

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2024

A N A C T

RELATING TO PUBLIC FINANCE -- MEDICAL ASSISTANCE AND PUBLIC ASSISTANCE CASELOAD ESTIMATING CONFERENCES

Introduced By: Senators DiPalma, Valverde, Lauria, Miller, Pearson, and Acosta

Date Introduced: March 01, 2024

Referred To: Senate Finance

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 35-17-1 of the General Laws in Chapter 35-17 entitled "Medical
2 Assistance and Public Assistance Caseload Estimating Conferences" is hereby amended to read as
3 follows:

4 **35-17-1. Purpose and membership.**

5 (a) In order to provide for a more stable and accurate method of financial planning and
6 budgeting, it is hereby declared the intention of the legislature that there be a procedure for the
7 determination of official estimates of anticipated medical assistance expenditures and public
8 assistance caseloads, upon which the executive budget shall be based and for which appropriations
9 by the general assembly shall be made.

10 (b) The state budget officer, the house fiscal advisor, and the senate fiscal advisor shall
11 meet in regularly scheduled caseload estimating conferences (C.E.C.). These conferences shall be
12 open public meetings.

13 (c) The chairpersonship of each regularly scheduled C.E.C. will rotate among the state
14 budget officer, the house fiscal advisor, and the senate fiscal advisor, hereinafter referred to as
15 principals. The schedule shall be arranged so that no chairperson shall preside over two (2)
16 successive regularly scheduled conferences on the same subject.

17 (d) Representatives of all state agencies are to participate in all conferences for which their
18 input is germane.

1 (e) The department of human services shall provide monthly data to the members of the
2 caseload estimating conference by the fifteenth day of the following month. Monthly data shall
3 include, but is not limited to, [forecasted costs reflecting the recommended rates from the biennial](#)
4 [rate review pursuant to § 42-14.5-3\(t\)](#), actual caseloads and expenditures for the following case
5 assistance programs: Rhode Island Works, SSI state program, general public assistance, and child
6 care. For individuals eligible to receive the payment under § 40-6-27(a)(1)(vi), the report shall
7 include the number of individuals enrolled in a managed care plan receiving long-term-care
8 services and supports and the number receiving fee-for-service benefits. The executive office of
9 health and human services shall report relevant caseload information and expenditures for the
10 following medical assistance categories: hospitals, long-term care, managed care, pharmacy, and
11 other medical services. In the category of managed care, caseload information and expenditures for
12 the following populations shall be separately identified and reported: children with disabilities,
13 children in foster care, and children receiving adoption assistance and RItE Share enrollees under §
14 40-8.4-12(j). The information shall include the number of Medicaid recipients whose estate may
15 be subject to a recovery and the anticipated amount to be collected from those subject to recovery,
16 the total recoveries collected each month and number of estates attached to the collections and each
17 month, the number of open cases and the number of cases that have been open longer than three
18 months.

19 (f) Beginning July 1, 2021, the department of behavioral healthcare, developmental
20 disabilities and hospitals shall provide monthly data to the members of the caseload estimating
21 conference by the fifteenth day of the following month. Monthly data shall include, but is not
22 limited to, [forecasted costs reflecting the recommended rates from the biennial rate review pursuant](#)
23 [to § 42-14.5-3\(t\)](#), actual caseloads and expenditures for the private community developmental
24 disabilities services program. Information shall include, but not be limited to: the number of cases
25 and expenditures from the beginning of the fiscal year at the beginning of the prior month; cases
26 added and denied during the prior month; expenditures made; and the number of cases and
27 expenditures at the end of the month. The information concerning cases added and denied shall
28 include summary information and profiles of the service-demand request for eligible adults meeting
29 the state statutory definition for services from the division of developmental disabilities as
30 determined by the division, including age, Medicaid eligibility and agency selection placement with
31 a list of the services provided, and the reasons for the determinations of ineligibility for those cases
32 denied. The department shall also provide, monthly, the number of individuals in a shared-living
33 arrangement and how many may have returned to a twenty-four-hour (24) residential placement in
34 that month. The department shall also report, monthly, any and all information for the consent

1 decree that has been submitted to the federal court as well as the number of unduplicated individuals
2 employed; the place of employment; and the number of hours working. The department shall also
3 provide the amount of funding allocated to individuals above the assigned resource levels; the
4 number of individuals and the assigned resource level; and the reasons for the approved additional
5 resources. The department will also collect and forward to the house fiscal advisor, the senate fiscal
6 advisor, and the state budget officer, by November 1 of each year, the annual cost reports for each
7 community-based provider for the prior fiscal year. The department shall also provide the amount
8 of patient liability to be collected and the amount collected as well as the number of individuals
9 who have a financial obligation. The department will also provide a list of community-based
10 providers awarded an advanced payment for residential and community-based day programs; the
11 address for each property; and the value of the advancement. If the property is sold, the department
12 must report the final sale, including the purchaser, the value of the sale, and the name of the agency
13 that operated the facility. If residential property, the department must provide the number of
14 individuals residing in the home at the time of sale and identify the type of residential placement
15 that the individual(s) will be moving to. The department must report if the property will continue
16 to be licensed as a residential facility. The department will also report any newly licensed twenty-
17 four-hour (24) group home; the provider operating the facility; and the number of individuals
18 residing in the facility. Prior to December 1, 2017, the department will provide the authorizations
19 for community-based and day programs, including the unique number of individuals eligible to
20 receive the services and at the end of each month the unique number of individuals who participated
21 in the programs and claims processed.

