



# OFFICE OF MANAGEMENT & BUDGET

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## MEMORANDUM

**To:** The Honorable Marvin L. Abney, Chairman, House Finance Committee  
The Honorable Louis P. DiPalma, Chairman, Senate Finance Committee

**From:** Joseph Codega Jr., Budget Officer *John M. Codega Jr.*

**Date:** April 8, 2024

**Subject:** Amendments to the FY 2025 Appropriations Act (24-H-7225)

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### **Governor's Budget Amendment #8**

The Governor requests amendments to the FY 2025 Appropriations Act within Article 9, Relating to Health and Human Services. The provisions and policy goals underlying these amendments are set forth below, with associated legislative changes and/or additions detailed in the subsequent technical section.

**Article 9, Amendment #1:** This amendment proposes changes to the Office of the Health Insurance Commissioner comprehensive review of social and human service programs. The Governor's Recommended budget included a plan for implementing the review pursuant to statute but made no changes to the legislation going forward. The FY 2025 Governor's Recommended Budget for the recently completed review remains unchanged, but for future implementation the proposed changes would codify and further outline responsibilities of the Social and Human Services Review Advisory Council. Also, the rate review cycle would move to an annual rate review cycle that would focus on specific service areas each year starting July 1, 2024. The rate review would be conducted on a four-year cycle, with a defined service area being reviewed each year, to be revisited every four years thereafter. Furthermore, primary care services would be added to the review, the definitions of "rate review" and "rate setting" are clarified and future rate reviews may consider rate structure changes. An accompanying budget amendment is submitted under Governor's Budget Amendment #10 to revise resulting budgetary administrative needs of the OHIC rate review under the new proposal. The amendment would be effective upon passage.

**Article 9, Amendment #2:** This amendment further changes the effective date for establishing the certified community behavioral health clinic model from the original Governor's proposed date of July 1, 2024, to October 1, 2024, based upon impacts from most recent federal guidance. The FY 2025 Governor Recommended Budget had changed the statutory date from February 1, 2024, to July 1, 2024, based upon projections at that time. The budgetary impacts of this revision will be addressed following the May 2024 Caseload Estimating Conference.

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If you have any questions regarding these amendments, please feel free to call me or my staff at 222-6300.

cc: Sharon Reynolds Ferland, House Fiscal Advisor  
Stephen Whitney, Senate Fiscal Advisor  
Brian Daniels, Director, Office of Management and Budget  
Jonathan Womer, Director of Administration

**24-H-7225 RELATING TO MAKING APPROPRIATIONS IN SUPPORT OF FY 2025**  
**Article 9 – Relating to Health and Human Services**  
**Amendment #1**

Page 221, After Line 31: Insert the following new Sections 5, 6, and 7 and renumber subsequent sections accordingly:

SECTION 5. Section 42-14.5-2.1 of the General Laws in Chapter 42-14.5 entitled "The Rhode Island Health Care Reform Act of 2004 – Health Insurance Oversight" is hereby repealed.

**42-14.5-2.1. Definitions.**

As used in this chapter:

~~(1) "Accountability standards" means measures including service processes, client and population outcomes, practice standard compliance and fiscal integrity of social and human service providers on the individual contractual level and service type for all state contacts of the state or any subdivision or agency to include, but not limited to, 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. This may include mandatory reporting, consolidated, standardized reporting, audits regardless of organizational tax status, and accountability dashboards of aforementioned state departments or subdivisions that are regularly shared with the public.~~

~~(2) "Executive Office of Health and Human Services (EOHHS)" means the department that serves as "principal agency of the executive branch of state government" (§ 42-7.2-2) responsible for managing the departments and offices of: health (RIDOH), human services (DHS), healthy aging (OHA), veterans services (VETS), children, youth and families (DCYF), and~~

~~behavioral healthcare, developmental disabilities and hospitals (BHDDH). EOHHS is also designated as the single state agency with authority to administer the Medicaid program in Rhode Island.~~

~~(3) "Rate review" means the process of reviewing and reporting of specific trending factors that influence the cost of service that informs rate setting.~~

~~(4) "Rate setting" means the process of establishing rates for social and human service programs that are based on a thorough rate review process.~~

~~(5) "Social and human service program" means a social, mental health, developmental disability, child welfare, juvenile justice, prevention services, habilitative, rehabilitative, substance use disorder treatment, residential care, adult or adolescent day services, vocational, employment and training, or aging service program or accommodations purchased by the state.~~

