Medicaid

Medicaid

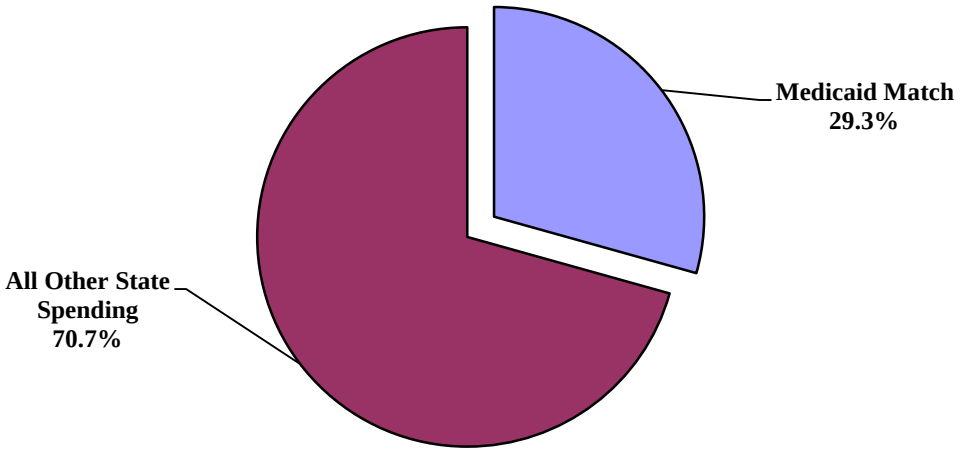
Medicaid is a health insurance program jointly funded by the federal government and the states to provide services to low-income children, pregnant women, parents of dependent children, the elderly, and people with disabilities. The federal government's share of expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP). The remainder is referred to as the nonfederal or state share. With passage of the Patient Protection and Affordable Care Act of 2010, states have the option of expanding coverage to include certain low-income adults with the federal government paying all program costs for the first three years and eventually paying 90 percent of the total cost.

Rhode Island provides medical assistance, residential care, community based services and case management activities to individuals who meet the eligibility criteria established for the various assistance programs operated by the Executive Office of Health and Human Services and the four departments under its umbrella: the Departments of Human Services; Behavioral Healthcare, Developmental Disabilities and Hospitals; Children, Youth and Families; and Health. The following table shows Medicaid spending by department, including administrative and direct benefits costs, and by percent of the total Medicaid budget.

FY 2021 Recommendation	General Revenues	All Funds	% of Medicaid
EOHHS	1,003,809,808	$ 2,640,437,142	83.3%
BHDDH	199,278,628	435,372,880	13.7%
Children, Youth and Families	29,964,347	62,931,004	2.0%
Human Services	12,302,754	29,666,063	0.9%
Health	1,001,302	3,206,932	0.1%
Total	**$ 1,246,356,839**	**$ 3,171,614,021**	**100%**

Medicaid as a Percent of the State Budget. Programs supported by Medicaid are 31.1 percent of total spending in the FY 2021 Governor's recommended budget and 29.3 percent of spending from general revenues.

FY 2021 State Medicaid Match vs All General Revenue Spending



The programs and recipients receiving Medicaid funded services are discussed separately in the pages that follow, including the state's mandated coverage for these populations, the number of individuals receiving

services and the costs, as well as other optional services that the state provides through the health and human service agencies.

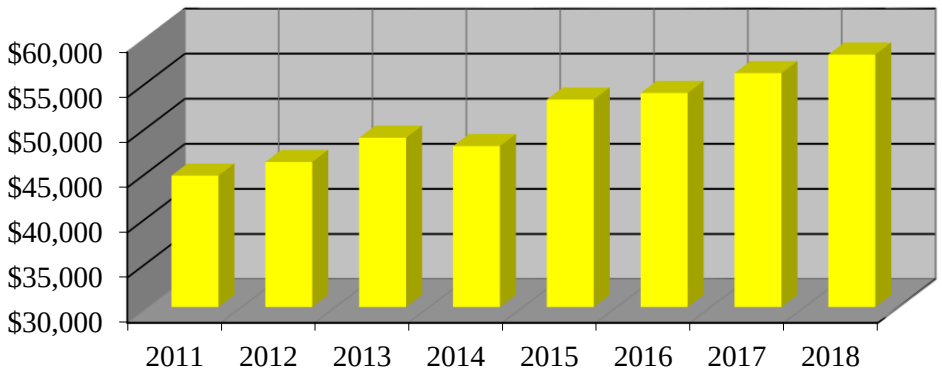
The 2012 Assembly concurred with the Governor's FY 2013 budget recommendation to shift Medicaid benefits to the Executive Office of Health and Human Services from the Department of Human Services. The 2014 Assembly transferred Medicaid funded behavioral health services from the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals to the Executive Office. The Executive Office's budget also includes medical benefit expenses for children and youth in the care of the Department of Children, Youth and Families.

Reinventing Medicaid. On February 26, 2015, Governor Raimondo signed an executive order establishing the Working Group to Reinvent Medicaid comprised of Medicaid stakeholders to conduct a comprehensive review of the Medicaid program and make recommendations for short and long-term plans to transform the program. The Governor included $92.3 million in savings in her recommended budget, including $46.4 million from general revenues in the health and human service agencies from the initiative. The Assembly enacted the FY 2016 budget with a majority of the proposals. A majority of the savings, $71.0 million, were from a reduction to rates paid to hospitals, nursing facilities and the managed care plans and there were other proposals that were never implemented.

Medicaid Rate. The federal medical assistance percentage (FMAP), also known as the federal Medicaid matching rate, is a calculation with significant impact on state health and human services spending. Each state has a Medicaid rate. The formula that determines an individual state's Medicaid rate is based on that state's three-year average per capita income relative to national per capita income and represents the portion of medical services delivered under the Medicaid program that the federal government will contribute. States with a higher per capita income level are reimbursed a smaller share of their costs.

By law, the Medicaid rate cannot be lower than 50 percent or higher than 83 percent. The federal contribution to any state's administrative costs for Medicaid services is set at 50 percent. The following chart shows the state's per capita income for the previous eight calendar years. The FY 2021 rate is based on 2016 through 2018 data. The per capita income data is released by the federal Bureau of Economic Analysis and is used by the federal government to calculate each state's Medicaid reimbursement rate.

State of Rhode Island Per Capita Personal Income



The following table includes the Rhode Island Medicaid rates used from FY 2016 through the projected FY 2021 rate. Enhanced rates were authorized as fiscal relief to states affecting FY 2008 through FY 2011. Since the Medicaid rate is published for the federal fiscal year that starts on October 1, the state uses a blended rate for its fiscal year. For example, Rhode Island's FY 2021 projected rate is based on one quarter of the federal fiscal year 2020 rate and three quarters of the federal fiscal year 2021 rate resulting in the different rate for budgetary purposes.

