, with the advice and consent of the senate, to lead RICHIP and serve a term of four (4) years, subject to oversight by an executive board. The director shall be compensated in accordance with the job title and job classification established by the division of human resources and approved by the general assembly. The duties of the director shall include:

(1) Employ staff and authorize reasonable expenditures, as necessary, from the RICHIP trust fund, to pay program expenses and to administer the program, including creation and oversight of RICHIP budgets;

(2) Oversee management of the RICHIP trust fund set forth in § 23-100-12(a) to ensure the operational well-being and fiscal solvency of the program, including ensuring that all available funds from all appropriate sources are collected and placed into the trust fund;

(3) Take any actions necessary and proper to implement the provisions of this chapter;

(4) Implement standardized claims and reporting procedures;

(5) Provide for timely payments to participating providers through a structure that is well organized and that eliminates unnecessary administrative costs, i.e., coordinate with the state comptroller to facilitate billing from and payments to providers using the state's computerized

financial system, the Rhode Island financial and accounting network system (RIFANS);

(6) Coordinate with federal healthcare programs, including Medicare and Medicaid, to obtain necessary waivers and streamline federal funding and reimbursement;

(7) Monitor billing and reimbursements to detect inappropriate behavior by providers and patients and create prohibitions and penalties regarding bad faith or criminal RICHIP participation, and procedures by which they will be enforced;

(8) Support the development of an integrated healthcare database for healthcare planning and quality assurance and ensure the legally required confidentiality of all health records it contains;

(9) Determine eligibility for RICHIP and establish procedures for enrollment, disenrollment and disqualification from RICHIP, as well as procedures for handling complaints and appeals from affected individuals, as set forth in § 29-100-5;

(10) Create RICHIP expenditure, status, and assessment reports, including, but not limited to, annual reports with the following:

(i) Performance of the program;

(ii) Fiscal condition of the program;

(iii) Recommendations for statutory changes;

(iv) Receipt of payments from the federal government;

(v) Whether current year goals and priorities were met; and

(vi) Future goals and priorities;

(11) Review RICHIP collections and disbursements on at least a quarterly basis and recommend adjustments needed to achieve budgetary targets and permit adequate access to care;

(12) Develop procedures for accommodating:

(i) Employer retiree health benefits for people who have been members of RICHIP but go to live as retirees out of the state;

(ii) Employer retiree health benefits for people who earned or accrued those benefits while residing in the state prior to the implementation of RICHIP and live as retirees out of the state; and

(iii) RICHIP coverage of healthcare services currently covered under the workers' compensation system, including whether and how to continue funding for those services under that system and whether and how to incorporate an element of experience rating; and

(13) No later than two (2) years after the effective date of this chapter, develop a proposal, consistent with the principles of this chapter, for provision and funding by the program of long-term care coverage.

(c) Board. There shall be a RICHIP board composed of nine (9) members serving terms of

four (4) years. Members shall be appointed by the governor with advice and consent of the senate. Members of the board shall have no pecuniary interest in any health insurance company or any business subject to regulation of the board and cannot have previously worked for a health insurance company. The duties of the board shall include:

(1) Annually establish a RICHIP benefits package for participants, including a formulary and a list of other medically necessary goods, as well as a procedure for handling complaints and appeals relating to the benefits package, pursuant to § 23-100-6.

(2) Establish RICHIP provider reimbursement and a procedure for handling provider complaints and appeals as set forth in § 23-100-9;

(3) Review budget proposals from providers pursuant to § 23-100-11(b); and

(4) The board shall be subject to chapter 46 of title 42 ("open meetings").

23-100-5. Coverage.

(a) All qualified Rhode Island residents may participate in RICHIP. The director shall establish procedures to determine eligibility, enrollment, disenrollment and disqualification, including criteria and procedures by which RICHIP can:

(1) Identify, automatically enroll, and provide a RICHIP card to qualified Rhode Island residents;

(2) Process applications from individuals seeking to obtain RICHIP coverage for dependents after the implementation date;

(3) Ensure eligible residents are knowledgeable and aware of their rights to health care;

(4) Determine whether an individual should be disenrolled (e.g., for leaving the state);

(5) Determine whether an individual should be disqualified (e.g., for fraudulent receipt of benefits or reimbursements);

(6) Determine appropriate actions that should be taken with respect to individuals who are disenrolled or disqualified (including civil and criminal penalties); and

(7) Permit individuals to request review and appeal decisions to disenroll or disqualify them.

(b) Medicare and Medicaid eligible coverage under RICHIP shall be as follows:

(1) If all necessary federal waivers are obtained, qualified Rhode Island residents eligible for federal Medicare ("Medicare eligible residents") shall continue to pay required fees to the federal government. RICHIP shall establish procedures to ensure that Medicare eligible residents shall have such amounts deducted from what they owe to RICHIP under § 23-100-12(h). RICHIP shall become the equivalent of qualifying coverage under Medicare part D and Medicare advantage programs, and as such shall be the vendor for coverage to RICHIP participants. RICHIP shall

provide Medicare eligible residents benefits equal to those available to all other RICHIP participants and equal to or greater than those available through the federal Medicare program. To streamline the process, RICHIP shall seek to receive federal reimbursements for services and goods to Medicare eligible residents and administer all Medicare funds.

(2) If all necessary federal waivers are obtained, RICHIP shall become the state's sole Medicaid provider. RICHIP shall create procedures to enroll all qualified Rhode Island residents eligible for Medicaid ("Medicaid eligible residents") in the federal Medicaid program to ensure a maximum amount of federal Medicaid funds go to the RICHIP trust fund. RICHIP shall provide benefits to Medicaid eligible residents equal to those available to all other RICHIP participants.

(3) If all necessary federal waivers are not granted from the Medicaid or Medicare programs operated under Title XVIII or XIX of the Social Security Act, the Medicaid or Medicare program for which a waiver is not granted shall act as the primary insurer for those eligible for such coverage, and RICHIP shall serve as the secondary or supplemental plan of health insurance coverage. Until such time as a waiver is granted, the plan shall not pay for services for persons otherwise eligible for the same healthcare benefits under the Medicaid or Medicare program. The director shall establish procedures for determining amounts owed by Medicare and Medicaid eligible residents for supplemental RICHIP coverage and the extent of such coverage.

(4) The director may require Rhode Island residents to provide information necessary to determine whether the resident is eligible for a federally matched public health program or for Medicare, or any program or benefit under Medicare.

(5) As a condition of eligibility or continued eligibility for healthcare services under RICHIP, a qualified Rhode Island resident who is eligible for benefits under Medicare shall enroll in Medicare, including Parts A, B, and D.

(c) Veterans. RICHIP shall serve as the secondary or supplemental plan of health insurance coverage for military veterans. The director shall establish procedures for determining amounts owed by military veterans who are qualified residents for such supplemental RICHIP coverage and the extent of such coverage.

(d) This chapter does not create any employment benefit, nor require, prohibit, or limit the providing of any employment benefit.

(e) This chapter does not affect or limit collective action or collective bargaining on the part of a healthcare provider with their employer or any other lawful collective action or collective bargaining.

23-100-6. Benefits.

(a) This chapter shall provide insurance coverage for services and goods (including

prescription drugs) deemed medically necessary by a qualified healthcare provider and that is currently covered under:

(1) Services and goods currently covered by the federal Medicare program (Social Security Act title XVIII) parts A, B and D;

(2) Services and goods covered by Medicaid as of January 1, 2025;

(3) Services and goods currently covered by the state's Children's Health Insurance Program;

(4) Essential health benefits mandated by the Affordable Care Act; and

(5) Services and goods within the following categories:

(i) Primary and preventive care;

(ii) Approved dietary and nutritional therapies;

(iii) Inpatient care;

(iv) Outpatient care;

(v) Emergency and urgently needed care;

(vi) Prescription drugs and medical devices;

(vii) Laboratory and diagnostic services;

(viii) Palliative care;

(ix) Mental health services;

(x) Oral health, including dental services, periodontics, oral surgery, and endodontics;

(xi) Substance abuse treatment services;

(xii) Physical therapy and chiropractic services;

(xiii) Vision care and vision correction;

(xiv) Hearing services, including coverage of hearing aids;

(xv) Podiatric care;

(xvi) Comprehensive family planning, reproductive, maternity, and newborn care;

(xvii) Short-term rehabilitative services and devices;

(xviii) Durable medical equipment;

(xix) Gender affirming health care; and

(xx) Diagnostic and routine medical testing.

(b) Additional coverage. The director shall create a procedure that may permit additional medically necessary goods and services beyond that provided by federal laws cited herein and within the areas set forth in § 23-100-5, if the coverage is for services and goods deemed medically necessary based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society

recommendations, and the views of physicians practicing in relevant clinical areas and any other relevant factors. The director shall create procedures for handling complaints and appeals concerning the benefits package.

(c) Restrictions shall not apply. In order for RICHIP participants to be able to receive medically necessary goods and services, this chapter shall override any state law that restricts the provision or use of state funds for any medically necessary goods or services, including those related to family planning and reproductive healthcare.

(d) Medically necessary goods:

(1) Prescription drug formulary:

(i) In general. The director shall establish a prescription drug formulary system, to be approved by the board, and encourage best-practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.

(ii) Promotion of generics. The formulary under this subsection shall promote the use of generic medications to the greatest extent possible.

(iii) Formulary updates and petition rights. The formulary under this subsection shall be updated frequently and the director shall create a procedure for patients and providers to make requests and appeal denials to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary.

(iv) Use of off-formulary medications. The director shall promulgate rules regarding the use of off-formulary medications which allow for patient access but do not compromise the formulary.

(v) Approved devices and equipment. The director shall present a list of medically necessary devices and equipment that shall be covered by RICHIP, subject to final approval by the board.

(vi) Bulk purchasing. The director shall seek and implement ways to obtain goods at the lowest possible cost, including bulk purchasing agreements.

23-100-7. Providers.

(a) Rhode Island providers.

(1) Licensing. Participating providers shall meet state licensing requirements in order to participate in RICHIP. No provider whose license is under suspension or has been revoked shall participate in the program.

(2) Participation. All providers may participate in RICHIP by providing items on the RICHIP benefits list for which they are licensed. Providers may elect either to participate fully, or not at all, in the program.

(3) For-profit providers. For-profit providers may continue to offer services and goods in Rhode Island, but are prohibited from charging patients more than RICHIP reimbursement rates for covered services and goods and shall notify qualified Rhode Island residents when the services and goods they offer will not be reimbursed fully under RICHIP.

(b) Out-of-state providers. Except for emergency and urgently needed service, as set forth in § 23-100-7(d), RICHIP shall not pay for healthcare services obtained outside of Rhode Island unless the following requirements are met:

(1) The out-of-state provider agrees to accept the RICHIP rate for out-of-state providers; and

(2) The services are medically necessary care.

(c) Out-of-state provider reimbursement. The program shall pay out-of-state healthcare providers at a rate equal to the average rate paid by commercial insurers or Medicare for the services rendered, whichever is higher.

(d) Out-of-state residents.

(1) In general. Rhode Island providers who provide any services to individuals who are not RICHIP participants shall not be reimbursed by RICHIP and shall seek reimbursement from those individuals or other sources.

(2) Emergency care exception. Nothing in this chapter shall prevent any individual from receiving or any provider from providing emergency healthcare services and goods in Rhode Island. The director shall adopt rules to provide reimbursement; however, the rules shall reasonably limit reimbursement to protect the fiscal integrity of RICHIP. The director shall implement procedures to secure reimbursement from any appropriate third-party funding source or from the individual to whom the emergency services were rendered.

23-100-8. Cross border employees.

(a) State residents employed out-of-state. If an individual is employed out-of-state by an employer that is subject to Rhode Island state law, the employer and employee shall be required to pay the payroll taxes as to that employee as if the employment were in the state. If an individual is employed out-of-state by an employer that is not subject to Rhode Island state law, the employee health coverage provided by the out-of-state employer to a resident working out-of-state shall serve as the employee's primary plan of health coverage, and RICHIP shall serve as the employee's secondary plan of health coverage. The director shall establish procedures for determining amounts owed by residents employed out-of-state for such supplemental secondary RICHIP coverage and the extent of such coverage.

(b) Out-of-state residents employed in the state. The payroll tax set forth in § 23-100-12(i)

shall apply to any out-of-state resident who is employed or self-employed in the state. However, such out-of-state residents shall be able to take a credit for amounts they spend on health benefits for themselves that would otherwise be covered by RICHIP if the individual were a RICHIP participant. The out-of-state resident's employer shall be able to take a credit against such payroll taxes regardless of the form of the health benefit (e.g., health insurance, a self-insured plan, direct services, or reimbursement for services), to ensure that the revenue proposal does not relate to employment benefits in violation of the Federal Employee Retirement Income Security Act ("ERISA") law. For non-employment-based spending by individuals, the credit shall be available for and limited to spending for health coverage (not out-of-pocket health spending). The credit shall be available without regard to how little is spent or how sparse the benefit. The credit may only be taken against the payroll taxes set forth in § 23-100-12(i). Any excess amount may not be applied to other tax liability. For employment-based health benefits, the credit shall be distributed between the employer and employee in the same proportion as the spending by each for the benefit. The employer and employee may each apply their respective portion of the credit to their respective portion of the payroll taxes set forth in § 23-100-12(i). If any provision of this clause or any application of it shall be ruled to violate ERISA, the provision or the application of it shall be null and void and the ruling shall not affect any other provision or application of this section or this chapter.

23-100-9. Provider reimbursement.

(a) Rates for services and goods. RICHIP reimbursement rates to providers shall be determined by the RICHIP board. These rates shall be equal to or greater than the federal Medicare rates available to Rhode Island qualified residents that are in effect at the time services and goods are provided. For outpatient behavioral health services, the minimum rate shall equal one hundred fifty percent (150%) of federal Medicare rates. If the director determines that there are no such federal Medicare reimbursement rates, the director shall set the minimum rate. The director shall review the rates at least annually, recommend changes to the board, and establish procedures by which complaints about reimbursement rates may be reviewed by the board.

(b) Billing and payments. Providers shall submit billing for services to RICHIP participants in the form of electronic invoices entered into RIFANS, the state's computerized financial system. The director shall coordinate the manner of processing and payment with the office of accounts and control and the RIFANS support team within the division of information technology. Payments shall be made by check or electronic funds transfer in accordance with terms and procedures coordinated by the director and the office of accounts and control and consistent with the fiduciary management of the RICHIP trust fund.

(c) Provider restrictions. In-state providers who accept any payment from RICHIP shall not bill any patient for any covered benefit. In-state providers cannot use any of their operating budgets for expansion, profit, excessive executive income, including bonuses, marketing, or major capital purchases or leases.

23-100-10. Private insurance companies.

(a) Non-duplication. It is unlawful for a private health insurer to sell health insurance coverage to qualified Rhode Island residents that duplicates the benefits provided under this chapter. Nothing in this chapter shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this chapter, including additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents (e.g., multiemployer plans can continue to provide wrap-around coverage for any benefits not provided by RICHIP).

(b) Displaced employees. Re-education and job placement of persons employed in Rhode Island-located enterprises who have lost their jobs as a result of this chapter shall be managed by the Rhode Island department of labor and training or an appropriate federal retraining program. The director may provide funds from RICHIP or funds otherwise appropriated for this purpose for retraining and assisting job transition for individuals employed or previously employed in the fields of health insurance, healthcare service plans, and other third-party payments for health care or those individuals providing services to healthcare providers to deal with third-party payers for health care, whose jobs may be or have been ended as a result of the implementation of the program, consistent with applicable laws.

23-100-11. Budgeting.

(a) Operating budget. Annually, the director shall create an operating budget for the program that includes the costs for all benefits set forth in § 23-100-5 and the costs for RICHIP administration. The director shall determine appropriate reimbursement rates for benefits pursuant to § 23-100-9(a). The operating budget shall be approved by the executive board prior to submission to the governor and general assembly.

(b) Capital expenditures. The director shall work with representatives from state entities involved with provider capital expenditures (e.g., the Rhode Island department of administration office of capital projects, the Rhode Island health and educational building corporation, etc.), and providers to help ensure that capital expenditures proposed by providers, including amounts to be spent on construction and renovation of health facilities and major equipment purchases, will address healthcare needs of RICHIP participants. To the extent that providers are seeking to use RICHIP funds for capital expenditures, the director shall have the authority to approve or deny such

expenditures.

(c) Prohibition against co-mingling operations and capital improvement funds. It is prohibited to use funds under this chapter that are earmarked:

(1) For operations for capital expenditures; or

(2) For capital expenditures for operations.

23-100-12. Financing.

(a) RICHIP trust fund. There shall be established a RICHIP trust fund into which funds collected pursuant to this chapter are deposited and from which funds are distributed. All money collected and received shall be used exclusively to finance RICHIP. The governor or general assembly may provide funds to the RICHIP trust fund, but may not remove or borrow funds from the RICHIP trust fund.

(b) Revenue proposal. After approval of the RICHIP executive board, the director shall submit to the governor and the general assembly a revenue plan and, if required, legislation (referred to collectively in this section as the "revenue proposal") to provide the revenue necessary to finance RICHIP. The initial revenue proposal shall be submitted once waiver negotiations have proceeded to a level deemed sufficient by the director and annually, thereafter. The basic structure of the initial revenue proposal will be based on a consideration of:

(1) Anticipated savings from a single payer program;

(2) Government funds available for health care;

(3) Private funds available for health care; and

(4) Replacing current regressive health insurance payments made to multiple health insurance carriers with progressive contributions to a single payer (RICHIP) in order to make healthcare insurance affordable and remove unnecessary barriers to healthcare access.

Subsequent proposals shall adjust the RICHIP contributions, based on projections from the total RICHIP costs in the previous year, and shall include a five (5) year plan for adjusting RICHIP contributions to best meet the goals set forth in this section and § 23-100-2.

(c) Anticipated savings. It is anticipated that RICHIP will lower healthcare costs by:

(1) Eliminating payments to private health insurance carriers;

(2) Reducing paperwork and administrative expenses for both providers and payers created by the marketing, sales, eligibility checks, network contract management, issues associated multiple benefit packages, and other administrative waste associated with the current multi-payer private health insurance system;

(3) Allowing the planning and delivery of a public health strategy for the entire population of Rhode Island;

(4) Improving access to preventive healthcare; and

(5) Negotiating on behalf of the state for bulk purchasing of medical supplies and pharmaceuticals.

