Medicaid

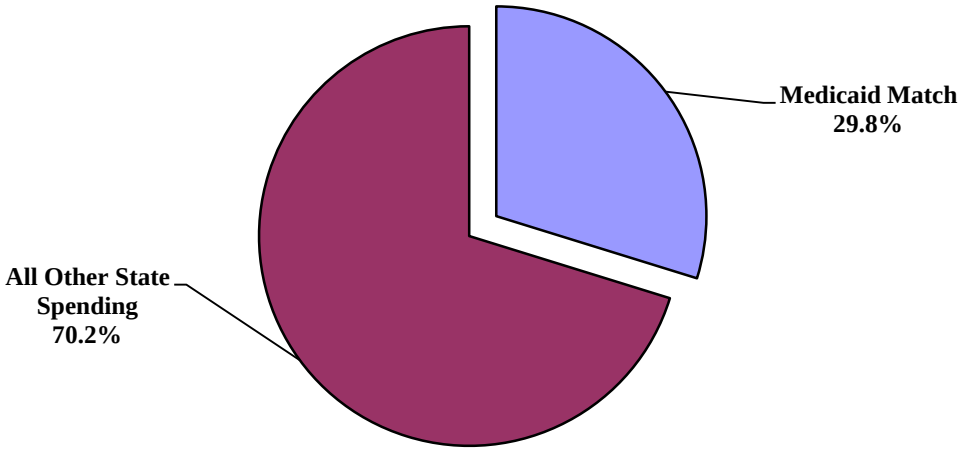
Medicaid is a health insurance program jointly funded by the federal government and the states to provide services to low-income children, pregnant women, parents of dependent children, elderly, and people with disabilities. The federal government's share of expenditures for most Medicaid services is 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: Human Services, Behavioral Healthcare, Developmental Disabilities and Hospitals, Children, Youth and Families, and Health. The following table shows Medicaid spending by department, including administrative costs and direct benefits, as well as by percent of the total Medicaid budget.

FY 2024 Enacted	General Revenues	All Funds	% of Medicaid
EOHHS	$ 1,252,922,088	$ 3,577,751,199	84.0%
BHDDH	305,342,512	552,839,661	13.0%
Children, Youth and Families	43,720,709	98,573,887	2.3%
Human Services	12,851,065	27,760,131	0.7%
Health	1,246,454	3,914,473	0.1%
Total	**$ 1,616,082,828**	**$ 4,260,839,351**	**100%**

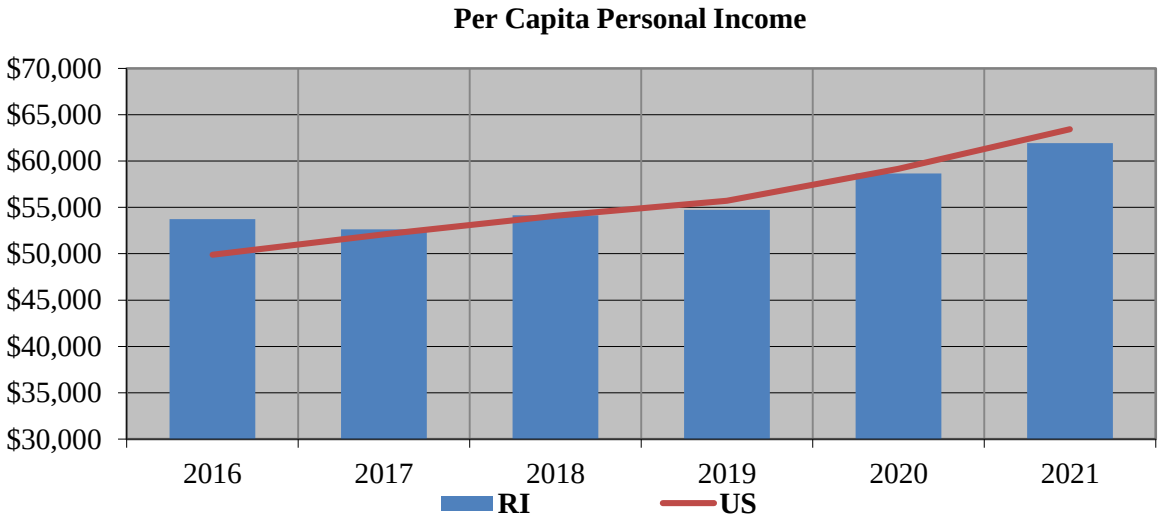
Medicaid as a Percent of the State Budget. Programs supported by Medicaid are 30.4 percent of total spending in the FY 2024 enacted budget and the state match for that requires 29.8 percent of spending from general revenues. The programs and recipients receiving Medicaid funded services are discussed 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 provided through the health and human service agencies.

FY 2024 State Medicaid Match vs All General Revenue Spending



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.

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 standard 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 chart above shows the state's per capita income for the previous six calendar years compared to the national average. The FY 2024 rate is based on 2019 through 2021 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.

The following table shows the regular federal fiscal year rate, the regular state fiscal year rate and the enhanced rates related to the pandemic for FY 2020 through FY 2024. As shown, the federal share has remained fairly consistent over the last several years.

