
STATE OF RHODE ISLAND

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE
PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

1. Fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent they are available.
2. Participation in the program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure.
3. Payment for physician, dentist and other individual practitioner services will be equal to the lesser of the billed charge or the State's fee for that service. Fee schedules are posted on the Executive Office of Health and Human Services web site under the Providers and Partners tab:
<http://www.eohhs.ri.gov/ProvidersPartners/GeneralInformation/ProviderDirectories/Hospitals.aspx>. All governmental and private service providers are reimbursed according to the same published fee schedule. The Medical Assistance Program rates were set as of July 1, 2017 and are effective for services on or after that date.
4. The following is a description of the payment structure by items of service.
 - a. Inpatient hospital services: as described in attachment 4.19A.
 - b. Outpatient hospital services: The Medical Assistance Program will pay for outpatient hospital services using a fee schedule approach based on, but necessarily identical to, the Medicare outpatient prospective payment system. Specific provisions are as follows:
 1. In general, payment will be by fee schedule, with the fee multiplied by the number of allowable units on the claim line. Fees will be derived as follows:
For visits, surgeries, imaging procedures, drugs, and other services where Medicare pays hospitals using Ambulatory Payment Classification (APC) groups, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of July 1, 2019 and is effective for services provided on or after that date. All rates are published on the EOHHS website at the address listed above. For the period of July 1, 2019 through June 30, 2020 outpatient rates will be increased by 7.2%. For the period of July 1, 2022 through June 30, 2023, outpatient rates will be increased by 5.0%. For each state fiscal year thereafter, the rates will be increased based on the change in the 'actual regulation market basket' as reflected in the CMS Outpatient Hospital Prospective Payment System Market Basket Update without productivity adjustment for the calendar year that contains the start of the current state fiscal year.
 - a. For physical, occupational, and speech therapy services, except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of July 1, 2019 and is effective for services provided on or after that date. All rates are published on the EOHHS website at the address listed above. For the period of July 1, 2019 through June 30, 2020 outpatient rates will be increased by 7.2%. for the period of July 1, 2022 through June 30, 2023, outpatient rates will be increased by 5.0%. For each state fiscal year thereafter, rates will be increased based on the change in the 'actual regulation market basket' – as reflected in the CMS Outpatient Hospital Prospective Payment System Market Basket Update without productivity adjustment for the calendar year that contains the start of the current fiscal year.
 - b. For laboratory services with dates of service on or after January 1, 2016, payment will be at the non-hospital community laboratory rate. The fees are effective for claims with a date of service on or after January 1, 2016. The fee schedule can be found on the EOHHS website at the address listed above.

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- c. For observation services, EOHHS will pay an hourly fee from the 8th to the 24th hour of observation. The agency's observation fee was set as of July 1, 2019 and is effective for services provided on or after that date. The observation fee is included in the fee schedule found on the EOHHS website at the address listed above. For the period of July 1, 2019 through June 30, outpatient rates will be increased by 7.2%. For the period of July 1, 2022 through June 30, 2023, outpatient rates will be increased by 5.0%. For each state fiscal year thereafter, the rates will be adjusted effective July 1st based on the change in the "actual regulation market basket" as reflected in the CMS Outpatient Hospital Prospective Payment System Market Basket Update without productivity adjustment for the calendar year that contains the start of the current state fiscal year.
- d. For any remaining outpatient hospital services covered by Medical Assistance, fees will be based on fees for similar services as identified elsewhere in the State plan. For unlisted services and other rare situations where no fee can be calculated, payment will be at a percentage of charges.
2. Payment by fee will be modified in the following situations:
- a. For bilateral services as appropriately designated by the modifier 50, payment will be at 150% of the otherwise applicable amount.
- b. For drugs covered under Section 340B of the Public Health Service Act as appropriately designated by the modifier UD, payment will be at 100% of billed charges.
3. Certain types of services are subject to discount payment when a claim contains more than one line showing procedure codes within each type of service. The line with the highest fee will be paid at 100%, the line with the second-highest fee will be paid at 50% of the otherwise-applicable fee, the line with the third highest fee will be paid at 25% of the otherwise-applicable fee, and the fourth and all subsequent lines will be paid zero. Discounting will only apply within each type of service. For example, if a claim contains three lines for an x-ray, a CT scan, and an ultrasound, each line will be paid 100%. The seven types of service are as follows:
- a. Significant procedures subject to discounting as designated by Medicare with APC Status "T." (In general, Medical Assistance will use the same list of procedures as Medicare, but specific exceptions may be made.)
- b. Computed topography scans
- c. Ultrasound
- d. X-rays
- e. Therapeutic radiology
- f. Nuclear medicine scans
- g. Magnetic Resonance Imaging
4. Some claim lines will be packaged, that is, the line will be considered paid but with a payment of zero. Packaging will apply to lines with anesthesia and recovery room codes (regardless of procedure code), lines without procedure codes, and lines with procedure codes designated as packaged under Medicare. (In general, Medical Assistance will use the same list of packaged procedures as Medicare, but specific exceptions may be made.)
5. Out-of-State hospitals will be reimbursed for outpatient surgery services provided to Rhode Island Medical Assistance Recipients at a rate equal to fifty-three (53%) of the out-of-state hospital's customary charge(s) for such services to Title XIX recipients in that state. The outpatient reimbursement for all other services, exclusive of laboratory, imaging, and physicians, will be sixty-four percent (64%) of the outpatient surgery rate.
6. Payment for all outpatient services will be final, with no year-end settlement process.
7. Hospital outpatient claims and payments are processed through MMIS.

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8. Only hospitals and provider based entities, in accordance with 42 CFR 413.65, are reimbursed according to the outpatient hospital reimbursement methodology.

9. Outpatient Supplemental Payment and UPL Calculation

- a. For the outpatient services provided for the period after July 1, 2022 each hospital licensed by the RI Department of Health, except those hospitals whose primary services and bed inventory are psychiatric, is paid an amount determined as follows:

- 1) Determine the sum of gross Medicaid payments (including TPL but excluding the cross-over claims for which Medicare is the primary payer) from Rhode Island MMIS and all other Medicaid FFS outpatient payments to hospitals made for outpatient and emergency department services provided during each hospital's fiscal year, including settlements.

