ARTICLE 9

RELATING TO MEDICAL ASSISTANCE

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

23-17-38.1. Hospitals — Licensing fee.

~~(a) There is imposed a hospital licensing fee for state fiscal year 2022 against each hospital in the state. The hospital licensing fee is equal to five and six hundred fifty-six thousandths percent (5.656%) of the net patient-services revenue of every hospital for the hospital's first fiscal year ending on or after January 1, 2020, except that the license fee for all hospitals located in Washington County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for Washington County hospitals is subject to approval by the Secretary of the U.S. Department of Health and Human Services of a state plan amendment submitted by the executive office of health and human services for the purpose of pursuing a waiver of the uniformity requirement for the hospital license fee. This licensing fee shall be administered and collected by the tax administrator, division of taxation within the department of revenue, and all the administration, collection, and other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before July 13, 2022, and payments shall be made by electronic transfer of monies to the general treasurer and deposited to the general fund. Every hospital shall, on or before June 15, 2022, make a return to the tax administrator containing the correct computation of net patient services revenue for the hospital fiscal year ending September 30, 2020, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.~~

~~(b)~~(a) There is ~~also~~ imposed a hospital licensing fee for state fiscal year 2023 against each hospital in the state. The hospital licensing fee is equal to five and forty-two hundredths percent (5.42%) of the net patient-services revenue of every hospital for the hospital's first fiscal year ending on or after January 1, 2021, except that the license fee for all hospitals located in Washington County, Rhode Island shall be discounted by thirty-seven percent (37%). The discount for Washington County hospitals is subject to approval by the Secretary of the U.S. Department of Health and Human Services of a state plan amendment submitted by the executive office of health and human services for the purpose of pursuing a waiver of the uniformity requirement for the

hospital license fee. This licensing fee shall be administered and collected by the tax administrator, division of taxation within the department of revenue, and all the administration, collection, and other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator on or before June 30, 2023, and payments shall be made by electronic transfer of monies to the general treasurer and deposited to the general fund. Every hospital shall, on or before May 25, 2023, make a return to the tax administrator containing the correct computation of net patient-services revenue for the hospital fiscal year ending September 30, 2021, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.

~~(c)~~(b) There is also imposed a hospital licensing fee described in subsections ~~(d)~~(c) through ~~(g)~~(f) for state fiscal years 2024 and 2025 against net patient-services revenue of every non-government owned hospital as defined herein for the hospital's first fiscal year ending on or after January 1, 2022. The hospital licensing fee shall have three (3) tiers with differing fees based on inpatient and outpatient net patient-services revenue. The executive office of health and human services, in consultation with the tax administrator, shall identify the hospitals in each tier, subject to the definitions in this section, by July 15, 2023, and shall notify each hospital of its tier by August 1, 2023.

~~(d)~~(c) Tier 1 is composed of hospitals that do not meet the description of either Tier 2 or Tier 3.

(1) The inpatient hospital licensing fee for Tier 1 is equal to thirteen and twelve hundredths percent (13.12%) of the inpatient net patient-services revenue derived from inpatient net patient-services revenue of every Tier 1 hospital.

(2) The outpatient hospital licensing fee for Tier 1 is equal to thirteen and thirty hundredths percent (13.30%) of the net patient-services revenue derived from outpatient net patient-services revenue of every Tier 1 hospital.

~~(e)~~(d) Tier 2 is composed of high Medicaid/uninsured cost hospitals and independent hospitals.

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

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

~~(f)~~(e) Tier 3 is composed of hospitals that are Medicare-designated low-volume hospitals

and rehabilitative hospitals.

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

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

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

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

~~(i)~~(h) This hospital licensing fee shall be administered and collected by the tax administrator, division of taxation within the department of revenue, and all the administration, collection, and other provisions of chapter 51 of title 44 shall apply. Every hospital shall pay the licensing fee to the tax administrator before June 30 of each fiscal year, and payments shall be made by electronic transfer of monies to the tax administrator and deposited to the general fund. Every hospital shall, on or before August 1, 2023, make a return to the tax administrator containing the correct computation of inpatient and outpatient net patient-services revenue for the hospital fiscal year ending in 2022, and the licensing fee due upon that amount. All returns shall be signed by the hospital's authorized representative, subject to the pains and penalties of perjury.