(d) Federal funds. The executive office of health and human services, in collaboration with the director, the board and the Medicaid office, shall seek and obtain waivers and other approvals relating to Medicaid, the Children's Health Insurance Program, Medicare, federal tax exemptions for health care, the ACA, and any other relevant federal programs in order that:

(1) Federal funds and other subsidies for health care that would otherwise be paid to the state and its residents and healthcare providers, would be paid by the federal government to the state and deposited into the RICHIP trust fund;

(2) Programs would be waived and such funding from federal programs in Rhode Island would be replaced or merged into RICHIP in order that it can operate as a single payer program;

(3) Maximum federal funding for health care is sought even if any necessary waivers or approvals are not obtained and multiple sources of funding with RICHIP trust fund monies are pooled, in order that RICHIP can act as much as possible like a single payer program to maximize benefits to Rhode Islanders; and

(4) Federal financial participation in the programs that are incorporated into RICHIP are not jeopardized.

(e) State funds. State funds that would otherwise be appropriated to any governmental agency, office, program, instrumentality, or institution for services and benefits covered under RICHIP shall be directed into the RICHIP trust fund. Payments to the fund pursuant to this section shall be in an amount equal to the money appropriated for those purposes in the fiscal year beginning immediately preceding the effective date of this chapter.

(f) Private funds. Private grants (e.g., from nonprofit corporations) and other funds specifically ear-marked for health care (e.g., from litigation against tobacco companies, opioid manufacturers, etc.), shall also be put into the RICHIP trust fund.

(g) Assignments from RICHIP participants. Receipt of healthcare services under the plan shall be deemed an assignment by the RICHIP participant of any right to payment for services from a policy of insurance, a health benefit plan or other source. The other source of healthcare benefits shall pay to the fund all amounts it is obligated to pay to, or on behalf of, the RICHIP participant for covered healthcare services. The director may commence any action necessary to recover the amounts due.

(h) Replacing current health insurance payments with progressive contributions. Instead of making health insurance payments to multiple carriers (i.e., for premiums, co-pays deductibles, and

costs in excess of caps) for limited coverage, individuals and entities subject to Rhode Island taxation pursuant to § 44-30-1 shall pay progressive contributions to the RICHIP trust fund (referred to collectively in this section as the "RICHIP contributions") for comprehensive coverage. These RICHIP contributions shall be set and adjusted over time to an appropriate level to:

(1) Cover the actual cost of the program;

(2) Ensure that higher brackets of income subject to specified taxes shall be assessed at a higher marginal rate than lower brackets; and

(3) Protect the economic welfare of small businesses, low-income earners and working families through tax credits or exemptions.

(i) Contributions based on earned income. The amounts currently paid by employers and employees for health insurance shall initially be replaced by a ten percent (10%) payroll tax, based on the projected average payroll of employees over three (3) previous calendar years. The employer shall pay eighty percent (80%) and the employee shall pay twenty percent (20%) of this payroll tax, except that an employer may agree to pay all or part of the employee's share. Self- employed individuals shall initially pay one-hundred percent (100%) of the payroll tax. The ten percent (10%) initial rate will be adjusted by the director in order that higher brackets of income subject to these taxes shall be assessed at a higher marginal rate than lower brackets and in order that small businesses and lower income earners receive a credit or exemption.

(j) Contributions based on unearned income. There shall be a progressive contribution based on unearned income, i.e., capital gains, dividends, interest, profits, and rents. Initially, the unearned income RICHIP contributions shall be equal to ten percent (10%) of such unearned income. The ten percent (10%) initial rate may be adjusted by the director to allow for a graduated progressive exemption or credit for individuals with lower unearned income levels.

23-100-13. Implementation.

(a) State laws and regulations.

(1) In general. The director shall work with the executive board and receive such assistance as may be necessary from other state agencies and entities to examine state laws and regulations and to make recommendations necessary to conform such laws and regulations to properly implement the RICHIP program. The director shall report recommendations to the governor and the general assembly.

(2) Anti-trust laws. The intent of this chapter is to exempt activities provided for under this chapter from state antitrust laws and to provide immunity from federal antitrust laws through the state action doctrine.

(b) The director shall complete an implementation plan to provide healthcare coverage for

qualified residents in accordance with this chapter within twelve (12) months of its effective date.

(c) The executive office of health and human services, in collaboration with the director, the board, and the Medicaid director, will have the initial responsibility of negotiating the waivers.

(d) Severability. If any provision or application of this chapter shall be held to be invalid, or to violate or be inconsistent with any applicable federal law or regulation, that shall not affect other provisions or applications of this chapter which can be given effect without that provision or application; and to that end, the provisions and applications of this chapter are severable.

SECTION 2. Chapter 22-11 of the General Laws entitled "Joint Committee on Legislative Services" is hereby amended by adding thereto the following section:

22-11-4.1. Employees needed to maximize federal Medicaid funding.

The joint committee on legislative services shall fund five (5) new FTEs for the senate fiscal office and five (5) new FTEs for the house fiscal office exclusively devoted to finding ways to maximize federal Medicaid funding, including compiling proposals for expanding eligibility to maximize the eligibility allowed by Centers for Medicare & Medicaid Services (CMS).

SECTION 3. Section 27-34.3-7 of the General Laws in Chapter 27-34.3 entitled "Rhode Island Life and Health Insurance Guaranty Association Act" is hereby amended to read as follows:

27-34.3-7. Board of directors.

(a) The board of directors of the association shall consist of:

(1) ~~Not less than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation~~ Nine (9) members appointed by the governor with advice and consent of the senate; and

(2) The commissioner or the commissioner's designee, who shall chair the board in a non-voting ex officio capacity. ~~Only member insurers shall be eligible to vote. The members of the board shall be selected by member insurers subject to the approval of the commissioner.~~ The board of directors, previously established under § 27-34.1-8 [repealed], shall continue to operate in accordance with the provision of this section. ~~Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.~~

(b) ~~In approving selections to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.~~

(c) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board shall not be compensated by the association for their services.

SECTION 4. Section 27-66-24 of the General Laws in Chapter 27-66 entitled "The Health

Insurance Conversions Act" is hereby amended to read as follows:

27-66-24. Exceptions — Rehabilitation, liquidation, or conservation.

~~No proposed conversion shall be subject to this chapter in~~ In the event that ~~the~~ a health insurance corporation, health maintenance corporation, a nonprofit hospital service corporation, nonprofit medical service corporation, pharmacy benefit manager, nonprofit dental service corporation, nonprofit optometric service corporation, or affiliate or subsidiary of them, hereinafter "the insurer," is subject to an order from the superior court directing the director to rehabilitate, liquidate, or conserve, as provided in §§ 27-19-28, 27-20-24, 27-41-18, or chapter 14.1, 14.2, 14.3, or 14.4 of this title~~.~~, certain additional conditions shall apply to the insurer:

(1) The insolvency, financial condition, or default of the insurer at any time shall not permit the insurer to fail to pay claims in a timely manner.

(2) Should the insurer fail to pay claims in a timely manner, those claims shall become a temporary obligation of the state, who shall pay them in a timely manner. Should the state be compelled to pay claims for this reason, the insurer shall owe the state a fine ten (10) times the value of all claims paid.

(3) The insolvency, financial condition, or default of the insurer at any time shall not permit the insurer to fail to pay state taxes on time. Should the insurer fail to pay taxes on time, the size of the tax obligation owed shall increase by a factor of ten (10).

(4) The Medicaid office shall be guaranteed a right of first refusal to acquire the insurer before alternate buyers are considered. Any obligations due to the state by the insurer shall be counted towards the purchase price of the insurer. The Rhode Island life and health insurance guaranty association, created pursuant to § 27-34.3-6, shall pay the costs of the acquisition, but all ownership shares shall be held by the Medicaid office.

SECTION 5. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 82

PRIOR AUTHORIZATION OF CERTAIN HEALTH INSURANCE POLICY CHANGES

27-82-1. Definitions.

For purposes of this chapter:

"Health insurer" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the health insurance commissioner, that contracts or offers to contract, to provide and/or insuring health services on a prepaid basis, including, but not limited to, policies of accident and sickness insurance subject to chapter 18 of title 27; any nonprofit hospital service corporation subject to chapter 19 of title 27; any nonprofit medical service corporation

subject to chapter 20 of title 27; any health maintenance organization subject to chapter 41 of title 27; any nonprofit dental service corporation subject to chapter 20.1 of title 27; any nonprofit optometric service corporation subject to chapter 20.2 of title 27; any pharmacy benefit manager; or any health benefit plan issued by the State of Rhode Island, a municipality, a quasi-public agency, or any other political subdivision of the State of Rhode Island to cover employees.

27-82-2. Prior authorization of general assembly.

(a) Prior authorization of the general assembly shall be required for certain policy changes by health insurers:

(1) Any change that increases the average amount charged annually to consumers on a per beneficiary basis;

(2) Any change that in any way reduces any benefits offered to plan beneficiaries;

(3) Any change that increases any premiums, deductibles, or copays;

(4) Ceasing offering any plan a health insurer offers within the State of Rhode Island; or

(5) Any other change that the health insurance commissioner or attorney general shall, through regulation, determine to require prior authorization of the general assembly.

(b) No rate reviews pursuant to those utilized in §§ 27-18-54, 27-19-30.1, 27-20-25.2, 27-41-27.2, and 42-62-13 shall be construed to exempt any health insurer from the prior authorization requirements of this chapter.

SECTION 6. Section 28-57-5 of the General Laws in Chapter 28-57 entitled "Healthy and Safe Families and Workplaces Act" is hereby amended to read as follows:

28-57-5. Accrual of paid sick and safe leave time.

(a) All employees employed by an employer of eighteen (18) or more employees in Rhode Island shall accrue a minimum of one hour of paid sick and safe leave time for every thirty five (35) hours worked up to a maximum of twenty-four (24) hours during calendar year 2018, thirty-two (32) hours during calendar year 2019, ~~and up to a maximum of~~ forty (40) hours per year from calendar year 2020 through calendar year 2024, and one hundred sixty (160) hours per year thereafter, unless the employer chooses to provide a higher annual limit in both accrual and use. In determining the number of employees who are employed by an employer for compensation, all employees defined in § 28-57-3(7) shall be counted.

(b) Employees who are exempt from the overtime requirements under 29 U.S.C. § 213(a)(1) of the federal Fair Labor Standards Act, 29 U.S.C. § 201 et seq., will be assumed to work forty (40) hours in each workweek for purposes of paid sick and safe leave time accrual unless their normal workweek is less than forty (40) hours, in which case paid sick and safe leave time accrues based upon that normal workweek.

(c) Paid sick and safe leave time as provided in this chapter shall begin to accrue at the commencement of employment or pursuant to the law's effective date [July 1, 2018], whichever is later. An employer may provide all paid sick and safe leave time that an employee is expected to accrue in a year at the beginning of the year.

(d) An employer may require a waiting period for newly hired employees of up to ninety (90) days. During this waiting period, an employee shall accrue earned sick time pursuant to this section or the employer's policy, if exempt under § 28-57-4(b), but shall not be permitted to use the earned sick time until after he or she has completed the waiting period.

(e) Paid sick and safe leave time shall be carried over to the following calendar year; however, an employee's use of paid sick and safe leave time provided under this chapter in each calendar year shall not exceed twenty-four (24) hours during calendar year 2018, and thirty-two (32) hours during calendar year 2019, and forty (40) hours per year thereafter. Alternatively, in lieu of carryover of unused earned paid sick and safe leave time from one year to the next, an employer may pay an employee for unused earned paid sick and safe leave time at the end of a year and provide the employee with an amount of paid sick and safe leave that meets or exceeds the requirements of this chapter that is available for the employee's immediate use at the beginning of the subsequent year.

(f) Nothing in this chapter shall be construed as requiring financial or other reimbursement to an employee from an employer upon the employee's termination, resignation, retirement, or other separation from employment for accrued paid sick and safe leave time that has not been used.

(g) If an employee is transferred to a separate division, entity, or location within the state, but remains employed by the same employer as defined in 29 C.F.R. § 791.2 of the federal Fair Labor Standards Act, 29 U.S.C. § 201 et seq., the employee is entitled to all paid sick and safe leave time accrued at the prior division, entity, or location and is entitled to use all paid sick and safe leave time as provided in this act. When there is a separation from employment and the employee is rehired within one hundred thirty-five (135) days of separation by the same employer, previously accrued paid sick and safe leave time that had not been used shall be reinstated. Further, the employee shall be entitled to use accrued paid sick and safe leave time and accrue additional sick and safe leave time at the re-commencement of employment.

(h) When a different employer succeeds or takes the place of an existing employer, all employees of the original employer who remain employed by the successor employer within the state are entitled to all earned paid sick and safe leave time they accrued when employed by the original employer, and are entitled to use earned paid sick and safe leave time previously accrued.

(i) At its discretion, an employer may loan sick and safe leave time to an employee in

advance of accrual by such employee.

(j) Temporary employees shall be entitled to use accrued paid sick and safe leave time beginning on the one hundred eightieth (180) calendar day following commencement of their employment, unless otherwise permitted by the employer. On and after the one hundred eightieth (180) calendar day of employment, employees may use paid sick and safe leave time as it is accrued. During this waiting period, an employee shall accrue earned sick time pursuant to this chapter, but shall not be permitted to use the earned sick time until after he or she has completed the waiting period.

(k) Seasonal employees shall be entitled to use accrued paid sick and safe leave time beginning on the one hundred fiftieth (150) calendar day following commencement of their employment, unless otherwise permitted by the employer. On and after the one hundred fiftieth (150) calendar day of employment, employees may use paid sick and safe leave time as it is accrued. During this waiting period, an employee shall accrue earned sick time pursuant to this chapter, but shall not be permitted to use the earned sick time until after he or she has completed the waiting period.

SECTION 7. Sections 40-8-2, 40-8-6, 40-8-10, 40-8-13, 40-8-13.4, 40-8-16, 40-8-19, 40-8-26 and 40-8-32 of the General Laws in Chapter 40-8 entitled "Medical Assistance" are hereby amended to read as follows:

40-8-2. Definitions.

As used in this chapter, unless the context shall otherwise require:

(1) "Dental service" means and includes emergency care, X-rays for diagnoses, extractions, palliative treatment, and the refitting and relining of existing dentures and prosthesis.

(2) "Department" means the department of human services.

(3) "Director" means the ~~director of human services~~ Medicaid director.

(4) "Drug" means and includes only drugs and biologicals prescribed by a licensed dentist or physician as are either included in the United States pharmacopoeia, national formulary, or are new and nonofficial drugs and remedies.

(5) "Inpatient" means a person admitted to and under treatment or care of a physician or surgeon in a hospital or nursing facility that meets standards of and complies with rules and regulations promulgated by the director.

(6) "Inpatient hospital services" means the following items and services furnished to an inpatient in a hospital other than a hospital, institution, or facility for tuberculosis or mental diseases:

(i) Bed and board;

(ii) Nursing services and other related services as are customarily furnished by the hospital for the care and treatment of inpatients and drugs, biologicals, supplies, appliances, and equipment for use in the hospital, as are customarily furnished by the hospital for the care and treatment of patients;

(iii)(A) Other diagnostic or therapeutic items or services, including, but not limited to, pathology, radiology, and anesthesiology furnished by the hospital or by others under arrangements made by the hospital, as are customarily furnished to inpatients either by the hospital or by others under such arrangements, and services as are customarily provided to inpatients in the hospital by an intern or resident-in-training under a teaching program having the approval of the Council on Medical Education and Hospitals of the American Medical Association or of any other recognized medical society approved by the director.

(B) The term "inpatient hospital services" shall be taken to include medical and surgical services provided by the inpatient's physician, but shall not include the services of a private-duty nurse or services in a hospital, institution, or facility maintained primarily for the treatment and care of patients with tuberculosis or mental diseases. Provided, further, it shall be taken to include only the following organ transplant operations: kidney, liver, cornea, pancreas, bone marrow, lung, heart, and heart/lung, and other organ transplant operations as may be designated by the director after consultation with medical advisory staff or medical consultants; and provided that any such transplant operation is determined by the director or his or her designee to be medically necessary. Prior written approval of the director, or his or her designee, shall be required for all covered organ transplant operations.

(C) In determining medical necessity for organ transplant procedures, the state plan shall adopt a case-by-case approach and shall focus on the medical indications and contra-indications in each instance; the progressive nature of the disease; the existence of any alternative therapies; the life-threatening nature of the disease; the general state of health of the patient apart from the particular organ disease; and any other relevant facts and circumstances related to the applicant and the particular transplant procedure.

(7) "Medicare equivalent rate" means the amount that would be paid for the relevant services as furnished by the relevant group of facilities under Medicare payment principles delineated in subchapter B of 42 CFR Chapter IV. Should no direct Medicare rates be available for the particular service and facility group, the Medicaid director will estimate the rate. Providers will have standing to bring an action in superior court for a higher rate, but intermediary insurers such as managed care entities shall have no standing to bring an action for a lower rate.

~~(7)~~(8) "Nursing services" means the following items and services furnished to an inpatient

in a nursing facility:

(i) Bed and board;

(ii) Nursing care and other related services as are customarily furnished to inpatients admitted to the nursing facility, and drugs, biologicals, supplies, appliances, and equipment for use in the facility, as are customarily furnished in the facility for the care and treatment of patients;

(iii) Other diagnostic or therapeutic items or services, legally furnished by the facility or by others under arrangements made by the facility, as are customarily furnished to inpatients either by the facility or by others under such arrangement;

(iv) Medical services provided in the facility by the inpatient's physician, or by an intern or resident-in-training of a hospital with which the facility is affiliated or that is under the same control, under a teaching program of the hospital approved as provided in subsection (6); and

(v) A personal-needs allowance of ~~seventy-five dollars ($75.00)~~ two hundred dollars ($200) per month.

~~(8)~~(9) "Relative with whom the dependent child is living" means and includes the father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece of any dependent child who maintains a home for the dependent child.

~~(9)~~(10) "Visiting nurse service" means part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse other than in a hospital or nursing home.

40-8-6. Review of application for benefits.