Medicaid Rates	FFY	SFY
2021	54.09%	53.81%
2020	52.95%	52.86%
2019	52.57%	52.29%
2018	51.45%	51.34%
2017	51.02%	50.87%
2016	50.42%	50.32%

Medicaid - CHIP Enhanced Rate. The federal medical assistance percentage rate not only determines the state and federal share of Medicaid, the state's largest health and human services program, but also applies to adoption assistance, foster care, and child care. The Medicaid rate is the basis for calculating the enhanced federal medical assistance percentage rate, the federal matching rate for the Children's Health Insurance Program (CHIP). The enhanced Medicaid rate reduces the state share by 30 percent. For example, if a state's Medicaid rate is 52 percent, its state share is 48 percent. That gets lowered to 33.6 percent under the enhanced rate of 66.7 percent. A state's Medicaid rate may increase or decrease depending on the adjustment to a state's per capita income, as does the enhanced Medicaid rate.

The Affordable Care Act increased the already enhanced rate by another 23 percentage points until FFY 2020 when it was lowered 11.5 extra points. The regular enhanced rate returns in FFY 2021. The FFY 2020 rate is 78.57 percent and staff has estimated that the rate for FFY 2021 and FFY 2022 will be 67.07 percent, based on the current state enhanced Medicaid rate for FFY 2020.

CHIP Rates	FFY	SFY
2022	67.07%	67.07%
2021	67.07%	69.95%
2020	78.57%	81.14%
2019	89.80%	89.61%
2018	89.02%	88.95%
2017	88.71%	88.61%
2016	88.29%	82.47%
2015	65.00%	65.04%

The Patient Protection and Affordable Care Act of 2010. On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act of 2010, commonly referred to as the Affordable Care Act, which provided for national health care reform. That was immediately followed by him signing a package of amendments called the Health Care and Education Reconciliation Act of 2010.

The Act required most citizens and legal residents to have health insurance by January 1, 2014, or pay a tax penalty, and expanded Medicaid coverage to individuals and families up to 138 percent of the federal poverty level; the threshold is 133 percent, but the Act includes a 5 percent disregard, essentially making the Medicaid eligibility threshold 138 percent. The Tax Cuts and Jobs Act of 2017 repealed the individual mandate to purchase health insurance, but did not make any changes to the expansion program.

The Affordable Care Act also provides for premium credits and cost-sharing subsidies for individuals and families between 139 percent and 400 percent of poverty; this also remains unchanged in the Tax Cuts and Jobs Act. The Act requires most employers to offer medical coverage, includes small business tax credits for employers with no more than 25 employees and provides for a temporary reinsurance program for employers providing health insurance coverage to individuals over 55 years of age but who are not eligible for Medicare. This provision was not changed.

The Affordable Care Act allows young adults to remain on a parent's or guardian's health plan until age 26; this provision became effective September 23, 2010. Regulations state that young adults are eligible

for this coverage regardless of any of the following factors: financial dependency, residency with parent, student status, employment or marital status. The law does not require that a plan or issuer offer dependent coverage, but that if coverage is offered, it must be extended to young adults up to age 26. Rhode Island requires insurance plans that cover dependent children to cover unmarried dependent children until age 19, or until age 25 if a student. If the dependent child is mentally or physically impaired, the plan must continue coverage after the specified age. This provision remains in current law.

Medicaid Expansion. Title II of the Act expands eligibility for Medicaid to lower income persons and assumes federal responsibility for much of the cost of this expansion. Beginning on January 1, 2014, all children, parents and adults without dependent children who are not entitled to Medicare and who have family incomes up to 138 percent of poverty became eligible for Medicaid. The 2013 Assembly expanded coverage to this population.

States are required to maintain the same income eligibility levels through December 31, 2013 for all adults, and this requirement is extended through September 30, 2019, or FY 2020, for children currently on Medicaid. This requirement has been extended until September 30, 2023 with the recent passage of the Healthy Kids Act that extended the Children's Health Insurance Program. For Rhode Island, this requirement applies to RIte Care eligibility for parents who are at or below 175 percent of poverty and children who are at or below 250 percent. The 2013 Assembly lowered the parent's threshold to 133 percent of poverty and included funding to assist in the transition to coverage through the health benefits exchange. The eligibility threshold for the parent was increased to 138 percent to match the threshold for the expansion program which is 133 percent of poverty after disregarding five percent of the annual income.

Similar to provisions in the American Recovery and Reinvestment Act, states cannot take actions to lower enrollment or make eligibility stricter. States can reduce provider fees, but must prove that the reduction will not make it harder for Medicaid patients to get needed care; states may eliminate optional benefits.

Between 2014 and 2016, the federal government paid 100 percent of the cost of covering newly-eligible individuals. On January 1, 2017, the Medicaid rate decreased to 95 percent. The rate was 94 percent for calendar year 2018; it dropped to 93 percent in 2019 and 90 percent on January 1, 2020 for all subsequent years, requiring a 10 percent state match.

Final FY 2017 expenses were $453.9 million, including $25.4 million from the state match. For FY 2018, those expenses were $453.9 million, of which $25.4 million is from general revenues, and FY 2019 totaled $488.1 million, of which $30.9 million is from general revenues. The FY 2020 enacted budget includes $483.1 million, of which $442.1 million is from federal funds and $41.1 million is from general revenues. The Governor's revised budget includes $470.6 million, of which $40.1 million is from general revenues and $462.1 million, of which $46.2 million is from general revenues, for FY 2021. The program's out-year estimates, including the state match, are shown in the following table.

Medicaid Expansion		
FY	**General Revenues**	**All Funds**
2019	$ 30.9	$ 488.1
2020	$ 41.1	$ 470.6
2021	$ 46.2	$ 462.1
2022	$ 47.1	$ 471.2
2023	$ 48.1	$ 481.1
2024	$ 49.2	$ 492.0
2025	$ 50.3	$ 503.0

$ in millions

HealthSource RI. In September 2011, Governor Chafee issued an executive order to establish the Rhode Island Health Benefits Exchange, renamed HealthSource RI, the marketplace for purchasing health insurance, known as the Exchange. The 2015 Assembly enacted Article 18 of 2015-H 5900, Substitute A, as amended, to establish the Health Benefits Exchange into general law as a division within the Department of Administration. It authorizes HealthSource RI to operate a state-based exchange to meet the minimum requirements of the federal act. It authorizes an assessment be charged by the Department, which cannot be more than the revenues that would be raised through the federally facilitated marketplace upon those insurers offering products on the exchange. The assessment is estimated to generate $7.1 million budgeted for FY 2020 and $7.6 million for FY 2021. The budget also includes $2.3 million from general revenues to be used in conjunction with the revenues from the assessment for the operations of HealthSource RI.

The 2019 Assembly also included Article 11 of 2019-H 5151, Substitute A, as amended, to address federal changes decreasing the assessment from 3.5 percent to 3.0 percent. The article decouples the state's premium assessment from the rate charged for federally facilitated marketplaces. It establishes a fee of 3.5 percent in statute, effective January 1, 2020.