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

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

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

(3) "Hospital" means the actual facilities and buildings in existence in Rhode Island,

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

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

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

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

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

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

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

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

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

~~(k)~~(j) The tax administrator in consultation with the executive office of health and human

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

~~(l)~~(k) The licensing fee imposed by subsection (a) shall apply to hospitals as defined herein that are duly licensed on July 1, ~~2021~~ 2022, and shall be in addition to the inspection fee imposed by § 23-17-38 and to any licensing fees previously imposed in accordance with this section.

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

~~(n)~~(l) The licensing fees imposed by subsections ~~(c)~~(b) through ~~(g)~~(f) shall apply to hospitals as defined herein that are duly licensed on July 1, 2023, and shall be in addition to the inspection fee imposed by § 23-17-38 and to any licensing fees previously imposed in accordance with this section.

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

35-17-1. Purpose and membership.

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

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

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

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

(e) The department of human services shall provide monthly data to the members of the caseload estimating conference by the fifteenth day of the following month. Monthly data shall include, but is not limited to, actual caseloads and expenditures for the following case assistance

programs: Rhode Island Works, SSI state program, general public assistance, and child care. For individuals eligible to receive the payment under § 40-6-27(a)(1)(vi), the report shall include the number of individuals enrolled in a managed care plan receiving long-term-care services and supports and the number receiving fee-for-service benefits. The executive office of health and human services shall report relevant caseload information and expenditures for the following medical assistance categories: hospitals, long-term care, managed care, pharmacy, and other medical services. In the category of managed care, caseload information and expenditures for the following populations shall be separately identified and reported: children with disabilities, children in foster care, and children receiving adoption assistance and RIte Share enrollees under § 40-8.4-12(j). The information shall include the number of Medicaid recipients whose estate may be subject to a recovery and the anticipated amount to be collected from those subject to recovery, the total recoveries collected each month and number of estates attached to the collections and each month, the number of open cases and the number of cases that have been open longer than three months.

(f) Beginning July 1, 2021, the department of behavioral healthcare, developmental disabilities and hospitals shall provide monthly data to the members of the caseload estimating conference by the ~~fifteenth~~ twenty-fifth day of the following month. Monthly data shall include, but is not limited to, actual caseloads and expenditures for the private community developmental disabilities services program. Information shall include, but not be limited to: the number of cases and expenditures from the beginning of the fiscal year at the beginning of the prior month; cases added and denied during the prior month; expenditures made; and the number of cases and expenditures at the end of the month. The information concerning cases added and denied shall include summary information and profiles of the service-demand request for eligible adults meeting the state statutory definition for services from the division of developmental disabilities as determined by the division, including age, Medicaid eligibility and agency selection placement with a list of the services provided, and the reasons for the determinations of ineligibility for those cases denied. The department shall also provide, monthly, the number of individuals in a shared-living arrangement and how many may have returned to a twenty-four-hour (24) residential placement in that month. The department shall also report, monthly, any and all information for the consent decree that has been submitted to the federal court as well as the number of unduplicated individuals employed; the place of employment; and the number of hours working. The department shall also provide the amount of funding allocated to individuals above the assigned resource levels; the number of individuals and the assigned resource level; and the reasons for the approved additional resources. The department will also collect and forward to the house fiscal advisor, the senate fiscal

advisor, and the state budget officer, by November 1 of each year, the annual cost reports for each community-based provider for the prior fiscal year. The department shall also provide the amount of patient liability to be collected and the amount collected as well as the number of individuals who have a financial obligation. The department will also provide a list of community-based providers awarded an advanced payment for residential and community-based day programs; the address for each property; and the value of the advancement. If the property is sold, the department must report the final sale, including the purchaser, the value of the sale, and the name of the agency that operated the facility. If residential property, the department must provide the number of individuals residing in the home at the time of sale and identify the type of residential placement that the individual(s) will be moving to. The department must report if the property will continue to be licensed as a residential facility. The department will also report any newly licensed twenty-four-hour (24) group home; the provider operating the facility; and the number of individuals residing in the facility. Prior to December 1, 2017, the department will provide the authorizations for community-based and day programs, including the unique number of individuals eligible to receive the services and at the end of each month the unique number of individuals who participated in the programs and claims processed.

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

SECTION 3. Section 40-8-19 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is hereby amended to read as follows:

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

(a) Rate reform.