Medicaid Rates	FFY		SFY	
	Regular	Enhanced	Regular	Enhanced
2024	54.75%	55.00%	54.75%	55.75%
2023	55.01%	60.16%	54.19%	60.09%
2022	54.88%	61.08%	54.68%	60.88%
2021	54.09%	60.29%	53.81%	60.01%
2020	52.95%	59.15%	52.86%	59.06%

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 2024 rate is based on one quarter of the

federal fiscal year 2023 rate and three quarters of the federal fiscal year 2024 rate resulting in the different rate for budgetary purposes.

Families First Coronavirus Response Act - Enhanced Medicaid Rate. On March 18, 2020, President Trump signed into law the Families First Coronavirus Response Act, which temporarily increases a state's Medicaid match rate by 6.2 percent for services provided from January 1, 2020 until the end of the public health emergency. In exchange, states may not terminate enrollment for those who no longer qualify for benefits.

On December 29, 2022, Congress passed the Consolidated Appropriations Act, 2023 which decouples the requirement for continued eligibility for Medicaid enrollees and related rate enhancement for the Medicaid match from the public health emergency declaration. The legislation lifts the prohibition on eligibility redeterminations as of March 31, 2023. States may start the 12-month redetermination process as early as February 1, 2023 but no later than April 1, 2023.

The enhanced Medicaid rate will be phased down through the second quarter of FY 2024. For FY 2023, the 6.2 percent enhanced rate will remain in effect for the third quarter as assumed in the November estimate, but will be phased down to 5.0 percent in the fourth quarter. For FY 2024, the enhanced rate will be 2.5 percent in the first quarter and 1.5 percent in the second quarter, which will mark the end of the rate enhancement. In order for states to receive the enhanced Medicaid rate, they must meet certain conditions. They must submit a renewal distribution and system readiness plan by February 1, 2023, if they begin the redetermination process in February, or by February 15, 2023, if they begin in either March or April. States must also report data related to the unwinding by the eighth day of the month in which the redetermination process starts. The FY 2023 final budget includes the enhanced rate through the fourth quarter and FY 2024 includes savings for the first two quarters. The redetermination process started April 1, 2023.

Savings from the enhanced Medicaid rate are partially offset by the state having to maintain enrollment of individuals who may no longer be eligible. The following table shows the gross savings to general revenues from the increased federal share for FY 2020 through the FY 2024 enacted budget totaling $692.6 million. These savings are offset by the fluctuations in enrollment which grew by approximately 74,200 individuals from February 2020 through March 2023. Enrollment is expected to decline as eligibility is recertified.

Gross General Revenue Savings		
FY 2024 Enacted	$	(36.1)
FY 2023 Final		(162.8)
FY 2022 Final		(280.0)
FY 2021 Final		(135.9)
FY 2020 Final		(77.8)
Total	**$**	**(692.6)**

$ in millions

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 is 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 to 78.57 percent. The regular enhanced rate returned in FFY 2021 at a rate of 67.28 percent and it is projected that FY 2024 will be 68.33 percent.

CHIP Rates	FFY	SFY
2024	68.51%	68.33%
2023	67.77%	67.93%
2022	68.42%	68.28%
2021	67.28%	70.10%
2020	78.57%	81.38%

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 eliminated the individual mandate penalty 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 remains in current law.

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 Medicaid eligibility 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. The 2013 Assembly expanded coverage to this population.

States were required to maintain the same income eligibility levels through December 31, 2013 for all adults, and this requirement was extended through September 30, 2019, or FY 2020, for children currently on Medicaid. It was extended again until September 30, 2023 with the 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 of 2009, the Affordable Care Act prohibits states from lowering enrollment or making eligibility stricter. States can reduce provider rates, 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.

The following table shows total program expenses and the state match for FY 2020 through the FY 2024 enacted budget and the out-years through FY 2028. Expenditures shown from FY 2021 through FY 2023 reflect caseload growth partially attributable to the prohibition on redeterminations during the public health emergency. As previously noted, redeterminations began April 1 and the state match for this program remains at ten percent; the delay in redeterminations did affect total state costs, which more than doubled.

Medicaid Expansion		
FY	General Revenues	All Funds
2028	$ 97.1	$ 893.4
2027	$ 95.2	$ 876.0
2026	$ 93.3	$ 858.5
2025	$ 91.4	$ 841.0
2024	$ 89.3	$ 821.7
2023	$ 87.6	$ 810.0
2022	$ 85.6	$ 802.7
2021	$ 68.8	$ 643.8
2020	$ 42.9	$ 487.3

$ 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 Exchange in general law as a division within the Department of Administration. It authorized HealthSource RI to operate a state-based exchange to meet the minimum requirements of the federal act. It also authorized an assessment be charged by the Department not to exceed revenues that would be raised through the federally facilitated marketplace upon those insurers offering products on the Exchange. The assessment is anticipated to generate $6.9 million for FY 2023.

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. The FY 2024 recommended budget includes $3.5 million from general revenues to be used in conjunction with these revenues for the operations of HealthSource RI.

