

**STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**9/1/2026 PUBLIC NOTICE OF PROPOSED AMENDMENT TO RHODE ISLAND MEDICAID
STATE PLAN**

In accordance Rhode Island General Laws 42-35, notice is hereby given that the Executive Office of Health and Human Services (EOHHS) proposes to make the following amendment to the Rhode Island State Plan under Title XIX of the Social Security Act:

OHIC Rate Review Updates: Health Home Services

EOHHS is seeking approval from the Centers for Medicare and Medicaid Services (CMS) to reflect changes in payment rates for Health Home Services. The state recently underwent a rate review for these services and subsequently increases were included in the state's FY2027 Budget. The proposed State Plan Amendment updates the State Plan with the rates as recommended in the state's budget. This amendment also includes technical updates and corrections to the State Plan Language.

The effective date of this state plan amendment is October 1, 2026. This change is expected to increase expenditures by approximately \$170,474 in SFY27 and \$187,717 in SFY28 (all funds).

This proposed amendment is accessible on the EOHHS website (www.eohhs.ri.gov) or available in hard copy upon request (401-462-1501 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by **October 1, 2026** to OHHS Policy, Executive Office of Health and Human Services, 3 West Rd, Cranston, RI, 02920, or OHHS.Policy@ohhs.ri.gov or via phone at (401) 462-2598.

In accordance with the Rhode Island General Laws 42-35-3, an oral hearing will be granted on the proposed State Plan Amendment if requested by twenty-five (25) persons, a state agency, or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within ten (10) days of this notice.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, or handicap in acceptance for or provision of services or employment in its programs or activities.

Original signed by Richard Charest, Secretary, Rhode Island Executive Office of Health and Human Services

Signed this 31st day of August, 2026

RI - Submission Package - RI2026MS00070 - Health Homes

Summary Reviewable Units News Related Actions

1945 Health Home Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | RI2026MS00070 | CEDAR Health Homes

 Spell Check Instructions  Request System Help

CMS-10434 OMB 0938-1188

Not Started


In Progress

Complete

Package Header

Package ID	RI2026MS00070	SPA ID	N/A
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	RI-24-0012		
	System-Derived		

View Implementation Guide

VIEW ALL RESPONSES

Payment Methodology

Collapse

The State's Health Home payment methodology will contain the following features

☒ Fee for Service

☒ Individual Rates Per Service

*

☒ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☒ Other

Describe below

*

Based on service provided:
T1023 - Program Intake Assessment
H2000 - Comprehensive Multi-disciplinary evaluation
H2021 - Community Based Wrap Around services (15-minute billing increments)

☐ Per Member, Per Month Rates

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

*

Payments are based on a fee schedule. Payments do not vary based on provider qualifications, individual care needs, or the intensity of the services provided.

☐ PCCM (description included in Service Delivery section)

☒ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Agency Rates

Collapse

Describe the rates used *

- ☐ FFS Rates included in plan
- ☐ Comprehensive methodology included in plan
- ☒ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date *

10/01/2026



Website where rates are displayed *

https://providersearch.riproviderportal.org/ProviderSearchEOHHS/FFSFeeSc

Rate Development

Collapse

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
 - a. the frequency with which the state will review the rates, and
 - b. the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Payments are based on a negotiated fee schedule. Payments do not vary based on provider qualifications, individual care needs, or the intensity of the services provided.

Cedar Family Centers will receive payment for the following deliverables:

1. \$385.39 upon completion of a family assessment which shall include the determination of the medical necessity of an individual for participation in the program. (Can be billed on an annual basis)
2. \$256.92 upon completion of a comprehensive Family Care Plan, Initial and then reviewed quarterly. (Can be billed up to 4 times per year)
3. Payment of \$22.40 per fifteen-minute unit (minimum one unit per month) for Community Based Wrap Around Services. Total payment of wrap around services shall be determined by frequency of use based on family need.