The director, or someone designated by him or her, shall review each application for benefits filed in accordance with regulations, and shall make a determination of whether the application will be honored and the extent of the benefits to be made available to the applicant, and shall, within ~~thirty (30)~~ fifteen (15) days after the filing, notify the applicant, in writing, of the determination. If the application is rejected, the notice to the applicant shall set forth therein the reason therefor. The director may at any time reconsider any determination.

40-8-10. Recovery of benefits paid in error.

Any person, who through ~~error or mistake of himself or herself or another~~ willful and knowing fraudulent misrepresentation, receives medical care benefits to which he or she is not entitled or with respect to which he or she was ineligible, shall be required to reimburse the state for the benefits ~~paid through error or mistake~~ that were paid out during a time period, not to exceed three years, where the person was not entitled to benefits but received them as a result of the willful and knowing fraudulent misrepresentation.

40-8-13. Rules, regulations, and fee schedules.

The director shall make and promulgate rules, regulations, and fee schedules not inconsistent with state law and fiscal procedures as he or she deems necessary for the proper administration of this chapter and to carry out the policy and purposes thereof, and to make the department's plan conform to the provisions of the federal Social Security Act, 42 U.S.C. § 1396 et seq., and any rules or regulations promulgated pursuant thereto. Except where explicitly authorized by this title, the director shall have no power to set any fee schedule below the Medicare equivalent rate; provided, however, that the director shall be empowered to provide a lower rate equal to the maximum rate where federal reimbursement can be obtained in the event that federal reimbursement cannot be obtained for the Medicare equivalent rate. For outpatient behavioral health services, the minimum fee schedule shall be set at one hundred fifty percent (150%) of the Medicare equivalent rate. The director shall attempt to obtain federal reimbursement for billing outpatient behavioral health services at one hundred fifty percent (150%) of the Medicare equivalent rate, but the state shall bear the costs of this higher rate for outpatient behavioral health services even if federal reimbursement cannot be obtained. Should federal financial participation be impossible to obtain for outpatient behavioral health services rate of one hundred fifty percent (150%) of the Medicare equivalent rate, the director shall impose a surtax on the tax imposed on health insurers pursuant to chapter 17 of title 44 in the amount necessary to defray the costs of the inability to obtain federal reimbursement for an outpatient behavioral health services rate of one hundred fifty percent (150%) of the Medicare equivalent rate.

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. Increases in the Medicaid fee-for-service DRG hospital payments for each annual twelve-month (12) period beginning July 1, 2023, 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, 2024, payments for inpatient services in fee-for-service Medicaid shall cease utilizing the DRG method of payment, and payments shall take place on a pure fee-for-services basis, unless a provider shall elect to utilize the DRG payment methodology. DRG rates shall be set equal to ninety percent (90%) of a reasonable estimate of the Medicare equivalent rate. Non-DRG rates shall be set by the Medicaid director through regulation in order that the projected overall per capita expenditures shall equal ninety-five percent (95%) of a reasonable estimate of the equivalent overall per capital expenditures that would have been reached under the Medicare equivalent rate.

(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) Increases in inpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2023, 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) All hospitals licensed in Rhode Island shall accept such payment rates as payment in full; and (I) For all such hospitals, compliance with the provisions of this section shall be a condition of participation in the Rhode Island Medicaid program. Beginning July 1, 2024, Medicaid managed care payment rates shall equal one hundred five percent (105%) of the fee-for-service rates set in subsection (b)(1)(i) of this section.

(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. Increases in the outpatient hospital payments for each annual twelve-month (12) period beginning July 1, 2023, 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) 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. Beginning July 1, 2024, fee-for-service and managed care outpatient rates shall equal the Medicare equivalent rate.

(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~~ phasing out the DRG method shall reward hospitals for providing the ~~most efficient~~ highest quality 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.~~

40-8-16. Notification of long-term care alternative.

(a) The department of human services, before authorizing care in a nursing home or intermediate-care facility for a person who is eligible to receive benefits pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et seq., and who is being discharged from a hospital to a nursing home, shall notify the person, in writing, of the provisions of the long-term-care alternative, a home- and a community-based program.

(b) If a person, eligible to receive benefits pursuant to Title XIX of the federal Social Security Act, requires services in a nursing home and desires to remain in his or her own home or the home of a responsible relative or other adult, the person or his or her representative shall so inform the department.

~~(c) The department shall not make payments pursuant to Title XIX of the federal Social Security Act for benefits until written notification documenting the person's choice as to a nursing home or home- and community-based services has been filed with the department.~~

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) 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. The inflation index shall be applied without regard for the transition

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

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

(i) For purposes of this subsection, compensation increases shall include base salary or hourly wage increases, benefits, other compensation, and associated payroll tax increases for eligible direct-care workers. This application of the inflation index shall apply for Medicaid reimbursement in nursing facilities for both managed care and fee-for-service. For purposes of this subsection, direct-care staff shall include registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), certified medication technicians, licensed physical therapists, licensed occupational therapists, licensed speech-language pathologists, mental health workers who are also certified nurse assistants, physical therapist assistants, 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.

(5) Commencing July 1, 2024, and for each subsequent year, the executive office of health and human services is hereby authorized and directed to amend its regulations for reimbursement to nursing facilities in order that each nursing facility shall be paid the Medicare equivalent rate. The provisions of subsection (a)(3)(iii) shall apply.

40-8-26. Community health centers.

(a) For the purposes of this section, the term community health centers refers to federally qualified health centers and rural health centers.

(b) To support the ability of community health centers to provide high-quality medical care to patients, the executive office of health and human services ("executive office") may adopt and implement an alternative payment methodology (APM) for determining a Medicaid per-visit reimbursement for community health centers that is compliant with the prospective payment system (PPS) provided for in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. The following principles are to ensure that the APM PPS rate determination methodology is part of the executive office overall value purchasing approach. For community health centers that do not agree to the principles of reimbursement that reflect the APM PPS, EOHHS shall reimburse such community health centers at the federal PPS rate, as required per section 1902(bb)(3) of the Social Security Act, 42 U.S.C. § 1396a(bb)(3). For community health centers that are reimbursed at the federal PPS rate, subsections (d) through (f) of this section apply.

(c) The APM PPS rate determination methodology will ~~(i) Fairly recognize the reasonable costs of providing services. Recognized reasonable costs will be those appropriate for the organization, management, and direct provision of services and (ii) Provide assurances to the executive office that services are provided in an effective and efficient manner, consistent with industry standards. Except for demonstrated cause and at the discretion of the executive office, the maximum reimbursement rate for a service (e.g., medical, dental) provided by an individual community health center shall not exceed one hundred twenty-five percent (125%) of the median rate for all community health centers within Rhode Island.~~ not only bill the community health center

on a fee-for-service basis at the Medicare equivalent rate but also make a series of quality incentive payments if the community health center meets certain quality incentives. Quality incentive payments shall be set at a percentage of the aggregate monthly billing. The quality incentive payments shall be as follows:

(1) Ten percent (10%) for meeting benchmarks set by the Medicaid director for screening patients for Medicaid eligibility.

(2) Five percent (5%) for meeting benchmarks set by the Medicaid director for enrolling patients who regularly smoke tobacco in smoking cessation programs.

(3) Ten percent (10%) for meeting benchmarks set by the director of human services for screening patients for supplemental nutrition assistance program eligibility.

(4) Ten percent (10%) for ensuring that no more than one percent (1%) of patients are ever not offered an appointment within a month if they request one.

(5) Up to fifteen percent (15%) for meeting benchmarks set by the Medicaid director for the improvement of air quality in patients' homes through directly funding interventions such as: air quality inspections, the installation of air filters, the installation of ventilation, and the replacement of gas stoves with electric stoves.

(6) Up to fifteen percent (15%) for meeting benchmarks set by the Medicaid director for the removal or mitigation of environmental toxins in patients' homes through the direct funding of removal or mitigation of environmental toxins. These toxins shall include, but shall not be limited to, lead, radon, asbestos, and carbon monoxide.

(d) Community health centers will cooperate fully and timely with reporting requirements established by the executive office.

(e) Reimbursement rates established through this methodology shall be incorporated into the PPS reconciliation for services provided to Medicaid-eligible persons who are enrolled in a health plan on the date of service. Monthly payments by the executive office related to PPS for persons enrolled in a health plan shall be made directly to the community health centers.

(f) Reimbursement rates established through ~~this~~ the APM methodology shall not be incorporated into the actuarially certified capitation rates paid to a health plan. The health plan shall be responsible for paying the full amount of the reimbursement rate to the community health center for each service eligible for reimbursement under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. If the ~~health plan has an alternative payment arrangement with the~~ community health center opts to utilize the APM methodology, the health plan ~~may establish a PPS reconciliation process for eligible services and make monthly payments related to PPS for persons enrolled in the health plan on the date of service~~ shall bear the full upside and

downside risk of decreased or increased costs from the APM methodology. The executive office will review, at least annually, the Medicaid reimbursement rates and reconciliation methodology used by the health plans for community health centers to ensure payments to each are made in compliance with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

40-8-32. Support for certain patients of nursing facilities.

(a) Definitions. For purposes of this section:

(1) "Applied income" shall mean the amount of income a Medicaid beneficiary is required to contribute to the cost of his or her care.

(2) "Authorized individual" shall mean a person who has authority over the income of a patient of a nursing facility, such as a person who has been given or has otherwise obtained authority over a patient's bank account; has been named as or has rights as a joint account holder; or is a fiduciary as defined below.

(3) "Costs of care" shall mean the costs of providing care to a patient of a nursing facility, including nursing care, personal care, meals, transportation, and any other costs, charges, and expenses incurred by a nursing facility in providing care to a patient. Costs of care shall not exceed the customary rate the nursing facility charges to a patient who pays for his or her care directly rather than through a governmental or other third-party payor.

(4) "Fiduciary" shall mean a person to whom power or property has been formally entrusted for the benefit of another, such as an attorney-in-fact, legal guardian, trustee, or representative payee.

(5) "Nursing facility" shall mean a nursing facility licensed under chapter 17 of title 23, that is a participating provider in the Rhode Island Medicaid program.

(6) "Penalty period" means the period of Medicaid ineligibility imposed pursuant to 42 U.S.C. § 1396p(c), as amended from time to time, on a person whose assets have been transferred for less than fair market value.

(7) "Uncompensated care" — Care and services provided by a nursing facility to a Medicaid applicant without receiving compensation therefore from Medicaid, Medicare, the Medicaid applicant, or other source. The acceptance of any payment representing actual or estimated applied income shall not disqualify the care and services provided from qualifying as uncompensated care.

(b) Penalty period resulting from transfer. Any transfer or assignment of assets resulting in the establishment or imposition of a penalty period shall create a debt that shall be due and owing to a nursing facility for the unpaid costs of care provided during the penalty period to a patient of

that facility who has been subject to the penalty period. The amount of the debt established shall not exceed the fair market value of the transferred assets at the time of transfer that are the subject of the penalty period. A nursing facility may bring an action to collect a debt for the unpaid costs of care given to a patient who has been subject to a penalty period, against ~~either~~ the transferor ~~or the transferee, or both~~. The provisions of this section shall not affect other rights or remedies of the parties.

(c) Applied income. A nursing facility may provide written notice to a patient who is a Medicaid recipient and any authorized individual of that patient:

(1) Of the amount of applied income due;

(2) Of the recipient's legal obligation to pay the applied income to the nursing facility; and

(3) That the recipient's failure to pay applied income due to a nursing facility not later than thirty (30) days after receiving notice from the nursing facility may result in a court action to recover the amount of applied income due.

A nursing facility that is owed applied income may, in addition to any other remedies authorized under law, bring a claim to recover the applied income against a patient and any authorized individual. If a court of competent jurisdiction determines, based upon clear and convincing evidence, that a defendant willfully failed to pay or withheld applied income due and owing to a nursing facility for more than thirty (30) days after receiving notice pursuant to subsection (c), the court may award the amount of the debt owed~~, court costs, and reasonable attorney's fees~~ to the nursing facility.

(d) Effects. Nothing contained in this section shall prohibit or otherwise diminish any other causes of action possessed by any such nursing facility. The death of the person receiving nursing facility care shall not nullify or otherwise affect the liability of the person or persons charged with the costs of care rendered or the applied income amount as referenced in this section.

SECTION 8. Sections 40-8-3.1, 40-8-9.1, 40-8-13.5, 40-8-15, 40-8-19.2 and 40-8-27 of the General Laws in Chapter 40-8 entitled "Medical Assistance" are hereby repealed.

~~**40-8-3.1. Life estate in property -- Retained powers.**~~

~~When an applicant or recipient of Medicaid owns a life estate in property that is his or her principal place of residence with the reserved power and authority, during his or her lifetime, to sell, convey, mortgage, or otherwise dispose of the real property without the consent or joinder by the holder(s) of the remainder interest, the principal place of residence shall not be regarded as an excluded resource for the purpose of Medicaid eligibility, unless the applicant or recipient individually, or through his or her guardian, conservator, or attorney in fact, conveys all outstanding remainder interest to him or herself.~~

An applicant or recipient who, by a deed created, executed and recorded on or before June 30, 2014, has reserved a life estate in property that is his or her principal place of residence with the reserved power and authority, during his or her lifetime, to sell, convey, mortgage, or otherwise dispose of the real property without the consent or joinder by the holder(s) of the remainder interest, shall not be ineligible for Medicaid on the basis of the deed, regardless of whether the transferee of the remainder interest is a person or persons, trust, or entity.

40-8-9.1. Notice.

Whenever an individual who is receiving medical assistance under this chapter transfers an interest in real or personal property, the individual shall notify the executive office of health and human services within ten (10) days of the transfer. The notice shall be sent to the individual's local office and the legal office of the executive office of health and human services and include, at a minimum, the individual's name, social security number or, if different, the executive office of health and human services identification number, the date of transfer, and the dollar value, if any, paid or received by the individual who received benefits under this chapter. In the event an individual fails to provide notice required by this section to the executive office of health and human services and in the event an individual has received medical assistance, any individual and/or entity, who knew or should have known that the individual failed to provide the notice and who receives any distribution of value as a result of the transfer, shall be liable to the executive office of health and human services to the extent of the value of the transfer. Moreover, any such individual shall be subject to the provisions of § 40-6-15 and any remedy provided by applicable state and federal laws and rules and regulations. Failure to comply with the notice requirements set forth in the section shall not affect the marketability of title to real estate transferred while the transferor is receiving medical assistance.

40-8-13.5. Hospital Incentive Program (HIP).

The secretary of the executive office of health and human services is authorized to seek the federal authorities required to implement a hospital incentive program (HIP). The HIP shall provide the participating licensed hospitals the ability to obtain certain payments for achieving performance goals established by the secretary. HIP payments shall commence no earlier than July 1, 2016.

40-8-15. Lien on deceased recipient's estate for assistance.

(a)(1) Upon the death of a recipient of Medicaid under Title XIX of the federal Social Security Act (42 U.S.C. § 1396 et seq. and referred to hereinafter as the "Act"), the total sum for Medicaid benefits so paid on behalf of a beneficiary who was fifty-five (55) years of age or older at the time of receipt shall be and constitute a lien upon the estate, as defined in subsection (a)(2), of the beneficiary in favor of the executive office of health and human services ("executive office").

~~The lien shall not be effective and shall not attach as against the estate of a beneficiary who is survived by a spouse, or a child who is under the age of twenty-one (21), or a child who is blind or permanently and totally disabled as defined in Title XVI of the federal Social Security Act, 42 U.S.C. § 1381 et seq. The lien shall attach against property of a beneficiary, which is included or includable in the decedent's probate estate, regardless of whether or not a probate proceeding has been commenced in the probate court by the executive office or by any other party. Provided, however, that such lien shall only attach and shall only be effective against the beneficiary's real property included or includable in the beneficiary's probate estate if such lien is recorded in the land evidence records and is in accordance with subsection (e). Decedents who have received Medicaid benefits are subject to the assignment and subrogation provisions of §§ 40-6-9 and 40-6-10.~~

~~(2) For purposes of this section, the term "estate" with respect to a deceased individual shall include all real and personal property and other assets included or includable within the individual's probate estate.~~

~~(b) The executive office is authorized to promulgate regulations to implement the terms, intent, and purpose of this section and to require the legal representative(s) and/or the heirs-at-law of the decedent to provide reasonable written notice to the executive office of the death of a beneficiary of Medicaid benefits who was fifty-five (55) years of age or older at the date of death, and to provide a statement identifying the decedent's property and the names and addresses of all persons entitled to take any share or interest of the estate as legatees or distributees thereof.~~

~~(c) The amount of reimbursement for Medicaid benefits imposed under this section shall also become a debt to the state from the person or entity liable for the payment thereof.~~

~~(d) Upon payment of the amount of reimbursement for Medicaid benefits imposed by this section, the secretary of the executive office, or his or her designee, shall issue a written discharge of lien.~~

~~(e) Provided, however, that no lien created under this section shall attach nor become effective upon any real property unless and until a statement of claim is recorded naming the debtor/owner of record of the property as of the date and time of recording of the statement of claim, and describing the real property by a description containing all of the following: (1) Tax assessor's plat and lot; and (2) Street address. The statement of claim shall be recorded in the records of land evidence in the town or city where the real property is situated. Notice of the lien shall be sent to the duly appointed executor or administrator, the decedent's legal representative, if known, or to the decedent's next of kin or heirs at law as stated in the decedent's last application for Medicaid benefits.~~

~~(f) The executive office shall establish procedures, in accordance with the standards specified by the Secretary, United States Department of Health and Human Services, under which the executive office shall waive, in whole or in part, the lien and reimbursement established by this section if the lien and reimbursement would cause an undue hardship, as determined by the executive office, on the basis of the criteria established by the secretary in accordance with 42 U.S.C. § 1396p(b)(3).~~

~~(g) Upon the filing of a petition for admission to probate of a decedent's will or for administration of a decedent's estate, when the decedent was fifty five (55) years or older at the time of death, a copy of the petition and a copy of the death certificate shall be sent to the executive office. Within thirty (30) days of a request by the executive office, an executor or administrator shall complete and send to the executive office a form prescribed by that office and shall provide such additional information as the office may require. In the event a petitioner fails to send a copy of the petition and a copy of the death certificate to the executive office and a decedent has received Medicaid benefits for which the executive office is authorized to recover, no distribution and/or payments, including administration fees, shall be disbursed. Any person and/or entity that receives a distribution of assets from the decedent's estate shall be liable to the executive office to the extent of such distribution.~~