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 Governor Raimondo's proposal to establish a reinsurance program, which was 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 became 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.

The penalty is collected by the tax administrator and deposited into a restricted account titled the Health Insurance Market Integrity Fund. The funds are used to provide reinsurance or payments to health insurance carriers, as a means of ensuring that premiums do not increase drastically, and 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 FY 2024 enacted budget includes $15.4 million, which is $9.7 million from federal funds and $5.7 million in revenue from the Shared Responsibility Payment penalty for individuals who do not have health insurance coverage, with certain exemptions. This includes $14.8 million to make reinsurance payments to health insurance carriers and $0.6 million for program administration.

The 2023 Assembly included Section 4 of Article 4 of 2023-H 5200, Substitute A, as amended, to exempt any person on Medicaid during calendar year 2023 from the current penalty assessed for not having health insurance.

Health System Transformation Program. The Assembly enacted Section 10 of Article 5 of 2015-H 5900, Substitute A, as amended, to authorize the Secretary of Health and Human Services to seek the federal

authority required to implement a program to provide participating hospitals and nursing facilities the ability to obtain certain payments for achieving performance goals established by the Secretary.

The 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 with a Medicaid match through a health workforce development partnership with the University of Rhode Island, Rhode Island College and the Community College of Rhode Island. A restricted receipt account was established so the activities can receive the federal Medicaid match.

The state received approval on October 20, 2016 for a five-year grant totaling $129.7 million for the Health System Transformation Project, which was later extended though FY 2024. Aggregate program and administrative expenses from FY 2017 through the FY 2024 enacted budget total $246.6 million.

As part of the project the state developed 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 second phase expanded opportunities through the Accountable Entities Incentive Arrangement. Pavements made to the separate entities through the shared savings agreement averaged approximately $25 million for FY 2018 through FY 2022. The Assembly included $24.0 million for FY 2023 and $20.9 million for FY 2024, the final year of the initiative.

The following table shows the progression of the grant and examples of the investments made for FY 2019 through FY 2024 in addition to the accountable entities arrangement.

Fiscal Year	Investment
2024	Workforce Transformation Initiative & Care Transformation Collaborative through DOH
2023	Dept. of Health's Care Transformation Collaborative for Practice Facilitation Services & Collaboration with URI/RIC & CCRI
2022	Real Jobs Healthcare Workforce Initiative with URI, RIC, CCRI & DLT. Continued program support for the Commission on the Deaf and Hard of Hearing
2021	Workforce Transformation Initiative and Care Transformation Collaborative through the Dept. of BHDDH
2020	Workforce Transformation Initiative and program support for the Commission on the Deaf and Hard of Hearing
2019	Healthcare Workforce Transformation Initiative with URI, CCRI & RIC

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, including $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. In September 2016, the old system was shut down and the new system became operational.

The state has been approved for a project plan that totals $792.6 million from all sources, including $202.6 million from general revenues, through federal fiscal year 2023. This includes $346.7 million from federal funds and $66.2 million from general revenues for design, development and implementation which totals $412.9 million. It also includes $243.4 million from federal funds and $136.3 million from general revenues for maintenance and operations which totals $379.7 million.

The state entered into a new three-year contact with Deloitte on June 28, 2021 effective through June 30, 2024 that will cost a total of $99.4 million, including $41.2 million from general revenues. The following table includes spending from FY 2016 through the FY 2024 enacted budget.

Unified Health Infrastructure Project/Contact Center	General Revenues	Federal Funds	Deloitte Settlement Funds	Other Restricted/IT Fund & HealthSource RI	Total
FY 2016 through FY 2022	**$ 85,461,210**	**$ 355,861,125**	**$ 49,262,860**	**$ 16,069,365**	**$ 510,939,033**
FY 2023 Enacted					
EOHHS	$ 13,918,551	$ 43,948,498	$ -	$ -	$ 57,867,049
DHS	14,412,005	15,903,542	-	-	30,315,547
HealthSource RI/Contact Center	1,621,654	-	-	5,105,234	6,726,888
Total	**$ 29,952,210**	**$ 59,852,040**	**$ -**	**$ 5,105,234**	**$ 94,909,484**
FY 2023 Final					
EOHHS	$ 13,112,762	$ 39,305,341	$ -	$ -	$ 52,418,103
DHS	11,325,679	14,096,536	-	-	25,422,215
HealthSource RI/Contact Center	913,461	-	-	4,895,420	5,808,881
Total	**$ 25,351,902**	**$ 53,401,877**	**$ -**	**$ 4,895,420**	**$ 83,649,199**
FY 2024 Gov. Rec.					
EOHHS	$ 12,694,750	$ 45,832,472	$ -	$ -	$ 58,527,222
DHS	13,779,328	16,164,528	-	-	29,943,856
HealthSource RI/Contact Center	1,003,672	-	-	5,094,513	6,098,185
Total	**$ 27,477,750**	**$ 61,997,000**	**$ -**	**$ 5,094,513**	**$ 94,569,263**
FY 2024 Enacted					
EOHHS	$ 14,381,097	$ 43,882,038	$ -	$ -	$ 58,263,135
DHS	13,559,111	18,389,865	-	-	31,948,976
HealthSource RI/Contact Center	2,204,186	-	-	5,166,245	7,370,431
Total	**$ 30,144,394**	**$ 62,271,903**	**$ -**	**$ 5,166,245**	**$ 97,582,542**
FY 2016 through FY 2024 Enacted Budget	**$ 140,957,506**	**$ 471,534,905**	**$ 49,262,860**	**$ 26,131,030**	**$ 692,170,774**