HealthSource RI, in addition to offering in-person assistance from professional health benefits navigators, also offers online tools to assist Rhode Island residents and small businesses with shopping for and purchasing health insurance. All plans offered through HealthSource RI meet minimum coverage requirements set by the federal government, including essential health benefits such as preventive care and annual physicals, doctor sick visits, hospitalizations, maternity care, emergency room visits, and prescription coverage.

Tools offered through HealthSource RI can be used by those who do not have coverage either through an individual plan or through an employer plan, are under-insured by their individual or employer plan, and those who are comparison shopping between their current plan and plans offered through the exchange. Small employers with fewer than 50 full-time employees may also use HealthSource RI to offer coverage options to their employees.

The Legislature required religious employers that purchase plans on the Exchange to offer their employees a full-choice option. The employers would not be responsible for any additional costs of a plan selected by an employee. It also required that if an employer elects the religious exemption variation, it must provide written notice to enrollees that the plan excludes coverage for abortion services.

HealthSource RI began accepting applications on October 1, 2013. Health plans offered through the marketplace are categorized into tiers based on the level of benefits and cost sharing requirements. Individuals in households with income below 400 percent of poverty who are not Medicaid eligible will receive federal subsidies to reduce the cost of commercial health plans purchased through the Exchange.

The 2013 Assembly lowered the state's threshold criteria for RIte Care parents to 133 percent of poverty and created a premium assistance program to aid in the transition to coverage through the Exchange with the state paying 50 percent of the cost of commercial coverage, after subtracting what the parents are currently paying for RIte Care coverage and any federal tax credits or subsidies that are available.

Reinsurance Program. The 2019 Assembly concurred with the Governor's proposal to establish a Reinsurance Program, which is envisioned to provide stability in the individual insurance market; legislation is contained in Article 11 of 2019-H 5151, Substitute A, as amended. It imposes a shared responsibility payment penalty for individuals who do not have health insurance coverage, with certain exemptions and is effective on January 1, 2020. For federal tax year 2017, the penalty per household was $695 per adult and $347.50 per child under 18 or 2.5 percent of the household's income; however, the penalty was capped at the national average premium for bronze level plans. It mirrors the federal penalty, with the exception of capping the penalty at the statewide average premium for bronze level plans offered

on the state's health benefits exchange. This currently equates to $2,388. The collections from tax year 2017 were approximately $11.0 million.

The penalty will be collected by the tax administrator and deposited into a restricted account titled the Health Insurance Market Integrity Fund. The funds will be used to provide reinsurance or payments to health insurance carriers, as a means of ensuring that premiums do not increase drastically, and for administrative costs. Remaining funds from the penalty can be used for preventative health care programs in consultation with the Executive Office of Health and Human Services. The legislation prohibits the use of general revenues for reinsurance payments. The Governor's budget assumes $9.6 million will be received from the Shared Responsibility Payment penalty of which $8.3 million will be used to make payments to health insurance carriers and $1.3 million is for administrative expenses.

Health System Transformation Program. The 2015 Assembly enacted Section 10 of Article 5 of 2015-H 5900 Substitute A, as amended, for the hospital and nursing facility incentive programs and authorized the Secretary of Health and Human Services to seek the federal authority required to implement a hospital and nursing home incentive program. The program provided participating hospitals and nursing facilities the ability to obtain certain payments for achieving performance goals established by the Secretary.

The 2016 Assembly included Section 9 of Article 7 of 2016-H 7545 Substitute A, as amended, to seek federal authority to fund the Rhode Island Health System Transformation Program and the Designated State Health Programs to seek Medicaid match through a health workforce development partnership with the University of Rhode Island, Rhode Island College and the Community College of Rhode Island.

The state received approval on October 20, 2016 for a five-year grant totaling $129.7 million for the Health System Transformation Project. The state, along with accompanying changes to its managed care contracts, will develop shared savings agreements between the managed care health plans and the certified affordable entities. The shared savings incentive programs are the Hospital and Nursing Home Incentive Program and the Accountable Entity Incentive Arrangement. The Executive Office spent $7.0 million in FY 2017 in the Medical Assistance program for incentive payments to nursing facilities.

The second phase expanded opportunities through the Accountable Entities and the FY 2018 final budget included $9.3 million for the administrative expenses. The Executive Office entered into the following financial arrangements: $2.0 million for its investment in the Healthcare Workforce Transformation initiative in coordination with the three state institutions of higher education, University of Rhode Island, Rhode Island College and the Community College of Rhode Island, $1.3 million for contracted evaluation and other oversight services through Conduent, and $0.8 million for contracted staffing for project management, financial operations, analysis, evaluation and federal compliance.

The Assembly concurred with the Governor's proposal to establish a restricted receipt account in the general fund so that healthcare workforce development activities at the state's public institutions of higher education can receive the federal match that is available to the state's Medicaid program through its Executive Office of Health and Human Services' Designated State Health Program. The Governor includes $39.5 million for program and administrative expenses for FY 2020 and $60.8 million for FY 2021. The aggregate spend from FY 2017 to the FY 2021 recommendation totals $140.0 million on programs and administrative expenses, which is $10.3 million more than the award.

Unified Health Infrastructure Project. The state received approval from the Centers for Medicare and Medicaid Services in April 2015 to implement a nine-year, $230.8 million project that includes $162.6 million from federal funds including Medicaid, matched by $50.6 million from general revenues. The project is a joint venture among the Executive Office of Health and Human Services, Department of Human Services, and HealthSource RI. That initial plan was subsequently increased to $363.7 million, including $79.0 million for the state match and would be a fully integrated system, RI Bridges, instead of two separate

systems for its human services eligibility, application and worker accessibility activities in the affected agencies as originally planned. This was in July 2015 and the system was to be operational one year later and in September 2016, the old system was shut down; the new system became operational.

There have been continuing concerns from the United States Department of Agriculture's Food and Nutrition Service about the system's functionality. To receive federal approval for matching funds, the state is required to submit its project plan quarterly until instructed otherwise by the federal government; the system is still not fully operational.

The most recent plan for FFY 2020 totals $656.0 million, including $154.0 million from general revenues. The state continues to be on a quarterly approval process. The FY 2020 enacted budget assumes the use of $33.2 million from the Deloitte settlement to offset state expenses and $16.8 million will be returned to the federal government. The Governor's revised recommended does not identify if the state share has changed or if there are any additional state costs. On February 12, the administration announced the final settlement that the state will retain $30.0 million. It remains unclear how this impacts state support for the project. The following table includes spending from FY 2016 to FY 2019 as well as the FY 2020 enacted budget and the Governor's recommendations.

