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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2026

A N A C T

RELATING TO HUMAN SERVICES -- MEDICAL ASSISTANCE--LONG-TERM CARE SERVICE AND FINANCE REFORM

Introduced By: Senators McKenney, Bissaillon, Urso, Tikoian, and Britto

Date Introduced: January 30, 2026

Referred To: Senate Finance

It is enacted by the General Assembly as follows:

SECTION 1. Section 40-8.9-9 of the General Laws in Chapter 40-8.9 entitled "Medical Assistance — Long-Term Care Service and Finance Reform" is hereby amended to read as follows:

40-8.9-9. Long-term-care rebalancing system reform goal.

(a) Notwithstanding any other provision of state law, the executive office of health and human services is authorized and directed to apply for, and obtain, any necessary waiver(s), waiver amendment(s), and/or state-plan amendments from the Secretary of the United States Department of Health and Human Services, and to promulgate rules necessary to adopt an affirmative plan of program design and implementation that addresses the goal of allocating a minimum of fifty percent (50%) of Medicaid long-term-care funding for persons aged sixty-five (65) and over and adults with disabilities, in addition to services for persons with developmental disabilities, to home- and community-based care; provided, further, the executive office shall report annually as part of its budget submission, the percentage distribution between institutional care and home- and community-based care by population and shall report current and projected waiting lists for long-term-care and home- and community-based care services. The executive office is further authorized and directed to prioritize investments in home- and community-based care and to maintain the integrity and financial viability of all current long-term-care services while pursuing this goal.

(b) The reformed long-term-care system rebalancing goal is person-centered and encourages individual self-determination, family involvement, interagency collaboration, and

individual choice through the provision of highly specialized and individually tailored home-based services. Additionally, individuals with severe behavioral, physical, or developmental disabilities must have the opportunity to live safe and healthful lives through access to a wide range of supportive services in an array of community-based settings, regardless of the complexity of their medical condition, the severity of their disability, or the challenges of their behavior. Delivery of services and supports in less-costly and less-restrictive community settings will enable children, adolescents, and adults to be able to curtail, delay, or avoid lengthy stays in long-term-care institutions, such as behavioral health residential-treatment facilities, long-term-care hospitals, intermediate-care facilities, and/or skilled nursing facilities.

(c) Pursuant to federal authority procured under § 42-7.2-16, the executive office of health and human services is directed and authorized to adopt a tiered set of criteria to be used to determine eligibility for services. The criteria shall be developed in collaboration with the state's health and human services departments and, to the extent feasible, any consumer group, advisory board, or other entity designated for these purposes, and shall encompass eligibility determinations for long-term-care services in nursing facilities, hospitals, and intermediate-care facilities for persons with intellectual disabilities, as well as home- and community-based alternatives, and shall provide a common standard of income eligibility for both institutional and home- and community-based care. The executive office is authorized to adopt clinical and/or functional criteria for admission to a nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities that are more stringent than those employed for access to home- and community-based services. The executive office is also authorized to promulgate rules that define the frequency of re-assessments for services provided for under this section. Levels of care may be applied in accordance with the following:

(1) The executive office shall continue to apply the level-of-care criteria in effect on April 1, 2021, for any recipient determined eligible for and receiving Medicaid-funded long-term services and supports in a nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities on or before that date, unless:

(i) The recipient transitions to home- and community-based services because he or she would no longer meet the level-of-care criteria in effect on April 1, 2021; or

(ii) The recipient chooses home- and community-based services over the nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities. For the purposes of this section, a failed community placement, as defined in regulations promulgated by the executive office, shall be considered a condition of clinical eligibility for the highest level of care. The executive office shall confer with the long-term-care ombudsperson with respect to the

determination of a failed placement under the ombudsperson's jurisdiction. Should any Medicaid recipient eligible for a nursing facility, hospital, or intermediate-care facility for persons with intellectual disabilities as of April 1, 2021, receive a determination of a failed community placement, the recipient shall have access to the highest level of care; furthermore, a recipient who has experienced a failed community placement shall be transitioned back into their former nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities whenever possible. Additionally, residents shall only be moved from a nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities in a manner consistent with applicable state and federal laws.

(2) Any Medicaid recipient eligible for the highest level of care who voluntarily leaves a nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities shall not be subject to any wait list for home- and community-based services.