The Outpatient UPL calculation is a reasonable estimate of the amount Medicare would pay for equivalent Medicaid services for outpatient services for non-state-owned hospitals. Specifically, a ratio of Medicare outpatient costs to Medicare outpatient charges is applied to Medicaid outpatient and emergency room charges to determine the total Medicaid UPL amount. This is then inflated to adjust from the cost report year to the UPL year. The State uses two inflation factors:

- a UPL Inflation factor which is the product of the "actual regulation market basket" as reflected in the CMS Outpatient Hospital Prospective Payment System Market Basket Update without productivity adjustment for the calendar years between the base data and the demonstration year. For example, a SFY 23 demonstration due 6/30/2023 uses hospital data from Report end dates of 9/30/2021 and 12/31/2021 (CY 2021); therefore, the UPL Inflation factor would be the product of CY 21 and CY 22 CMS Outpatient Hospital PPS Market Basket Updates without productivity adjustment.
- a Medicaid Inflation factor which is the Rhode Island General Assembly's inflationary adjustment enacted for the state demonstration year multiplied by the Rhode Island General Assembly's inflationary adjustment for enacted for the prior state fiscal year.

The Medicaid Provider Tax cost is added to the Inflated UPL amount to determine the Adjusted Medicare UPL amount.

- 2) Except for Bradley Hospital, Medicare routine and ancillary cost information is from each provider's as-filed Medicare cost report (CMS 2552), Worksheet D, Part V, Column 5, Line 202. Part 2, Line 49 (PPS services and sub-providers)

Medicare routine and ancillary charge information is from each provider's as-filed Medicare cost report (CMS 2552), Worksheet D, Part V, Column 2, Line 202. 30-40 (PPS services and subproviders)

For Bradley Hospital, Medicare routine and ancillary charge information is from the provider's as filed Medicare cost report (2552-10), Worksheet G-2, Part I, Column II, Line 28. To determine Bradley Hospital's outpatient cost information:

- A. Identify total inpatient charges (As filed Medicare cost report 2552-10, Worksheet G-2, Part I, Column I, Line 28)
- B. Identify total outpatient charges (detailed above)
- C. Calculate total inpatient and outpatient charges (A + B)
- D. Calculate the percentage of outpatient charges to total charges (B / C)
- E. Identify total inpatient and outpatient costs from as filed Medicare Cost report 2552-20, Worksheet G-2, Part II, Column 2, Line 43.

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F. Calculate total amount of outpatient costs ($D * E$)

The State shall use a Medicare cost report for the hospital's fiscal year beginning in the federal fiscal year two years prior to the state demonstration year. For example, a SFY 23 demonstration submitted in June 2023 (end of SFY 23, within FFY 23) would use a Medicare cost report for the hospital fiscal year beginning in FFY 21 (10/1/2020 and 1/1/2021 report start dates, both in FFY 21)

- 3) Total Medicaid outpatient and emergency room payments Inflated to Demonstration Year are then subtracted from the Adjusted Medicare UPL amount to determine the UPL gap, which is the basis for the size of the outpatient supplemental payment. The UPL gap is calculated using an aggregate of the individual hospital gaps non-state owned hospitals.
 - 4) The aggregate UPL gap is distributed quarterly (by the 20th of July, October, January, and April) among all eligible hospitals based on the percentage relationship of each hospital's Medicaid payments to total Medicaid payments for all non-state-owned hospitals. Eligible hospitals are actual facilities and buildings in existence in Rhode Island, that provide short-term acute outpatient care to persons who require definitive diagnosis and treatment for injury, illness, disabilities, or pregnancy.
- c. Payment will be made for rural health clinic services at the reasonable cost rate per visit established by the Medicare carrier. Payment for each ambulatory service, other than rural health clinic services, will be made in accordance with the rates or charges established for those services when provided in other settings.

5. Payment Adjustment for Provider Preventable Conditions**Citation**

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for nonpayment under Section(s) 4.19-B of this State Plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

___ Additional Other Provider-Preventable Conditions identified below:

In compliance with 42 CFR 447.26, Medicaid agency assures that:

1. No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2. Reductions in provider payment may be limited to the extent that the following apply:
 - a. The identified PPC would otherwise result in an increase in payment.
 - b. The State can reasonable isolate for non-payment the portion of the payment directly related to treatment for, and related to, the PPC.
3. Non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

In order to determine the non-payment amount, for services paid under Section 4.19(B) of this State plan, the Medicaid agency will utilize modifiers that are self-reported by providers on claims that indicate if an OPPC occurred. When one of the OPPC modifiers is present on the claim, the Medicaid agency will calculate a non-payment amount to ensure that the services rendered which the OPPC pertains to are not paid by the Medicaid agency.

This provision applies to all providers contracted with the Medicaid.

In the event that individual cases are identified throughout the PPC implementation period, July 1, 2012 through January 10, 2013, the State will adjust reimbursements according to the methodology above.

- No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

- Reductions in provider payment may be limited to the extent that the following apply: (z) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

A state plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

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(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)	S5125 Minimum Reimbursement Rate	Attendant Care Services per 15-minute increments	\$5.81	\$8.83	\$14.64
Aide/Assistant Provider)	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

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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 value, 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

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- 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 (CAN) 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 Assistants 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 Assistants 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 3
 - Or, if they receive the following minimum scores in two or more areas:

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- “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. Effective July 1, 2022 dental services will be paid either:

On the basis of a negotiated fee schedule that can be found here: <https://eohhs.ri.gov/providers-partners/fee-schedules> or;

As a bundled encounter payment or negotiated reimbursement rate. A bundled payment or negotiated reimbursement rate is paid when the following requirement are met:

A dental service provider must meet the certification standards established by EOHHS for Medicaid Dental Services in order to provide mobile dental services and receive a bundled payment or negotiate reimbursement rate for services rendered.