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 received approval to extend the waiver until December 31, 2023. The FY 2023 final budget includes $500,000, of which $250,000 is from general revenues, for the Executive Office of Health and Human Services to work with a consultant to prepare the waiver renewal. The FY 2024 enacted budget includes $0.9 million, of which $0.3 million is from general revenues, for a contractor to assist with finalizing the waiver and assisting with the implementation once approved.

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 allows 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.

The Medicaid resolution language included in Article 13 of 2018-H 7200, Substitute A, as amended, granted legislative approval to seek extension of the waiver.

Waiver Proposals Approved and Part of the Budget	
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 in the waiver that impact youth and families.

Waiver Proposals Approved and Not Funded as Part of the Budget	
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 and 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 their home due to child welfare or juvenile justice involvement, or who may need extended residential psychiatric treatment

The next table shows proposals affecting adults that have been approved but are not included in any budgets.

Waiver Proposals Approved and Not Funded as Part of the Budget	
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 and adults • Services may include but are not limited to: home-based specialized treatment; home-based treatment support; individual specific orientation; transitional services; 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 disorders 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 is now 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, to retain the requirement for Assembly approval for previous Category II and III changes which will now be identified as formal amendments and state plan changes, respectively.

Poverty Guidelines

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

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." The 2023 guidelines are shown in the following table.

Percent of Federal Poverty Level based on Annual Income									
Family Size	**100%**	**125%**	**133%**	**138%**	**150%**	**180%**	**185%**	**225%**	**250%**
1	$ 14,580	$ 18,225	$ 19,391	$ 20,120	$ 21,870	$ 26,244	$ 26,973	$ 32,805	$ 36,450
2	19,720	24,650	26,228	27,214	29,580	35,496	36,482	44,370	49,300
3	24,860	31,075	33,064	34,307	37,290	44,748	45,991	55,935	62,150
4	30,000	37,500	39,900	41,400	45,000	54,000	55,500	67,500	75,000
5	35,140	43,925	46,736	48,493	52,710	63,252	65,009	79,065	87,850
6	40,280	50,350	53,572	55,586	60,420	72,504	74,518	90,630	100,700
7	45,420	56,775	60,409	62,680	68,130	81,756	84,027	102,195	113,550
8	50,560	63,200	67,245	69,773	75,840	91,008	93,536	113,760	126,400

For families with more than 8 members, add $5,140 for each additional member for the 100 percent calculation.

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, and also a resident of the state.

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 pages that follow.

Populations	
Mandatory	**Optional**
Low income Medicare beneficiaries up to 135% of poverty	Low income elderly or adults with disabilities and individuals eligible for home and 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

Coverage for Children Regardless of Immigration Status. The FY 2023 enacted budget extended medical benefits coverage, funded solely from state sources, to children whose family income is at or below 250 percent of poverty regardless of immigration status. The legislative change was included in Section 6 of Article 12 of 2022-H 7123, Substitute A, as amended.

Pregnant and Post-Partum Women. Medical services are provided to pregnant women whose annual income is at or below 250 percent of the poverty level. States are federally required to provide services to women at or below 133 percent of poverty. Women who are not otherwise eligible for Medicaid lose coverage after 60 days post-partum. Previously, the state offered a limited Medicaid benefit to post-partum women up to 250 percent of poverty for up to 24 months. The American Rescue Plan Act created a new state Medicaid option to extend full Medicaid coverage for women who are 12 months post-partum and the Assembly included Section 7 of Article 12 of 2022-H 7123, Substitute A, as amended, to extend full coverage to approximately 1,000 women. It also expanded full coverage to the population not eligible for Medicaid because of immigration status assuming about 500 participants would receive benefits.

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 adopted 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 who are in foster care or adopted through the Department of Children, Youth and Families.

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. Individuals are 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).

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

The second program available 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 making 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 must 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 recently produced Executive Office of Health and Human Services' Rhode Island Annual Medicaid Expenditure Report was submitted in December 2022 and includes Medicaid spending by population and cost per person for FY 2021 as shown in the following table.