Unified Health Infrastructure Project/Contact Center	General Revenues	Federal Funds	Deloitte Settlement Funds	Other Restricted/IT Fund & HealthSource RI	Total
FY 2016 through FY 2019*	**$ 41,279,437**	**$ 209,915,048**	**$ -**	**$ 7,768,211**	**$ 194,504,317**
FY 2020 Enacted					
EOHHS	$ 2,048,556	$ 62,876,509	$ 6,614,152	$ -	$ 71,539,217
DHS	(2,447,271)	12,270,554	24,714,185	-	34,537,468
HealthSource RI/Contact Center	-	-	1,914,836	2,059,952	3,974,788
Total	**$ (398,715)**	**$ 75,147,063**	**$ 33,243,173**	**$ 2,059,952**	**$ 110,051,473**
FY 2020 Revised					
EOHHS	$ 1,909,372	$ 43,173,269	$ 6,527,952	$ -	$ 51,610,593
DHS	(2,502,646)	12,104,456	24,714,185	-	34,315,995
HealthSource RI/Contact Center	-	-	1,914,836	1,992,959	3,907,795
Total	**$ (593,274)**	**$ 55,277,725**	**$ 33,156,973**	**$ 1,992,959**	**$ 89,834,383**
FY 2020 Govenor Revised					
EOHHS	$ (6,574,707)	$ 40,657,950	$ 26,937,365	$ 1,600,247	$ 62,620,855
DHS	2,047,842	10,781,067	21,970,869	-	34,799,778
HealthSource RI/Contact Center	-	-	1,091,766	3,278,043	4,369,809
Total	**$ (4,526,865)**	**$ 51,439,017**	**$ 50,000,000**	**$ 4,878,290**	**$ 101,790,442**
FY 2021 Request					
EOHHS	$ 10,162,054	$ 44,673,286	$ -	$ -	$ 54,835,340
DHS	11,146,054	13,441,861	-	-	24,587,915
HealthSource RI/Contact Center	-	-	-	4,710,025	4,710,025
Total	**$ 21,308,108**	**$ 58,115,147**	**$ -**	**$ 4,710,025**	**$ 84,133,280**
FY 2021 Governor Recommendation					
EOHHS	$ 9,713,034	$ 41,492,922	$ -	$ -	$ 51,205,956
DHS	12,674,528	14,658,834	-	-	27,333,362
HealthSource RI/Contact Center	333,813	-	-	4,592,582	4,926,395
Total	**$ 22,721,375**	**$ 56,151,756**	**$ -**	**$ 4,592,582**	**$ 83,465,713**

**Funding in EOHHS and DHS*

Rhode Island Consumer Choice Global Compact Waiver. The Rhode Island Consumer Choice Global Compact Waiver, or Medicaid Global Waiver, was approved by the Centers for Medicare and Medicaid Services on January 16, 2009. The Global Waiver establishes a new federal-state agreement that provides Rhode Island with the flexibility to provide services in the least restrictive, most cost effective way to meet the needs of its citizens. It was in effect until December 31, 2013, at which time the state applied for and received an extension until December 31, 2018, renaming it the 1115 Research and Demonstration Waiver. The state recently received approval to extend the waiver until December 31, 2023.

Programs under the waiver include RIte Care, Rhody Health Partners, Rhody Health Options, home and community based services to elderly residents, residential and community support programs to adults with behavioral health and developmental disabilities, and breast and cervical cancer treatments. It also allowed the state to leverage Medicaid for services that were previously state-only in the Departments of Human Services, Behavioral Healthcare, Developmental Disabilities and Hospitals, and Children, Youth and Families.

As part of the Medicaid resolution language included in Article 13 of 2018-H 7200, Substitute A, as amended, the state has legislative approval to seek extension of the waiver. The following table includes the new benefits that were included in the extension and is in the Governor's FY 2021 recommended budget.

Proposals Approved and Part of the Governor's Recommendation	
Program	*Explanation*
Covering Family Home Visiting Program	• Able to receive federal matching funds for evidence-based home visiting services for Medicaid eligible pregnant women and children up to age four who are at-risk for adverse health, behavioral, and educational outcomes • Aimed at improving maternal and child health outcomes, encouraging positive parenting, and promoting child development and school readiness

The next table shows proposals that have been approved but not included in the FY 2020 or FY 2021 budgets that impact youth and families.

Proposals Approved and Not Funded as Part of the Governor's Recommendations	
Programs for Youth and Families	*Explanation*
Facilitating Medicaid Eligibility for Children with Special Needs	• Eligibility category established for children who meet the SSI disability criteria, but whose household income & assets exceed the SSI resource limits, and who need care in a psychiatric residential treatment facility • Allows children who meet the SSI disability criteria and require care in a residential treatment facility to become Medicaid eligible and receive residential care without parents needing to voluntarily relinquish custody to the Department of Children, Youth and Families
Enhancing Peer Support Services for Parents & Youth	• Able to receive federal matching funds for peer mentoring services to children, youth, and young adults, and their families, who have complex behavioral health needs and are at risk of removal from the home due to child welfare or juvenile justice involvement, or who may need extended residential psychiatric treatment

The next table shows proposals that have been approved but not included in the FY 2020 or FY 2021 budgets that impact adults.

Proposals Approved and Not Funded as Part of the Governor's Recommendations	
Programs for Adults	*Explanation*
Supporting Home- and Community-Based Therapeutic Services for the Adult Population	• Expansion of current in-home/community-based skill building and therapeutic/clinical services offered to children to adults • Services may include but are not limited to: home-based specialized treatment; home-based treatment support; individual specific orientation; transitional service; lead therapy; life skill building; specialized treatment consultation by a behavioral health clinician; and treatment coordination
Access to Care for Homebound Individuals	• Cover home-based primary care services only for Medicaid eligible individuals who are homebound, have functional limitations that make it difficult to access primary care, or for whom routine office based primary care is not effective because of complex medical, social, and/or behavioral health conditions
Waive the Institutions of Mental Disease (IMD) Exclusion	• Waiver of the IMD exclusion to allow Medicaid coverage for residential treatment services in a facility with 16 or more beds for individuals who have substance use disorders • **CMS has approved a waiver of the IMD exclusion for substance abuse disorder only, not mental health**

One aspect that did change was the process that the state has to adhere to in order to amend the waiver. Previously, the process was dictated by the nature of the change and identified as either a Category I, II or

III change. The following table shows each separate category, gives brief explanations and examples, and identifies whether or not Assembly approval is required.

Category	Assembly Approval	Global Waiver Change	Examples Waiver Changes
I	No	Any administrative change that does not affect eligibility, benefits, healthcare delivery, payment methods or cost sharing	General operating procedures, instruments to determine level of care and prior authorization procedures
II	Yes	State plan amendment change that does not change the special terms and conditions of the global waiver or expenditure authority	Benefit packages, payment methods, and cost sharing levels that do not affect eligibility
III	Yes	Requires modifying the current waiver or expenditure authority	All eligibility changes, changes to spend down levels, aggregate changes to cost sharing that exceed current limit

As part of the waiver extension, the Centers for Medicare and Medicaid Services notified the state that the process to approve requested waiver changes would be streamlined and the separate categories eliminated. There would now be one process to make formal amendment changes that were previously considered Category III. The Assembly included Section 9 of Article 13 of 2019-H 5151, Substitute A, as amended, that retains Assembly approval for previous Category II and III changes which will now be identified as formal amendment and state plan changes, respectively.