The following services and facility fee are part of a bundled payment or negotiated rate per specific billing code listed here <https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/0/Uploads/Documents/dental.pdf>.

Diagnostic services

Radiographs/Diagnostic Imaging includes transmission of diagnostic information and review by a dentist at a separate site if applicable/

Preventive procedures including dental prophylaxis of natural teeth and/or dentures, application of fluoride varnish, caries-arresting medicament application, oral hygiene instruction, nutrition counseling.

Palliative (emergency) treatment of dental pain-minor procedure Procedures which fall outside of bundled encounter payment or negotiated reimbursement rate should be billed using the negotiated fee schedule codes and rates found here: <https://eohhs.ri.gov/providers-partners/fee-schedules>.

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 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 drug reimbursed at 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

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- 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 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.

(3) 340B 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 defined in "47.502) for the drug plus a \$8.96 professional dispensing fee. Nominal Price as defined in {47.502 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 percent 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 defined in "47.502).

(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.

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Items on the basis of the current prevailing rate at which the item is generally available to the public in the State of Rhode Island.

(4) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of eyeglasses. The agency's fee schedule rate was set as of April 1993 for frames and March 2009 for lenses and is effective for services provided on or after those dates. All rates are published at <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf>

m. Nurse midwife services: except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of nurse mid-wife services. The agency's fee schedule rate was set as of 2000 and is effective for services provided on or after that date. All rates are published at <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf>

n. Hospice Services: Reimbursement for Hospice care will be made at predetermined rates for each day in which a beneficiary is under the care of the Hospice. The daily rate is applicable to the type and intensity of services furnished to the beneficiary for that day.

Effective July 1, 2019, with the exception of payment for physician services, base rates for levels of hospice care are as follows:

- Routine Home Care Days 1-60: \$239.05 per day
- Routine Home Care Days 60+: \$187.75 per day
- Continuous Home Care: \$50.40 per hour
- Inpatient Respite Care: \$225.22 per day
- General Inpatient Care: \$920.81 per day
- Service Intensity Add-On (SIA)-Clinical Social Worker: \$50.44 per hour
- Service Intensity Add-On (SIA)-Registered Nurse: \$53.68 per hour

Effective October 1, 2019, the hospice rates will be for each individual level of hospice care to pay the greater of either:

1. The hospice rate listed above; or
2. The current Medicaid minimum hospice rate published by CMS (effective 10/1/19)

The following methodology will be used to calculate the subsequent hospice rates for the individual levels of care:

- Each July 1, the rates effective October 1st of the previous calendar year will be increased by the March release of the New England Consumer Price Index card, containing February data, as determined by the United States Department of Labor for medical care.

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- Each October 1, the fee schedule rates will be updated for each individual level of hospice care to pay the greater of either:
 1. The state's current calendar year's July 1st hospice rate; or
 2. The current Medicaid minimum hospice rate published by CMS

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers. The current rates will be published at <http://www.eohhs.ri.gov/ProvidersPartners/FeeSchedule.aspx>.

Effective July 1, 2019, the rate for Hospice providers room and board expenses in a skilled nursing facility shall be ninety-five percent (95%) of the state plan skilled nursing facility rate. The hospice provider is responsible for passing the room and board payment through to the nursing facility.

For each hospice, the total number of inpatient days (both for general inpatient care and inpatient respite care) must not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid members enrolled in the hospice during the same period, beginning with services rendered October 1 or each year and ending September 30 of the next year.

p. Home and community-based services: except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of home and community-based services. The agency's fee schedule rate was set as of July 1, 2018 and is effective for services provided on or after that date. All rates are published at

<http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/HomeandCommunityBasedServices.aspx>

q. Rehabilitative services: except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set as of February 2012 and is effective for services provided on or after that date. All rates are published at

<http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf>

r. Case management services: except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of rehabilitative services. The agency's fee schedule rate was set under the specific program that case management operates in a specific instance and is effective for services provided on or after those dates. All rates are published at

<http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf>

STATE OF RHODE ISLAND

(z) Alternative Payment Methodology for Tribal Facilities Recognized as 638 FQHCs

For Tribal Facilities Recognized as 638 FQHCs, dates of service on or after December 1, 2021, these FQHCs may elect to be reimbursed under the Alternate Payment Methodology. Reimbursement to an Indian Health Services (IHS) clinic enrolled as an FQHC shall be as follows:

1. IHS/Tribal 638 facilities are reimbursed in accordance with the most recently published Federal Register notice addressing the OMB AIR.
2. There is no limit to the number of OMB AIR Encounters that can be billed per day by Tribal Facilities Recognized as 638 FQHCs.
3. The state will pay 638 FQHCs using an Alternative Payment Methodology that is equivalent to the OMB All Inclusive Rate (AIR). The state will pay the outpatient per visit rate (excluding Medicare) and this rate will be updated each calendar year to align with the most recently approved outpatient rate for that calendar year as published in the federal register. Consistent with the requirements of section 1902(bb) of the Act, the state will ensure that the AIR is not less than the amount the 638 FQHC would have received pursuant to the FQHC Prospective Payment System methodology described at section 1902(bb).

STATE OF RHODE ISLAND

Community Health Worker Services Payment:**Payment methodology:**

Service time billed must be for either direct contact with a beneficiary (in-person or through telehealth) or for collateral services on an individual basis. Collateral services are those delivered on behalf of an individual beneficiary but that are not delivered in that beneficiary's presence/directly to the beneficiary. The collateral service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

Rates established are inclusive of travel time and time spent conducting outreach to a new patient not yet receiving any CHW services.

The bases of payment are:

1. 15-minute units of service for individuals (new patients)
2. 15-minute units of service for individuals (established patients)
3. 15-minute units of service for groups of 2 or more beneficiaries

Rates and Rate Increases:

The current rates will be published at: <https://eohhs.ri.gov/providers-partners/fee-schedules>. These rates are effective as of July 1, 2021.