~~(6) "Social and human service provider" means a provider of social and human service programs pursuant to a contract with the state or any subdivision or agency to include, but not be limited to, 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.~~

~~(7) "State government and the provider network" refers to the contractual relationship between a state agency or subdivision of a state agency and private companies the state contracts with to provide the network of mandated and discretionary social and human services.~~

SECTION 6. Section 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" is hereby amended to read as follows:

**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 shall include 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, 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 transition from fee-for-service and toward global and other alternative payment methodologies for the payment for healthcare services. Alternative payment methodologies should be assessed for their likelihood to promote access to affordable health insurance, 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:~~ conduct the social and human services rate review as required under chapter 42-166.

~~(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.~~

SECTION 7. Title 42 of the General Laws entitled “State Affairs and Government” is hereby amended by adding thereto the following chapter:

#### **CHAPTER 42-166**

#### **SOCIAL AND HUMAN SERVICES RATE REVIEW**

##### **42-166-1. Findings.**

(1) Social and human services, which include behavioral health services, children’s services, home and community-based services, intellectual and developmental disability services, and primary care services are critical services provided by the state of Rhode Island to eligible program enrollees.

(2) A regularly scheduled, evidence-based, transparent, systematic review of Rhode Island’s reimbursement rates for social and human services is necessary to ensure that adequate rates are being paid to providers.

(3) Adequate social and human services reimbursement rates are intended to enable timely access to such services, to promote the efficient delivery of such services, and to protect the interest of those who pay for such services.

##### **42-166-2. Definitions**

As used in this chapter:

(1) “Behavioral health services” means mental health and substance use disorder services including, but not limited to, outpatient, residential, and mobile services.

(2) “Children’s services” means services for children that include, but are not limited to, behavioral health services, home-based therapeutic services, early intervention services, residential services, child welfare services, and intellectual and developmental disability services.

(3) “Home and community-based services” means any long-term-care services and supports available in a person’s home or a community-based living arrangement that are designed to enable people who meet the LTSS level of care to stay in their homes that the state is authorized to provide under the Medicaid state plan, the Medicaid section 1115 waiver, or any similar program.

(4) “Executive office of health and human services”, as established under § 42-7.2-2, means the state agency that serves as the principal agency of the executive branch of state government for managing the departments and offices of health, human services, healthy aging, veterans services, children, youth and families, and behavioral healthcare, developmental disabilities and hospitals.

(5) “Intellectual and developmental disability services” means services for adults who are eligible, or likely to be found eligible, for publicly funded developmental disability services through the department of behavioral healthcare, developmental disabilities & hospitals as defined in Rhode Island general laws § 40.1-21-4.3(5).

(6) “Office of the health insurance commissioner” or “the office” means the state agency established under § 42-14.5-1.

(7) “Primary care services” means professional services rendered by primary care providers at a primary care site of care.

(8) “Rate review” means the process of reviewing specific influences on the cost of service that is conducted by the office of the health insurance commissioner and used to develop a recommended reimbursement rate methodology, recommended reimbursement rate adjustments, and in some instances recommended rate structure reconfiguration, for social and human services.

(9) “Rate setting” means a process of establishing rates by the agency authorized under state or federal law to do so for social and human services that are based on a rate review process.

(10) “Social and human services” are comprised of behavioral health services, children’s services, home and community-based services, intellectual and developmental disability services, and primary care services.

(11) “Social and human services reimbursement rates” means reimbursement rates for social and human services provided to eligible program enrollees that are paid by the state to contracted providers pursuant to a state established fee schedule, including the Medicaid fee-for-service fee schedule. Social and human services rates shall include child welfare services provided by the department of children, youth, and families contingent upon the department establishing a fee schedule for such services. Social and human services rates shall not include rates for services provided under the department of human services’ vocational rehabilitation program or childcare assistance program unless such rates are included in the Medicaid fee-for-service fee schedule.

**42-166-3. Rate Review Process.**

(a) The office of the health insurance commissioner shall conduct a social and human services rate review in accordance with the schedule set forth in subsection 42-166-3(b).

(1) The office shall conduct each social and human services rate review contingent upon funding provided by the general assembly for necessary staff and for a qualified firm or firms, selected by the office, to assist in the social and human services rate review.