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

(2) The executive office shall review the current methodology for providing Medicaid payments to nursing facilities, including other long-term-care services providers, and is authorized

to modify the principles of reimbursement to replace the current cost-based methodology rates with rates based on a price-based methodology to be paid to all facilities with recognition of the acuity of patients and the relative Medicaid occupancy, and to include the following elements to be developed by the executive office:

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

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

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

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

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

(vi) Adjustment of rates by the change in a recognized national nursing home inflation index to be applied on October 1 of each year, beginning October 1, 2012. This adjustment will not occur on October 1, 2013, October 1, 2014, or October 1, 2015, but will occur on April 1, 2015. The adjustment of rates will also not occur on October 1, 2017, October 1, 2018, October 1, 2019, and October 2022. Effective July 1, 2018, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2017, both fee-for-service and managed care, will be increased by one and one-half percent (1.5%) and further increased by one percent (1%) on October 1, 2018, and further increased by one percent (1%) on October 1, 2019. Effective October 1, 2022, rates paid to nursing facilities from the rates approved by the Centers for Medicare and Medicaid Services and in effect on October 1, 2021, both fee-for-service and managed care, will be increased by three percent (3%). In addition to the annual nursing home inflation index adjustment, there shall be a base rate staffing adjustment of one-half percent (0.5%) on October 1, 2021, one percent (1.0%) on October 1, 2022, and one and one-half percent (1.5%) on October 1, 2023. 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.

SECTION 4. Sections 40-8.3-2 and 40-8.3-3 of the General Laws in Chapter 40-8.3 entitled "Uncompensated Care" are hereby amended to read as follows:

40-8.3-2. Definitions.

As used in this chapter:

(1) "Base year" means, for the purpose of calculating a disproportionate share payment for any fiscal year ending after September 30, ~~2022~~ 2023, the period from October 1, ~~2020~~ 2021, through September 30, ~~2021~~ 2022, and for any fiscal year ending after September 30, ~~2023~~ 2024, the period from October 1, ~~2021~~ 2022, through September 30, ~~2022~~ 2023.

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

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

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

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

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

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

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

40-8.3-3. Implementation.

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

~~(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $145.1 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and~~

~~(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital’s uncompensated care costs for the base year, inflated by the uncompensated care index to the total uncompensated care costs for the base year~~

~~inflated by the uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before June 30, 2022, and are expressly conditioned upon approval on or before July 5, 2022, by the Secretary of the United States Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2022 for the disproportionate share payments.~~

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

(1) That the DSH Plan to all participating hospitals, not to exceed an aggregate limit of $159.0 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH Plan; and

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated-care costs for the base year, inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by the uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before June 15, 2023, and are expressly conditioned upon approval on or before June 23, 2023, by the Secretary of the United States Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2023 for the disproportionate share payments.

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

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

(2) That the Pool D allotment shall be distributed among the participating hospitals in direct proportion to the individual participating hospital's uncompensated-care costs for the base year, inflated by the uncompensated-care index to the total uncompensated-care costs for the base year inflated by the uncompensated-care index for all participating hospitals. The disproportionate share payments shall be made on or before June ~~15~~ 30, 2024, and are expressly conditioned upon approval

on or before June 23, 2024, by the Secretary of the United States Department of Health and Human Services, or his or her authorized representative, of all Medicaid state plan amendments necessary to secure for the state the benefit of federal financial participation in federal fiscal year 2024 for the disproportionate share payments.

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

(1) That the DSH plan to all participating hospitals, not to exceed an aggregate limit of $34.7 million, shall be allocated by the executive office of health and human services to the Pool D component of the DSH plan; and

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

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

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

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

SECTION 5. Rhode Island Medicaid Reform Act of 2008 Resolution.

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

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

WHEREAS, Rhode Island General Laws section 42-7.2-5(3)(i) provides that the secretary of the executive office of health and human Services is responsible for the review and coordination

of any Medicaid section 1115 demonstration waiver requests and renewals as well as any initiatives and proposals requiring amendments to the Medicaid state plan or category II or III changes as described in the demonstration, "with potential to affect the scope, amount, or duration of publicly-funded health care services, provider payments or reimbursements, or access to or the availability of benefits and services provided by Rhode Island general and public laws"; and

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

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

(a) Nursing Facility Payment Technical Correction. The executive office of health and human services will clarify that the "other direct care" component of the nursing facility per diem may be revised as necessary based on increases from the most recently finalized year of the cost report used in the State's rate review.

(b) DSH Uncompensated Care Calculation. The executive office of health and human services proposes to seek approval from the federal centers for Medicare and Medicaid services to evaluate the impact of the recently enacted hospital directed payments for payments as a percentage of commercial equivalent rates in the calculation of base year uncompensated care used for disproportionate share hospital payments.