(3) No nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities shall be denied payment for services rendered to a Medicaid recipient on the grounds that the recipient does not meet level-of-care criteria unless and until the executive office has:

(i) Performed an individual assessment of the recipient at issue and provided written notice to the nursing home, hospital, or intermediate-care facility for persons with intellectual disabilities that the recipient does not meet level-of-care criteria; and

(ii) The recipient has either appealed that level-of-care determination and been unsuccessful, or any appeal period available to the recipient regarding that level-of-care determination has expired.

(d) The executive office is further authorized to consolidate all home- and community-based services currently provided pursuant to 42 U.S.C. § 1396n into a single system of home- and community-based services that include options for consumer direction and shared living. The resulting single home- and community-based services system shall replace and supersede all 42 U.S.C. § 1396n programs when fully implemented. Notwithstanding the foregoing, the resulting single program home- and community-based services system shall include the continued funding of assisted-living services at any assisted-living facility financed by the Rhode Island housing and mortgage finance corporation prior to January 1, 2006, and shall be in accordance with chapter 66.8 of title 42 as long as assisted-living services are a covered Medicaid benefit.

(e) The executive office is authorized to promulgate rules that permit certain optional services including, but not limited to, homemaker services, home modifications, respite, and physical therapy evaluations to be offered to persons at risk for Medicaid-funded long-term care subject to availability of state-appropriated funding for these purposes.

(f) To promote the expansion of home- and community-based service capacity, the executive office is authorized to pursue payment methodology reforms that increase access to homemaker, personal care (home health aide), assisted living, adult supportive-care homes, and adult day services, as follows:

(1) Development of revised or new Medicaid certification standards that increase access to service specialization and scheduling accommodations by using payment strategies designed to achieve specific quality and health outcomes.

(2) Development of Medicaid certification standards for state-authorized providers of adult day services, excluding providers of services authorized under § 40.1-24-1(3), assisted living, and adult supportive care (as defined under chapter 17.24 of title 23) that establish for each, an acuity-based, tiered service and payment methodology tied to: licensure authority; level of beneficiary needs; the scope of services and supports provided; and specific quality and outcome measures.

The standards for adult day services for persons eligible for Medicaid-funded long-term services may differ from those who do not meet the clinical/functional criteria set forth in § 40-8.10-3.

(3) As the state's Medicaid program seeks to assist more beneficiaries requiring long-term services and supports in home- and community-based settings, the demand for home-care workers has increased, and wages for these workers has not kept pace with neighboring states, leading to high turnover and vacancy rates in the state's home-care industry, the executive office shall institute a one-time increase in the base-payment rates for FY 2019, as described below, for home-care service providers to promote increased access to and an adequate supply of highly trained home-healthcare professionals, in amount to be determined by the appropriations process, for the purpose of raising wages for personal care attendants and home health aides to be implemented by such providers.

(i) A prospective base adjustment, effective not later than July 1, 2018, of ten percent (10%) of the current base rate for home-care providers, home nursing care providers, and hospice providers contracted with the executive office of health and human services and its subordinate agencies to deliver Medicaid fee-for-service personal care attendant services.

(ii) A prospective base adjustment, effective not later than July 1, 2018, of twenty percent (20%) of the current base rate for home-care providers, home nursing care providers, and hospice providers contracted with the executive office of health and human services and its subordinate agencies to deliver Medicaid fee-for-service skilled nursing and therapeutic services and hospice care.

(iii) Effective upon passage of this section, hospice provider reimbursement, exclusively

for room and board expenses for individuals residing in a skilled nursing facility, shall revert to the rate methodology in effect on June 30, 2018, and these room and board expenses shall be exempted from any and all annual rate increases to hospice providers as provided for in this section.

(iv) On the first of July in each year, beginning on July 1, 2019, the executive office of health and human services will initiate an annual inflation increase to the base rate for home-care providers, home nursing care providers, and hospice providers contracted with the executive office and its subordinate agencies to deliver Medicaid fee-for-service personal care attendant services, skilled nursing and therapeutic services and hospice care. The base rate increase shall be a percentage amount equal to the New England Consumer Price Index card as determined by the United States Department of Labor for medical care and for compliance with all federal and state laws, regulations, and rules, and all national accreditation program requirements, except as of July 1, 2025, and thereafter, when no annual inflation increase shall occur for these rates.

(v) On the first of July following the release of a rate review report conducted by the office of the health insurance commissioner in accordance with § 42-14.5-3(t), the executive office of health and human services shall adopt the rate percentage increase applicable to the services of this subsection within the health insurance commissioner's report in accordance with § 42-14.5-3(t). All Medicaid programs operated by the executive office of health and human services, its subordinate agencies, contractors and all commercial lines within health insurance companies that are contracted with the Medicaid Program shall not reimburse home care providers, home nursing care providers and hospice providers less than fee-for-service rates.