FY 2021 Medicaid Annual Report					
Populations	**Persons**	**% of Population**	**Costs***	**% of Cost**	**Annual Cost/Person**
Children/Parents	167,757	51.5%	$ 656.5	22.7%	$ 3,504
Expansion	92,077	28.3%	$ 662.9	22.9%	$ 6,186
Elderly	22,000	6.8%	$ 567.7	19.6%	$ 29,124
Disabled - Children	12,498	3.8%	$ 224.1	7.7%	$ 14,052
Disabled - Adults	31,110	9.6%	$ 785.6	27.1%	$ 23,496
Total	**325,442**	**100%**	**$ 2,896.9**	**100%**	

**in millions*

The 2022 annual report includes Medicaid expenditures that total $3,238.9 million from federal and state funds on both direct benefits and administrative expenses. Of this total, $2,896.9 million, or 89 percent of the expenses, are for benefits for covered services for full enrollees. There is another $188.4 million, or seven percent of expenses, for partial enrollees, uncompensated care payments made to hospitals, payments to local education agencies, Medicare premium payments the state makes on behalf of eligible individuals, and costs not otherwise matchable expenses. The report also includes $153.6 million, or five percent of program costs, on administrative expenses. Of the total spent on Medicaid benefits, $1,102.9 million, or 38.1 percent, was spent on mandatory services for mandatory populations.

FY 2021 Medicaid Annual Report		All Funds	% of Total
Mandatory Populations	Mandatory Services	$ 1,102.9	38.1%
	Optional Services	$ 504.5	17.4%
	Subtotal - Mandatory Populations	**$ 1,607.4**	**55.5%**
Optional Populations	Mandatory Services	$ 902.7	31.2%
	Optional Services	$ 386.7	13.3%
	Subtotal - Optional Populations	**$ 1,289.4**	**44.5%**
Total Expenses		**$ 2,896.9**	**100%**

$ in millions

The requirements to submit the annual report are contained in Rhode Island General Law, Section 42-7.2-5 and, starting in 2020, the report must include: expenditures, including administrative expenses, 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 annual report, which is due by September 15, is also required to include expenditures by mandatory populations receiving mandatory services and, reported separately, optional services, as well as optional populations receiving mandatory services and, reported separately, optional services for each state agency receiving Medicaid funds.

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 and X-ray	Rehabilitation and other therapies
In/outpatient hospital services	Clinical Services
Early, Periodic, Screening Diagnostic and Treatment (EPSDT) Services	Dental, dentures, prosthetic devices and 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 and 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 and 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. These programs are described in the sections that follow.

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 $66,250) 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 $35,245). 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 Assembly added Section 7 of Article 13 of 2019-H 5151, Substitute A, as amended, to require 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 included in the medical assistance report after that. The objective was 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 May 2023 caseload testimony reported enrollment of about 2,700. The 2021 Assembly enacted a new reporting requirement for the Executive Office of Health and Human Services to report employer sponsored insurance plans that meet the cost effectiveness criteria for RIte Share, discussed in the next section.

RIte Share Outreach and Reporting. As previously 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 2,000 reported in November 2020. In response to a proposal from Governor Raimondo that would have implemented a new fee for large employers whose workers were on Medicaid, public testimony at the House Finance Committee hearing revealed that there were many instances where the employer was not aware that an employee was on RIte Care.

The Assembly adopted 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 identify 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.

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.

Governor Raimondo's FY 2021 recommended budget proposed a significant change to 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. 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 not comply at all or an employer who provides false information would be assessed a $5,000 penalty. The current public health emergency has affected employment and, with it, access to employer sponsored insurance. The Executive Office also noted during the November 2020 caseload conference that the delay in enacting the FY 2021 budget and the current pandemic would delay implementation and any savings from this proposal to FY 2022. The Assembly did not adopt this proposal.

Governor McKee recommended the same proposal for his FY 2022 budget, as Governor Raimondo did in her FY 2021 recommendation, to have 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. 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 not comply at all or an employer who provides false information would be assessed a $5,000 penalty. The recommended budget assumed savings of $2.7 million, including $0.7 million from general revenues, representing six months.

The 2021 Assembly did not concur with these changes but did include Section 5 of Article 12 of H-6122, Substitute A, as amended, to require the Executive Office of Health and Human Services to report employer sponsored insurance plans that meet the cost effectiveness criteria for RIte Share. Information in the report

is to be used for screening for Medicaid enrollment to encourage RIte Share participation. By October 1, 2021, the report must include any employers with 300 or more employees meeting the requirement. By January 1, 2022, the report must include employers with 100 or more employees. The most recent January report was to be submitted to the chairpersons of the house and senate finance committees as well as the house fiscal advisor, the senate fiscal advisor, and the state budget officer. That report was submitted mid-January and noted that as of the December 2022, there are 403 employers who have an average of 100-299 employees during calendar year 2022, of which 119 are participating. Additionally, of the 143 employers who have an average of 300 or more employees during calendar year 2022, only 68 are participating. The report does not contain required information on which specific employer sponsored health plans meet the cost effectiveness criteria; it only contains aggregated information.

RIte Share Cost Sharing Requirement. RIte Share recipients with annual incomes above 150 percent of federal poverty 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 contracts with Neighborhood Health Plan of Rhode Island to manage the acute care and long term care services for these individuals through its Integrity program.

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.

Telemedicine Services. The Centers for Medicare and Medicaid Services permit states broad flexibility to cover telehealth services through the Medicaid program such as telephonic, video technology commonly available on smart phones and other devices. As a result, a state does not need federal approval to reimburse providers for telehealth services in the same way or pay at the same rate that it pays for face-to-face services.