~~(h) Compliance with the provisions of this section shall be consistent with the requirements set forth in § 33-11-5 and the requirements of the affidavit of notice set forth in § 33-11-5.2. Nothing in these sections shall limit the executive office from recovery, to the extent of the distribution, in accordance with all state and federal laws.~~

~~(i) To ensure the financial integrity of the Medicaid eligibility determination, benefit renewal, and estate recovery processes in this and related sections, the secretary of health and human services is authorized and directed to, by no later than August 1, 2018: (1) Implement an automated asset verification system, as mandated by § 1940 of the Act, that uses electronic data sources to verify the ownership and value of countable resources held in financial institutions and any real property for applicants and beneficiaries subject to resource and asset tests pursuant to the Act in § 1902(e)(14)(D); (2) Apply the provisions required under §§ 1902(a)(18) and 1917(c) of the Act pertaining to the disposition of assets for less than fair market value by applicants and beneficiaries for Medicaid long-term services and supports and their spouses, without regard to whether they are subject to or exempted from resources and asset tests as mandated by federal guidance; and (3) Pursue any state plan or waiver amendments from the United States Centers for Medicare and Medicaid Services and promulgate such rules, regulations, and procedures he or she deems necessary to carry out the requirements set forth herein and ensure the state plan and~~

~~Medicaid policy conform and comply with applicable provisions of Title XIX.~~

~~**40-8-19.2. Nursing Facility Incentive Program (HIP).**~~

~~The secretary of the executive office of health and human services is authorized to seek the federal authority required to implement a nursing facility incentive program (NFIP). The NFIP shall provide the participating licensed nursing facilities the ability to obtain certain payments for achieving performance goals established by the secretary. NFIP payments shall commence no earlier than July 1, 2016.~~

~~**40-8-27. Cooperation by providers.**~~

~~Medicaid providers who employ individuals applying for benefits under any chapter of this title shall comply in a timely manner with requests made by the department for any documents describing employer-sponsored health insurance coverage or benefits the provider offers that are necessary to determine eligibility for the state's premium assistance program pursuant to § 40-8.4-12. Documents requested by the department may include, but are not limited to, certificates of coverage or a summary of benefits and employee obligations. Upon receiving notification that the department has determined that the employee is eligible for premium assistance under § 40-8.4-12, the provider shall accept the enrollment of the employee and his or her family in the employer-based health insurance plan without regard to any seasonal enrollment restrictions, including open-enrollment restrictions, and/or the impact on the employee's wages. Additionally, the Medicaid provider employing such persons shall not offer "pay in lieu of benefits." Providers who do not comply with the provisions set forth in this section shall be subject to suspension as a participating Medicaid provider.~~

SECTION 9. Sections 40-8.4-4, 40-8.4-5, 40-8.4-10, 40-8.4-12, 40-8.4-15 and 40-8.4-19 of the General Laws in Chapter 40-8.4 entitled "Health Care for Families" are hereby amended to read as follows:

40-8.4-4. Eligibility.

(a) Medical assistance for families. There is hereby established a category of medical assistance eligibility pursuant to § 1931 of Title XIX of the Social Security Act, 42 U.S.C. § 1396u-1, for families whose income and resources are no greater than the standards in effect in the aid to families with dependent children program on July 16, 1996, or such increased standards as the department may determine. The executive office of health and human services is directed to amend the medical assistance Title XIX state plan and to submit to the United States Department of Health and Human Services an amendment to the RIte Care waiver project to provide for medical assistance coverage to families under this chapter in the same amount, scope, and duration as coverage provided to comparable groups under the waiver. The department is further authorized

and directed to submit amendments and/or requests for waivers to the Title XXI state plan as may be necessary to maximize federal contribution for provision of medical assistance coverage provided pursuant to this chapter, including providing medical coverage as a "qualified state" in accordance with Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. Implementation of expanded coverage under this chapter shall not be delayed pending federal review of any Title XXI amendment or waiver.

(b) Income. The secretary of the executive office of health and human services is authorized and directed to amend the medical assistance Title XIX state plan or RIte Care waiver to provide medical assistance coverage through expanded income disregards or other methodology for parents or relative caretakers whose income levels are below one hundred thirty-three percent (133%) of the federal poverty level.

(c) Healthcare coverage provided under this section shall also be provided without regard to availability of federal financial participation to a noncitizen family member who is a resident of Rhode Island, 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. § 1397 et seq.] of the Social Security Act as necessary in order to implement the state plan amendment. The executive office of health and human services is directed to ensure that federal financial participation is assessed to the maximum extent allowable to provide coverage pursuant to this section, at least every two (2) years, and that state-only funds will be used only if federal financial participation is not available.

40-8.4-5. Managed care.

The delivery and financing of the healthcare services provided under this chapter ~~shall~~ may be provided through a system of managed care. ~~A managed care system integrates an efficient financing mechanism with quality service delivery; provides a "medical home" to ensure appropriate care and deter unnecessary and inappropriate care; and places emphasis on preventive and primary health care.~~ Beginning July 1, 2028, all payments shall be provided directly by the state without an intermediate payment to a managed care entity or other form of health insurance company. Beginning July 1, 2024, no new contracts may be entered into between the Medicaid office and an intermediate payor such as a managed care entity or other form of health insurance company for the payment of healthcare services pursuant to this chapter.

40-8.4-10. Regulations.

(a) The ~~department of human services~~ Medicaid director is authorized to promulgate any regulations necessary to implement this chapter.

(b) When promulgating any rule or regulation necessary to implement this chapter, or any

rule or regulation related to RIte Care, the ~~department~~ Medicaid director shall send the notice referred to in § 42-35-3 and a true copy of the rule referred to in § 42-35-4 of the Rhode Island administrative procedures act to each of the co-chairpersons of the permanent joint committee on health care oversight established by § 40-8.4-14.

40-8.4-12. RIte Share health insurance premium assistance program.

(a) **Basic RIte Share health insurance premium assistance program.** Under the terms of Section 1906 of Title XIX of the U.S. Social Security Act, 42 U.S.C. § 1396e, states are permitted to pay a Medicaid-eligible person's share of the costs for enrolling in employer-sponsored health insurance (ESI) coverage if it is cost-effective to do so. Pursuant to the general assembly's direction in the Rhode Island health reform act of 2000, the Medicaid agency requested and obtained federal approval under § 1916, 42 U.S.C. § 1396o, to establish the RIte Share premium assistance program to subsidize the costs of enrolling Medicaid-eligible persons and families in employer-sponsored health insurance plans that have been approved as meeting certain cost and coverage requirements. ~~The Medicaid agency also obtained, at the general assembly's direction, federal authority to require any such persons with access to ESI coverage to enroll as a condition of retaining eligibility providing that doing so meets the criteria established in Title XIX for obtaining federal matching funds.~~

(b) **Definitions.** For the purposes of this section, the following definitions apply:

(1) "Cost-effective" means that the portion of the ESI that the state would subsidize, as well as wrap-around costs, would on average cost less to the state than enrolling that same person/family in a managed-care delivery system.

(2) "Cost sharing" means any co-payments, deductibles, or co-insurance associated with ESI.

(3) "Employee premium" means the monthly premium share a person or family is required to pay to the employer to obtain and maintain ESI coverage.

(4) "Employer-sponsored insurance" or "ESI" means health insurance or a group health plan offered to employees by an employer. This includes plans purchased by small employers through the state health insurance marketplace, healthsource, RI (HSRI).

(5) "Policy holder" means the person in the household with access to ESI, typically the employee.

(6) "RIte Share-approved employer-sponsored insurance (ESI)" means an employer-sponsored health insurance plan that meets the coverage and cost-effectiveness criteria for RIte Share.

(7) "RIte Share buy-in" means the monthly amount an Medicaid-ineligible policy holder

must pay toward RIte Share-approved ESI that covers the Medicaid-eligible children, young adults, or spouses with access to the ESI. The buy-in only applies in instances when household income is above one hundred fifty percent (150%) of the FPL.

(8) "RIte Share premium assistance program" means the Rhode Island Medicaid premium assistance program in which the State pays the eligible Medicaid member's share of the cost of enrolling in a RIte Share-approved ESI plan. This allows the state to share the cost of the health insurance coverage with the employer.

(9) "RIte Share unit" means the entity within the executive office of health and human services (EOHHS) responsible for assessing the cost-effectiveness of ESI, contacting employers about ESI as appropriate, initiating the RIte Share enrollment and disenrollment process, handling member communications, and managing the overall operations of the RIte Share program.

(10) "Third-party liability (TPL)" means other health insurance coverage. This insurance is in addition to Medicaid and is usually provided through an employer. Since Medicaid is always the payer of last resort, the TPL is always the primary coverage.

(11) "Wrap-around services or coverage" means any healthcare services not included in the ESI plan that would have been covered had the Medicaid member been enrolled in a RIte Care or Rhody Health Partners plan. Coverage of deductibles and co-insurance is included in the wrap. Co-payments to providers are not covered as part of the wrap-around coverage.

(c) **RIte Share populations.** Medicaid beneficiaries ~~subject to~~ eligible for RIte Share include: children, families, parent and caretakers eligible for Medicaid or the children's health insurance program (CHIP) under this chapter or chapter 12.3 of title 42; and adults between the ages of nineteen (19) and sixty-four (64) who are eligible under chapter 8.12 of this title, not receiving or eligible to receive Medicare, and are enrolled in managed care delivery systems. The following conditions apply:

(1) The income of Medicaid beneficiaries shall affect whether and in what manner they ~~must~~ may participate in RIte Share as follows:

(i) Income at or below one hundred fifty percent (150%) of FPL — Persons and families determined to have household income at or below one hundred fifty percent (150%) of the federal poverty level (FPL) guidelines based on the modified adjusted gross income (MAGI) standard or other standard approved by the secretary are required to participate in RIte Share if a Medicaid-eligible adult or parent/caretaker has access to cost-effective ESI. Enrolling in ESI through RIte Share shall be a condition of maintaining Medicaid health coverage for any eligible adult with access to such coverage.

(ii) Income above one hundred fifty percent (150%) of FPL and policy holder is not

Medicaid-eligible — Premium assistance is available when the household includes Medicaid-eligible members, but the ESI policy holder (typically a parent/caretaker, or spouse) is not eligible for Medicaid. Premium assistance for parents/caretakers and other household members who are not Medicaid-eligible may be provided in circumstances when enrollment of the Medicaid-eligible family members in the approved ESI plan is contingent upon enrollment of the ineligible policy holder and the executive office of health and human services (executive office) determines, based on a methodology adopted for such purposes, that it is cost-effective to provide premium assistance for family or spousal coverage.

(d) **RIte Share enrollment ~~as~~ not a condition of eligibility.** RIte Share enrollment shall be purely voluntary and shall never be a condition of eligibility for Medicaid. ~~For Medicaid beneficiaries over the age of nineteen (19), enrollment in RIte Share shall be a condition of eligibility except as exempted below and by regulations promulgated by the executive office.~~

~~(1) Medicaid-eligible children and young adults up to age nineteen (19) shall not be required to enroll in a parent/caretaker relative's ESI as a condition of maintaining Medicaid eligibility if the person with access to RIte Share approved ESI does not enroll as required. These Medicaid-eligible children and young adults shall remain eligible for Medicaid and shall be enrolled in a RIte Care plan.~~

~~(2) There shall be a limited six month (6) exemption from the mandatory enrollment requirement for persons participating in the RI works program pursuant to chapter 5.2 of this title.~~

(e) **Approval of health insurance plans for premium assistance.** The executive office of health and human services shall adopt regulations providing for the approval of employer-based health insurance plans for premium assistance and shall approve employer-based health insurance plans based on these regulations. In order for an employer-based health insurance plan to gain approval, the executive office must determine that the benefits offered by the employer-based health insurance plan are substantially similar in amount, scope, and duration to the benefits provided to Medicaid-eligible persons enrolled in a Medicaid managed care plan, when the plan is evaluated in conjunction with available supplemental benefits provided by the office. The office shall obtain and make available to persons otherwise eligible for Medicaid identified in this section as supplemental benefits those benefits not reasonably available under employer-based health insurance plans that are required for Medicaid beneficiaries by state law or federal law or regulation. ~~Once it has been determined by the Medicaid agency that the ESI offered by a particular employer is RIte Share approved, all Medicaid members with access to that employer's plan are required to participate in RIte Share. Failure to meet the mandatory enrollment requirement shall result in the termination of the Medicaid eligibility of the policy holder and other Medicaid~~

~~members nineteen (19) or older in the household who could be covered under the ESI until the policy holder complies with the RIte Share enrollment procedures established by the executive office.~~

(f) **Premium assistance.** The executive office shall provide premium assistance by paying all ~~or a portion~~ of the employee's cost for covering the eligible person and/or his or her family under such a RIte Share-approved ESI plan subject to the buy-in provisions in this section.

(g) **Buy-in.** Persons who can afford it shall share in the cost. — The executive office is authorized and directed to apply for and obtain any necessary state plan and/or waiver amendments from the Secretary of the United States Department of Health and Human Services (DHHS) to require that persons enrolled in a RIte Share-approved employer-based health plan who have income equal to or greater than one hundred fifty percent (150%) of the FPL to buy-in to pay a share of the costs based on the ability to pay, provided that the buy-in cost shall not exceed five percent (5%) of the person's annual income. The executive office shall implement the buy-in by regulation, and shall consider co-payments, premium shares, or other reasonable means to do so.

(h) **Maximization of federal contribution.** The executive office of health and human services is authorized and directed to apply for and obtain federal approvals and waivers necessary to maximize the federal contribution for provision of medical assistance coverage under this section, including the authorization to amend the Title XXI state plan and to obtain any waivers necessary to reduce barriers to provide premium assistance to recipients as provided for in Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq.

(i) **Implementation by regulation.** The executive office of health and human services is authorized and directed to adopt regulations to ensure the establishment and implementation of the premium assistance program in accordance with the intent and purpose of this section, the requirements of Title XIX, Title XXI, and any approved federal waivers.

(j) ~~**Outreach and reporting.** The executive office of health and human services shall develop a plan to identify Medicaid eligible individuals who have access to employer sponsored insurance and increase the use of RIte Share benefits. Beginning October 1, 2019, the executive office shall submit the plan to be included as part of the reporting requirements under § 35-17-1. Starting January 1, 2020, the executive office of health and human services shall include the number of Medicaid recipients with access to employer sponsored insurance, the number of plans that did not meet the cost-effectiveness criteria for RIte Share, and enrollment in the premium assistance program as part of the reporting requirements under § 35-17-1.~~

~~(k) **Employer sponsored insurance.** The executive office of health and human services shall dedicate staff and resources to reporting monthly as part of the requirements under § 35-17-1~~

~~which employer sponsored insurance plans meet the cost effectiveness criteria for RIte Share. Information in the report shall be used for screening for Medicaid enrollment to encourage Rite Share participation. By October 1, 2021, the report shall include any employers with 300 or more employees. By January 1, 2022, the report shall include employers with 100 or more employees. The January report shall also be provided to the chairperson of the house finance committee; the chairperson of the senate finance committee; the house fiscal advisor; the senate fiscal advisor; and the state budget officer.~~

40-8.4-15. Advisory commission on health care.

(a) There is hereby established an advisory commission to be known as the "advisory commission on health care" to advise the director of the department of human services on all matters relating to the RIte Care and RIte Share programs, and other matters concerning access for all Rhode Islanders to quality health care in the most affordable, economical manner. The director of the department of human services shall serve ex officio as chairperson. The director shall appoint the eighteen (18) members:

(1) Three (3) of whom shall represent the healthcare providers;

(2) Three (3) of whom shall represent ~~the healthcare insurers~~ members of the public with significant healthcare conditions;

(3) Three (3) of whom shall represent healthcare consumers or consumer organizations;

(4) Two (2) of whom shall represent organized labor;

(5) One of whom shall be the health care advocate in the office of the attorney general;

(6) Three (3) of whom shall represent employers; and

(7) Three (3) of whom shall be other members of the public.

(b) The commission may study all aspects of the provisions of the RIte Care and RIte Share programs involving purchasers of health care, including employers, consumers, and the state, health insurers, providers of health care, and healthcare facilities, and all matters related to the interaction among these groups, including methods to achieve more effective and timely resolution of disputes, better communication, speedier, more reliable and less-costly administrative processes, claims, payments, and other reimbursement matters, and the application of new processes or technologies to such issues.

(c) Members of the commission shall be appointed in the month of July, each to hold office until the last day of June in the second year of his or her appointment or until his or her successor is appointed by the director.

(d) The commission shall meet at least quarterly, and the initial meeting of the commission shall take place on or before September 15, 2000. The commission may meet more frequently than

quarterly at the call of the chair or at the call of any three (3) members of the commission.

(e) Members of the permanent joint committee on health care oversight established pursuant to § 40-8.4-14 shall be notified of each meeting of the commission and shall be invited to participate.

40-8.4-19. ~~Managed healthcare delivery systems for families~~ Cost sharing.

~~(a) Notwithstanding any other provision of state law, the delivery and financing of the healthcare services provided under this chapter shall be provided through a system of managed care. "Managed care" is defined as systems that: integrate an efficient financing mechanism with quality service delivery; provide a "medical home" to ensure appropriate care and deter unnecessary services; and place emphasis on preventive and primary care.~~

~~(b) Enrollment in managed care health delivery systems is mandatory for individuals eligible for medical assistance under this chapter. This includes children in substitute care, children receiving medical assistance through an adoption subsidy, and children eligible for medical assistance based on their disability. Beneficiaries with third-party medical coverage or insurance may be exempt from mandatory managed care in accordance with rules and regulations promulgated by the department of human services for such purposes.~~

~~(c)~~ Individuals who can afford to contribute shall share in the cost. The department of human services is authorized and directed to apply for and obtain any necessary waivers and/or state plan amendments from the Secretary of the United States Department of Health and Human Services, including, but not limited to, a waiver of the appropriate sections of Title XIX, 42 U.S.C. § 1396 et seq., to require that beneficiaries eligible under this chapter or chapter 12.3 of title 42, with incomes equal to or greater than one hundred fifty percent (150%) of the federal poverty level, pay a share of the costs of health coverage based on the ability to pay. The department of human services shall implement this cost-sharing obligation by regulation, and shall consider co-payments, premium shares, or other reasonable means to do so in accordance with approved provisions of appropriate waivers and/or state plan amendments approved by the Secretary of the United States Department of Health and Human Services.