(g) As the state's Medicaid program seeks to assist more beneficiaries requiring long-term services and supports in home- and community-based settings, the demand for home-care workers has increased, and wages for these workers has not kept pace with neighboring states, leading to high turnover and vacancy rates in the state's home-care industry. To promote increased access to and an adequate supply of direct-care workers, the executive office shall institute a payment methodology change, in Medicaid fee-for-service and managed care, for FY 2022, that shall be passed through directly to the direct-care workers' wages who are employed by home nursing care and home-care providers licensed by the Rhode Island department of health, as described below:

(1) Effective July 1, ~~2021~~2026, increase the existing shift differential modifier and overtime rate by ~~$0.19~~ one and one-half (1.5) times the base rate per fifteen (15) minutes ~~for personal care and combined personal care/homemaker~~ and two (2) times the base rate per fifteen (15) minutes for personal care, combined personal care/homemaker and private duty nursing for overnight, weekends and shifts during federal and state recognized holidays. The shift differential modifier, overtime rate, overnight rate, weekend rates and holiday rates will be reviewed within

the rate review report in accordance with § 42-14.5-3(t) in order to be competitive with rates set in Massachusetts and Connecticut.

~~(i) Employers must pass on one hundred percent (100%) of the shift differential modifier increase per fifteen minute (15) unit of service to the CNAs who rendered such services. This compensation shall be provided in addition to the rate of compensation that the employee was receiving as of June 30, 2021. For an employee hired after June 30, 2021, the agency shall use not less than the lowest compensation paid to an employee of similar functions and duties as of June 30, 2021, as the base compensation to which the increase is applied.~~

~~(ii) Employers must provide to EOHHS an annual compliance statement showing wages as of June 30, 2021, amounts received from the increases outlined herein, and compliance with this section by July 1, 2022. EOHHS may adopt any additional necessary regulations and processes to oversee this subsection.~~

(2) Effective January 1, 2022, establish a new behavioral healthcare enhancement of $0.39 per fifteen (15) minutes for personal care, combined personal care/homemaker, and homemaker only for providers who ~~have at least thirty percent (30%) of~~ are actively participating at least once annually in behavioral health training by their direct-care workers (which includes licensed certified nursing assistants (CNA) and homemakers) ~~certified~~ becoming and maintaining certification in behavioral healthcare training. This rate enhancement is subject to the annual cost inflation factor increase in accordance with § 40-8.9-9(f)(3)(iv).

(i) Employers must pass on one hundred percent (100%) of the behavioral healthcare enhancement per fifteen (15) minute unit of service rendered by only those CNAs and homemakers who have completed the thirty (30) hour behavioral health certificate training program offered by Rhode Island College, or a training program that is prospectively determined to be compliant per EOHHS, to those CNAs and homemakers. This compensation shall be provided in addition to the rate of compensation that the employee was receiving as of December 31, 2021. For an employee hired after December 31, 2021, the agency shall use not less than the lowest compensation paid to an employee of similar functions and duties as of December 31, 2021, as the base compensation to which the increase is applied. Rate funding for compensation for the employee will continue should the program expire.

(ii) By January 1, 2023, employers must provide to EOHHS an annual compliance statement showing wages as of December 31, 2021, amounts received from the increases outlined herein, and compliance with this section, including which behavioral healthcare training programs were utilized. EOHHS may adopt any additional necessary regulations and processes to oversee this subsection.

(3) By July 1, 2026, comply with 29 C.F.R. § 785 by reimbursing providers for all time and travel costs attributed to a direct care employee providing care to and from a Medicaid beneficiary.

(4) By July 1, 2026, establish a ten percent (10%) enhancement rate for providers to send a direct care employee to a Medicaid beneficiary that resides in a community that has a population density of under one thousand (1,000) and a population size of under twenty-five thousand (25,000) in accordance with federal Rural Health Transformation ("RHT"), Pub. L. 119-21, § 71401(2025) funding and the Rhode Island department of health's office of rural health.

(h) The executive office shall implement a long-term-care-options counseling program to provide individuals, or their representatives, or both, with long-term-care consultations that shall include, at a minimum, information about: long-term-care options, sources, and methods of both public and private payment for long-term-care services and an assessment of an individual's functional capabilities and opportunities for maximizing independence. Each individual admitted to, or seeking admission to, a long-term-care facility, regardless of the payment source, shall be informed by the facility of the availability of the long-term-care-options counseling program and shall be provided with long-term-care-options consultation if they so request. Each individual who applies for Medicaid long-term-care services shall be provided with a long-term-care consultation.