22 (g) The executive office of health and human services shall provide direct assistance to the
23 department of behavioral healthcare, developmental disabilities and hospitals to facilitate
24 compliance with the monthly reporting requirements in addition to preparation for the caseload
25 estimating conferences.

26 SECTION 2. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The
27 Rhode Island Health Care Reform Act of 2004 — Health Insurance Oversight" is hereby amended
28 to read as follows:

29 **42-14.5-3. Powers and duties.**

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

31 (a) To conduct quarterly public meetings throughout the state, separate and distinct from
32 rate hearings pursuant to § 42-62-13, regarding the rates, services, and operations of insurers
33 licensed to provide health insurance in the state; the effects of such rates, services, and operations
34 on consumers, medical care providers, patients, and the market environment in which the insurers

1 operate; and efforts to bring new health insurers into the Rhode Island market. Notice of not less
2 than ten (10) days of the hearing(s) shall go to the general assembly, the governor, the Rhode Island
3 Medical Society, the Hospital Association of Rhode Island, the director of health, the attorney
4 general, and the chambers of commerce. Public notice shall be posted on the department's website
5 and given in the newspaper of general circulation, and to any entity in writing requesting notice.

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

17 (c) To establish a consumer/business/labor/medical advisory council to obtain information
18 and present concerns of consumers, business, and medical providers affected by health insurance
19 decisions. The council shall develop proposals to allow the market for small business health
20 insurance to be affordable and fairer. The council shall be involved in the planning and conduct of
21 the quarterly public meetings in accordance with subsection (a). The advisory council shall develop
22 measures to inform small businesses of an insurance complaint process to ensure that small
23 businesses that experience rate increases in a given year may request and receive a formal review
24 by the department. The advisory council shall assess views of the health provider community
25 relative to insurance rates of reimbursement, billing, and reimbursement procedures, and the
26 insurers' role in promoting efficient and high-quality health care. The advisory council shall issue
27 an annual report of findings and recommendations to the governor and the general assembly and
28 present its findings at hearings before the house and senate finance committees. The advisory
29 council is to be diverse in interests and shall include representatives of community consumer
30 organizations; small businesses, other than those involved in the sale of insurance products; and
31 hospital, medical, and other health provider organizations. Such representatives shall be nominated
32 by their respective organizations. The advisory council shall be co-chaired by the health insurance
33 commissioner and a community consumer organization or small business member to be elected by
34 the full advisory council.

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (1) The analysis shall forecast the likely rate increases required to effect the changes

1 recommended pursuant to the preceding subsection (g) in the direct-pay market and small-employer
2 health insurance market over the next five (5) years, based on the current rating structure and
3 current products.

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

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

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

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

18 (6) The health insurance commissioner shall work with an insurance market merger task
19 force to assist with the analysis. The task force shall be chaired by the health insurance
20 commissioner and shall include, but not be limited to, representatives of the general assembly, the
21 business community, small-employer carriers as defined in § 27-50-3, carriers offering coverage in
22 the individual market in Rhode Island, health insurance brokers, and members of the general public.

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

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

31 (h) To establish and convene a workgroup representing healthcare providers and health
32 insurers for the purpose of coordinating the development of processes, guidelines, and standards to
33 streamline healthcare administration that are to be adopted by payors and providers of healthcare
34 services operating in the state. This workgroup shall include representatives with expertise who

1 would contribute to the streamlining of healthcare administration and who are selected from
2 hospitals, physician practices, community behavioral health organizations, each health insurer, and
3 other affected entities. The workgroup shall also include at least one designee each from the Rhode
4 Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the
5 Rhode Island Health Center Association, and the Hospital Association of Rhode Island. In any year
6 that the workgroup meets and submits recommendations to the office of the health insurance
7 commissioner, the office of the health insurance commissioner shall submit such recommendations
8 to the health and human services committees of the Rhode Island house of representatives and the
9 Rhode Island senate prior to the implementation of any such recommendations and subsequently
10 shall submit a report to the general assembly by June 30, 2024. The report shall include the
11 recommendations the commissioner may implement, with supporting rationale. The workgroup
12 shall consider and make recommendations for:

13 (1) Establishing a consistent standard for electronic eligibility and coverage verification.