SECTION 10. Section 40-8.4-13 of the General Laws in Chapter 40-8.4 entitled "Health Care for Families" is hereby repealed in its entirety.

~~**40-8.4-13. Utilization of available employer-based health insurance.**~~

~~To the extent permitted under Titles XIX and XXI of the Social Security Act, 42 U.S.C. § 1396 et seq. and 42 U.S.C. § 1397aa et seq., or by waiver from the Secretary of the United States Department of Health and Human Services, the department of human services shall adopt regulations to restrict eligibility for RIte Care under this chapter and/or chapter 12.3 of title 42, or~~

~~the RIte Share program under § 40-8.4-12, for certain periods of time for certain individuals or families who have access to, or have refused or terminated employer-based health insurance and for certain periods of time for certain individuals but not including children whose employer has terminated their employer-based health insurance. The department is authorized and directed to amend the medical assistance Title XIX and XXI state plans, and/or to seek and obtain appropriate federal approvals or waivers to implement this section.~~

SECTION 11. Sections 40-8.5-1 and 40-8.5-1.1 of the General Laws in Chapter 40-8.5 entitled "Health Care for Elderly and Disabled Residents Act" are hereby amended to read as follows:

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

The department of human services is hereby authorized and directed to amend its Title XIX state plan to provide for categorically needy medical assistance coverage as permitted pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as amended, to individuals who are sixty-five (65) years or older or are disabled, as determined under § 1614(a)(3) of the Social Security Act, 42 U.S.C. § 1382c(a)(3), as amended, whose income does not exceed ~~one hundred percent (100%)~~ one hundred thirty-three percent (133%) of the federal poverty level (as revised annually) applicable to the individual's family size, and whose resources do not exceed four thousand dollars ($4,000) per individual, or six thousand dollars ($6,000) per couple. The department shall provide medical assistance coverage to such elderly or disabled persons in the same amount, duration, and scope as provided to other categorically needy persons under the state's Title XIX state plan.

40-8.5-1.1. Managed healthcare delivery systems.

(a) The delivery and financing of the healthcare services provided under this chapter may be provided through a system of managed care. Beginning July 1, 2028, all payments shall be provided directly by the state without an intermediate payment to a managed care entity or other form of health insurance company. Beginning July 1, 2024, no new contracts may be entered into between the Medicaid office and an intermediate payor such as a managed care entity or other form of health insurance company for the payment of healthcare services pursuant to this chapter. ~~To ensure that all medical assistance beneficiaries, including the elderly and all individuals with disabilities, have access to quality and affordable health care, the executive office of health and human services ("executive office") is authorized to implement mandatory managed-care health systems.~~

~~(b) "Managed care" is defined as systems that: integrate an efficient financing mechanism with quality service delivery; provide a "medical home" to ensure appropriate care and deter~~

~~unnecessary services; and place emphasis on preventive and primary care. For purposes of this section, managed care systems may also be defined to include a primary care case management model, community health teams, and/or other such arrangements that meet standards established by the executive office and serve the purposes of this section. Managed care systems may also include services and supports that optimize the health and independence of beneficiaries who are determined to need Medicaid-funded long-term care under chapter 8.10 of this title or to be at risk for the care under applicable federal state plan or waiver authorities and the rules and regulations promulgated by the executive office. Any Medicaid beneficiaries who have third-party medical coverage or insurance may be provided such services through an entity certified by, or in a contractual arrangement with, the executive office or, as deemed appropriate, exempt from mandatory managed care in accordance with rules and regulations promulgated by the executive office.~~

~~(c) In accordance with § 42-12.4-7, the executive office is authorized to obtain any approval through waiver(s), category II or III changes, and/or state plan amendments, from the Secretary of the United States Department of Health and Human Services, that are necessary to implement mandatory, managed healthcare delivery systems for all Medicaid beneficiaries. The waiver(s), category II or III changes, and/or state plan amendments shall include the authorization to extend managed care to cover long-term care services and supports. Authorization shall also include, as deemed appropriate, exempting certain beneficiaries with third-party medical coverage or insurance from mandatory managed care in accordance with rules and regulations promulgated by the executive office.~~

~~(d)~~(b) To ensure the delivery of timely and appropriate services to persons who become eligible for Medicaid by virtue of their eligibility for a United States Social Security Administration program, the executive office is authorized to seek any and all data-sharing agreements or other agreements with the Social Security Administration as may be necessary to receive timely and accurate diagnostic data and clinical assessments. This information shall be used exclusively for the purpose of service planning, and shall be held and exchanged in accordance with all applicable state and federal medical record confidentiality laws and regulations.

SECTION 12. Sections 40-8.12-2 and 40-8.12-3 of the General Laws in Chapter 40-8.12 entitled "Health Care for Adults" are hereby amended to read as follows:

40-8.12-2. Eligibility.

(a) Medicaid coverage for nonpregnant adults without children. There is hereby established, effective January 1, 2014, a category of Medicaid eligibility pursuant to Title XIX of the Social Security Act, as amended by the U.S. Patient Protection and Affordable Care Act (ACA)

of 2010, 42 U.S.C. § 1396u-1, for adults ages nineteen (19) to sixty-four (64) who do not have dependent children and do not qualify for Medicaid under Rhode Island general laws applying to families with children and adults who are blind, aged, or living with a disability. The executive office of health and human services is directed to make any amendments to the Medicaid state plan and waiver authorities established under Title XIX necessary to implement this expansion in eligibility and ensure the maximum federal contribution for health insurance coverage provided pursuant to this chapter.

(b) Income. The secretary of the executive office of health and human services is authorized and directed to amend the Medicaid Title XIX state plan and, as deemed necessary, any waiver authority to effectuate this expansion of coverage to any Rhode Islander who qualifies for Medicaid eligibility under this chapter with income at or below one hundred and thirty-three percent (133%) of the federal poverty level, based on modified adjusted-gross income.

(c) Delivery system. ~~The executive office of health and human services is authorized and directed to apply for and obtain any waiver authorities necessary to provide persons eligible under this chapter with managed, coordinated healthcare coverage consistent with the principles set forth in chapter 12.4 of title 42, pertaining to a healthcare home.~~ Beginning July 1, 2028, all payments shall be provided directly by the state without an intermediate payment to a managed care entity or other form of health insurance company. Beginning July 1, 2024, no new contracts may be entered into between the Medicaid office and an intermediate payor such as a managed care entity or other form of health insurance company for the payment of healthcare services pursuant to this chapter.

40-8.12-3. Premium assistance program.

~~(a)~~ The executive office of health and human services is directed to amend its rules and regulations to implement a premium assistance program for adults with dependent children, enrolled in the state's health-benefits exchange, whose annual income and resources meet the guidelines established in § 40-8.4-4 in effect on December 1, 2013. The premium assistance will pay one-half of the cost of a commercial plan that a parent may incur after subtracting the cost-sharing requirement under § 40-8.4-4 as of December 31, 2013, and any applicable federal tax credits available. The office is also directed to amend the 1115 waiver demonstration extension and the medical assistance Title XIX state plan for this program if it is determined that it is eligible for funding pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.

~~(b) The executive office of health and human services shall require any individual receiving benefits under a state-funded, healthcare assistance program to apply for any health insurance for which he or she is eligible, including health insurance available through the health benefits exchange. Nothing shall preclude the state from using funds appropriated for Affordable Care Act~~

~~transition expenses to reduce the impact on an individual who has been transitioned from a state program to a health insurance plan available through the health benefits exchange. It shall not be deemed cost-effective for the state if it would result in a loss of benefits or an increase in the cost of healthcare services for the person above an amount deemed de minimus as determined by state regulation.~~

SECTION 13. Chapter 44-8.13 of the General Law entitled "Long-Term Managed Care Arrangements" is hereby repealed in its entirety.

~~**40-8.13-1. Definitions.**~~

~~For purposes of this section the following terms shall have the meanings indicated:~~

~~(1) "Beneficiary" means an individual who is eligible for medical assistance under the Rhode Island Medicaid state plan established in accordance with 42 U.S.C. § 1396, and includes individuals who are additionally eligible for benefits under the Medicare program (42 U.S.C. § 1395 et seq.) or other health plan.~~

~~(2) "Duals demonstration project" means a demonstration project established pursuant to the financial alignment demonstration established under section 2602 of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) [42 U.S.C. § 1315b], involving a three-way contract between Rhode Island, the federal Centers for Medicare and Medicaid Services ("CMS"), and qualified health plans, and covering healthcare services provided to beneficiaries.~~

~~(3) "EOHHS" means the Rhode Island executive office of health and human services.~~

~~(4) "EOHHS level-of-care tool" refers to a set of criteria established by EOHHS and used in January, 2014 to determine the long-term-care needs of a beneficiary as well as the appropriate setting for delivery of that care.~~

~~(5) "Long-term-care services and supports" means a spectrum of services covered by the Rhode Island Medicaid program and/or the Medicare program, that are required by individuals with functional impairments and/or chronic illness, and includes skilled or custodial nursing facility care, as well as various home- and community-based services.~~

~~(6) "Managed care organization" means any health plan, health maintenance organization, managed care plan, or other person or entity that enters into a contract with the state under which it is granted the authority to arrange for the provision of, and/or payment for, long-term-care supports and services to eligible beneficiaries under a managed long-term-care arrangement.~~

~~(7) "Managed long-term-care arrangement" means any arrangement under which a managed care organization is granted some or all of the responsibility for providing and/or paying for long-term-care services and supports that would otherwise be provided or paid under the Rhode Island Medicaid program. The term includes, but is not limited to, a duals demonstration project,~~

and/or phase I and phase II of the integrated care initiative established by the executive office of health and human services.

(8) "Plan of care" means a care plan established by a nursing facility in accordance with state and federal regulations and that identifies specific care and services provided to a beneficiary.

40-8.13-2. Beneficiary choice.

Any managed long-term care arrangement shall offer beneficiaries the option to decline participation and remain in traditional Medicaid and, if a duals demonstration project, traditional Medicare. Beneficiaries must be provided with sufficient information to make an informed choice regarding enrollment, including:

(1) Any changes in the beneficiary's payment or other financial obligations with respect to long-term care services and supports as a result of enrollment;

(2) Any changes in the nature of the long-term care services and supports available to the beneficiary as a result of enrollment, including specific descriptions of new services that will be available or existing services that will be curtailed or terminated;

(3) A contact person who can assist the beneficiary in making decisions about enrollment;

(4) Individualized information regarding whether the managed care organization's network includes the healthcare providers with whom beneficiaries have established provider relationships. Directing beneficiaries to a website identifying the plan's provider network shall not be sufficient to satisfy this requirement; and

(5) The deadline by which the beneficiary must make a choice regarding enrollment, and the length of time a beneficiary must remain enrolled in a managed care organization before being permitted to change plans or opt out of the arrangement.

40-8.13-3. Ombudsman process.

EOHHS shall designate an ombudsperson to advocate for beneficiaries enrolled in a managed long-term care arrangement. The ombudsperson shall advocate for beneficiaries through complaint and appeal processes and ensure that necessary healthcare services are provided. At the time of enrollment, a managed care organization must inform enrollees of the availability of the ombudsperson, including contact information.

40-8.13-4. Provider/plan liaison.

EOHHS shall designate an individual, not employed by or otherwise under contract with a participating managed care organization, who shall act as liaison between healthcare providers and managed care organizations, for the purpose of facilitating communications and ensuring that issues and concerns are promptly addressed.

40-8.13-5. Financial principles under managed care.

~~(a) To the extent that financial savings are a goal under any managed long-term care arrangement, it is the intent of the legislature to achieve savings through administrative efficiencies, care coordination, improvements in care outcomes and in a way that encourages the highest quality care for patients and maximizes value for the managed care organization and the state. Therefore, any managed long-term care arrangement shall include a requirement that the managed care organization reimburse providers for services in accordance with these principles. Notwithstanding any law to the contrary, for the twelve-month (12) period beginning July 1, 2015, Medicaid managed long-term care payment rates to nursing facilities established pursuant to this section shall not exceed ninety-eight percent (98.0%) of the rates in effect on April 1, 2015.~~

~~(1) For a duals demonstration project, the managed care organization:~~

~~(i) Shall not combine the rates of payment for post-acute skilled and rehabilitation care provided by a nursing facility and long-term and chronic care provided by a nursing facility in order to establish a single-payment rate for dual-eligible beneficiaries requiring skilled nursing services;~~

~~(ii) Shall pay nursing facilities providing post-acute skilled and rehabilitation care or long-term and chronic care rates that reflect the different level of services and intensity required to provide these services; and~~

~~(iii) For purposes of determining the appropriate rate for the type of care identified in subsection (a)(1)(ii) of this section, the managed care organization shall pay no less than the rates that would be paid for that care under traditional Medicare and Rhode Island Medicaid for these service types. The managed care organization shall not, however, be required to use the same payment methodology.~~

~~The state shall not enter into any agreement with a managed care organization in connection with a duals demonstration project unless that agreement conforms to this section, and any existing such agreement shall be amended as necessary to conform to this subsection.~~

~~(2) For a managed long-term care arrangement that is not a duals demonstration project, the managed care organization shall reimburse providers in an amount not less than the amount that would be paid for the same care by the executive office of health and human services under the Medicaid program. The managed care organization shall not, however, be required to use the same payment methodology as the executive office of health and human services.~~

~~(3) Notwithstanding any provisions of the general or public laws to the contrary, the protections of subsections (a)(1) and (a)(2) of this section may be waived by a nursing facility in the event it elects to accept a payment model developed jointly by the managed care organization and skilled nursing facilities, that is intended to promote quality of care and cost effectiveness, including, but not limited to, bundled payment initiatives, value based purchasing arrangements,~~

~~gainsharing, and similar models.~~

~~(b) Notwithstanding any law to the contrary, for the twelve-month (12) period beginning July 1, 2015, Medicaid managed long-term care payment rates to nursing facilities established pursuant to this section shall not exceed ninety-eight percent (98.0%) of the rates in effect on April 1, 2015.~~

~~**40-8.13-6. Payment incentives.**~~

~~In order to encourage quality improvement and promote appropriate utilization incentives for providers in a managed long-term care arrangement, a managed care organization may use incentive or bonus payment programs that are in addition to the rates identified in § 40-8.13-5.~~

~~**40-8.13-7. Willing provider.**~~

~~A managed care organization must contract with and cover services furnished by any nursing facility licensed under chapter 17 of title 23 and certified by CMS that provides Medicaid-covered nursing facility services pursuant to a provider agreement with the state, provided that the nursing facility is not disqualified under the managed care organization's quality standards that are applicable to all nursing facilities; and the nursing facility is willing to accept the reimbursement rates described in § 40-8.13-5.~~

~~**40-8.13-8. Level of care tool.**~~

~~A managed long-term care arrangement must require that all participating managed care organizations use only the EOHHS level of care tool in determining coverage of long-term care supports and services for beneficiaries. EOHHS may amend the level of care tool provided that any changes are established in consultation with beneficiaries and providers of Medicaid covered long-term care supports and services, and are based upon reasonable medical evidence or consensus, in consideration of the specific needs of Rhode Island beneficiaries. Notwithstanding any other provisions herein, however, in the case of a duals demonstration project, a managed care organization may use a different level of care tool for determining coverage of services that would otherwise be covered by Medicare, since the criteria established by EOHHS are directed towards Medicaid covered services; provided, that the level of care tool is based on reasonable medical evidence or consensus in consideration of the specific needs of Rhode Island beneficiaries.~~

~~**40-8.13-9. Case management/plan of care.**~~

~~No managed care organization acting under a managed long-term care arrangement may require a provider to change a plan of care if the provider reasonably believes that such an action would conflict with the provider's responsibility to develop an appropriate care plan under state and federal regulations.~~

~~**40-8.13-10. Care transitions.**~~

~~In the event that a beneficiary:~~

~~(1) Has been determined to meet level of care requirements for nursing facility coverage as of the date of his or her enrollment in a managed care organization; or~~

~~(2) Has been determined to meet level of care requirements for nursing facility coverage by a managed care organization after enrollment; and there is a change in condition whereby the managed care organization determines that the beneficiary no longer meets such level of care requirements, the nursing facility shall promptly arrange for an appropriate and safe discharge (with the assistance of the managed care organization if the facility requests it), and the managed care organization shall continue to pay for the beneficiary's nursing facility care at the same rate until the beneficiary is discharged.~~

~~**40-8.13-11. Reporting requirements.**~~

~~EOHHS shall report to the general assembly and shall make available to interested persons a separate accounting of state expenditures for long-term care supports and services under any managed long-term care arrangement, specifically and separately identifying expenditures for home- and community-based services, assisted living services, hospice services within nursing facilities, hospice services outside of nursing facilities, and nursing facility services. Such reports shall be made twice annually, six (6) months apart, beginning six (6) months following the implementation of any managed long-term care arrangement, and shall include a detailed report of utilization of each service. In order to facilitate reporting, any managed long-term care arrangement shall include a requirement that a participating managed care organization make timely reports of the data necessary to compile the reports.~~

SECTION 14. Sections 42-7.2-10, 42-7.2-16 and 42-7.2-16.1 of the General Laws in Chapter 42-7.2 entitled "Office of Health and Human Services" are hereby amended to read as follows:

42-7.2-10. Appropriations and disbursements.

(a) The general assembly shall annually appropriate such sums as it may deem necessary for the purpose of carrying out the provisions of this chapter. The state controller is hereby authorized and directed to draw his or her orders upon the general treasurer for the payment of such sum or sums, or so much thereof as may from time to time be required, upon receipt by him or her of proper vouchers approved by the secretary of the executive office of health and human services, or his or her designee.

(b) The general assembly shall, through the utilization of federal Medicaid reimbursement for administrative costs, and additional funds, appropriate such funds as may be necessary to hire additional personnel for the Medicaid office as follows: one hundred (100) outreach social workers

to encourage, assist and expedite individuals applying for Medicaid benefits; one hundred (100) new programmers in order to build digital infrastructure for the Medicaid office; thirty (30) new social workers and ten (10) new programmers to help increase spend down program utilization and feasibility and examine possible legal changes necessary to increase spend down program eligibility; and fifty (50) additional personnel for building administrative capacity. The Medicaid office shall be exempt from any limitations placed on the number of full-time equivalent personnel employed by the executive office of health and human services.