Cedar will provide EOHHS reports on performance measures at least annually to ensure that the billed services were delivered and that all deliverables are complete and of a high quality. EOHHS will review the following:

- Timeliness of assessment
- Timeliness of Family Care Plan development
- Timeliness of Family Care plan goals being met
- Family care plan coordination documentation
- Completion of family satisfaction survey
- Documentation of all completed activity related to claims submissions
- Documentation of annual BMI and Depression Screening completions
- Documentation of annual immunization/screenings review

EOHHS meets regularly with the Cedar Family Centers to review performance, utilization of services, compliance, quality assurance, and continuous quality improvement.

Assurances

Collapse

☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Home services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved *

EOHHS will ensure non-duplication of payment for similar services through regular monitoring of the State of RI MMIS system which employs system edits that ensure non-duplication.

☒ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Collapse

Saved Documents

- Maximum file size : 10MB

- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

☐	Name	Date Created	↑
No items available			

UPLOAD  Drop or paste file here

DELETE DOCUMENT(S)SAVE DOCUMENT(S)

Validation & Navigation

Would you like to validate the reviewable unit data?

☐ Yes ☒ No

Warning: Any field containing more than 4000 characters will be truncated when saved.

Navigate to Reviewable Unit

-- Select Reviewable Unit --

Not Started

In Progress

Complete

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

EXITSAVE REVIEWABLE UNITGO TO SELECTED REVIEWABLE UNIT

RI - Submission Package - RI2026MS00150 - Health Homes

Summary Reviewable Units News Related Actions

1945 Health Home Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | RI2026MS00150 | Migrated_HH.CONVERTED Rhode Island-2 Health Home Services

 Spell Check Instructions |  Request System Help

CMS-10434 OMB 0938-1188

Not Started


In Progress

Complete

Package Header

Package ID

RI2026MS00150

Submission Type

Official

Approval Date

N/A

Superseded SPA ID

RI-24-0014
System-Derived

SPA ID

N/A

Initial Submission Date

N/A

Effective Date

N/A

View Implementation Guide

VIEW ALL RESPONSES

Payment Methodology

Collapse

The State's Health Home payment methodology will contain the following features

- ☒ Fee for Service
- ☐ Individual Rates Per Service

☐ Per Member, Per Month Rates

☒ Comprehensive Methodology Included in the Plan

☒ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☒ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

- *

Per Diem Rate to CMHO for Integrated Health Home (IHH)

1. 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).

2. 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.

3. Providers must agree to contract and accept the established rates as the sole and complete payment in full for services delivered to beneficiaries, except for any potential payments made from the beneficiary's applied income, authorized co-payments, or cost sharing spend down liability.

4. The State will not include the cost of room and board or for non-Medicaid services as a component of the rate for services authorized by this section of the state plan.

5. The State will pay for services under this section on the basis of the methodology described in the section titled "Basis for IHH Methodology" of this document.

6. The amount of time allocated to IHH for any individual staff member is reflective of the actual time that staff member is expected to spend providing reimbursable IHH services to Medicaid recipients.

7. Providers are required to collect and submit complete encounter data for all IHH claims on a monthly basis utilizing standard Medicaid coding and units in an electronic format. 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.

8. The State assures that IHH services under this submission will be separate and distinct and that duplicate payment will not be made for similar services available under other program authorities.

9. The base rates were set as of October 1, 2026 and are described below.

10. Basis for IHH Methodology for IHH:

The process is based on a CMS approved methodology that utilizes reliable estimates of the actual costs to the provider agencies for staff and operating/support and then feeding those costs into a fee model. The process also included the development of a standard core IHH team composition and suggested caseload based on estimates of available staff hours and client need. Flexibility is given to the providers for the costs of the entire team. Ten positions are noted as core expectations that consists of one (1) Master's level coordinator, two (2) registered nurses, one (1) hospital liaison, five (5) CPST specialists and one (1) peer specialist.

Agencies will also be able to flex staff by need to certain teams. Agencies are still accountable to the entire number of staff, cost and salaries for all positions for Health Homes of the agency. Any deviation from the model must have clinical and financial justification that is approved by BHDDH, the state Mental Health Authority. The goal is to give providers flexibility so that providers are able to manage the team to obtain the outcomes.