The following methodology will be used to calculate annual adjustments to rates for CHW services:

- Each July 1, the rates that were in effect on October 1st of the preceding calendar year will be trended by the March release of the New England Consumer Price Index Card, as determined by the United States Department of Labor for medical care (which contains February data).

Limitations or prior authorization requirements:

There are no limitations or prior authorization requirements.

STATE OF RHODE ISLAND

Reimbursement for Preventive Services: Doula Services.1. Payment Methodology:

- a. Payment is based on a fee schedule; and the specific fees are determined by the stage of pregnancy (prenatal, labor/delivery, or postpartum). The rates are accessible on the EOHHS website here: <https://eohhs.ri.gov/providers-partners/fee-schedules>. A doula may not receive more than \$1500.00 per pregnancy. In order to bill each visit for the rate, the doula must have visited the member for at least 60 minutes.
- b. The rates are structured to capture all of the staff costs associated with providing doula services, including providing emotional and physical support with traditional comfort measures and educational materials, as well as assistance during the transition to parenthood in the initial postpartum period; education on pregnancy, labor, and birth; meetings with the member's interdisciplinary care team; screening; case management; postpartum and/or bereavement supports; telephone time; travel time; and time writing case notes.
- c. Payment does not include room and board.
- d. All visits will be documented and billed for reimbursement with the proper billing code as described in the provider manual.

2. Rate Increases:

EOHHS does not increase rates based on a set inflation factor on a pre-determined basis.

3. Date of Effective Rates:

EOHHS' rates were set as of July 1, 2021 and are effective for services on or after that date.

STATE OF RHODE ISLAND

Reimbursement for Preventive Services: First Connections Services

1. Payment methodology

- a. Agencies bill the state Medicaid agency or RIDOH directly on a per-visit basis
- b. The rates are structured to capture the cost of direct services, including intake visits and care coordination, and indirect services, such as billing activities in accordance with 2CFR 200 and the RI approved cost allocation plan.

2. Rate Increases:

EOHHS does not increase rates based on a set inflation factor on a pre-determined basis. The State will provide a temporary rate increase effective July 1, 2022 through June 30, 2023 for the services below to stabilize the First Connections program following the high volume of referrals and need for care coordination during the COVID PHE.

Provider Type	Code	Description of Code	New Rate for Code per HCBS eFMAP Increase
010- Skilled Nursing 059- Early Intervention	99502TD	Home visit newborn care and assessment; Nurse	\$343.44
010- Skilled Nursing 059- Early Intervention	99502AJ	Home visit newborn care and assessment; Social Worker	\$271.40
010- Skilled Nursing 059- Early Intervention	99502	Home visit for newborn care and assessment	\$239.83
010- Skilled Nursing 059- Early Intervention	H1000	Prenatal care, at risk assessment	\$396.92

3. Date of Effective Rates

EOHHS' rates were set as of April 1, 2022 and are effective for services on or after that date. Effective June 30, 2023, the temporary rate increases reflected in the table above will end and the rates will return to the amounts effective prior to July 1, 2022.

STATE OF RHODE ISLAND

1905(a)13 Preventive Services

Parents as Teachers

1. Payment methodology

- a. Agencies bill the state Medicaid agency or RIDOH directly on a per-visit basis
- b. The rates are structured to capture the cost of direct services, including intake visits and care coordination, and indirect services, such as billing activities in accordance with 2CFR 200 and the RI approved cost allocation plan.

2. Rate Increases:

EOHHS does not increase rates based on a set inflation factor on a pre-determined basis

3. Date of Effective Rates

EOHHS' rates were set as of October 1, 2022 and are effective for services on or after that date.

STATE OF RHODE ISLAND

Diagnostic Services**Lead Investigations****Payment Methodology**

The payment basis for this service is a one-time investigation amount to determine the source of lead. Payment is limited to a health professional's time and activities during an on-site investigation of a child's home (r primary residence). The child must be diagnosed as having an elevated blood lead level. Medicaid reimbursement is not available for any testing of substances (water, paint, etc.) which are sent to a laboratory for analysis.

Rate Increases

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

TN No: 08-011

Supersedes

TN No: 00=006Approval Date: 5/27/2009Effective Date: 9/01/2008

STATE OF RHODE ISLAND

Rehabilitative Services

All payments of Rehabilitative Services are made directly to the qualified Medicaid professional or to the agencies employing the providers. Payments to agencies will be for discrete units of service. All providers rendering the service will meet qualifications as detailed below.

All willing and qualified providers are permitted to participate in accordance with 42 CFR §431.51. The State varies the fee schedule based on the education level or other qualifications of the provider.

Governmental and Private Providers

There are no governmental providers of this service.

Publication:

All rates are published and can be found at www.dhs.ri.gov.

Clinician's Services

Payments are made to or on behalf of the qualified provider. Individual payments are made in recognition, either directly or to an employer, of an individual qualified practitioner's service. The basis of payment is a 15-minute unit of service per qualified provider.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

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STATE OF RHODE ISLAND

Rehabilitative Services (cont.)**Adult Behavioral Health Services****Community Psychiatric Supportive Treatment (CPST)****Payment Methodology**

Service time billed must be for direct, face-to-face contact with a client or collateral on an individual basis. Travel time,

telephone time, and time spent writing case notes are not billable.

The basis of payment is a 15-minute unit of service per qualified provider. Payments are made to or on behalf of the qualified provider.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Psychiatric Rehabilitation Services (PRS)**Payment Methodology**

A PRS visit must last a minimum of 60 minutes in order to bill. After meeting the minimum requirement, time spent face-to-face with the client during any single continuous contact over and above the initial 60 minutes may be billed in 5-minute units per qualified provider.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Crisis Intervention Services**Payment Methodology**

Billable crisis intervention services can include an emergency intake on a new client if that client is in crisis, but cannot include the routine intakes that occur when this service is also used as the central intake point for the provider. Crisis intervention services delivered by telephone are not reimbursable. The need for extensive telephone work has been calculated into the overall fee structure. A crisis worker can bill for only one eligible client at any given time.