Governor Raimondo signed an Executive Order that allowed health care providers to be reimbursed by health insurers for telemedicine services during the public health emergency. For services delivered by in-network providers, the rates paid can be no lower than if the services had been delivered through traditional (in-person) methods. This action suspended the prohibition for this activity included in Rhode Island General Law, Section 27-81-4(b). The Assembly enacted 2021-H 6032, Substitute A, as amended, which was signed by the Governor on July 6, 2021, to require coverage for telemedicine services in certain circumstances for both commercial insurers and the Medicaid program at the same rates as face-to-face visits. The Office of the Health Insurance Commissioner promulgated the necessary rules and regulations.

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 to individuals with disabilities, court ordered psychiatric patients, and those with behavioral health issues. Prior to October 2022, the hospital was comprised of the Zambarano and Cranston campuses, which included the 52-bed Benton facility for forensic patients. On October 25, 2022, the state received approval to separately operate that facility, now known as the Rhode Island State Psychiatric Facility. Both are 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.

The need to separately license the Rhode Island State Psychiatric Facility was based on several issues at Eleanor Slater Hospital when it was determined that the state was not in compliance with billing practices that were required in order to claim Medicaid for services provided at the hospital that were disclosed over several months by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals and Office of Management and Budget, beginning in March 2020.

The first issue was that Rhode Island was not in compliance with the federal rule regarding Medicaid funding for facilities that have more psychiatric patients than medical ones, or what is considered an Institute of Mental Disease. It was revealed that state had not been out of compliance with the federal rule about the patient mix from August 2019 through February 2020. During this part of the process, other issues relating to the proper regulatory processes were revealed and rectified.

The second issue was the appropriateness of the state's practice of billing Medicaid for expenses incurred serving its forensic population. The state sought clarification from the Centers for Medicare and Medicaid Services which eventually issued guidance that Rhode Island could not bill Medicaid for the 50 forensic patients. A third billing issue was uncovered after a review of the remaining non-forensic patients and that it could not bill Medicaid, or Medicare, for an unidentified number of patients because their conditions did not warrant a hospital level of care. The Executive Office filed a Medicaid state plan amendment to formalize how the state can bill Medicaid for patients currently receiving services at the state hospital but are not in need of a hospital level of care and was granted federal authority in late March 2021.

During this time, Governor Raimondo requested an amendment on October 23, 2020 to provide $64.9 million, including $53.6 million from Rhode Island Capital Plan funds, to build a new nursing facility on the Zambarano campus but the Assembly did not include it in the FY 2021 budget. The Assembly also did not concur when Governor McKee submitted a similar proposal for a new building.

Governor McKee's FY 2022 recommended budget assumed the state would remain in compliance, as it was reported to be in December 2020, with the required ratio of medical to psychiatric patients to avoid designation as an Institute for Mental Disease (IMD) and the related disqualification from most Medicaid billings. On April 12, 2021, the Governor requested an amendment that added $5.3 million from Medicaid funds for FY 2021, which was later lowered based on new information that recent reviews of patient medical records resulted in changes to previously reported diagnoses that moved the facility back out of compliance on its patient mix, putting the Medicaid billing back in jeopardy. The loss of federal Medicaid and related funds impacted the FY 2020, FY 2021 and FY 2022 budgets.

Using FY 2019 as a baseline for allowable Medicaid funded expenses, the state had to use general revenues to replace approximately $62.0 million to $63.0 million annually over those three years for a total of approximately $190 million. There was also a loss of $15.0 million in Medicaid funds related to prior year billings that were pending resolution because of issues with the Unified Health Infrastructure Project, bringing the cumulative state costs related to this ongoing issue to over $200 million. This estimate excludes the loss of additional general revenue relief from an opportunity for enhanced Medicaid match that would have been available throughout the public health emergency. The FY 2021 audited closing showed the recapture of some of that prior year match and the Governor's FY 2022 revised budget increased the Medicaid yield for the smaller pool of billable patients as noted above. Combined, that was estimated to recapture roughly $40 million of the general revenue backfill.

For FY 2023, Governor McKee recommended two changes at the state hospital. First, he included $108.2 million from Rhode Island Capital Plan funds to construct a new 110-bed long-term care facility on the Zambarano campus to replace the Beazley building. Second, he separated the Benton facility for forensic patients into a stand-alone, entirely general revenue funded, psychiatric facility to address compliance and billing issues with Medicaid, and added five new administrative positions at the facility. Having the two distinct hospitals would allow the state to count only medical and civil psychiatric patients in the Eleanor

Slater Hospital patient mix. The hospital came back into compliance at its December 2022 review as expected and the FY 2023 final budget includes $26.0 million in Medicaid funds. The FY 2024 enacted budget includes a full year at $50.4 million.

Residential Services and Other Programs

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 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.

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.