Medicaid Expenses - State/National Comparison. The Medicaid report has compared national and state 2013 Medicaid spending using the Medicaid and Children's Health Insurance Program Payment and Access Commission (MACPAC) MACStats Data Book (December 2015). The updated MACStats Data Book (December 2016 and 2017) includes national and state 2013 spending; however, certain information for Rhode Island is not listed because as footnoted: *"State was excluded due to data reliability concerns regarding completeness of monthly claims and enrollment data."* The information has not been updated for 2013 data and as such is being excluded from this year's edition of the report. Prior House Fiscal Advisory Staff analyses show the older data.

Poverty Guidelines

The federal poverty guidelines are used for purposes of determining financial eligibility for certain state and federal programs, including several programs in state agencies under the Executive Office. The 2020 guidelines are shown in the following table.

Percent of Federal Poverty Level based on Annual Income								
Family Size	100%	133%	138%	150%	180%	185%	225%	250%
1	$ 12,760	$ 16,971	$ 17,609	$ 19,140	$ 22,968	$ 23,606	$ 28,710	$ 31,900
2	17,240	22,929	23,791	25,860	31,032	31,894	38,790	43,100
3	21,720	28,888	29,974	32,580	39,096	40,182	48,870	54,300
4	26,200	34,846	36,156	39,300	47,160	48,470	58,950	65,500
5	30,680	40,804	42,338	46,020	55,224	56,758	69,030	76,700
6	35,160	46,763	48,521	52,740	63,288	65,046	79,110	87,900
7	39,640	52,721	54,703	59,460	71,352	73,334	89,190	99,100
8	44,120	58,680	60,886	66,180	79,416	81,622	99,270	110,300

For families with more than 8 members, add $4,480 for each additional member for the 100 percent calculation.

The poverty guidelines are based on the calculations made for the poverty threshold used by the United States Census Bureau mainly for statistical purposes, for instance, preparing the estimates of the number of Americans in poverty for each year's report.

They are issued each year, generally in the winter, in the Federal Register by the United States Department of Health and Human Services. The guidelines are thresholds used to determine financial eligibility for certain federal programs. They are adjusted for families of different sizes.

Both the thresholds and the guidelines are updated annually for price changes using the Consumer Price Index for All Urban Consumers (CPI-U). The poverty guidelines are sometimes loosely referred to as the "federal poverty level" or "poverty line."

Medicaid Recipients

Citizenship Requirements. To be eligible to receive Medicaid funded services, an individual must generally either be a citizen or legal resident for at least five years. Individuals must also be a resident of the state in which they are applying for benefits.

Pregnant Women. Medical services are provided to pregnant women whose annual income is at or below 250 percent of the poverty level. States are mandated to provide services to women at or below 133 percent of poverty.

Children and Parents. Medical services are provided to children whose family income is at or below 250 percent of poverty and parents if the income is at or below 133 percent of poverty through the RIte Care and RIte Share programs. Medical services are also provided to children who are placed in foster care or an adoptive placement through the Department of Children, Youth and Families.

Children with Special Health Care Needs. Medical services are provided to children with special health care needs including children in the Department of Children, Youth and Families' care who are in foster care and adoptive placement.

The following table shows the populations to which a state must provide medical benefits and the eligibility criteria established in Rhode Island. Each is discussed separately in the following pages.

Populations	
Mandatory	**Optional**
Low income Medicare beneficiaries up to 135% of poverty	Low income elderly or adults with disabilities and individuals eligible for home & community care waiver services
Children up to age 1 at or below 185% of poverty; Parents and children age 1 to 19 at or below 133% of poverty	Children to 250% of poverty
Supplemental Security Income or Social Security Disability Insurance recipients	Non-disabled adults, without dependent children, ages 19 through 64 with income at or below 138% of poverty
	Individuals who are medically needy
	Women eligible for breast and cervical cancer treatment services
Children in adoption assistance or who live in foster care under a Title IV-E program	Children under 18 who would otherwise need institutional care

Low Income Elderly. Individuals age 65 and older are eligible for medical benefits based on income and resources. They are eligible for community and/or long term care services if they meet income guidelines and the level of care requirements for the state's programs.

Medicaid Eligible Disabled Non-Elderly Adults. The state provides medical and cash assistance benefits to an adult, under the age of 65, if that individual meets the Social Security Administration definition of disabled. A person is considered disabled if they have a physical or mental disability, expected to last longer than six months and result in their death.

There are two programs that provide a monthly cash assistance benefit to a disabled individual: Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI).

If an individual is determined to be disabled and has a work history of 40 quarters, he or she may first be eligible for Social Security Disability Insurance, which is not considered to be a public assistance program. This is a federal program where the individual receives a monthly payment.

The second program available to a disabled individual is the Supplemental Security Income program. This is a federal public assistance program for individuals with limited income and resources. Individuals may be eligible for both the Social Security Disability Insurance program and the Supplemental Security Income program if they meet the income eligibility requirements. States have the option of providing a state payment in addition to the federal payment. Rhode Island began to make this supplemental payment in 1987.

Non-Disabled Adults without Dependent Children. The 2013 Assembly expanded Medicaid coverage to non-disabled adults without dependent children between the ages of 19 and 64 at or below 138 percent of federal poverty, consistent with the changes under the Affordable Care Act.

Breast and Cervical Cancer Treatment. The state provides breast and cervical cancer treatment services through the Medicaid global waiver. A woman must first be screened through the Department of Health's women's cancer screening program before she can receive Medicaid covered treatment services and be at or below 250 percent of poverty.

Medicaid - Benefits

States must provide mandatory benefits to certain populations. States can also choose to cover additional populations and provide additional benefits beyond what is mandated by the federal government. If a state chooses to extend coverage to additional populations, it must provide the same mandatory services it gives to its mandatory populations.

The most recent Executive Office of Health and Human Services' Rhode Island Annual Medicaid Expenditure Report includes Medicaid spending by population and cost per person for FY 2016 as shown in the following table.

Populations	Persons	% of Population	Costs*	% of Cost	Annual Cost/Person
Children/Parents	153,342	54.4%	$ 537.0	25.9%	$ 3,504
Expansion	64,989	23.1%	402.0	19.4%	$ 6,186
Elderly	19,198	6.8%	559.0	27.0%	$ 29,124
Disabled - Children	12,025	4.3%	170.0	8.2%	$ 14,052
Disabled - Adults	32,080	11.4%	402.0	19.4%	$ 23,496
Total	**281,634**	**100%**	**$ 2,070.0**	**100.0%**	

**in millions*

The report typically included a breakdown of cost by mandatory and optional populations and mandatory and optional services. However, this has been excluded from the report since FY 2014. It was included in the report for FY 2013 spending, which is shown in the next table. The 2019 Assembly passed legislation that requires the Executive Office of Health and Human Services to include this information, as well as

administrative expenses, in its annual spending report for FY 2019 expenses to be submitted in the spring of 2020. The state spent $1,785.0 million from federal and state funds on Medicaid services in FY 2013. Of this total, $615.0 million, or 34.0 percent, was spent on mandatory services for mandatory populations.