The basis of payment is a 30-minute unit of service per qualified provider. Payments are made to or on behalf of the qualified provider.

Rehabilitative Services (cont.)**Rate Increases**

The State does not increase rates based on a set inflation factor on a pre-determined basis. The State may provide a temporary rate increase to improve access to care through direct care workforce recruitment and retention initiatives. Additional funding provided through rate increases shall be used

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Rehabilitative Services (cont.)

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.

Date of Effective Rates

The agency rates were set as of January 1, 2008 and are effective for services on or after that date. Effective December 1, 2021 through March 31, 2022 there is a temporary rate increase of 255% higher than the agency rate set as of January 1, 2008 for X0341 HH:TG "Adult Mental Health Residential Service." Effective April 1, 2022 the rates will be the agency rates set as of January 1, 2008

Residential ServicesPayment Methodology

The Mental Health Psychiatric Rehabilitation Residences (MHPRR) rate is structured to capture all of the staff costs associated with providing the basic, routine day-to-day rehabilitative care uniformly provided to all residents whether on or off-site. This would include therapeutic services to enhance basic skills and appropriate behaviors to allow the residents to participate, to the fullest extent possible, in normalized activities in their community.

Rates are paid according to the intensity of services that are needed and provided. Rates range from \$85 to \$525 per day.

- \$85: On-Site Supportive Psychiatric Rehabilitative Apartments
- \$125: Supportive Mental Health Psychiatric Rehabilitative Residence Apartments
- \$125: Basic Mental Health Psychiatric Rehabilitative Residences
- \$175: Specialized Mental Health Psychiatric Rehabilitative Residence
- \$525: Enhanced Mental Health Psychiatric Rehabilitative Residences

The Enhanced Mental Health Psychiatric Rehabilitative Residences is available to providers that provide services for patients with complex mental health needs that are being discharged from hospital settings and require enhanced services in a community setting. Individuals who will require these enhanced services include those with a dual diagnosis of behavioral health and developmental disabilities, co-occurring disorders (mental health disorder and substance use disorder), comorbidities (behavioral health disorder and significant medical conditions), those who have suffered a traumatic brain injury (TBI) with a dual mental health related diagnosis, persons who have exhibited serious self-injurious behaviors or violence against others; those who have been convicted of sexual offenses or who exhibit sex offender behaviors, and fire starters. The three (3) categories of Enhanced MHPRR are:

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1. Medically Intensive MHPRR: Individuals diagnosed with mental illness and complex medical conditions, requiring increased medical monitoring, personal care assistance, and specialized environmental modifications.
2. Intensive Behavioral MHPRR: Provides increased therapeutic interventions and supervision, including one-to-one support on a consistent basis that focuses on identifying triggers and precipitant behaviors, coping skills, improving communication skills, addressing issues around substance use, and identifying and resolving barriers to the traditional MHPRR setting. Other individuals appropriate for this service are those with non-acute suicidality with a high risk of self-harm who have been determined to no longer be appropriate for an inpatient setting. This category includes two subspecialty groups:
 - a. Intensive Fire Safety MHPRR: Provides enhanced supervision and monitoring for fire setting behavior, therapeutic interventions to address individually identified risk behaviors, and a physical setting to minimize the risk of fire.
 - b. Sex Offender MHPRR: Provides a safe and therapeutic environment for individuals who have been convicted of a sexual offense and/or who are at risk for offending.
3. Intensive Forensic Supportive MHPRR: Individuals who are no longer clinically severely symptomatic but must be provided with a highly structured and secure environment for prolonged periods of time awaiting the resolution of criminal proceedings. This category includes two subspecialty groups:
 - a. Intensive Fire Safety MHPRR: Provides enhanced supervision and monitoring for fire setting behavior, therapeutic interventions to address individually identified risk behaviors, and a physical setting to minimize the risk of fire.
 - b. Sex Offender MHPRR: Provides a safe and therapeutic environment for individuals who have been convicted of a sexual offense and/or are at risk for offending.

Payment is on a per diem basis.

Payment does not include room and board.

The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

- a. Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and'
- b. Cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

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Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date. The Enhanced Mental Health Psychiatric Rehabilitative Residences rate is effective January 1, 2023

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Rehabilitative Services (cont.)**Substance Abuse Assessment Services**Payment Methodology

Payment is based on a fee schedule of 15-minute units per qualified provider.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Outpatient Counseling ServicesPayment Methodology

Payment is based on a fee schedule of 15-minute units per qualified provider.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Detoxification ServicesPayment Methodology

Payment is based on a per diem basis.

The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

- a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;
- b. cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

STATE OF RHODE ISLAND

Rehabilitative Services (cont.)**Substance Abuse Residential Services****Payment Methodology**

The rate is structure to capture all of the staff cost associated with providing the basis, routine day-to-day rehabilitative care uniformly provided to all residents that either takes place in the program, or is provided by staff of the program.

Payment is on a per diem basis.

Payment does not include room and board.

The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

- a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;
- b. cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Day/Evening Treatment**Payment Methodology**

Payment is on a per diem basis.

The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

- a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;
- b. cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

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Rehabilitative Services (cont.)**Children's Behavioral Health Services****Child and Adolescent Intensive Treatment Services (CAITS)****Payment Methodology**

Reimbursement is based on the units of service approved as part of an authorized Treatment Plan. CAITS requires prior authorization (PA) from DHS. The maximum number of units is fixed for each procedure code and should be delivered within 16 weeks or less. Although the authorization process approves a set number of units per procedure, how services are delivered is directly determined by the treatment needs of each child. This authorization process allows providers the flexibility to utilize units in accordance with need.

The maximum hours and unit of payment for each reimbursable service are described below. The maximum hour limits do not apply to EPSDT.