Staffing Model (per 200 clients):

Title

FTE

Master's Level Program Director

1

Registered Nurse

2

Hospital Liaison

1

CPST Specialist

5- 6

Peer Specialist

1

Medical Assistant

1 (optional)

IHH

OCCUPANCY

v_PKG_1.0%

CLIENTS

200

Program

Staff:

Qualifications: FTE

Cost/FTE Total Cost

Master's Level Coordinator

1.0 \$108,058 \$108,058

Registered Nurse

2.0 \$111,737 \$223,473

Hospital Liaison 1.0

\$60,598 \$60,598

CPST Specialist BA

6.0 \$60,598 \$363,589

Peer Specialist 1.0

\$59,928 \$59,928

Medical Assistant

1.0 \$53,963 \$53,963

\$634,288

12.0

Fringe (Included in base cost)

0

Total base staff cost

\$634,288

Total all staff cost

\$869,609

Total administration and operating at state average

59% \$513,069

Total all costs
\$1,382,678

All CMHOs will be required to report on a quarterly basis on a set of required metrics. EOHHS and BHDDH will support the importance of standardized reporting on outcome measures to ensure providers are increasing quality so clients make gains in overall health.

Providers not meeting performance targets shall submit corrective action plans describing how full compliance will be accomplished. BHDDH and EOHHS will monitor progress and compliance with corrective action plans. If improvement is not detected, these measures will be added to the following year's measures.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☒ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

*

☒ Tiered Rates based on

☐ Severity of each individual's chronic conditions

☒ Capabilities of the team of health care professionals, designated provider, or health team

☐ Other

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

- *
- Per Diem Rate to CMHO for Integrated Health Home (IHH)
1. 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).
 2. 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.
 3. Providers must agree to contract and accept the established rates as the sole and complete payment in full for services delivered to beneficiaries, except for any potential payments made from the beneficiary's applied income, authorized co-payments, or cost sharing spend down liability.
 4. The State will not include the cost of room and board or for non-Medicaid services as a component of the rate for services authorized by this section of the state plan.
 5. The State will pay for services under this section on the basis of the methodology described in the section titled "Basis for IHH Methodology" of this document.
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 7. Providers are required to collect and submit complete encounter data for all IHH claims on a monthly basis

utilizing standard Medicaid coding and units in an electronic format. 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.

8. The State assures that IHH services under this submission will be separate and distinct and that duplicate payment will not be made for similar services available under other program authorities.

9. The base rates were set as of October 1, 2026 and are described below.

10. Basis for IHH Methodology for IHH:

The process is based on a CMS approved methodology that utilizes reliable estimates of the actual costs to the provider agencies for staff and operating/support and then feeding those costs into a fee model. The process also included the development of a standard core IHH team composition and suggested caseload based on estimates of available staff hours and client need. Flexibility is given to the providers for the costs of the entire team. Ten positions are noted as core expectations that consists of one (1) Master's level coordinator, two (2) registered nurses, one (1) hospital liaison, five (5) CPST specialists and one (1) peer specialist.

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FTE

Master's Level Program Director

1

Registered Nurse

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Hospital Liaison

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CPST Specialist

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Peer Specialist

1

Medical Assistant

1 (optional)

IHH

OCCUPANCY

v_PKG_1.0%

CLIENTS

200

Program

Staff:		
Qualifications:	FTE	
Cost/FTE		Total Cost

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1.0	\$108,058	\$108,058

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2.0	\$111,737	\$223,473

Hospital Liaison	1.0	
\$60,598		\$60,598

CPST Specialist BA		
6.0	\$60,598	\$363,589

Peer Specialist	1.0	
\$59,928		\$59,928

Medical Assistant		
1.0	\$53,963	\$53,963

\$634,288

12.0		
Fringe (Included in base cost)		
0		

Total base staff cost		
\$634,288		

Total all staff cost		
\$869,609		

Total administration and operating at state average		
59%		\$513,069

Total all costs		
\$1,382,678		

All CMHOs will be required to report on a quarterly basis on a set of required metrics. EOHHS and BHDDH will support the importance of standardized reporting on outcome measures to ensure providers are increasing quality so clients make gains in overall health. Providers not meeting performance targets shall submit corrective action plans describing how full compliance will be accomplished. BHDDH and EOHHS will monitor progress and compliance with corrective action plans. If improvement is not detected, these measures will be added to the following year's measures.