(c) Provider Reimbursement Rates. The secretary of the executive office of health and human services is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the applicable department's rules, regulations, and procedures required to implement updates to Medicaid provider reimbursement rates consisting of rate increases equal one hundred (100) percent of the increases recommended in the Social and Human Service Programs Review Final Report produced by the office of the health insurance commissioner pursuant to Rhode Island General Laws section 42-14.5-3(t)(2)(x) and including any revisions to these recommendations noted by the executive office of health and human services in its FY 2025 budget submission. This shall further include the recommendation that these rate updates shall be effective on October 1, 2024. This will also include a thirty percent (30%) increase to rates paid for skilled professional services provided by home care agencies omitted from the Commissioner's report.

(d) HealthSource RI Automatic Enrollment. The executive office of health and human

services and HealthSource RI may establish and operate a program for automatically enrolling qualified individuals who lose Medicaid coverage into Qualified Health Plans ("QHP"). HealthSource RI may use funds available through the American Rescue Plan Act, funds collected pursuant to R.I. Gen. Laws § 42-157-4(a), or funds otherwise appropriated by the Rhode Island General Assembly to HealthSource RI to pay the first month's premium for individuals who qualify for this program. HealthSource RI may use the information available in the state's integrated eligibility system, known as "RI Bridges," to authorize advance payments of the premium tax credit, as defined by 45 C.F.R. § 155.20, on behalf of applicable tax filers. The executive office of health and human services and HealthSource RI may terminate this program if the federal requirements provide that an individual whose household income is expected to be no greater than one hundred fifty percent (150%) of the federal poverty level is required to contribute an amount greater than zero (0) for purposes of calculating the premium assistance amount, as defined in 26 U.S.C. § 36B(b)(3)(A). HealthSource RI, in consultation with the executive office of health and human services, may promulgate regulations establishing the scope and parameters of this program.

(e) Nursing Facility Payment – RUG to PDPM. 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 department's rules, regulations, and procedures to switch nursing facility payment from the Resource Utilization Group (RUG) to the Patient-Driven Payment Model (PDPM) payment system and to make technical corrections to modernize nursing facility payment."

(f) ORS CNOM. 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 department's rules, regulations, and procedures to increase eligibility to 400 percent of poverty for Medicaid-funded services through the Department of Human Services' Office of Rehabilitation Services.

(g) Adult Dental Services to Managed Care. 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 department's rules, regulations, and procedures to authorize the expansion of the RIte Smiles managed care program to adults and additional services. The change would be in effect January 1, 2025.

(h) Ambulatory Dental Rates. The secretary of the executive office of health and human services is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the department's rules, regulations, and procedures to set Medicaid reimbursements rates for dental procedures performed in an ambulatory surgical center at 95

percent of the total payment listed on the Medicare Part B Hospital Outpatient Prospective Payment System (OOPS) as of January 1, 2024. Beginning January 1, 2025, the reimbursement rates will be annually updated to reflect 95 percent of the Medicare Part B OOPS rate.

(i) Chiropractic Rates. The secretary of the executive office of health and human services is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the department's rules, regulations, and procedures to pay chiropractic rates.

(j) Hospital Care Transitions Initiative. 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 department's rules, regulations, and procedures to leverage Medicaid for the Hospital Care Transitions Initiative.

(k) PACE Rates. The Secretary of the Executive Office is authorized to pursue and implement a state plan amendment modifying the rate-setting methodology for Program of All Inclusive Care for the Elderly (PACE). Under the current State Plan, the change in a single market basket is used to adjust the rates in non-rebasing years. The Executive Office proposes to revise this methodology to incorporate Medicaid program changes, fee schedule changes, and mix changes during years that do not include a full rebasing of the rates. This change will increase reimbursement parity and ensure that legislatively mandated fee schedule adjustments that apply to Medicaid FFS and Medicaid Managed Care are reflected in the rates paid to PACE.

(l) Consolidated Appropriations Act of 2023, Section 5121 Compliance. The secretary of the executive office of health and human services is authorized to pursue and implement any waiver amendments, state plan amendments, and/or changes to the applicable department's rules, regulations, and procedures required to provide federally mandatory Medicaid services to Medicaid-eligible individuals under age 21 and individuals under 26 eligible for Medicaid under the former foster care children group in the thirty (30) days prior to their release from incarceration. 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 Rhode Island General Laws section 42-12.4; and be it further;

RESOLVED, That this Joint Resolution shall take effect on July 1, 2024.

SECTION 6. This article shall take effect upon passage, except for Section 5 which shall take effect as of July 1, 2024.