Individual/Family Therapy

Payment is in 15-minute units per qualified provider

The maximum number of units is limited to 40 hours

Family Training and Support Worker Services

Payment is in 15-minute units per qualified provider

The maximum number of units is limited to 18 hours

Treatment Plan Development

Payment is on the basis of a fee schedule. Payment is limited to the development of one treatment plan.

Rate Increases

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of August 1, 2008 and are effective for services on or after that date.

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Rehabilitative Services (cont.)**Mental Health Emergency Service Interventions;****Comprehensive Emergency Services****Enhanced Early Start****Day Treatment Program****Payment Methodology**

Services are reimbursed based on a fee schedule.

Fees are determined on a per diem basis.

The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

- a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;
- b. cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates were set as of January 1, 2008 and are effective for services on or after that date.

Residential Treatment Programs**Payment Methodology**

The rate is structure to capture all of the staff cost associated with providing the basis, routine day-to-day rehabilitative care uniformly provided to all residents that either takes place in the program, or is provided by staff of the program.

Payment is on a per diem basis.

Payment does not include room and board.

The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

- a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;
- b. cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

Rate Increases:

The State does not increase rates based on a set inflation factor on a pre-determined basis.

Date of Effective Rates:

The agency rates (accessible at

<https://providersearch.riproviderportal.org/ProviderSearchEOHHS/FFSFeeSchedule.aspx>) were set as of October 1, 2022 and are effective for services on or after that date.

STATE OF RHODE ISLAND

Rehabilitative Services (cont.)

Adult Day Health Services

Payment Methodology:

Services are reimbursed based upon acuity. The RI Medicaid Agency pays Adult Day Health (ADH) providers for Adult Day Health only if 1) the ADH services are medically necessary as outlined in the Provider Certification Standards, 2) the participant meets the clinical criteria for RI Medicaid Payment and 3) the ADH provider has obtained clinical authorization for RI Medicaid payment in accordance with the requirements set forth in the Provider Certification Standards. The RI Medicaid Agency pays one of two different payment rates for ADH services depending on the level of care and services provided to a participant by an ADH provider, as defined herein. Payment rates do not include room and board.

Basic Level of Services

- The RI Medicaid Agency pays the Basic Rate if the clinical determination is Preventive and the ADH furnishes Basic level of services. Basic level of services include the provision of the coordination of health and social services, including the availability of nursing services, health oversight and monitoring, skilled services, personal care, and care coordination as identified in the person centered care plan, aimed at stabilizing or improving self-care as well as preventing or postponing or reducing the need for institutional placement.

Enhanced Level of Services

- The RI Medicaid Agency pays the Enhanced Rate if the clinical determination is Preventive and the ADH furnishes Enhanced level of services. Enhanced level of services include the provision of:
 - a. Daily assistance* , on site in the center, with at least two (2) Activities of Daily Living (ADL) described herein, or;
 - b. Daily assistance* , on site in the center, with at least one skilled service, by a Registered Professional Nurse (RN) or a Licensed Practical Nurse (LPN), or;
 - c. Daily assistance* , on site in the center, with at least one (1) ADL described herein which requires a two-person assist to complete the ADL, or;
 - d. Daily assistance* , on site in the center, with at least 3 ADLs as described herein when supervision and cueing are needed to complete the ADLs identified, or;

An individual who has been diagnosed with Alzheimer' s disease or other related dementia, or a mental health diagnosis, as determined by a physician, and requires regular staff interventions due to safety concerns related to elopement risk or other behaviors and inappropriate behaviors that adversely impact themselves or others. Such behaviors and interventions must be documented in the participant's care plan and in the required progress notes.

*Daily assistance means every day of attendance.

Payment Rates

Code	Per Full Day Rate (Five (5) or more hrs. including transportation to and from provider)	Description
S5102-U1 U2	\$ 78.00	Enhanced Level of Services
S5102 U2	\$ 58.00	Basic I-Level of Services
S5105	\$65.00	Retainer payments

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Rehabilitative Services (cont.)

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Code	Per Half Day Rate (Three (3) or more hrs including transportation to and from provider)	Description
S5012-U1	\$ 39.00	Enhanced Level of Services
S5102	\$ 29.00	Basic Level of Services
Code	15-minutes increments	Description
T1016	\$15	Case Management

The State Medicaid agency will have a contract with each entity receiving payment under this service that will require that the entity furnish to the Medicaid agency on an annual basis the following:

- a. Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;
- b. Cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

Rate Increases

The State does not increase rates based on a set inflation factor on a pre-determined basis. The State will provide a temporary rate increase 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.

Date of Effective Rates:

The agency rates were set as of October 1, 2018 and are effective for services on or after that date. Effective November 1, 2021 through March 31, 2022, there is a temporary increase of 120% higher than the current rates listed in the payment rates table. Effective April 1, 2022, this temporary rate increase will end and the rate will be the rates listed in the payment rates table above.

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STATE OF RHODE ISLAND

Rehabilitative Services (cont.)

Centers of Excellence for Opioid Treatment

Payment Methodology:

Effective November 1, 2016, the RI Medicaid Agency pays Centers of Excellence for Opioid Treatment (COE) providers for services only if 1) the participant has been diagnosed with opioid use disorder and is appropriate for MAT and 2) the COE provider has obtained certification as a COE from RI BHDDH in accordance with the requirements set forth in the Provider Certification Standards. The RI Medicaid Agency will pay COE providers a one-time payment per enrollee for induction activities at the time of initial enrollment/assessment and thereafter, a per diem payment until date of discharge to community, but no longer than six (6) months, unless the provider was granted approval from BHDDH for extension of enhanced COE services. The RI Medicaid Agency pays one of two different induction payment rates for COE services depending on the capacity of providers, as defined herein. Providers are not able to bill the induction fee and a per diem rate on the same day.

COE Induction Fee

COEs will be certified at two levels to ensure timely access to MAT services. Level 1 providers are those that have the ability to meet the requirement of admitting all individuals within twenty-four (24) hours of referral. Level 2 providers are those that have the ability to meet the requirements to admit all patients within forty-eight (48) hours Saturday through Thursday and within seventy-two (72) hours for referrals made on Friday. Level 1 providers will receive an enhanced rate for induction to support the requirement of having physician availability seven (7) days per week. The Induction payment is structured to capture the costs for the initial assessment process (complete biopsychosocial assessments, physical examination, observed medication induction, and initial individualized treatment planning).

