Table of Contents

State/Territory Name: RI

State Plan Amendment (SPA) #: 22-0015

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

December 7, 2022

Ana Novais, Acting Secretary
Executive Office of Health and Human Services
State of Rhode Island
3 West Road, Virks Building
Cranston, RI 02920

RE: TN 22-0015

Dear Ms. Novais,

We have reviewed the proposed Rhode Island State Plan Amendment (SPA) to Attachment 4.19-B, RI-22-0015, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 22, 2022 to increase home health rates and technical correction to recognize ACHC accrediation.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1, 2022. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

As described in the state's letter to CMS dated April 29, 2022 regarding its Hospital Licensing Fee (HLF) and in CMS's response letter dated May 19, 2022, please note that CMS's approval of this State Plan Amendment (SPA) whose non-federal share source may include the HLF relates only to the requested change in payment methodology, not the source of non-federal share. Approval of this SPA does not relieve the state of its responsibility to comply with federal laws and regulations, and to ensure that claims for federal financial participation are consistent with all applicable requirements.

If you have any additional questions or need further assistance, please contact Lindsay Michael at 410-786-7197 or Lindsay.Michael@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0015

2. STATE: RI

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.70

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 1,863,953
b. FFY 2023 $ 7,562,058

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19B, Page 2a
Attachment 4.19B, Page 2b
Attachment 4.19B, Page 2c
Attachment 4.19B, Page 2d
Attachment 4.19B, Page 2e

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19B, Page 2a
Attachment 4.19B, Page 2b
Attachment 4.19B, Page 2c
Attachment 4.19B, Page 2d
Attachment 4.19B, Page 2e

9. SUBJECT OF AMENDMENT

Home Health rate increase and technical correction to recognize ACHC accreditation.

10. GOVERNOR'S REVIEW *(Check One)*

( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Ana Novais

13. TITLE
Acting Secretary

14. DATE SUBMITTED
September 22, 2022

15. RETURN TO
EOHHS
3 West Rd. Virks Building
Cranston, RI 02920

FOR CMS USE ONLY

16. DATE RECEIVED
September 22, 2022

17. DATE APPROVED
December 7, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, DRR

22. REMARKS

Instructions on Back

(2) Early, periodic, screening, diagnosis, and treatment of individuals under 21 years of age: on the basis of a negotiated fee schedule.

(3) Family planning services, drugs and supplies for individuals of child-bearing age when such services are under the supervision of a physician, as determined according to the elements inherent in the family planning service or the drugs and contraceptive devices necessary: on the basis of a negotiated physician fee schedule and the pharmacy fee schedule.

e. Physicians' services: on the basis of a negotiated fee schedule

f. Medical care of any other type of remedial care recognized under State law furnished by licensed practitioners within the scope of their practice as defined by law limited to:

(1) Podiatry services: on the basis of a negotiated fee schedule.
(2) Optometry services: on the basis of a negotiated fee schedule.

g. Home Health Services: In order for EOHHS to calculate the applicable Home Health base rate, each provider must submit a completed General Application for Enhanced Home Health Reimbursement to EOHHS. Base rates, which are defined as the minimum reimbursement rate plus any additional enhancements that the provider qualifies for, are available on the fee schedule, updated as of July 1, 2022, and available at https://eohhs.ri.gov/providers-partners/fee-schedules.

Effective November 1, 2021 through March 31, 2022, the State will provide a temporary rate increase for the services below to improve access to care through direct care workforce recruitment and retention initiatives. Additional funding provided through rate increases shall be used to increase compensation (direct pay and benefits) to direct care workforce through March 31, 2023. Providers will attend a training, sign attestation forms agreeing to this use of funds, and submit quarterly reports on their use of these funds to the State Medicaid office for the duration of the funding period.

Provider Type	Code	Description of Code	Allowed Amount 10/31/2021	Amount Increase above 10/31/2021 Rate	Total Allowed Amount 11/1/2021
Skilled Nursing Homecare Providers	G0156	Services of Home Health or Hospice Settings per 15 minutes increments	$7.36	$5.74	$13.10
	X0043	Home Health and Nursing and Therapy Visits	$111.83	$87.23	$199.06
Severely Disabled Nursing Homecare Provider	S5125 Minimum Reimbursement Rate	Attendant Care Services per 15- minute increments	$5.62	$6.01	$11.63
	T1000	Private Duty Independent Nursing Services per 15 minute increments	$14.01	$9.11	$23.12
Home Care Agencies (Personal Care Aide/Assistant Provider)	S5125 Minimum Reimbursement Rate	Attendant Care Services per 15-minute increments	$5.81	$8.83	$14.64
	S5130 minimum Reimbursement Rate	Homemaker Service per 15-minute increments	$5.44	$6.80	$12.24
	T1001	Nursing Assessment/Evaluation	$101.37	$111.51	$212.88

Effective April 1, 2022, this temporary rate increase will end and the rates will return to those listed in the fee schedule effective July 1, 2021 through June 30, 2022, available at https://eohhs ri.gov/providers-partners/fee schedules

Effective July 1, 2019, and each July 1 thereafter, the base rates for personal care attendant services and skilled nursing and therapeutic services, provided by home care providers and home nursing care providers, will be increased by the New England Consumer Price Index card as determined by the United States Department of Labor for medical care data that is released in March, containing the February data.