~~(b)~~(c) For the purpose of recording federal financial participation associated with qualifying healthcare workforce development activities at the state's public institutions of higher education, and pursuant to the Rhode Island designated state health programs (DSHP), as approved by the Centers for Medicare & Medicaid Services (CMC) October 20, 2016, in the 11-W-00242/1 amendment to Rhode Island's section 1115 Demonstration Waiver, there is hereby established a restricted-receipt account entitled "Health System Transformation Project" in the general fund of the state and included in the budget of the office of health and human services. Due to the COVID-19 pandemic, the office of health and human services is forbidden from utilizing any funds within the health system transformation project restricted receipts account for any imposition of downside risk for providers. No payment models that impose downside risk or in any way deviate from fee-for-service shall be utilized for the Medicaid program without explicit authorization by the general assembly.

~~(c)~~(d) There are hereby created within the general fund of the state and housed within the budget of the office of health and human services two restricted receipt accounts, respectively entitled "HCBS Support-ARPA" and "HCBS Admin Support-ARPA". Amounts deposited into these accounts are equivalent to the general revenue savings generated by the enhanced federal match received on eligible home and community-based services between April 1, 2021, and March 31, 2022, allowable under Section 9817 of the American Rescue Plan Act of 2021, Pub. L. No. 117-2. Funds deposited into the "HCBS Support-ARPA" account will be used to finance the state share of newly eligible Medicaid expenditures by the office of health and human services and its sister agencies, including the department of children, youth and families, the department of health, and the department of behavioral healthcare, developmental disabilities and hospitals. Funds deposited into the "HCBS Admin Support-ARPA" account will be used to finance the state share of allowable administrative expenditures attendant to the implementation of these newly eligible Medicaid expenditures. The accounts created under this subsection shall be exempt from the indirect cost recovery provisions of § 35-4-27.

~~(d)~~(e) There is hereby created within the general fund of the state and housed within the

budget of the office of health and human services a restricted receipt account entitled "Rhode Island Statewide Opioid Abatement Account" for the purpose of receiving and expending monies from settlement agreements with opioid manufacturers, pharmaceutical distributors, pharmacies, or their affiliates, as well as monies resulting from bankruptcy proceedings of the same entities. The executive office of health and human services shall deposit any revenues from such sources that are designated for opioid abatement purposes into the restricted receipt account. Funds from this account shall only be used for forward-looking opioid abatement efforts as defined and limited by any settlement agreements, state-city and town agreements, or court orders pertaining to the use of such funds. By January 1 of each calendar year, the secretary of health and human services shall report to the governor, the speaker of the house of representatives, the president of the senate, and the attorney general on the expenditures that were funded using monies from the Rhode Island statewide opioid abatement account and the amount of funds spent. The account created under this subsection shall be exempt from the indirect cost recovery provisions of § 35-4-27. No governmental entity has the authority to assert a claim against the entities with which the attorney general has entered into settlement agreements concerning the manufacturing, marketing, distributing, or selling of opioids that are the subject of the Rhode Island Memorandum of Understanding Between the State and Cities and Towns Receiving Opioid Settlement Funds executed by every city and town and the attorney general and wherein every city and town agreed to release all such claims against these settling entities, and any amendment thereto. Governmental entity means any state or local governmental entity or sub-entity and includes, but is not limited to, school districts, fire districts, and any other such districts. The claims that shall not be asserted are the released claims, as that term is defined in the settlement agreements executed by the attorney general, or, if not defined therein, the claims sought to be released in such settlement agreements.

42-7.2-16. ~~Medicaid System Reform 2008~~ Medicaid System Reform.

(a) The executive office of health and human services, in conjunction with the department of human services, the department of children, youth and families, the department of health and the department of behavioral healthcare, developmental disabilities and hospitals, is authorized to design options that further ~~the reforms in Medicaid initiated in 2008~~ Medicaid reform to ensure that the program: transitions to a Medicare level of care as a first step in the transition to a state-level Medicare for All system; phases out the use of intermediary insurance companies such as managed care entities; transitions to the management of health insurers acquired due to insolvency, smoothly integrating publicly owned health insurers with the Medicaid system; utilizes payment models such as fee-for-service that incentivize higher quality of care and more utilization of care; provides for the financial health of Rhode Island healthcare providers; encourages fair wages and benefits for

Rhode Island's healthcare workforce; develops and builds out the Medicaid office's human capital, technological infrastructure, expertise, and general ability to manage healthcare payments to prepare for the transition to a single-payer Medicare-for-All system; and guides the transition of the Rhode Island healthcare funding system to a state-level Medicare-for-All system. ~~utilizes competitive and value based purchasing to maximize the available service options, promotes accountability and transparency, and encourages and rewards healthy outcomes, independence, and responsible choices; promotes efficiencies and the coordination of services across all health and human services agencies; and ensures the state will have a fiscally sound source of publicly-financed health care for Rhode Islanders in need.~~

(b) Principles and goals. In developing and implementing this system of reform, the executive office of health and human services and the four (4) health and human services departments shall pursue the following principles and goals:

(1) Empower consumers to make reasoned and cost-effective choices about their health by providing them with the information and array of service options they need and offering rewards for healthy decisions;

(2) Encourage personal responsibility by assuring the information available to beneficiaries is easy to understand and accurate, provide that a fiscal intermediary is provided when necessary, and adequate access to needed services;

(3) When appropriate, promote community-based care solutions by transitioning beneficiaries from institutional settings back into the community and by providing the needed assistance and supports to beneficiaries requiring long-term care or residential services who wish to remain, or are better served in the community;

(4) Enable consumers to receive individualized health care that is outcome-oriented, focused on prevention, disease management, recovery and maintaining independence;

(5) Promote competition between healthcare providers to ensure best value purchasing, to leverage resources and to create opportunities for improving service quality and performance;

(6) Redesign purchasing and payment methods to ~~assure fiscal accountability and encourage and to reward service quality and cost-effectiveness by tying reimbursements to evidence-based performance measures and standards, including those related to patient satisfaction~~ promote payment models such as fee-for-service that incentivize higher quality of care and more utilization of care and phase out the use of payment models that shift risk to providers; and

(7) Continually improve technology to take advantage of recent innovations and advances that help decision makers, consumers and providers to make informed and cost-effective decisions regarding health care.

(c) The executive office of health and human services shall annually submit a report to the governor and the general assembly describing the status of the administration and implementation of the Medicaid Section 1115 demonstration waiver.

42-7.2-16.1. Reinventing Medicaid Act of 2015.

~~(a)~~ Findings. The Rhode Island Medicaid program is an integral component of the state's healthcare system that provides crucial services and supports to many Rhode Islanders. ~~As the program's reach has expanded, the costs of the program have continued to rise and the delivery of care has become more fragmented and uncoordinated. Given the crucial role of the Medicaid program to the state, it is of compelling importance that the state conduct a fundamental restructuring of its Medicaid program that achieves measurable improvement in health outcomes for the people and transforms the healthcare system to one that pays for the outcomes and quality they deserve at a sustainable, predictable and affordable cost.~~ The Reinventing Medicaid Act of 2015, as implemented in the budget for fiscal year two thousand sixteen (FY2016), involved drastic cuts to the Medicaid program, along with policies that shifted risk to providers away from intermediary insurers. Since the passage of that act, the finances of healthcare providers in Rhode Island have deteriorated significantly, and it is therefore the duty of the general assembly to seek corrective action to restore critical investments in the Medicaid system and redesign payment models to remove risk from providers and concentrate risk in private insurance companies during their phase-out period along the transition to Medicare-for-All.

~~(b) The Working Group to Reinvent Medicaid, which was established to refine the principles and goals of the Medicaid reforms begun in 2008, was directed to present to the general assembly and the governor initiatives to improve the value, quality, and outcomes of the health care funded by the Medicaid program.~~

SECTION 15. Chapter 42-12.1 of the General Laws entitled "Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals" is hereby amended by adding thereto the following section:

42-12.1-11. The Rhode Island institute for mental disease.

(a) There is hereby established a state hospital for the care for Rhode Islanders in need of hospital-level inpatient behavioral healthcare known as the Rhode Island institute for mental disease. The Rhode Island institute for mental disease shall fall within the purview of the department, and the chief executive officer, chief financial officer, and chief medical officer shall be appointed by the governor with advice and consent of the senate.

(b) All forensic patients in the care of the Eleanor Slater Hospital shall be immediately transferred to the Rhode Island institute for mental disease.

(c) The Reagan Building of the Eleanor Slater Hospital shall be immediately transferred to the Rhode Island institute for mental disease.

(d) A section of the Zambarano Building of the Eleanor Slater Hospital shall be designated by the department for the use of the Rhode Island institute for mental disease.

(e) In the event that the director determines that the patient mix at the Eleanor Slater Hospital may be at risk of jeopardizing federal Medicaid reimbursement through the classification of the Eleanor Slater Hospital as an institution for mental disease, the director shall be empowered to administratively transfer inpatient behavioral health patients at Eleanor Slater Hospital to the Rhode Island institute for mental disease.

(f) The Medicaid director is hereby directed to apply for a waiver to allow for Medicaid reimbursement of some or all inpatient behavioral health patients at the Rhode Island institute for mental disease.

SECTION 16. Sections 42-12.3-2, 42-12.3-3, 42-12.3-5, 42-12.3-7 and 42-12.3-9 of the General Laws in Chapter 42-12.3 entitled "Health Care for Children and Pregnant Women" are hereby amended to read as follows:

42-12.3-2. Purposes.

(a) It is the intent of the general assembly to assure access to the comprehensive health care by providing health insurance to all Rhode Islanders who are uninsured;

Universal comprehensive coverage for all Rhode Islanders is a goal to be achieved over the course of several years;

The first step in providing comprehensive health coverage is to assure coverage for the most vulnerable residents of the state;

Uninsured pregnant women and children under age ~~eight (8)~~ nineteen (19) are among the most vulnerable residents of the state; and

The governor's health care advisory committee has provided advice and recommendations in its report of January, 1993 to improve access to health care for pregnant women and children up to age six (6);

The objectives to meet the goal of comprehensive health coverage are:

(1) Every child under age ~~eight (8)~~ nineteen (19) in Rhode Island will have a reliable source of health coverage and health care;

(2) Every pregnant woman in Rhode Island will have early and comprehensive prenatal and maternity care services;

(3) All low income families will have improved access to family planning and reproductive services; and

(4) Every pregnant woman and child in Rhode Island will receive effective, preventive primary care.

(b) To assure access to care and availability of services, the following principles will guide the design of the health care act:

(1) There will be equal access to health care for children and pregnant women, regardless of the type of coverage;

(2) There shall be an emphasis on primary and preventive care which will include a "medical home" for every child;

(3) Current deficiencies in the fee for service delivery system will be addressed;

(4) In addition to accessibility of health care, provisions must be made to address language, cultural and transportation barriers;

(5) Enrollment must be both timely and accomplished in a user friendly fashion;

(6) An adequate source of primary care providers should be developed;

(7) An enhanced set of services should be developed to support and address the needs of families at risk.

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

(a) The 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 persons 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 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 person 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 person ~~lawfully admitted for permanent residence on or after August 22, 1996~~, without regard to the availability of federal financial participation, provided such pregnant person satisfies all other eligibility requirements. The 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.

(c) The 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 secretary of health and human services shall provide enhanced services, as appropriate, to pregnant persons as defined in subsections (a) and (b), as well as to other pregnant persons 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 executive office has the authority to limit the amount, scope, and duration of these enhanced services.

(f) The 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 persons 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-month (12) 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.

(h) Any person eligible for services under subsections (a) and (b) of this section, or otherwise 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, shall also be entitled to services for any termination of pregnancy permitted under § 23-4.13-2; provided, however, that no federal funds shall be used to pay for such services, except as authorized under federal law.

42-12.3-5. Managed care.

The delivery and financing of the health care services provided pursuant to §§ 42-12.3-3 and 42-12.3-4 ~~shall~~ may be provided through a system of managed care. The delivery and financing of the healthcare services provided under this chapter may be provided through a system of managed care. Beginning July 1, 2028, all payments shall be provided directly by the state without an intermediate payment to a managed care entity or other form of health insurance company. Beginning July 1, 2024, no new contracts may be entered into between the Medicaid office and an intermediate payor such as a managed care entity or other form of health insurance company for the payment of healthcare services pursuant to this chapter.

~~A managed care system integrates an efficient financing mechanism with quality service delivery, provides a "medical home" to assure appropriate care and deter unnecessary and inappropriate care, and places emphasis on preventive and primary health care. In developing a managed care system the department of human services shall consider managed care models recognized by the health care financing administration. The department of human services is hereby authorized and directed to seek any necessary approvals or waivers from the U.S. Department of Health and Human Services, Health Care Financing Administration, needed to assure that services are provided through a mandatory managed care system. Certain health services may be provided on an interim basis through a fee for service arrangement upon a finding that there are temporary barriers to implementation of mandatory managed care for a particular population or particular geographic area. Nothing in this section shall prohibit the department of human services from providing enhanced services to medical assistance recipients within existing appropriations.~~

42-12.3-7. Financial contributions.

The department of human services may not require the payment of enrollment fees, sliding fees, deductibles, co-payments, and/or other contributions based on ability to pay. ~~These fees shall be established by rules and regulations to be promulgated by the department of human services or the department of health, as appropriate.~~

42-12.3-9. Insurance coverage — Third party insurance.

(a) ~~No payment will be made nor service provided in the RIte Start or RIte Track program with respect to any health care that is covered or would be covered, by any employee welfare benefit plan under which a woman or child is either covered or eligible to be covered either as an employee or dependent, whether or not coverage under such plan is elected.~~

~~(b)~~ A premium may be charged for participation in the RIte Track or RIte Start programs for eligible individuals whose family incomes are in excess of two hundred fifty percent (250%) of the federal poverty level and who have voluntarily terminated health care insurance within one year of the date of application for benefits under this chapter.

~~(c)~~(b) Every family who is eligible to participate in the RIte Track program, who has an additional child who because of age is not eligible for RIte Track, or whose child becomes ineligible for RIte Track because of his or her age, may be offered by the managed care provider with whom the family is enrolled, the opportunity to enroll such ineligible child or children in the same managed care program on a self-pay basis at the same cost, charge or premium as is being charged to the state under the provisions of this chapter for other covered children within the managed care program. The family may also purchase a package of enhanced services at the same cost or charge to the department.

SECTION 17. Section 42-12.3-14 of the General Laws in Chapter 42-12.3 entitled "Health Care for Children and Pregnant Women" is hereby repealed in its entirety.

~~**42-12.3-14. Benefits and coverage -- Exclusion.**~~

~~For as long as the United States Department of Health and Human Services, Health Care Financing Administration Project No. 11-W-0004/1-01 entitled "RIte Care" remains in effect, any health care services provided pursuant to this chapter shall be exempt from all mandatory benefits and coverage as may otherwise be provided for in the general laws.~~

SECTION 18. Sections 42-14.5-2 and 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" are hereby amended to read as follows:

42-14.5-2. Purpose.

With respect to health insurance as defined in § 42-14-5, the health insurance commissioner shall discharge the powers and duties of office to:

(1) ~~Guard the solvency of health insurers~~ Claw back excessive profits, reserves charges, and other monies that health insurers may have accumulated against the public interest of the people of Rhode Island;

(2) Protect the interests of consumers;

(3) Encourage fair treatment of health care providers;

(4) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; ~~and~~

(5) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access; and

(6) Facilitate the transformation of the healthcare payments system to a state-level Medicare-for-All system.

42-14.5-3. Powers and duties.

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

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

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

(c) To establish a consumer/business/labor/medical advisory council to obtain information and present concerns of consumers, business, and medical providers affected by health insurance decisions. The council shall develop proposals to allow the market for small business health insurance to be affordable and fairer. The council shall be involved in the planning and conduct of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) The health insurance commissioner shall work with an insurance market merger task force to assist with the analysis. The task force shall be chaired by the health insurance commissioner and shall include, but not be limited to, representatives of the general assembly, the

business community, small-employer carriers as defined in § 27-50-3, carriers offering coverage in the individual market in Rhode Island, health insurance brokers, and members of the general public.

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

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

(h) To establish and convene a workgroup representing healthcare providers ~~and health insurers~~ for the purpose of coordinating the development of processes, guidelines, and standards to streamline healthcare administration that are to be adopted by payors and providers of healthcare services operating in the state. This workgroup shall include representatives with expertise who would contribute to the streamlining of healthcare administration and who are selected from hospitals, physician practices, community behavioral health organizations~~, each health insurer~~, labor union representing healthcare workers, and other affected entities. The workgroup shall also include at least one designee each from the Rhode Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the Rhode Island Health Center Association, and the Hospital Association of Rhode Island. In any year that the workgroup meets and submits recommendations to the office of the health insurance commissioner, the office of the health insurance commissioner shall submit such recommendations to the health and human services committees of the Rhode Island house of representatives and the Rhode Island senate prior to the implementation of any such recommendations and subsequently shall submit a report to the general assembly by June 30, 2024. The report shall include the recommendations the commissioner may implement, with supporting rationale. The workgroup shall consider and make recommendations for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to:

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

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

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

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

(v) Develop and implement the use of programs that implement selective prior authorization requirements, based on stratification of healthcare providers' performance and adherence to evidence-based medicine with the input of contracted healthcare providers and/or provider organizations. Such criteria shall be transparent and easily accessible to contracted providers. Such selective prior authorization programs shall be available when healthcare providers participate directly with the insurer in risk-based payment contracts and may be available to providers who do not participate in risk-based contracts;

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

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

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

(B) Supporting:

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

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

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

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

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

(C) Requiring communication between healthcare providers, health plans, and patients to facilitate continuity of care and minimize disruptions in needed treatment which may be satisfied by posting to provider-accessible websites or similar electronic portals or services;

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

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

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

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

(5) No provision of this subsection (h) shall preclude the ongoing work of the office of

health insurance commissioner's administrative simplification task force, which includes meetings with key stakeholders in order to improve, and provide recommendations regarding, the prior authorization process.