Conflict-Free Case Management Services. Federal changes require that person-centered planning and conflict-free case management services be provided independently from the agency providing the direct service. This includes Medicaid beneficiaries who receive long term services and supports in a home or community-based setting. Currently, direct services are determined by community-based agencies through a case management process, which may result in those services being provided by the same agency. Individuals affected by this include the elderly and disabled in the Executive Office of Health and Human Services and the Department of Human Services' Office of Healthy Aging. Case management services provided through the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals' Division of Developmental Disabilities must also be conflict-free.

The Assembly included Section 7 of Article 9 of 2023-H 5200, Substitute A, as amended, to direct the Executive Office of Health and Human Services to establish a conflict-free case management system by January 1, 2024 for individuals receiving home and community-based services through the Medicaid program. This is required to come into compliance with federal regulations that require that person-centered planning and case management services be provided independently from the agency providing the direct service to avoid a conflict of interest.

The Budget includes $14.4 million, of which $6.5 million is from general revenues in the Executive Office's budget to cover the cost statewide for half a year. This is offset by savings of $0.3 million, including $0.1 million in the Office of Healthy Aging. The enacted budget also includes $1.7 million, of which $0.2 million is from general revenues, for the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals' portion of the Executive Office of Health and Human Services' Wellsky technology contract for case management services.

Certified Community Behavioral Health Clinics. The Assembly enacted Section 4 of Article 12 of 2022-H 7123, Substitute A, as amended, to authorize the Executive Office of Health and Human Services to submit a state Medicaid plan amendment to establish certified community behavioral health clinics in accordance with the federal model. The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals will define additional criteria for certification and services provided. The FY 2023 budget includes $30.0 million from State Fiscal Recovery funds to support the infrastructure needed to expand the number of clinics and assist with the rate reimbursement structure tied to the federal model. If approved, the new model will be established for FY 2024.

The article required that by August 1, 2022, the Executive Office use the appropriate purchasing process for any organizations that want to participate in the program. By October 1, 2022, the organizations must submit cost reports developed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals to the Executive Office. The reports must include the cost it would take to provide the required services. By December 1, 2022, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, in coordination with the Executive Office, must prepare an analysis of the proposals, determine how many organizations can be certified, and the cost for each one. Funding for the clinics was to be included in the Governor's FY 2024 recommended budget. Finally, the Executive Office must apply for the federal Certified Community Behavioral Health Clinics Demonstration Program if another round of funding becomes available.

Based on the Governor's recommendation, the Assembly included Section 8 of Article 9 of 2023-H 5200, Substitute A, as amended, to delay the implementation of the new model from July 1, 2023 to February 1, 2024. It repeals the current deadlines for organizations to submit their cost reports, and for the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals and the Executive Office of Health and Human Services to complete their analyses and determination of which clinics can be certified, and the cost for each one. The FY 2024 budget includes $1.7 million, of which $6.9 million is from general revenues, to cover the five months of costs consistent with the delayed start proposed. It appears these costs are subject to change when the required analyses are complete. Annualizing expenses for FY 2025 results in $52.1 million of program costs, including approximately $17 million from general revenues, subject to the Medicaid match rate. The Budget also adds $0.6 million, including $0.3 million from general revenues, for one new position and three contractors to support the initiative.

Certified Community Behavioral Health Clinics - Federal Model

Benchmark	Date	Action Completed	Section 8
Engage with the Division of Purchases to determine the appropriate process for organizations that want to participate	August 1, 2022	Yes	Retains the deadline
Organizations will submit cost reports developed by the Dept. of BHDDH to EOHHS that includes costs for required services	November 1, 2022	No	Repeals the deadlines
BHDDH, with EOHHS, will prepare an analysis of the proposals and determine how many organizations can be certified with the cost for each one	January 15, 2023	No	

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 private developmental disability organizations. The Governor's FY 2022 recommended budget assumed the closure of the state-run system and transfer of program recipients to the community-based one. The Assembly did not concur.

Services provided under the Medicaid Global Waiver are optional 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.

Medicaid funded services, provided through the waiver, for this eligible population include residential care, day programming and supportive services. The Assembly adopted Section 7 of 2018-H 7200, Substitute A, as amended, to update the Medicaid waiver to reflect its current practice for services to developmentally disabled adults. 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 they meet at least one defined exception*

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 an 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 the $954 monthly Supplemental Security Income check, which places them below the 135 percent of the federal poverty level required for the program.

Recent Changes. The Assembly included Section 10 of 2023-H 5200, Substitute A, as amended, for the Executive Office of Health and Human Services to seek federal approval to allow individuals with developmental disabilities who enter an acute care facility, such as a hospital, to still have access to their personal care attendants. That section also includes the necessary language to seek federal approval to allow parents and other relatives to be paid to provide services for individuals with developmental disabilities receiving services through the community-based system. This makes permanent the opportunity allowed during the pandemic for this payment, also referred to as Appendix K. The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals is required to report the number of participants and expenses in its monthly caseload report.

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 applies to those who meet the state's definition of an individual with a disability pursuant to the Rhode Island General Laws.