Home Health Base Rate methodology: Minimum reimbursement rates will be adjusted based on the following qualifications:

1. Staff Education and Training
   - Enhanced Reimbursement per 15-minutes for all Personal Care and Combination Personal Care/Homemaker services provided by a qualified agency.
   - Qualifications: The qualified agency must offer in-services at a frequency at least 20% over the RI Department of Health's licensure requirement. This means that at least fourteen (14) one-hour in-services will be required in a year.
   - How to Receive Enhancement: A plan of scheduled in-service topics, dates, times and instructors should be submitted to EOHHS for the six month period following initial application for this enhancement. To continue receiving the enhanced base rate beyond the initial six-month period, the agency must submit for each in-service the title, training objectives, number of CNAs on the payroll on the date of the in-service, and a copy of the in-service sign-in sheet. Submissions should be for at least seven (7) in-services over a six-month period.
2. National Accreditation or State Agency Accreditation

   National:
   - Enhanced Reimbursement per 15-minutes of Personal Care and Combination Personal Care/Homemaker services provided by a qualified agency.
   - Qualifications: An agency with current National Accreditation is entitled to this enhancement.
     - Community Health Accreditation Program (CHAP) or
     - Council on Accreditation (COA) or
     - Joint Commission for Accreditation of Healthcare Facilities (JCAHO) or
     - Accreditation Commission for Health Care (ACHC)
   - How to Receive Enhancements: Submit current CHAP, COA, JCAHO, or ACHC Accreditation certificate, and copy of the most recent survey results. Submit new certificate(s) and survey results as they are completed to continue payment of the enhanced base rate.

   Note: Agencies can either receive State Accreditation or National Accreditation, not both.

   State:
   - Enhanced Reimbursement per 15-minutes of Personal Care and Combination Personal Care/Homemaker services provided by a qualified agency. The goal of this standard is to encourage home health agencies to development and implement initiatives that result in high valve, client-oriented, effective care and services.
   - Qualifications: Available to home health agencies with State accreditation.
   - How to Receive Enhancement: Submit application for an on-site review and successfully meet Accreditation Standards. In addition, at the request of the home health agency, EOHHS will review evidence provided that demonstrates exceeding Department of Health Regulations. Evidence may be demonstrated through policy, procedures, client records, personnel records, meeting minutes, strategic plans, etc. Emphasis will be placed on how the evidence is linked between the different sources i.e. policy/procedure compliance noted in record documentation.
3. Client Satisfaction, Continuity of Care, and Worker Satisfaction

- Enhanced Reimbursement per 15-minutes of Personal Care and Combination Personal Care and Homemaker Services for each of these three areas (client satisfaction, continuity of care, and worker satisfaction) based on former enhanced standards.
- Qualifications: Maintain compliance with applicable standards. If found out of compliance during random site visits, providers may lose the enhancement for the area out of compliance or be asked to submit a corrective action plan.

4. Behavioral Healthcare Training
   - Effective January 1, 2022, Enhanced Reimbursement per 15-minutes for all Personal Care, Combination Personal Care/Homemaker services, and Homemaker only services provided by a qualified agency.
   - Qualifications: The qualified agency must have at least thirty percent (30%) of their direct care workers (which include Certified Nursing Assistants (CNA) and Homemakers) certified in behavioral healthcare training.
   - How to Receive Enhancement: No later than December 15, 2021 each agency must submit to EOHHS the names of all Nursing Assistants and Homemakers employed by the agency as of November 30, 2021 and shall indicate those Nursing Assistant and Homemakers who have obtained a Behavioral Health certificate from Rhode Island College or other EOHHS-approved training provider. Documentation of employees' Behavioral Health certification shall be provided to EOHHS upon request. Beginning in calendar year 2022 and annually thereafter, the agency must submit to EOHHS, no later than June 1st, the names of all Nursing Assistants and Homemakers employed by the agency as of May 15th of that corresponding calendar year and shall indicate those Nursing Assistant and Homemakers who have obtained a Behavioral Health certificate from Rhode Island College or other EOHHS-approved training provider. Documentation of employees' Behavioral Health certification shall be provided to EOHHS upon request.

If providers are providing care outside of regular business hours or are providing care to individuals with higher acuity, providers may receive an additional two (2) add-ons, if they bill using modifiers. These add-ons are in addition to the base rates defined above.