Per Diem COE Rate

Post induction, the RI Medicaid Agency will pay providers a per diem bundled rate until date of discharge to community, but no longer than six (6) months. The per diem bundled rate accounts for all COE services (continued individualize treatment planning; individual and group counseling; randomized toxicology; coordination of care with other treatment providers; referral for services not provided at the COE or to higher levels of care; case management to address other support service needs; wellness promotion activities; consultation and support to community buprenorphine physicians; discharge planning; readmission and re-stabilization of individuals who have relapsed or are experiencing crisis). COE rates do not include the cost of the medications, nor does it include the continued outpatient clinical, case management and peer support services that COEs will provide to patients who have successfully discharged to the community. The COE provider will need to bill FFS for these services.

Payment Rates

Payment Type	Payment Amount	Limitations
Level 1 Induction Fee	\$600.00 per member	Limited to one induction fee per enrollee per six (6) month enrollment. Providers must seek prior authorization if more than one induction must occur in the six (6) month period, (if patient is discharged and then relapses).
Level 2 Induction Fee	\$400.00 per member	Limited to one induction fee per enrollee per six (6) month enrollment. Providers must seek prior authorization if more than one induction must occur in the six (6) month period, (if patient is discharged and then relapses).
Per Diem Bundled Rate	\$17.86 per member per day	Limited to six (6) months duration, unless the provider was granted approval from BHDDH for extension of enhanced COE services

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Rehabilitative Services (cont.)**Assertive Community Treatment Service Bundle****Services Included In the Bundle:**

- A. Service Coordination/Case Management
- B. Crisis Assessment and Intervention
- C. Symptom Assessment and Management
- D. Medication Prescription, Administration, Monitoring and Documentation
- E. Dual Diagnosis Substance Use Disorder Services
- F. Work-Related Services
- G. Services to support activities of daily living in community-based settings
- H. Social/Interpersonal Relationship and Leisure-Time Skill Training
- I. Peer Support Services
- J. Other Support Services--Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not limited to:
 - 1. Medical and dental services
 - 2. Safe, clean, affordable housing
 - 3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance)
 - 4. Social service
 - 5. Transportation
 - 6. Legal advocacy and representation
- K. Education, Support, and Consultation to Clients' Families and Other Major Supports

Bundle Payment Unit:

The bundle payment unit is one month.

Providers Eligible to be Paid Through the Bundled Payment Rate:

Providers must be Community Mental Health Centers or other private, not-for-profit providers of mental health services who are licensed by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). The bundled rate will only be paid once per beneficiary per month.

Billing Requirements:

STATE OF RHODE ISLAND

Rehabilitative Services (cont.)

1. All providers must conform to the requirements of the current Rules and Regulations for the Licensing of Behavioral Healthcare Organizations, and all other applicable state and local fire and safety codes and ordinances.
2. Providers must be enrolled in the RI Medicaid Program and agree to meet all requirements, such as, timely access to care and matching beneficiaries service needs.
3. Providers are required to collect and submit complete encounter data for all ACT claims on a monthly basis utilizing standard Medicaid coding and units in an electronic format determined by EOHHS and BHDDH. The state will conduct an analysis of the data to develop recipient profiles, study service patterns, and analyze program costs vs. services received by recipients, for potential adjustments to the case rate as well as for consideration of alternative payment methodologies. Analysis will be conducted at least annually.
4. At least one of the services listed above must be provided within the payment unit (one month) in order for providers to bill the bundled rate.
5. Providers delivering services through the bundle will be paid through that bundled payment rate and cannot bill separately.

Bundled Payment Rate (Monthly Unit): \$1,267. This is the rate set as of January 1, 2016.

The State may provide a temporary rate increase for ACT 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.

Date of Temporary Effective Rates:

Effective December 1, 2021 through March 31, 2022, there is a temporary rate increase of 255% higher than the rates set as of January 1, 2016. Effective April 1, 2022, this temporary rate increase will end, and the rate will be the rates set as of January 1, 2016.

Assurances:

The state will periodically monitor the actual provision of services paid under a bundled rate to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part of the bundle

TN No: 21-0025-A

Supersedes

TN No: NEW

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STATE OF RHODE ISLAND

a. Federally Qualified Health Centers

- ☒ The payment methodology for FQHCs/RHCs will conform to section 702 of the BIPA 2000 legislation.
- ☒ The payment methodology for FQHCs and RHCs will conform to the BIPA 2000 requirements Prospective Payment System.
- ☒ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:
1. Is agreed to by the State and the center or clinic, and
 2. Results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

Until the PPS is calculated, the State shall continue to reimburse the core and ambulatory services provided in a FQHC/RHC under its current methodology: one hundred percent (100%) of reasonable cost as defined by the Medicare cost reimbursement principles as set forth in 42CR Part 413.

t. Certified Pediatric Nurse Practitioners and Certified Family Nurse Practitioners: according to negotiated fee schedule.

u. Homemaker Services: Standard fee per fifteen minutes of service.

x. Personal emergency Response System: according to negotiated fee schedule.

y. Transportation Services: In the plan, state-developed fee schedule rates are the same for both governmental and private providers of emergency transportation. All rates are published at <http://www.eohhs.ri.gov/ProvidersPartners/BillingampClaims/FeeSchedule.aspx>

STATE OF RHODE ISLAND

y. Preventive Services:

- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Smoking Cessation. The agency's fee schedule rate was set as of October 1, 2010 and is effective for services provided on or after that date. All rates are published on the DHS website www.dhs.ri.gov.
- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Nutritional Services. The agency's fee schedule rate was set as of January 1, 2002 and is effective for services provided on or after that date. All rates are published on the DHS website www.dhs.ri.gov.