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

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

(k) To ~~monitor the~~ prevent by regulation transition from fee-for-service and toward global and other alternative payment methodologies for the payment for healthcare services that the health insurance commissioner shall deem against the interest of public health. The health insurance commissioner shall have no power to impose, encourage, or in any way incentivize any rate caps, global budgets, episode-based payments, or capitation structures in the payment models utilized in contracts between health insurers and providers. Alternative payment methodologies should be assessed for their likelihood to ~~promote~~ damage access to affordable health ~~insurance~~ care, health outcomes, and performance.

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

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

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

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

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

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

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

(1) Utilization review;

(2) Contracting; and

(3) Licensing and regulation.

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

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

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

(r) To direct insurers toward policies and practices that address the behavioral health needs of the public and greater integration of physical and behavioral healthcare delivery.

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

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

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

(i) The firm shall undertake a comprehensive review of all social and human service programs having a contract with or licensed by the state or any subdivision of the department of children, youth and families (DCYF), the department of behavioral healthcare, developmental

disabilities and hospitals (BHDDH), the department of human services (DHS), the department of health (DOH), and Medicaid for the purposes of:

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

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

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

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

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

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

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

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

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

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

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

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

(iv) An assessment and detailed reporting on the structure of the state government as it

relates to the provision of services by social and human service providers including eligibility and functions of the provider network to be completed by January 1, 2023;

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

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

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

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

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

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

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

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

process starting October 1, 2023, and biennially thereafter.

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

(w) To approve or deny any compensation of employees of health insurers subject to the laws of the State of Rhode Island in excess of one million dollars ($1,000,000) per employee.

(x) To approve or deny dividends of stock buybacks of health insurers subject to the laws of the State of Rhode Island.

SECTION 19. Section 44-17-1 of the General Laws in Chapter 44-17 entitled "Taxation of Insurance Companies" is hereby amended to read as follows:

44-17-1. Companies required to file — Payment of tax — Retaliatory rates.

(a) Every domestic, foreign, or alien insurance company, mutual association, organization, or other insurer, including any health maintenance organization as defined in § 27-41-2, any medical malpractice insurance joint underwriters association as defined in § 42-14.1-1, any nonprofit dental service corporation as defined in § 27-20.1-2 and any nonprofit hospital or medical service corporation as defined in chapters 19 and 20 of title 27, except companies mentioned in § 44-17-6 and organizations defined in § 27-25-1, transacting business in this state, shall, on or before April 15 in each year, file with the tax administrator, in the form that he or she may prescribe, a return under oath or affirmation signed by a duly authorized officer or agent of the company, containing information that may be deemed necessary for the determination of the tax imposed by this chapter, and shall at the same time pay an annual tax to the tax administrator of ~~two percent (2%)~~ three percent (3%) of the gross premiums on contracts of insurance, except for ocean marine insurance as referred to in § 44-17-6, covering property and risks within the state, written during the calendar year ending December 31st next preceding.

(b) Qualifying insurers for purposes of this section means every domestic, foreign, or alien insurance company, mutual association, organization, or other insurer and excludes:

(1) Health maintenance organizations, as defined in § 27-41-2;

(2) Nonprofit dental service corporations, as defined in § 27-20.1-2; and

(3) Nonprofit hospital or medical service corporations, as defined in §§ 27-19-1 and 27-20-1.

(c) For tax years 2018 and thereafter, the rate of taxation may be reduced as set forth below and, if so reduced, shall be fully applicable to qualifying insurers instead of the two percent (2%) rate listed in subsection (a). In the case of foreign or alien companies, except as provided in § 27-2-17(d), the tax shall not be less in amount than is imposed by the laws of the state or country under

which the companies are organized upon like companies incorporated in this state or upon its agents, if doing business to the same extent in the state or country. The tax rate shall not be reduced for gross premiums written on contracts of health insurance as defined in § 42-14-5(c) but shall remain at ~~two percent (2%)~~ three percent (3%) or the appropriate retaliatory tax rate, whichever is higher.

~~(d) For qualifying insurers, the premium tax rate may be decreased based upon Rhode Island jobs added by the industry as detailed below:~~

~~(1) A committee shall be established for the purpose of implementing tax rates using the framework established herein. The committee shall be comprised of the following persons or their designees: the secretary of commerce, the director of the department of business regulation, the director of the department of revenue, and the director of the office of management and budget. No rule may be issued pursuant to this section without the prior, unanimous approval of the committee;~~

~~(2) On the timetable listed below, the committee shall determine whether qualifying insurers have added new qualifying jobs in this state in the preceding calendar year. A qualifying job for purposes of this section is any employee with total annual wages equal to or greater than forty percent (40%) of the average annual wages of the Rhode Island insurance industry, as published by the annual employment and wages report of the Rhode Island department of labor and training, in NAICS code 5241;~~

~~(3) If the committee determines that there has been a sufficient net increase in qualifying jobs in the preceding calendar year(s) to offset a material reduction in the premium tax, it shall calculate a reduced premium tax rate. Such rate shall be determined via a method selected by the committee and designed such that the estimated personal income tax generated by the increase in qualifying jobs is at least one hundred and twenty-five percent (125%) of the anticipated reduction in premium tax receipts resulting from the new rate. For purposes of this calculation, the committee may consider personal income tax withholdings or receipts, but in no event may the committee include for the purposes of determining revenue neutrality income taxes that are subject to segregation pursuant to § 44-48.3-8(f) or that are otherwise available to the general fund;~~

~~(4) Any reduced rate established pursuant to this section must be established in a rulemaking proceeding pursuant to chapter 35 of title 42, subject to the following conditions:~~

~~(i) Any net increase in qualifying jobs and the resultant premium tax reduction and revenue impact shall be determined in any rulemaking proceeding conducted under this section and shall be set forth in a report included in the rulemaking record, which report shall also include a description of the data sources and calculation methods used. The first such report shall also include a calculation of the baseline level of employment of qualifying insurers for the calendar year 2015;~~

~~and~~

~~(ii) Notwithstanding any provision of the law to the contrary, no rule changing the tax rate shall take effect until one hundred and twenty (120) days after notice of the rate change is provided to the speaker of the house, the president of the senate, the house and senate fiscal advisors, and the auditor general, which notice shall include the report required under the preceding provision.~~

~~(5) For each of the first three (3) rulemaking proceedings required under this section, the tax rate may remain unchanged or be decreased consistent with the requirements of this section, but may not be increased. These first three (3) rulemaking proceedings shall be conducted by the division of taxation and occur in the following manner:~~

~~(i) The first rulemaking proceeding shall take place in calendar year 2017. This proceeding shall establish a rule that sets forth: (A) A new premium tax rate, if allowed under the requirements of this section, which rate shall take effect in 2018, and (B) A method for calculating the number of jobs at qualifying insurers;~~

~~(ii) The second rulemaking proceeding shall take place in calendar year 2018. This proceeding shall establish a rule that sets forth: (A) A new premium tax rate, if allowed under the requirements of this section, which rate shall take effect in 2019, and (B) The changes, if any, to the method for calculating the number of jobs at qualifying insurers; and~~

~~(iii) The third rulemaking proceeding shall take place in calendar year 2019. This proceeding shall establish a rule that sets forth: (A) A new premium tax rate, if allowed under the requirements of this section, which rate shall take effect in 2020, and (B) The changes, if any, to the method for calculating the number of jobs at qualifying insurers.~~

~~(6) The tax rate established in the regulation following regulatory proceedings that take place in 2019 shall remain in effect through and including 2023. In calendar year 2023, the department of business regulation will conduct a rulemaking proceeding and issue a rule that sets forth: (A) A new premium tax rate, if allowed under the requirements of this section, which rate shall take effect in 2024, and (B) The changes, if any, to the method for calculating the number of jobs at qualifying insurers. A rule issued by the department of business regulation may decrease the tax rate if the requirements for a rate reduction contained in this section are met, or it may increase the tax rate to the extent necessary to achieve the overall revenue level sought when the then existing tax rate was established. Any rate established shall be no lower than one percent (1%) and no higher than two percent (2%). This proceeding shall be repeated every three (3) calendar years thereafter, however, the base for determination of job increases or decreases shall remain the number of jobs existing during calendar year 2022;~~

~~(7) No reduction in the premium tax rate pursuant to this section shall be allowed absent a~~

~~determination that qualifying insurers have added in this state at least three hundred fifty (350) new, full-time, qualifying jobs above the baseline level of employment of qualifying insurers for the calendar year 2015;~~

~~(8) Notwithstanding any provision of this section to the contrary, the premium tax rate shall never be set lower than one percent (1%);~~

~~(9) The division of taxation may adopt implementation guidelines, directives, criteria, rules and regulations pursuant to chapter 35 of title 42 as are necessary to implement this section; and~~

~~(10) The calculation of revenue impacts under this section is at the sole discretion of the committee established under subsection (d)(1). Notwithstanding any provision of law to the contrary, any administrative action or rule setting a tax rate pursuant to this section or failing or declining to alter a tax rate pursuant to this section shall not be subject to judicial review under chapter 35 of title 42.~~

(d) The department of revenue shall calculate the impacts of changes made to Medicaid taking effect during or after fiscal year two thousand twenty-five (FY2025) on state funds, excluding increased federal reimbursements, hereinafter the "Medicaid adjustment." Should the Medicaid adjustment exceed the revenue impact of raising the gross premiums tax rate from two percent (2%) to three percent (3%), hereinafter the "insurance premium tax rate adjustment revenue bonus," a surtax shall be imposed on gross premiums written on contracts of health insurance as defined in § 42-14-5(c) at the rate that shall raise aggregate revenue equal to the Medicaid adjustment minus the insurance premium tax rate adjustment revenue bonus.

SECTION 20. Section 44-51-3 of the General Laws in Chapter 44-51 entitled "Nursing Facility Provider Assessment Act" is hereby amended to read as follows:

44-51-3. Imposition of assessment — Nursing facilities.

(a) For purposes of this section, a “nursing facility” means a person or governmental unit licensed in accordance with chapter 17 of title 23 to establish, maintain, and operate a nursing facility.

(b) An assessment is imposed upon the gross patient revenue received by every nursing facility in each month beginning January 1, 2008, at a rate of ~~five and one-half percent (5.5%)~~ six percent (6%) for services provided on or after January 1, 2008. Every provider shall pay the monthly assessment no later than the twenty-fifth (25th) day of each month following the month of receipt of gross patient revenue.

(c) The assessment imposed by this section shall be repealed on the effective date of the repeal or a restricted amendment of those provisions of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) that permit federal financial

participation to match state funds generated by taxes.

(d) If, after applying the applicable federal law and/or rules, regulations, or standards relating to health care providers, the tax administrator determines that the assessment rate established in subsection (b) of this section exceeds the maximum rate of assessment that federal law will allow without reduction in federal financial participation, then the tax administrator is directed to reduce the assessment to a rate equal to the maximum rate which the federal law will allow without reduction in federal participation. Provided, however, that the authority of the tax administrator to lower the assessment rate established in subsection (b) of this section shall be limited solely to such determination.

(e) In order that the tax administrator may properly carry out his/her responsibilities under this section, the director of the department of human services shall notify the tax administrator of any damages in federal law and/or any rules, regulations, or standards which affect any rates for health care provider assessments.

SECTION 21. Title 44 of the General Laws entitled "TAXATION" is hereby amended by adding thereto the following chapter:

CHAPTER 72

PRIVATE HEALTHCARE PROVIDERS ASSESSMENT ACT

44-72-1. Short title.

This chapter shall be known and may be cited as the "Private HealthCare Providers Assessment Act."

44-72-2. Definitions.

Except where the context otherwise requires, the following words and phrases as used in this chapter shall have the following meaning:

(1) "Administrator" means the tax administrator.

(2) "Assessment" means the assessment imposed upon gross patient revenue pursuant to this chapter.

(3) "Eligible provider" means a privately operated healthcare facility, which is eligible for taxation up to six percent (6%) of gross patient revenue pursuant to 42 CFR 433.68. Nursing facilities taxed pursuant to § 44-51-3 and hospital facilities taxed pursuant to § 23-17-38.1 shall not be considered providers subject to taxation under this chapter.

(4) "Gross patient revenue" means the gross amount received on a cash basis by the provider from all patient care services. Charitable contributions, donated goods and services, fund raising proceeds, endowment support, income from meals on wheels, income from investments, and other nonpatient revenues defined by the tax administrator upon the recommendation of the

department of human services shall not be considered as "gross patient revenue".

(5) "Person" means any individual, corporation, company, association, partnership, joint stock association, and the legal successor thereof.

44-72-3. Imposition of assessment.

(a) An assessment is imposed upon the gross patient revenue received by every eligible provider in each month beginning July 1, 2024, at a rate of six percent (6%) for services provided on or after July 1, 2024. Every eligible provider shall pay the monthly assessment no later than the twenty-fifth day of each month following the month of receipt of gross patient revenue.

(b) The assessment rate established in subsection (a) of this section shall be reduced by the effective rate of any tax subject to the six percent (6%) limit established pursuant to 42 CFR 433.68 imposed on the eligible provider in other chapters of the general laws in order that the total aggregate tax shall be at a rate of six percent (6%).

(c) If, after applying the applicable federal law and/or rules, regulations, or standards relating to healthcare providers, the tax administrator determines that the assessment rate established in subsection (a) of this section exceeds the maximum rate of assessment that federal law will allow without reduction in federal financial participation, then the tax administrator is directed to reduce the assessment to a rate equal to the maximum rate which the federal law will allow without reduction in federal participation. Provided, however, that the authority of the tax administrator to lower the assessment rate established in subsection (a) of this section shall be limited solely to such determination. In order that the tax administrator may properly carry out his/her responsibilities under this section, the director of the department of human services shall notify the tax administrator of any changes in federal law and/or any rules, regulations, or standards which affect any rates for healthcare provider assessments.

44-72-4. Returns.

(a) Every eligible provider shall on or before the twenty-fifth day of the month following the month of receipt of gross patient revenue make a return to the tax administrator.

(b) The tax administrator shall adopt rules, pursuant to this chapter, relative to the form of the return and the data which it must contain for the correct computation of gross patient revenue and the assessment upon that amount. All returns shall be signed by the eligible provider or by its authorized representative, subject to the pains and penalties of perjury. If a return shows an overpayment of the assessment due, the tax administrator shall refund or credit the overpayment to the eligible provider.

(c) For good cause, the tax administrator may extend the time within which an eligible provider is required to file a return, and if the return is filed during the period of extension, no

penalty or late filing charge may be imposed for failure to file the return at the time required by this chapter, but the provider may be liable for interest as prescribed in this chapter. Failure to file the return during the period for the extension shall void the extension.

44-72-5. Set-off for delinquent assessments.

If an eligible provider shall fail to pay an assessment within thirty (30) days of its due date, the tax administrator may request any agency of state government making payments to the eligible provider to set off the amount of the delinquency against any payment due the provider from the agency of state government and remit the sum to the tax administrator. Upon receipt of the set off request from the tax administrator, any agency of state government is authorized and empowered to set off the amount of the delinquency against any payment or amounts due the eligible provider. The amount of set-off shall be credited against the assessment due from the eligible provider.

44-72-6. Assessment on available information -- Interest on delinquencies -- Penalties -- Collection powers.

If any eligible provider shall fail to file a return within the time required by this chapter, or shall file an insufficient or incorrect return, or shall not pay the assessment imposed by this chapter when it is due, the tax administrator shall assess upon the information as may be available, which shall be payable upon demand and shall bear interest at the annual rate provided by § 44-1-7 from the date when the assessment should have been paid. If any part of the assessment made is due to negligence or intentional disregard of the provisions of this chapter, a penalty of ten percent (10%) of the amount of the determination shall be added to the assessment. The tax administrator shall collect the assessment with interest in the same manner and with the same powers as are prescribed for collection of taxes in this title.

44-72-7. Claims for refund -- Hearing upon denial.

(a) Any eligible provider subject to the provisions of this chapter may file a claim for refund with the tax administrator at any time within two (2) years after the assessment has been paid. If the tax administrator shall determine that the assessment has been overpaid, he or she shall make a refund with interest from the date of overpayment.

(b) Any eligible provider whose claim for refund has been denied may, within thirty (30) days from the date of the mailing by the tax administrator of the notice of the decision, request a hearing and the tax administrator shall, as soon as practicable, set a time and place for the hearing and shall notify the eligible provider.

44-72-8. Hearing by administrator on application.

Any eligible provider aggrieved by the action of the tax administrator in determining the amount of any assessment or penalty imposed under the provisions of this chapter may apply to the

tax administrator, in writing, within thirty (30) days after the notice of the action is mailed to it, for a hearing relative to the assessment or penalty. The tax administrator shall fix a time and place for the hearing and shall notify the provider. Upon the hearing, the tax administrator shall correct manifest errors, if any, disclosed at the hearing and assess and collect the amount lawfully due together with any penalty or interest.

44-72-9. Appeals.

Appeals from administrative orders or decisions made pursuant to any provisions of this chapter shall be to the sixth division district court pursuant to §§ 8-8-24 through 8-8-29. The eligible provider's right to appeal under this section shall be expressly made conditional upon prepayment of all assessments, interest, and penalties unless the provider moves for and is granted an exemption from the prepayment requirement pursuant to § 8-8-26. If the court, after appeal, holds that the eligible provider is entitled to a refund, the eligible provider shall also be paid interest on the amount at the rate provided in § 44-1-7.1.

44-72-10. Eligible provider records.

Every eligible provider shall:

(1) Keep records as may be necessary to determine the amount of its liability under this chapter.

(2) Preserve those records for the period of three (3) years following the date of filing of any return required by this chapter, or until any litigation or prosecution under this chapter is finally determined.

(3) Make those records available for inspection by the tax administrator or the administrator's authorized agents, upon demand, at reasonable times during regular business hours.

44-72-11. Method of payment and deposit of assessment.

(a) The payments required by this chapter may be made by electronic transfer of monies to the general treasurer and deposited to the general fund.

(b) The general treasurer is authorized to establish an account or accounts and to take all steps necessary to facilitate the electronic transfer of monies. The general treasurer shall provide the tax administrator with a record of any monies transferred and deposited.

44-72-12. Rules and regulations.

The tax administrator shall make and promulgate rules, regulations, and procedures not inconsistent with state law and fiscal procedures as the tax administrator deems necessary for the proper administration of this chapter and to implement the provisions, policy, and purposes of this chapter.

44-72-13. Release of assessment information.