1. Shift Differential:
   - Reimbursement: Effective July 1, 2021 $0.56 per 15-minutes of Personal Care and Personal Care/Homemaker Combination services provided during qualified times.
   - Qualifications: Only services provided between 3:00PM and 7:00AM on weekdays, or services on weekends or State holidays qualify for this enhanced reimbursement.
   - How to Receive Reimbursement: Submit claims in the correct amount (Base Amount plus any other enhancements plus shift differential enhancement) to DXC with modifiers.
2. High acuity patients:
   - Reimbursement: $0.25 per 15-minutes of Personal Care and Combination Personal Care and Homemaker Service provided to a client assessed as being high acuity by the agency Registered Nurse based on sections of the Minimum Data Set (MDS) for Home Care.
   - Qualifications: A client is considered high acuity if they receive a following minimum score by an agency Registered Nurse in one area:
     - "5" on Section B, Items 1, 2, and 3, OR
     - "16" on Section E, Item 1, OR
     - "8" on Section E, Items 2 and 3, OR
     - "36" on Section H, Items 1, 2, and 3Or, if they receive the following minimum scores in two or more areas

- "3" on Section B, Items 1, 2, and 3
- "8" on Section E, Item 1
- "4" on Section E, Item 2 and 3
- "18" on Section H, Items 1, 2, and 3

- How to Receive Reimbursement: Submit the adapted MDS on all Medical Assistance clients directly to DXC. All MDS forms must be signed by an R.N., dated, and totaled for each section. Claims submitted for clients meeting the acuity standard should be billed at the correct amount with a modifier.

Note: Some claims may have two modifiers if the client meets the high acuity determination and the service is provided evenings, nights, weekends or holidays.

h. Dental services: on the basis of a negotiated fee schedule.

i. Prescribed drugs, dentures, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by the optometrist, whichever the individual may select.

(1) Outpatient and Specialty Drugs Dispensing Fee and Ingredient Cost

a. Payment for covered outpatient and specialty drugs dispensed to beneficiaries residing in the community includes the drug's ingredient cost plus an $8.96 professional dispensing fee. For drugs reimbursed at the providers' usual and customary charge to the public, there will be no professional dispensing fee added.

b. Payment for outpatient and specialty drugs dispensed to beneficiaries residing in an institutional long-term care facility will include the drug ingredient cost plus a $7.90 professional dispensing fee. For drugs reimbursed as the providers' usual and customary charge to the public, there will be no professional dispensing fee added.

c. The drug ingredient cost reimbursement shall be the lowest of:

i. The National Average Drug Acquisition Cost (NADAC); or
ii. Wholesale Acquisition Cost (WAC) + 0%; or
iii. The Federal Upper Limit (FUL); or
iv. The State Maximum Allowed Cost (SMAC); or
v. First Data Bank Consolidated Price 2 (SWD) – 19%; or
vi. Submitted price; or
vii. The providers' usual and customary (U & C) charge to the public, as identified by the claim charge.

(2) Clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence.

a. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence will include the drug ingredient cost plus $8.96 professional dispensing fee. For drugs reimbursed at the providers' usual and customary charge to the public, there will be no professional dispensing fee included.

b. The drug ingredient cost reimbursement shall be the lowest of:

i. The National Average Drug Acquisition Cost (NADAC); or
ii. Wholesale Acquisition Cost (WAC) + 0%; or
iii. The State Maximum Allowed Cost (SMAC); or
iv. First Data Bank Consolidated Price 2 (SWD) – 19%; or
v. Submitted price; or
vi. The providers' usual and customary (U & C) charge to the public as identified by the claim charge.

(3) 340 B Covered Entities

340B covered entities that fill Medicaid beneficiaries' prescriptions with drugs purchased at the prices authorized under Section 340B of the Public Health Services Act will be reimbursed at the actual acquisition cost for the drug plus a $8.96 professional dispensing fee. Drugs acquired by a covered entity under the 340B program and dispensed by the covered entity's contract pharmacy are not reimbursed.

Facilities purchasing drugs through the Federal Supply Schedule (FSS) or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program will be reimbursed no more than the actual acquisition cost for the drug plus $8.96 professional dispensing fee.

(4) Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) will be reimbursed no more than the actual acquisition cost (as defined in §447.502) for the drug plus a $8.96 professional dispensing fee. Nominal Price as defined in §447.502 of the Code of Federal Regulations, Part 42 means a price that is less than 10 percent of the average manufacturer price (AMP) in the same quarter for which the AMP is computed

(5) Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at 106% of the Average Sales Price (ASP). PADs without an ASP on the CMS reference file will be reimbursed at the provider's acquisition cost. Covered entities using drugs purchased at the prices authorized under Section 340B of the Public Health Services Act for Medicaid members must bill Medicaid their actual acquisition cost (as defined in §447.502).

(6) All Indian Health Service, tribal, and urban Indian pharmacies are paid at the encounter rate (also known as the "OMB Rate" or "IHS All-Inclusive Rate").

(7) Investigational drugs are not a covered service.

(8) Dentures: on the basis of a negotiated fee schedule.

(9) Surgical and prosthetic devices: all payments are made for covered

*The output for First Data Bank's Consolidated Price 2(SWD) is based on the application of the following criteria:

1. If suggested Wholesale Price (SWP) is available, SWP will be output
2. If SWP is not available, WAC will be output.
3. If neither SWP nor WAC are available, Direct Price will be output