STATE OF RHODE ISLAND

z. Physical Therapy, Occupational Therapy, and Speech Therapy

- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physical Therapy. The agency's fee schedule rate was set as of October 1, 2018 and is effective for services provided on or after that date. All rates are published at <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf>
- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Occupational Therapy. The agency's fee schedule rate was set as of October 1, 2018 and is effective for services provided on or after that date. All rates are published at <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf>
- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Speech Therapy. The agency's fee schedule rate was set as of October 1, 2018 and is effective for services provided on or after that date. All rates are published at <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf>

STATE OF RHODE ISLAND

1905(a)(29) Medication-Assisted Treatment (MAT)

The state utilizes the following payment methodologies for MAT services:

- Methadone is paid for via a fee schedule, effective October 1, 2020, which is accessible here <https://eohhs.ri.gov/providers-partners/fee-schedules>
 - Methadone is reimbursed as a part of a bundle that includes administration and labs.
- Buprenorphine is reimbursed in accordance with the payment methodology for Covered Outpatient Drugs, as described on Attachment 4.10B Page 2a-2b
- Naltrexone is reimbursed in accordance with payment methodology for Covered Outpatient Drugs, as described on Attachment 4.10B Page 2a-2b
- Group Therapy is reimbursed on a fee for service basis described on Attachment 4.10B Page 3.5
- Individual Therapy is reimbursed on a fee for service basis described on Attachment 4.10B Page 3.5
- The reimbursement for unbundled prescribed drugs and biologicals used to treat opioid use disorder will be reimbursed using the same methodology as described for Prescribed Drugs located in Attachment 4.19-B, pages 2c and 2d, for drugs that are dispensed or administered

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Rhode Island

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ____ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ____ of this attachment, for those groups and payments listed below and designated with the letters "NR".
4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ____ of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Rhode Island

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A <u>SP</u>	Deductibles <u>SP</u>	Coinsurance
	Part B <u>SP</u>	Deductibles <u>SP</u>	Coinsurance
Other Medicaid Recipients	Part A <u>SP</u>	Deductibles <u>SP</u>	Coinsurance
	Part B <u>SP</u>	Deductibles <u>SP</u>	Coinsurance
Dual Eligible (QMB Plus)	Part A <u>SP</u>	Deductibles <u>SP</u>	Coinsurance
	Part B <u>SP</u>	Deductibles <u>SP</u>	Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Rhode Island

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

State Plan under Title XIX of the Social Security Act**State: Rhode Island****Increased Primary Care Service Payment**

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting. Rhode Island has only one Medicare GPCI.

☐ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all countries for each code:

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code. The adjustments are based on rates calculated by Deloitte. The state will not adjust the fee schedule for changes in Medicare throughout the year

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

x The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99288, 99315, 99316, 99339, 99340, 99344, 99345, 99350, 99359, 99363, 99364,
99366, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99401, 99402, 99403,
99404, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444,
99450, 99455, 99456, 99485, 99486, 99487, 99488, 99489, 99495, 99496

(Primary Care Services Affected by this Payment Methodology - continued)

x The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

90460, 90461, 99224, 99225, 99226 (all codes added effective 1/1/2011)

Physician Services - Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate as implemented by the state in CYs 2013 and 2014.

___ Medicare Physician Fee Schedule rate

x State regional maximum administration fee set by the Vaccines for Children program

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

___ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: _____.

x A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate: \$8.16

 Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/2014 but not prior to December 31, 2014. All rates are published at <https://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/MedicaidPrimaryCareFeeIncrease/tabid/1009/Default.aspx>

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/2014 but not prior to December 31, 2014. All rates are published at <https://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/MedicaidPrimaryCareFeeIncrease/tabid/1009/Default.aspx>

The Rhode Island Medical Assistance Program will recognize payment for reserve bed days in Intermediate Care Facilities for the Mentally Retarded as provided for in Section 42 CFR 447.40. Reserved bed days will be considered for the temporary absence of an ICF-MR resident in the following instances.

1. Hospitalization
2. An overnight visit with family as a part of an individual treatment plan
3. Participation in resident camp and other overnight recreational activities as a part of an individual treatment plan

This policy is being implemented in order to facilitate compliance with the provisions of Section 42 CFR 442.414 which require ICF-MF's to encourage frequent and informal home visits by ICF-MR residents and have rules which will make it easy to arrange home visits. Additionally, this provision is being made in order to minimize the physical and emotional stress when residents are required to leave Intermediate Care Facilities for the Mentally Retarded for the purpose of obtaining acute hospital care and to allow residents to participate in overnight family home visits and other recreational activities related to the individual treatment plan.

All temporary absences except for hospitalizations from the Intermediate Care Facility for the Mentally Retarded must be documented in the individual treatment plan. The individual treatment plan must provide for the temporary absence from the facility and the reason for the absence. In cases of hospi-

talization, in order for the facility to assign reserve bed days, the attending physician must document in the medical record that the resident should be able to return to the ICF-MR upon discharge from the hospital.

The Medical Assistance Program will only recognize reserve bed days for each individual that are reasonable in number. For example, it is anticipated that resident camp experience will be for a period of one or two weeks and that visits with family will be normally for weekends and holidays. The number of reserve bed days assigned should be at a level as to reflect the fact that the primary place of residence is the Intermediate Care Facility for the Mentally Retarded and not the family residence.

On a monthly basis, the facility must submit a copy of the attached Reserved Bed Days Reporting Form to the Department of Social and Rehabilitative Services, NIC Unit, 600 New London Avenue, Cranston, Rhode Island 02920.

Every reserved bed day properly assigned by an Intermediate Care Facility for the Mentally Retarded and recognized for payment by the Rhode Island Medical Assistance Program will count as an occupied bed day for the purpose of reimbursement for Intermediate Care Facility services.

RESERVED BED DAYS REPORTING FORM

Facility _____

Month _____

Year _____

Resident
Name

Medical Assistance
Case Number

Dates of Reserved
Bed Days

Number of Reserved
Bed Days

Reason for Absence
From Facility