14 Such standard shall:

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

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

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

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

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

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

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

34 (ii) Publishing any variations from codes and mutually exclusive codes by payors in a

1 manner that makes for simple retrieval and implementation by providers;

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

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

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

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

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

19 (3) Developing and promoting widespread adoption by payors and providers of guidelines
20 to:

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

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

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

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

1 authorization number; and transmit an admission notification;

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

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

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

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

20 (B) Supporting:

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

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

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

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

34 (B) Requiring continuity of care for medical services, including behavioral health services,

1 and prescription medications for patients on appropriate, chronic, stable therapy through
2 minimizing repetitive prior authorization requirements; and which for prescription medication shall
3 be allowed only on an annual review, with exception for labeled limitation, to establish continued
4 benefit of treatment; and

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

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

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

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

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

19 (5) No provision of this subsection (h) shall preclude the ongoing work of the office of
20 health insurance commissioner's administrative simplification task force, which includes meetings
21 with key stakeholders in order to improve, and provide recommendations regarding, the prior
22 authorization process.

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

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

34 (k) To monitor the transition from fee-for-service and toward global and other alternative

1 payment methodologies for the payment for healthcare services. Alternative payment
2 methodologies should be assessed for their likelihood to promote access to affordable health
3 insurance, health outcomes, and performance.

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

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

10 (1) The impact of the current, mandated healthcare benefits as defined in §§ 27-18-48.1,
11 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41 of title 27, and §§ 27-
12 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health
13 insurance for fully insured employers, subject to available resources;

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

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

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

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

25 (1) Utilization review;

26 (2) Contracting; and

27 (3) Licensing and regulation.

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

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

1 healthcare transformation efforts.

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

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

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

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

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

13 (i) The firm shall undertake a comprehensive review of all social and human service
14 programs having a contract with or licensed by the state or any subdivision of the department of
15 children, youth and families (DCYF), the department of behavioral healthcare, developmental
16 disabilities and hospitals (BHDDH), the department of human services (DHS), the department of
17 health (DOH), and Medicaid for the purposes of:

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

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

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

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

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

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

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

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

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

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

9 (ii) An assessment and detailed reporting on eligibility standards and processes of all
10 mandatory and discretionary social and human service programs to be completed by January 1,
11 2023;

12 (iii) An assessment and detailed reporting on utilization trends from the period of January
13 1, 2017, through December 31, 2021, for social and human service programs to be completed by
14 January 1, 2023;

15 (iv) An assessment and detailed reporting on the structure of the state government as it
16 relates to the provision of services by social and human service providers including eligibility and
17 functions of the provider network to be completed by January 1, 2023;

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

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

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

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

27 (ix) An assessment and reporting on usual and customary rates paid by private insurers and
28 private pay for similar social and human service providers, both nationally and regionally, by April
29 1, 2023; and

30 (x) Completion of the development of an assessment and review process that includes the
31 following components: eligibility; scope of services; relationship of social and human service
32 provider and the state; national and regional rate comparisons and accountability standards that
33 result in recommended rate adjustments; and this process shall be completed by September 1, 2023,
34 and conducted biennially hereafter. The biennial rate setting shall be consistent with payment

1 requirements established in § 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. §
2 1396a(a)(30)(A), and all federal and state law, regulations, and quality and safety standards. The
3 results and findings of this process shall be transparent, and public meetings shall be conducted to
4 allow providers, recipients, and other interested parties an opportunity to ask questions and provide
5 comment beginning in September 2023 and biennially thereafter.

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

8 (u) Annually, each department (namely, EOHHS, DCYF, DOH, DHS, and BHDDH) shall
9 include the corresponding components of the assessment and review (i.e., eligibility; scope of
10 services; relationship of social and human service provider and the state; and national and regional
11 rate comparisons and accountability standards including any changes or substantive issues between
12 biennial reviews) including the recommended rates from the most recent assessment and review
13 with their annual budget submission to the office of management and budget and provide a detailed
14 explanation and impact statement if any rate variances exist between submitted recommended
15 budget and the corresponding recommended rate from the most recent assessment and review
16 process starting October 1, 2023, and biennially thereafter. [The governor shall appropriate the](#)
17 [recommended rates for each aforementioned department in the governor's annual budget](#)
18 [submission. These departments shall also forecast anticipated costs for the recommended rates](#)
19 [during each caseload estimating for the upcoming fiscal year.](#)

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

23 SECTION 3. This act shall take effect upon passage.

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LC004836
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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO PUBLIC FINANCE -- MEDICAL ASSISTANCE AND PUBLIC
ASSISTANCE CASELOAD ESTIMATING CONFERENCES

1 This act would require that the department of human services and the department of
2 behavioral healthcare, developmental disabilities and hospitals provide forecasted costs reflecting
3 the recommended rate review on a monthly basis, and that the governor include the recommended
4 rates for each department in the governor's annual budget submission.

5 This act would take effect upon passage.

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