FY 2013 Medicaid		Gen. Rev.	All Funds
Mandatory Populations	Mandatory Services	$ 298.4	$ 615.0
	Optional Services	134.9	278.0
	Subtotal - Mandatory Populations	*$ 433.3*	*$ 893.0*
Optional Populations	Mandatory Services	$ 311.0	$ 641.0
	Optional Services	121.8	251.0
	Subtotal - Optional Populations	*$ 432.8*	*$ 892.0*
Total Expenses		**$ 866.1**	**$ 1,785.0**

$ in millions

The requirements to submit the annual report are contained in Rhode Island General Laws, Section 42-7.5 (4) and include reporting on: expenditures, outcomes and utilization rates by population and sub-population served (e.g. families with children, persons with disabilities, children in foster care, children receiving adoption assistance, adults ages 19 to 64, and elders); expenditures, outcomes and utilization rates by each state department or other municipal or public entity receiving federal reimbursement under Medicaid; and expenditures, outcomes and utilization rates by type of service and/or service provider.

The following table shows both the mandatory and optional benefits provided through the state's Medicaid program for acute care services. Acute care services are direct medical benefits provided to eligible individuals including doctor visits, hospital services, rehabilitation, and prescription coverage.

Acute Care Benefits	
Mandatory	**Optional**
Physician services	Prescriptions
Lab & X-ray	Rehabilitation & other therapies
In/outpatient hospital services	Clinical Services
Early, Periodic, Screening Diagnostic and Treatment (EPSDT) Services	Dental, dentures, prosthetic devices & eyeglasses
Family planning services and supplies	Case management
Federally qualified health centers and rural health clinic services	Durable medical equipment
Nurse midwife as state law permits	Tuberculosis related services
Certified pediatric & family nurse practitioner services	Medical remedial care provided by other licensed professionals

In addition, the next table includes both the mandatory and optional benefits provided through the state's Medicaid program for long term care and home and community care services.

Long Term Care Benefits	
Mandatory	**Optional**
Institutional	
Nursing facility services for those 21 or older needing that level of care	Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
	Individuals 65 or older in an institute of mental disease
	Inpatient psychiatric hospital service for those under 21
Home and Community Care Services	
Home health care services for those entitled to nursing home care	Home & community based care/other home health care
	Targeted case management
	Hospice/Personal care
	Respiratory care services for ventilator dependent individuals
	PACE Program

Medicaid Programs

The state provides medical benefits, residential, and home and community based services to qualified individuals. The following sections describe the programs.

Medical Benefits

RIte Care/RIte Share. The state provides medical benefits to children and their parents who meet the eligibility criteria for the RIte Care program. The federal government mandates that states provide Medicaid benefits to children up to age 19 whose family income is at or below 133 percent of poverty, children in foster care and adoptive assistance, and parents whose income is at or below 50 percent of the poverty level.

The federal government allows states to provide medical benefits to individuals beyond the populations it mandates and that coverage is provided through Medicaid waivers. Rhode Island chooses to provide benefits to children whose family income is at or below 250 percent of poverty (for example, a family of four with an income that does not exceed $60,625) and to parents if the family income is at or below 133 percent of poverty (for that same family of four, an income that is not above $31,322). If a family's income is at or below 200 percent of poverty, the child (or children) would receive RIte Care benefits, but the parent (or parents) would not because the annual income is too high. The Centers for Medicare and Medicaid Services issued a ruling that requires states to use the new methodology mandated under the Affordable Care Act for verifying income that uses a family's modified adjusted gross income (MAGI) instead of family income with certain disregards.

Under the methodology conversion, states have a higher income threshold for certain populations because the disregards are adjusted using the new calculation with the intent to not make any person ineligible for benefits because of the conversion. For Rhode Island, this conversion changes the income threshold for children, increasing it from 250 percent with the disregards to 261 percent. For Rhode Island, the income threshold for parents was raised to the mandatory level of 138 percent which is not impacted by the MAGI conversion.

RIte Share participants are eligible for RIte Care but have access to employer sponsored insurance for which the state pays monthly cost sharing requirements and deductibles. The 2019 Assembly added Section 7 of Article 13 of 2019-H 5151, Substitute A, as amended, that requires a plan be submitted by October 1, by

the Executive Office of Health and Human Services to identify Medicaid eligible individuals who have access to employer sponsored health insurance. Beginning January 1, 2020, the information is to be included in the medical assistance report. The objective is to increase enrollment in the lower cost benefit that enrolls Medicaid beneficiaries in employer sponsored insurance to levels that existed prior to the launch of the Unified Health Infrastructure Project which totaled approximately 8,400. The November 2019 caseload testimony reported enrollment of less than 4,000.

RIte Share Outreach and Reporting. As noted, prior to the September 2016 launch of the Unified Health Infrastructure Project (UHIP), there were 8,400 individuals covered through RIte Share compared to the 3,500 reported in March 2019. The Governor proposed in her FY 2020 budget recommendation a new fee for large employers whose workers were on Medicaid. The budget projected $14.5 million in net revenue. There was testimony at the House Finance Committee hearing on this proposal that there were many instances where the employer was not aware that an employee was on RIte Care.

The Assembly rejected this proposal and required the state to revisit efforts to increase enrollment in the RIte share Program after noting that enrollment was less than half of what it was before the launch of UHIP. The FY 2020 enacted budget includes savings of $2.4 million from increasing RIte Share enrollment and assumes an additional 2,000 individuals would get coverage.

The Assembly included Section 7 of Article 13 of 2019-H 5151, Substitute A, as amended, for the Executive Office to submit a plan by October 1, 2019 to revisit the existing RIte Share program to maximize enrollment and identifying who has access to other health insurance. After that, the Executive Office is required to submit the following information in its monthly medical assistance report starting January 1, 2020: the number of individuals with access to third party insurance, the number of plans that meet the cost effectiveness criteria, and the enrollment in RIte Share.

The January 2020 monthly report does not contain the required information. Instead it includes the number of individuals working over 30 hours, the number of employers with plans not meeting the cost effectiveness criteria and RIte Share enrollment. The report includes the following statement: *"The state does not have full ESI information for all employees in the state, and therefore cannot produce the number of Medicaid beneficiaries with access to ESI. The Governor's recommended budget includes a provision to require for profit employers with more than 50 employees to provide this information to the state, so we could better meet this reporting requirement and improve enrollment in our RIte Share program."*

It should be noted that under current law, RIte Share enrollment is a condition of eligibility for anyone over age 19, except in limited circumstances. If the state has approved an employer sponsored plan, the family is required to participate in RIte Share. If a family does not sign up for the employer sponsored health insurance, the adults will have their Medicaid eligibility terminated and any children will remain on RIte Care with the full Medicaid benefit.

The Governor's FY 2021 recommended budget significantly changes the way the RIte Share program currently operates by having employers with at least 50 workers, excluding non-profits, submit employee-specific information to the Executive Office and Division of Taxation so a determination can be made if a Medicaid eligible individual has access to employer sponsored insurance. On a quarterly basis, an employer would also report which workers are no longer employed. An employer would submit data and enrollment reports for its workers and whether or not they are enrolled in the employer sponsored insurance. The employer would also have to notify the Executive Office when a new employee is offered insurance during an open enrollment period. The employer also would have to participate in an employer education and outreach campaign, and could not offer any financial incentives for an employee to turn down the offer of insurance. As the program currently operates, the RIte Share Unit's three employees do the outreach and collect the information.