The populations addressed in the consent decree are individuals with intellectual and developmental disabilities who include: the Rhode Island Youth Transition Target Population who are transition-age youth attending Rhode Island secondary schools; the Rhode Island Exit Target Population who are transition age youth during the 2013-2014, 2014-2015, or 2015-2016 school years; the Rhode Island Sheltered Workshop Target Population who perform sheltered workshop tasks or have received day activity services in the previous year; and the Rhode Island Day Target Population who 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. The first court monitor, Charles Moseley, resigned in the fall of 2019 and was replaced by Dr. A. Anthony Antosh, who started December 1, 2019. Payment for the monitor and coordinator is in the Executive Office of Health and Human Services budget and totals $400,000 for FY 2023 and recommended for FY 2024. 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 conducts investigations and verifies data and documentation that is necessary to determine if the state is in compliance with the consent decree.

The state complied with the consent decree by establishing and distributing funds from an $800,000 Workshop Conversion Trust Fund, which was to be administered by the Paul V. Sherlock Center on Disabilities at Rhode Island College. The fund supported start-up costs for agencies who converted 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. There were nine agencies that took part in this opportunity.

The state also created an employment first task force that included 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 must ensure available funding for services and 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."

Starting in February 2020, Judge John J. McConnell issued a series of court orders that included Dr. Antosh conducting a comprehensive review of the current status of the consent decree. The court monitor established five working groups that were assigned specific issues to address. Dr. Antosh filed his report with the court on November 30, 2020 and Judge McConnell issued a court order on January 6, 2021 for the state to develop a three-year budget addressing the issues in the analysis.

Judge McConnell issued a subsequent court order on March 16, clarifying the January 6 court order, instructing the state to continue to develop a negotiated three-year budget strategy that will support the requirements of the consent decree. The plan will include addressing the problem of low compensation and turnover that prevent the ability to maintain a stable and competitive workforce. It should also include transitioning to a community-based model, aligning funding and reimbursements to the provider and aligning with federal standards for Medicaid eligible services. It also includes finding ways to develop individualized plans and budgets to promote access to employment and other integrated activities, providing adequate transportation and funding for technology purchases. The court order also establishes consistent data collection and reporting requirements to facilitate proper forecasting of program costs.

The order indicates that final budget plans may take a different approach to bring the state into compliance with the consent decree. The state had to report the progress being made on April 30, May 31 and June 30, 2021. There was an initial status hearing on April 27, 2021, where it was reported that the state met with providers and discussed a minimum rate reimbursement of $15 an hour for direct support professionals.

The Governor also proposed legislation in Sections 5 and 6 of Article 3 of 2021-H 6122 to add expenses for the community-based system for adults with developmental disabilities to the semi-annual medical assistance and public assistance caseload conference, effective on July 1, 2022. The Assembly included Sections 6 and 8 of Article 3 of 2021-H 6122, Substitute A, as amended, to make the change and added that the Executive Office of Health and Human Services provide direct assistance to the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals to facilitate compliance with reporting requirements and preparation for the caseload conferences. The November 2021 Caseload Estimating Conference was the first one that included the Department.

On October 15, 2021, the court accepted the state's "Action Plan" to address compliance with the consent decree that included increases in the reimbursement rates for direct support professionals to an average of $20 an hour. The following table shows the items and status.

Action Plan	Description	Status
Rate Review	Completed by 12/2022 & recommended changes in the FY 2024 recommended budget	Review Done & Funded in FY 2024
DSP Wages	FY 2023: $18/hour FY 2024: $20/hour – Both years: Overnight & supervisor wages will increase proportionally	Funded in FY 2023 and FY 2024
Transformation Fund	$12.0 million to be used for integrated day activities and supported employment services	Funded
Technology	$2.0 million for individuals for technology purchases (example, iPads)	

Coronavirus Impact. The public health emergency limited the ability of the agencies to provide community-based services to individuals outside of their residences. Individuals living either in a 24-hour group home, shared living, or an apartment or home with family, have stayed home. This meant that the providers could not be reimbursed for day activities. The state took several actions to address the effect on providers. For FY 2020, the Department provided a temporary ten percent rate increase totaling $3.0 million and retainer

payments totaling $15.6 million. The FY 2021 budget included $13.0 million for one-time payments to 40 agencies to be passed through to direct support staff who make less than $20 an hour and to supplement the response to the public health emergency by addressing any business interruptions, including loss of revenue.

Human Service Agencies

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 as Enacted FY 2024.* 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				
Disabled and adults, without dependent children	X				
Residential and Other Services					
Nursing and hospice services	X				
Assisted living; home & community based services to the elderly	X	X			
Foster care and group home placements				X	
Community based services - developmentally disabled			X		
Mental health and substance abuse treatment services	X			X	
Eleanor Slater Hospital			X		
HIV surveillance and treatment services	X				X

Medical benefits are those primarily provided through the three managed care plans, Neighborhood Health Plan of Rhode Island, UnitedHealthcare and Tufts Health Plan. Benefits include: doctor's office visits, prescriptions, lab tests, hospital and emergency care, drug and alcohol treatment, mental health services and referrals to specialists, which are funded through the Executive Office of Health and Human Services. The plans also pay for short term and long term residential treatment services for those with behavioral health issues and/or substance use disorders.

Residential and other community-based services are those provided outside medical benefits through the departments budgets.