(i) The executive office shall implement, no later than January 1, 2024, a statewide network and rate methodology for conflict-free case management for individuals receiving Medicaid-funded home and community-based services. The executive office shall coordinate implementation with the state's health and human services departments and divisions authorized to deliver Medicaid-funded home and community-based service programs, including the department of behavioral healthcare, developmental disabilities and hospitals; the department of human services; and the office of healthy aging. It is in the best interest of the Rhode Islanders eligible to receive Medicaid home and community-based services under this chapter, title 40.1, title 42, or any other general laws to provide equitable access to conflict-free case management that shall include person-centered planning, service arranging, and quality monitoring in the amount, duration, and scope required by federal law and regulations. It is necessary to ensure that there is a robust network of qualified conflict-free case management entities with the capacity to serve all participants on a statewide basis and in a manner that promotes choice, self-reliance, and community integration. The executive office, as the designated single state Medicaid authority and agency responsible for coordinating policy and planning for health and human services under § 42-7.2-1 et seq., is directed to establish a statewide conflict-free case management network under the management of the executive office and to seek any Medicaid waivers, state plan amendments, and changes in rules,

regulations, and procedures that may be necessary to ensure that recipients of Medicaid home and community-based services have access to conflict-free case management in a timely manner and in accordance with the federal requirements that must be met to preserve financial participation.

(j) The executive office is also authorized, subject to availability of appropriation of funding, and federal, Medicaid-matching funds, to pay for certain services and supports necessary to transition or divert beneficiaries from institutional or restrictive settings and optimize their health and safety when receiving care in a home or the community. The secretary is authorized to obtain any state plan or waiver authorities required to maximize the federal funds available to support expanded access to home- and community-transition and stabilization services; provided, however, payments shall not exceed an annual or per-person amount.

(k) To ensure persons with long-term-care needs who remain living at home have adequate resources to deal with housing maintenance and unanticipated housing-related costs, the secretary is authorized to develop higher resource eligibility limits for persons or obtain any state plan or waiver authorities necessary to change the financial eligibility criteria for long-term services and supports to enable beneficiaries receiving home and community waiver services to have the resources to continue living in their own homes or rental units or other home-based settings.

(*l*) The executive office shall implement, no later than January 1, 2016, the following home- and community-based service and payment reforms:

(1) [Deleted by P.L. 2021, ch. 162, art. 12, § 6.]

(2) Adult day services level of need criteria and acuity-based, tiered-payment methodology; and

(3) Payment reforms that encourage home- and community-based providers to provide the specialized services and accommodations beneficiaries need to avoid or delay institutional care.

(m) The secretary is authorized to seek any Medicaid section 1115 waiver or state-plan amendments and take any administrative actions necessary to ensure timely adoption of any new or amended rules, regulations, policies, or procedures and any system enhancements or changes, for which appropriations have been authorized, that are necessary to facilitate implementation of the requirements of this section by the dates established. The secretary shall reserve the discretion to exercise the authority established under §§ 42-7.2-5(6)(v) and 42-7.2-6.1, in consultation with the governor, to meet the legislative directives established herein.

SECTION 2. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO HUMAN SERVICES -- MEDICAL ASSISTANCE--LONG-TERM CARE SERVICE AND FINANCE REFORM

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This act would establish Medicaid fee-for-service reimbursement rates set by the general assembly as the rate floor for Medicaid managed care by home care, home nursing care and hospice providers licensed by the department of health, establish rate modifiers to incentivize direct care workers to provide care during evenings, nights, Sundays and holidays as well as hard-to-serve Medicaid beneficiaries that reside in department of health defined low density population communities, comply with federal department of labor rules on time and travel for direct care workers, and adopt the rate review recommendations from the office of the health insurance commissioner for home care, home nursing care and hospice providers.

This act reduces administrative burden on Medicaid-contracted home care providers and the Executive Office of Health and Human Services by eliminating a statutory reporting requirement that is no longer relevant to current and future Medicaid home care reimbursement rates.

This act would also permit the Rhode Island Partnership for Home Care, with oversight by the Executive Office of Health and Human Services, to coordinate behavioral health training to licensed nurse assistants and homemakers delivering paraprofessional care services to Medicaid home care beneficiaries

This act would take effect upon passage.

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