Any employer who does not comply in a timely manner would be assessed a $2,500 penalty by the Division of Taxation; one who does comply at all or an employer who provides false information will be assessed a $5,000 penalty. The Governor's FY 2021 recommendation includes savings of $19.0 million, including $5.6 million from general revenues from increasing enrollment by approximately 19,000 individuals to 25,000.

RIte Share Cost Sharing Requirement. RIte Share recipients with annual incomes above 150 percent of the federal poverty level pay a monthly cost sharing requirement that is no more than five percent of their annual income. The following chart shows the three separate payments based on a family's annual income, approximately three percent.

RIte Share Co-Pays	
Poverty Level	**Current Payments**
150% up to 185%	$61
185% up to 200%	$77
200% up to 250%	$92

The 2013 Assembly eliminated the monthly cost sharing requirement for families whose children receive coverage through RIte Care so that a family receiving coverage through the Exchange will not have two monthly premiums: one for the child(ren) in RIte Care and the monthly cost for commercial health coverage.

Extended Family Planning. The state provides extended family planning services to post-partum women with an income at or below 250 percent of poverty, for up to 24 months, if the mother loses RIte Care coverage 60 days after having a child.

Foster Care. The state provides RIte Care benefits to a child in a foster care placement. The state does not provide benefits to the biological parent or the foster parent. The child is also covered by Medicaid if determined to be eligible for disability through the Supplemental Security Income program.

Adoptive Assistance. The state provides RIte Care benefits to a child in adoptive assistance. The child is also covered by Medicaid if determined to be eligible for disability through the Supplemental Security Income program.

Children with Special Health Care Needs - Katie Beckett Option. The state chooses to provide home care and other services to children under the age of 18 who would require an institutional level of care. The income eligibility is based on the child's income and not the family's income. States can also choose to provide this service as a waiver, which would include a limited number of placements, or as an option under the Medicaid state plan, which is not limited. Rhode Island provides the services under the state plan option allowing for an unlimited number of program participants.

Early Intervention. The state provides services to children from birth to age three who have presented with a disability through the early intervention program. The services include physical, speech and occupational therapies.

Rhody Health Partners. For adults who are disabled but not receiving Medicare, the state provides medical benefits through Rhody Health Partners. This is a managed care system with plans through either Neighborhood Health Plan of Rhode Island, UnitedHealthcare or Tufts.

Rhody Health Options. For adults who are eligible for both Medicare and Medicaid, the state entered into a contract with Neighborhood Health Plan of Rhode Island to manage the acute care and long term care services for these individuals.

Fee-for-Service System. Individuals who are eligible for both Medicare and Medicaid, known as dual eligibles, receive medical benefits through the traditional fee-for-service system.

Long Term Care Residential and Community Care Services

Nursing Homes. The state reimburses 84 nursing homes that provide long term residential care to elderly and disabled individuals who require a nursing home level of care.

Hospice Services. Hospice services are provided to the terminally ill if there is a medical prognosis that life expectancy is six months or less. Services are provided in either the home setting, a nursing home, or other institutional setting.

Assisted Living Facilities. The state provides eligible residents access to assisted living facilities, a less expensive alternative to residing in a nursing home. Individuals can access this option, available through the Medicaid Global Waiver.

Home and Community Care Services. Through the Medicaid Global Waiver, the state provides home care and community care services to allow individuals to remain in their home instead of moving into a nursing home.

Eleanor Slater Hospital. The Eleanor Slater Hospital is the state's only public hospital and provides long-term care services with the support of acute medical services. It is a 495-bed facility licensed by the Department of Health, accredited by the Joint Commission on the Accreditation of Healthcare Organizations, and certified by the Centers for Medicare and Medicaid Services. It is a two-campus hospital consisting of the Pastore campus in Cranston and the Zambarano unit in Burrillville. The state provides long term services to individuals with disabilities, court ordered psychiatric patients, and those with behavioral health issues.

Residential Services and Other Programs

Mental Health Treatment Services. The state provides mental health treatment services through the Medicaid waiver. For Medicaid funded services, managed care organizations must adhere to the requirement of the Mental Health Parity and Addiction Equity Act of 2008 which was later amended by the Affordable Care Act.

Substance Abuse Treatment Services. As an option under Medicaid, states can also choose to provide substance abuse treatment services to Medicaid eligible individuals. For Medicaid funded services, managed care organizations must adhere to the requirement of the Mental Health Parity and Addiction Equity Act of 2008 which was later amended by the Affordable Care Act.

Adults with Developmental Disabilities. States are mandated to provide Medicaid funded medical benefits to developmentally disabled adults who require a nursing home level of care and to those who are Supplemental Security Income recipients. The state operates a state-run system for about 120 adults with developmental disabilities and the remaining 3,800 individuals receive residential and community based services through a private developmental disability organizations. The Governor's FY 2021 recommended budget assumes the closure of the state-run system and a transfer of program recipients to the community based one.

Services provided under the Medicaid Global Waiver are optional services with mandated medical benefits being paid for through the Executive Office of Health and Human Services' budget. The federal regulations governing the waiver mandate that in order to receive services a person must meet three eligibility criteria: diagnostic, functional and financial.

For an individual to meet the *diagnostic* criteria, he or she must have mental retardation, defined as an intelligence quotient that is 70 or less, or another type of developmental disability. States have the ability to define developmental disabilities differently using a more expansive definition and consequently serve different populations. Rhode Island uses the expanded developmental disability definition. Section 40.1-21-4.3 of the Rhode Island General Laws defines a developmentally disabled adult as someone who is 18 years of age or older, not under the jurisdiction of the Department of Children, Youth and Families, and who is either a developmentally disabled adult or is a person with a severe, chronic disability.

Functional eligibility requires an individual to have a substantial functional limitation in three or more of the following life activities: self-care, receptive and expressive language learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

Financial eligibility requires a person to be income eligible for services. In most cases, the only source of income for individuals with developmental disabilities is a $774.92 monthly Supplemental Security Income check, which places them below the 135 percent of the federal poverty level required for the program.

Medicaid funded services, provided through the waiver, for this eligible population include residential care, day programming and supportive services. The Assembly passed Section 7 of 2018-H 7200, Substitute A, as amended, to update the Medicaid waiver to reflect what is in its current practice for services to developmentally disabled adults. The state is in the process of finalizing this portion of the wavier but anticipates federal approval. The following table shows the tiers and description of options and supports.