(b) Beginning on July 1, 2024, and every July 1 thereafter, social and human services shall be reviewed on an annual cycle in the following order:

(1) Primary care services and home and community-based services.

(2) Intellectual and developmental disability services.

(3) Behavioral health services.

(4) Children's services.

(c) Notwithstanding 42-166-3(b), the office may use its discretion to include or exclude services in any given annual rate review cycle. Reasons that the office may include or exclude services in a rate review cycle include but are not limited to: adequate resources appropriated to conduct the rate review, utilization of services, the effective date of service reimbursement rates, the number of members receiving services, data availability for services, feedback from the social and human services advisory council established under 42-166-4, subject matter experts, and the public.

(d) The office shall produce the following reports. Once completed, each report shall be submitted to the governor, speaker of the house, president of the senate, chairs of the house and senate finance committees, chairs of the house and senate health and human services committee, the secretary of the executive office of health and human services, and other state agency directors as deemed necessary by the office, including but not limited to state agencies with the relevant rate setting authority:



(1) A report including all social and human services reimbursement rates and the effective date of each rate shall be completed on or before December 1, 2024, and every December 1 thereafter.

(2) A report including all social and human services utilization trends over the previous five state fiscal years shall be completed on or before April 1, 2025, and every April 1 thereafter.

(3) A report that compares social and human services reimbursement rates pursuant to the schedule set forth in 42-166-3(b), to available and applicable commercial allowed rate benchmarks, commercial billed rate benchmarks, Medicaid managed care organization rate benchmarks, Medicare rate benchmarks, and at the discretion of the office Medicaid rate benchmarks from other states, shall be completed on or before April 1, 2025, and every April 1 thereafter.

(4) A report documenting the accessibility of services to recipients of the social and human services pursuant to the schedule set forth in 42-166-3(b) shall be completed on or before April 1, 2025, and every April 1 thereafter.

(e) The office shall meet with state agencies relevant to the social and human services review, including but not limited to state agencies with the relevant rate setting authority, on a regular basis, at a frequency determined by the office, to facilitate the review process. As requested by the office for the purpose of performing its duties under this chapter, state agencies shall cooperate with the office.

(f) On or before August 1, 2025, and each August 1 thereafter, the office shall submit recommended rate adjustments for the social and human services pursuant to the schedule set forth in 42-166-3(b), to the governor, speaker of the house, president of the senate, chairs of the house and senate finance committees, chairs of the house and senate health and

human services committee, the secretary of the executive office of health and human services, and other state agency directors as deemed necessary by the office, including but not limited to state agencies with the relevant rate setting authority.

(1) When making recommended rate adjustments, the office may take into consideration influences on service costs, relevant benchmarking information, accessibility of services, and any other information deemed relevant by the office.

(2) The methodology and reasoning the office uses to construct recommended rate adjustments shall be clearly documented and transparent.

(g) On or before September 1, 2025, and on or before each September 1 thereafter, the office shall hold a public meeting on its final rate recommendations for selected social and human services reimbursement rates submitted on August 1 so that the public has an opportunity to ask questions and provide comment.

**42-166-4. Social and Human Services Review Advisory Council.**

(a) To ensure that the social and human services review is carried out to the highest standards of credibility, integrity, and transparency, the office shall convene a public body to act in an advisory capacity for the office on all aspects of the social and human services review. This public body shall be known as the social and human services review advisory council.

(b) The health insurance commissioner shall appoint members with requisite expertise related to social and human services to the advisory council that shall serve at the pleasure of the Commissioner.

(c) The advisory council members shall provide advice to the office that is consistent with advancing the welfare of the public regardless of organizational affiliation. Advisory council members will lend their expertise and knowledge of the structure of social and human

services to facilitate the review process. The office shall retain all decision-making authority regarding the social and human services review. The advisory council shall not vote or reach final decision on matters concerning the social and human services review. The advisory council shall be a forum for discussion from which the office shall gather input.

(d) The advisory council shall meet at a frequency determined by the office. Meetings shall be conducted in accordance with the open meetings act, R.I. Gen. Laws § 42-46-1 et seq. with the intent to allow providers, recipients, and other stakeholders an opportunity to ask questions and provide comment.

**24-H-7225 RELATING TO MAKING APPROPRIATIONS IN SUPPORT OF FY 2025**  
**Article 9 – Relating to Health and Human Services**  
**Amendment #2**

Page 221, Line 15: Strike “July 1, 2024” and replace with “October 1, 2024”.