Notwithstanding any other provisions of the general laws, the tax administrator shall not be prohibited from providing assessment information to the director of the department of human services or his or her designee, with respect to the assessment imposed by this chapter; provided that, the director of human services and the director's agents and employees may use or disclose that information only for purposes directly connected with the administration of the duties and programs of the department of human services.

44-72-14. Severability.

If any provision of this chapter or the application of this chapter to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared to be severable.

SECTION 22. Relating to Capital Development Programs - Statewide Referendum.

Section 1. Proposition to be submitted to the people. -- At the general election to be held on the Tuesday next after the first Monday in November, 2024, there shall be submitted to the people of the State of Rhode Island, for their approval or rejection, the following proposition:

"Shall the action of the general assembly, by an act passed at the January 2023 session, authorizing the issuance of a bond, refunding bond, and/or temporary note of the State of Rhode Island for the local capital projects and in the total amount with respect to the projects listed below be approved, and the issuance of a bond, refunding bond, and/or temporary note authorized in accordance with the provisions of said act?

Funding

The bond, refunding bond and/or temporary note shall be allocated to the Medicaid office for oversight of the funds.

Project

(1) Group homes, assisted living facilities, and recovery beds $300,000,000

Approval of this question will allow the State of Rhode Island to issue general obligation bonds, refunding bonds, and/or temporary notes in an amount not to exceed three hundred million dollars ($300,000,000) for expansion of and investment in Rhode Island Community Living and Supports. One hundred million dollars ($100,000,000) shall be allocated for investment in and expansion of state group homes operated by Rhode Island Community Living and Supports. One hundred million dollars ($100,000,000) shall be allocated for the construction of assisted living-level care facilities for people with mental illnesses and developmental disabilities operated by Rhode Island Community Living and Supports for persons who are eligible for Medicaid. One hundred million dollars ($100,000,000) shall be allocated for the construction of inpatient recovery

facilities operated by Rhode Island Community Living and Supports for persons who are eligible for Medicaid and suffering from substance abuse issues in need of inpatient recovery services. None of these funds may be allocated to private facilities.

(2) Hospital facilities expansion $50,000,000

Approval of this question will allow the State of Rhode Island to issue general obligation bonds, refunding bonds, and/or temporary notes in an amount not to exceed fifty million dollars ($50,000,000) for the improvement of state operated hospital facilities.

(3) University of Rhode Island Medical School $500,000,000

Approval of this question will allow the State of Rhode Island to issue a general obligation bond, refunding bond, and/or temporary note in an amount not to exceed five hundred million dollars ($500,000,000) for the construction of a medical school at the University of Rhode Island. The Medicaid office shall work with the University of Rhode Island Medical School to establish a reasonable annual contribution to fund the debt service on this bond from tuition revenue. While these contributions shall continue until the entire debt service costs are paid, the Medicaid office may allow for an amortization schedule that lasts for up to fifty (50) years."

Section 2. Ballot labels and applicability of general election laws. -- The secretary of state shall prepare and deliver to the state board of elections ballot labels for each of the projects provided for in Section 1 hereof with the designations "approve" or "reject" provided next to the description of each such project to enable voters to approve or reject each such proposition. The general election laws, so far as consistent herewith, shall apply to this proposition.

Section 3. Approval of projects by people. -- If a majority of the people voting on the proposition in Section 1 hereof shall vote to approve any project stated therein, said project shall be deemed to be approved by the people. The authority to issue bonds, refunding bonds and/or temporary notes of the state shall be limited to the aggregate amount for all such projects as set forth in the proposition, which have been approved by the people.

Section 4. Bonds for capital development program. -- The general treasurer is hereby authorized and empowered, with the approval of the governor, and in accordance with the provisions of this act to issue capital development bonds in serial form, in the name of and on behalf of the State of Rhode Island, in amounts as may be specified by the governor in an aggregate principal amount not to exceed the total amount for all projects approved by the people and designated as "capital development loan of 2024 bonds." Provided, however, that the aggregate principal amount of such capital development bonds and of any temporary notes outstanding at any one time issued in anticipation thereof pursuant to Section 7 hereof shall not exceed the total amount for all such projects approved by the people. All provisions in this act relating to "bonds" shall also

be deemed to apply to "refunding bonds."

Capital development bonds issued under this act shall be in denominations of one thousand dollars ($1,000) each, or multiples thereof, and shall be payable in any coin or currency of the United States which at the time of payment shall be legal tender for public and private debts.

These capital development bonds shall bear such date or dates, mature at specified time or times, but not mature beyond the end of the twentieth state fiscal year following the fiscal year in which they are issued; bear interest payable semi-annually at a specified rate or different or varying rates; be payable at designated time or times at specified place or places; be subject to express terms of redemption or recall, with or without premium; be in a form, with or without interest coupons attached; carry such registration, conversion, reconversion, transfer, debt retirement, acceleration and other provisions as may be fixed by the general treasurer, with the approval of the governor, upon each issue of such capital development bonds at the time of each issue. Whenever the governor shall approve the issuance of such capital development bonds, the governor's approval shall be certified to the secretary of state; the bonds shall be signed by the general treasurer and countersigned by the secretary of state and shall bear the seal of the state. The signature approval of the governor shall be endorsed on each bond.

Section 5. Refunding bonds for 2024 capital development program. -- The general treasurer is hereby authorized and empowered, with the approval of the governor, and in accordance with the provisions of this act, to issue bonds to refund the 2024 capital development program bonds, in the name of and on behalf of the state, in amounts as may be specified by the governor in an aggregate principal amount not to exceed the total amount approved by the people, to be designated as "capital development program loan of 2024 refunding bonds" (hereinafter "refunding bonds"). The general treasurer with the approval of the governor shall fix the terms and form of any refunding bonds issued under this act in the same manner as the capital development bonds issued under this act, except that the refunding bonds may not mature more than twenty (20) years from the date of original issue of the capital development bonds being refunded. The proceeds of the refunding bonds, exclusive of any premium and accrual interest and net the underwriters' cost, and cost of bond insurance, shall, upon their receipt, be paid by the general treasurer immediately to the paying agent for the capital development bonds which are to be called and prepaid. The paying agent shall hold the refunding bond proceeds in trust until they are applied to prepay the capital development bonds. While the proceeds are held in trust, the proceeds may be invested for the benefit of the state in obligations of the United States of America or the State of Rhode Island.

If the general treasurer shall deposit with the paying agent for the capital development bonds the proceeds of the refunding bonds, or proceeds from other sources, amounts that, when

invested in obligations of the United States or the State of Rhode Island, are sufficient to pay all principal, interest, and premium, if any, on the capital development bonds until these bonds are called for prepayment, then such capital development bonds shall not be considered debts of the State of Rhode Island for any purpose starting from the date of deposit of such monies with the paying agent. The refunding bonds shall continue to be a debt of the state until paid.

The term "bond" shall include "note," and the term "refunding bonds" shall include "refunding notes" when used in this act.

Section 6. Proceeds of capital development program. -- The general treasurer is directed to deposit the proceeds from the sale of capital development bonds issued under this act, exclusive of premiums and accrued interest and net the underwriters' cost, and cost of bond insurance, in one or more of the depositories in which the funds of the state may be lawfully kept in special accounts (hereinafter cumulatively referred to as "such capital development bond fund") appropriately designated for each of the projects set forth in Section 1 hereof which shall have been approved by the people to be used for the purpose of paying the cost of all such projects so approved.

All monies in the capital development bond fund shall be expended for the purposes specified in the proposition provided for in Section 1 hereof under the direction and supervision of the director of administration (hereinafter referred to as "director"). The director, or designee, shall be vested with all power and authority necessary or incidental to the purposes of this act, including, but not limited to, the following authority:

(1) To acquire land or other real property or any interest, estate, or right therein as may be necessary or advantageous to accomplish the purposes of this act;

(2) To direct payment for the preparation of any reports, plans and specifications, and relocation expenses and other costs such as for furnishings, equipment designing, inspecting, and engineering, required in connection with the implementation of any projects set forth in Section 1 hereof;

(3) To direct payment for the costs of construction, rehabilitation, enlargement, provision of service utilities, and razing of facilities, and other improvements to land in connection with the implementation of any projects set forth in Section 1 hereof; and

(4) To direct payment for the cost of equipment, supplies, devices, materials, and labor for repair, renovation, or conversion of systems and structures as necessary for the 2023 capital development program bonds or notes hereunder from the proceeds thereof. No funds shall be expended in excess of the amount of the capital development bond fund designated for each project authorized in Section 1 hereof.

Section 7. Sale of bonds and notes. --Any bonds or notes issued under the authority of this

act shall be sold at not less than the principal amount thereof, in such mode and on such terms and conditions as the general treasurer, with the approval of the governor, shall deem to be in the best interests of the state.

Any bonds or notes issued under the provisions of this act and coupons on any capital development bonds, if properly executed by the manual or electronic signatures of officers of the state in office on the date of execution, shall be valid and binding according. to their tenor, notwithstanding that before the delivery thereof and payment therefor, any or all such officers shall for any reason have ceased to hold office.

Section 8. Bonds and notes to be tax exempt and general obligations of the state. -- All bonds and notes issued under the authority of this act shall be exempt from taxation in the state and shall be general obligations of the state, and the full faith and credit of the state is hereby pledged for the due payment of the principal and interest on each of such bonds and notes as the same shall become due.

Section 9. Investment of monies in fund. -- All monies in the capital development fund not immediately required for payment pursuant to the provisions of this act may be invested by the investment commission, as established by chapter 10 of title 35, entitled "state investment commission," pursuant to the provisions of such chapter; provided, however, that the securities in which the capital development fund is invested shall remain a part of the capital development fund until exchanged for other securities; and provided further, that the income from investments of the capital development fund shall become a part of the general fund of the state and shall be applied to the payment of debt service charges of the state, unless directed by federal law or regulation to be used for some other purpose, or to the extent necessary, to rebate to the United States treasury any income from investments (including gains from the disposition of investments) of proceeds of bonds or notes to the extent deemed necessary to exempt (in whole or in part) the interest paid on such bonds or notes from federal income taxation.

Section 10. Appropriation. -- To the extent the debt service on these bonds is not otherwise provided, a sum sufficient to pay the interest and principal due each year on bonds and notes hereunder is hereby annually appropriated out of any money in the treasury not otherwise appropriated.

Section 11. Advances from general fund. -- The general treasurer is authorized, with the approval of the director and the governor, in anticipation of the issuance of bonds or notes under the authority of this act, to advance to the capital development bond fund for the purposes specified in Section 1 hereof, any funds of the state not specifically held for any particular purpose; provided, however, that all advances made to the capital development bond fund shall be returned to the

general fund from the capital development bond fund forthwith upon the receipt by the capital development fund of proceeds resulting from the issue of bonds or notes to the extent of such advances.

Section 12. Federal assistance and private funds. -- In carrying out this act, the director, or designee, is authorized on behalf of the state, with the approval of the governor, to apply for and accept any federal assistance which may become available for the purpose of this act, whether in the form of a loan or grant or otherwise, to accept the provision of any federal legislation therefor, to enter into, act and carry out contracts in connection therewith, to act as agent for the federal government in connection therewith, or to designate a subordinate so to act. Where federal assistance is made available, the project shall be carried out in accordance with applicable federal law, the rules and regulations thereunder and the contract or contracts providing for federal assistance, notwithstanding any contrary provisions of state law. Subject to the foregoing, any federal funds received for the purposes of this act shall be deposited in the capital development bond fund and expended as a part thereof. The director or designee may also utilize any private funds that may be made available for the purposes of this act.

Section 13. Effective Date. -- Sections 1, 2, 3, 10, 11 and 12 of this act shall take effect upon passage. The remaining sections of this act shall take effect when and if the state board of elections shall certify to the secretary of state that a majority of the qualified electors voting on the proposition contained in Section 1 hereof have indicated their approval of all or any projects thereunder.

SECTION 23. Rhode Island Medicaid Reform Act of 2008 Joint 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 chapter 12.4 of title 42; and

WHEREAS, Rhode Island General Laws § 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 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) Raising Nursing Facility Personal Needs Allowance. The Executive Office proposes raising the personal needs allowance for nursing facility residents to two hundred dollars ($200).

(b) Medicare Equivalent Rate. The Executive Office proposes raising all Medicaid rates, except for hospital rates, dental rates, and outpatient behavioral health rates to equal the Medicare equivalent rate. Specific to early intervention services, a payment of fifty dollars ($50.00) per member per month payment shall be established in addition to these rates, and a floor of fifty percent (50%) rate increase shall be established within the calculation of the Medicare equivalent rate.

(c) Setting Outpatient Behavioral Healthcare Rates at one hundred fifty percent (150%) of Medicare Equivalent Rates. The Executive Office proposes to set outpatient behavioral health rates at one hundred fifty percent (150%) of the Medicare equivalent rate. The Executive Office will maximize federal financial participation if and when available, though state-only funds will be used if federal financial participation is not available.

(d) FQHC APM Modernization. The Executive Office proposes certain modifications to modernize and standardize the alternative payment methodology option for federally qualified health centers.

(e) Hospital Payment Modernization. The Executive Office proposes certain changes to hospital payment rates to modernize payment methodologies to encourage utilization and quality. Inpatient FFS DRG rates will be set at ninety percent (90%) of the Medicare equivalent rate, inpatient non-DRG FFS rates will be established at ninety-five percent (95%) of the Medicare equivalent rate, inpatient managed care rates will be set at one hundred five percent (105%) of FFS rates, and outpatient rates will be set at one hundred percent (100%) of Medicare rates.

(f) RIteShare Freedom of Choice. The Executive Office proposes to make employee participation in the RIteShare program voluntary.

(g) Elderly and Disabled Eligibility Expansion. The Executive Office proposes expanding Medicaid eligibility for elderly and disabled residents to one hundred thirty-three percent (133%) of the federal poverty level.

(h) Payments Streamlining. The Executive Office proposes a multifaceted initiative to

begin the phase-out of intermediary payers such as managed care entities, streamlining payments and reducing wasteful expenditures on intermediary payers.

(i) Medicaid Office Expansion. The Executive Office proposes an expansion of Medicaid office staffing to improve administrative capacities.

(j) COVID-19 Adjustments to Health System Transformation Project. The Executive Office proposes to eliminate the imposition of downside risk as part of the Health System Transformation Project to protect the solvency of providers in light of the COVID-19 pandemic.

(k) Rhode Island Institute for Mental Disease. The Executive Office proposes to construct a new Institution for Mental Disease (IMD) to serve vulnerable Rhode Island residents. The Executive Office seeks a waiver of the IMD exclusion rule similar to that granted to Vermont to allow federal Medicaid reimbursement.

(l) Raising Nursing Facility Assessment Rate. The Executive Office proposes to raise the nursing facility assessment rate to six percent (6%).

(m) Universal Provider Assessment. Consistent with overall goals of transitioning all services to a model where rates are at the Medicare equivalent rate, the Executive Office proposes to extend the existing nursing facility assessment model to cover all providers eligible for taxation under federal regulations to help defray the costs of the state component.

(n) Dental Optimization. The Executive Office proposes to make an array of changes to dental benefits offered under Medicaid. Rates will be the rates utilized in § 27-18-54; § 27-19-30.1 § 27-20-25.2; and § 27-41-27.2; billing will be extended to teledentistry services, Silver Diamine Fluoride (code D1354), and denture billing (codes D5130, D5140, D5221, D5222, D5213, and D5214); the mobile dentistry encounter rate will be raised to the FQHC rate; and a fifty percent (50%) payment shall be established for undeliverable dentures.

(o) Commencement of Inpatient Substance Use Disorder Recovery Bed Federal Billing. The Executive Office proposes to utilize the IMD waiver authority granted in 2019 to begin federal reimbursement billing for inpatient substance use disorder recovery beds, a service that will also see a rate increase pursuant to subsection (d). The Executive Office also proposes a general obligation bond referendum to fund the necessary capital expenditures associated with the expansion of RICLAS to inpatient substance use disorder recovery services.

(p) Coverage of Abortion Services. The Executive Office proposes to end the exclusion of abortion care from covered Medicaid services. The Executive Office will maximize federal financial participation if and when available, though state-only funds will be used if federal financial participation is not available.

(q) Transition to State-Level Medicare for All. The Executive Office proposes to begin the

process of negotiating the necessary waivers for a transition to a state-level Medicare for All health care payments system for Rhode Island. These waivers shall include the combining of all federal health care funding streams into the system financing including, but not limited to, Medicaid, Medicare, federal health care tax exemptions, and exchange subsides established pursuant to the U.S. Patient Protection and Affordable Care Act of 2010. The Executive Office plans to begin the transition process after the completion of the raising of the Medicaid system to a Medicare standard of care and the associated stabilization of the Rhode Island health care workforce and provider network; provided, however, that the Executive Office, understanding the complexity of the proposed waiver application, reserves the right to begin the waiver negotiation process before the transition of Medicaid to a Medicare standard is complete. The Executive Office shall only proceed with the waiver and transition should waiver conditions be favorable to the state as a whole, in the judgment of the Executive Office. In the event that a full waiver cannot be complete, and health insurers have been acquired by the Medicaid Office due to insolvency and the Medicaid Office's goal of payer system stabilization, the Executive Office is empowered to seek limited waivers for the streamlining and integration of acquired health insurers with the Medicaid system. The Executive Office shall submit the final approved waiver and transition plan to the general assembly for final approval.

(r) 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.

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 chapter 12.4 of title 42; and be it further;

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

SECTION 24. This act shall take effect upon passage; however, the RICHIP program shall not come into operation until the necessary waivers are obtained, and the final financing proposal

is approved by the general assembly.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY -- THE RHODE ISLAND COMPREHENSIVE HEALTH INSURANCE PROGRAM

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This act would establish a universal, comprehensive, affordable single-payer health care insurance program and help control health care costs, which would be referred to as, "the Rhode Island Comprehensive Health Insurance Program" (RICHIP). The program would be paid for by consolidating government and private payments to multiple insurance carriers into a more economical and efficient improved Medicare-for-all style single-payer program and substituting lower progressive taxes for higher health insurance premiums, co-pays, deductibles and costs due to caps. This program would save Rhode Islanders from the current overly expensive, inefficient and unsustainable multi-payer health insurance system that unnecessarily prevents access to medically necessary health care.

This act would take effect upon passage; however, the RICHIP program would not come into operation until the necessary waivers are obtained, and the final financing proposal is approved by the general assembly.

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