DD/ID Needs-Based Service Tier Classifications and Options		
Tier	**Service Options**	**Available Supports**
Tier D and E (Highest): ***Extraordinary Needs***	• Living with family/caregiver • Independent Living • Shared Living • Community Support Residence • Group Home/Specialized Group Home	• Community Residential Support or access to overnight support services • Integrated Employment Supports • Integrated Community and/or Day Supports • Transportation
Tier C (Highest): ***Significant Needs***	• Living with family/caregiver • Independent Living • Shared Living • Community Support Residence • Group Home	• Community Residential Support or access to overnight support services • Integrated Employment Supports • Integrated Community and/or Day Supports • Transportation
Tier B (High): ***Moderate Needs*** **Tier A (High):** ***Mild Needs***	• Living with Family/Caregiver • Independent Living • Community Support Residence • **Shared Living • *Group Home	• Access to overnight support services • Integrated Employment supports • Integrated Community and/or Day Supports • Transportation

**Tier A or B individuals will have access to residential services in a group home if they meet at least one defined exception*
***Tier A will have access to shared living services if meet at least one defined exception*

Foster Care. The state provides foster care services to children in its custody.

Group Homes. The state provides placement in group home settings to children in its custody.

Bradley Hospital Group Homes Psychiatric Hospitalization. The state provides short-term treatment and crisis stabilization for children in acute distress, comprehensive evaluations, and long-term treatment. The state pays for psychiatric hospitalization services for Medicaid eligible children and children who are uninsured at the Emma Pendleton Bradley Hospital in East Providence.

Bradley Hospital Group Homes. There are five group homes that are run by Bradley Hospital for children ages 4 to 21, located in East Providence (Rumford House and Swan House), East Greenwich (Greenwich House), North Providence (Hill House), and Warwick (Heritage House).

HIV Treatment Services. The state provides treatment and supportive services to HIV positive individuals who are uninsured and with income up to 400 percent of poverty. As of January 1, 2014, individuals are either eligible for the Medicaid expansion program or benefits through the Exchange. Benefits will still be provided using the Ryan White federal grant and any rebate funding the state receives from drug purchases through that grant.

Executive Office of Health and Human Services

The Executive Office of Health and Human Services is the umbrella agency for the four health and human service departments and each agency is analyzed separately in the *House Fiscal Advisory Staff Budget Analysis FY 2021*. The following table shows the services provided by population and the department that is responsible for the expenses.

Programs	EOHHS	DHS	BHDDH	DCYF	DOH
Medical Benefits					
Children and parents	X				
Elderly	X	X			
Disabled and adults, without dependent children	X				
Residential and Other Services					
Nursing and hospice services	X				
Assisted living/home & communtiy based services - elderly	X	X			
Foster care and group home placements				X	
Community based services - developmentally disabled			X		
Mental health and substance abuse treatment services			X		
HIV surveillance and treatment services	X				X

Department of Justice Consent Decree

On January 14, 2014, Rhode Island entered into an interim settlement with the federal government and on April 8, 2014, signed a consent decree to settle United States v. State of Rhode Island and City of Providence, which addressed the statewide day activity service system for individuals with intellectual and developmental disabilities. State agency parties to the agreement are: Department of Behavioral Healthcare, Developmental Disabilities and Hospitals; Department of Human Services; Department of Elementary and Secondary Education; and the Office of the Attorney General. The Department of Justice finding is for those who meet the state's definition of an individual with a disability pursuant to Rhode Island General Laws.

The populations addressed in the consent decree are individuals with intellectual and developmental disabilities that include: the Rhode Island Youth Transition Target Population that are transition-age youth attending Rhode Island secondary schools; the Rhode Island Exit Target Population that are transition age youth during the 2013-2014, 2014-2015, or 2015-2016 school years; the Rhode Island Sheltered Workshop Target Population that perform sheltered workshop tasks or have received day activity services in the previous year; and the Rhode Island Day Target Population that receive day activity services in facility-based day program settings or have received such services in the previous year.

The consent decree has two fiscal components: a monitor and a trust fund. Charles Moseley from the National Association of State Directors of Developmental Disabilities Services has been assigned as the monitor. The consent decree stipulates the state payment to the monitor is not to exceed $300,000 annually. The monitor is responsible for approving the training component of the consent decree related to career development and transition plans and will also approve outreach and education programs. The monitor will also conduct factual investigations and verification of data and documentation that is necessary to determine

if the state is in compliance with the consent decree. The monitor has reporting requirements that started on April 1, 2014 through April 1, 2015 and every six months (180 days) after that.

The consent decree also stipulates that by October 1, 2014, the state will establish and begin distributing funds from an $800,000 Workshop Conversion Trust Fund, which will be administered by the Paul V. Sherlock Center on Disabilities at Rhode Island College. The fund will support start-up costs for providers who convert services to supported employment and will be administered by the director of the Department of Human Services and the associate director of the Office of Rehabilitation Services.

The state also had to create an employment first task force no later than May 1, 2014 that includes but is not limited to: the Community Provider Network of Rhode Island, the Paul V. Sherlock Center on Disabilities at Rhode Island College, the Rhode Island Disability Law Center, the Rhode Island Developmental Disabilities Council, the Rhode Island Parent Information Network, individuals with intellectual and developmental disabilities and parent and family representatives.

The state will ensure available funding for services and will reallocate resources expended on the sheltered workshop plans and segregated day programs to fund supported employment and/or integrated day services as individuals transition to supported employment and/or integrated day only placements, in order to have funding "follow the person."

The 2016 Assembly expanded the information contained in the current monthly report being submitted by the Department to include any reports that have been submitted to the federal court related to the consent decree along with the number of unduplicated individuals employed, the place of employment and the number of hours working. The Department must also report transitions to and from 24-hour residential placements, collection of patient liability, approvals and funding for services above the resource allocation levels.

The Department submitted the documentation presented to the federal court but it has not, and reported that it cannot, report on the number of individuals employed, the place of employment or the number of hours working since it does not track that information.

The 2017 Assembly also expanded the reporting requirements to capture data on services provided and any sale of state owned property if revenue is used to offset advanced payments made to community based providers. The state made advanced payments to 25 privately operated agencies that provide services to adults with developmental disabilities who resided at the state-run Ladd School, through a community based system of residential care and/or day programs. Advanced payments were made for both residential service and community based day programs that supported one month of services in the new system and as of July 1, 2017 totaled $13.3 million. Another step taken by the state to foster a community based system was to have the residential and day programs operate from buildings owned by the state.

The Department of Administration's Office of Accounts and Control required each of the 25 agencies to sign an individual memorandum of understanding that includes the payment amount that was advanced to that agency and the terms under which the agency can retain the payment. An agency was required to return the payment if: the agency closes, is no longer licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, is no longer certified by the Division of Developmental Disabilities, or if an individual site within the scope of the original agreement ceases operations. For state accounting purposes, the payments are treated as a receivable so any payments that have been made were booked as a revenue that paid down the advanced payment.

The Governor requested and the Assembly concurred with legislation to allow revenues from the sale of state-owned residential property supporting group home services for adults with developmental disabilities, to be used to pay down the $13.3 million in advanced payments made by the state to private agencies.

There is also a requirement that provider annual cost reports be submitted by the Department to the House and Senate fiscal advisors and the State Budget Officer by November 1st of each year. That information was submitted electronically in January 2020.