Provide a comprehensive description of the policies the state will use to establish Health Home alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

See response to above.

Agency Rates

Collapse

Describe the rates used *

- ☐ FFS Rates included in plan
- ☒ Comprehensive methodology included in plan
- ☐ The agency rates are set as of the following date and are effective for services provided on or after that date

Rate Development

Collapse

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
 - a. the frequency with which the state will review the rates, and
 - b. the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

See description of rate development above.

Assurances

Collapse

- ☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Home services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved *

To avoid duplication of payment for similar services, the State has employed an on-line portal developed by Hewlett Packard Enterprises that validates the dates of enrollment in Health Home programs. Providers must enter client data into the on-line portal. If the client is already a client of another Health Home program, including Opiate Treatment Health Home, the portal will give them an error message. This provides the State with assurances that duplicate programming and billing does not occur.

- ☒ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- ☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- ☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Collapse

Saved Documents

- Maximum file size : 10MB
- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

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Validation & Navigation

Would you like to validate the reviewable unit data?

Navigate to Reviewable Unit

☐ Yes ☒ No

-- Select Reviewable Unit --

Warning: Any field containing more than 4000 characters will be truncated when saved.

Not Started


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PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

EXIT

SAVE REVIEWABLE UNIT

GO TO SELECTED REVIEWABLE UNIT

MEDICAID | Medicaid State Plan | Health Homes | RI2026MS00120 | RI-26-0007 | MIGRATED_HH.RI Opioid Treatment Program Health Home Services

CMS-10434 OMB 0938-1188

Complete

Package ID	RI2026MS00120
Submission Type	Official
Approval Date	N/A
Superseded SPA ID	RI-13-279-X
	System-Derived

Effective Date N/A

[VIEW ALL RESPONSES](#)

Collapse

☒ Fee for Service

☒ Individual Rates Per Service

*

✓ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☒ Other

Describe below

* The Rhode Island State Medicaid Plan currently covers methadone maintenance treatment services at OTPs with a bundled weekly rate. As this rate includes treatment and wraparound services that could be considered as Health Home services, this rate will be reduced for any patient that does not opt-out of Health Homes and matched at the current level. RI seeks 90-10 matching funds only for the costs directly linked to providing the Health Home services. The OTP provider initiates a claim for the weekly rate, using a new procedure code for Health Home services. As methadone maintenance treatment services are considered an in-plan benefit for individuals with RiteCare, the Health Home payment weekly rate will be reduced to reflect the higher rate paid by MCOs, with

the total between the two (MCO payment and HH payment) equivalent to the rate for all other Medicaid clients.

- ☐ Per Member, Per Month Rates
- ☐ Comprehensive Methodology Included in the Plan
- ☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

- * Payments are based on a fee schedule. Payments do not vary based on provider qualifications, individual care needs, or the intensity of the services provided.

- ☐ PCCM (description included in Service Delivery section)
- ☐ Risk Based Managed Care (description included in Service Delivery section)
- ☒ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

*

- ☐ Tiered Rates based on

Provide a comprehensive description of the policies the state will use to establish Health Home alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

The methodology to develop costs for the Health Home service is based on the cost to employ key health professionals (salary and fringe benefits) who will provide the Health Home services. The staffing enhancements are based on a model of 4.55 FTEs for every 125 OTP patients served. The Health Home payment is a weekly, bundled rate per patient. The OTP provider initiates a claim for the weekly rate, using a new procedure code for Health Home services. The provider may make a weekly claim using the Health Home code for a patient who receives an average of one encounter per week in one month. Encounters will be recorded in fifteen minute increments and providers will be required to submit monthly encounter data to BHDDH. The first six months of data will establish a baseline average for encounters per agency and guide a rates review. It is expected that the average rate across HH teams should be significantly higher than billing minimum requirements with utilization based on patient needs. The weekly rates of \$99.33 for FFS Medicaid and \$59.60 for RiteCare clients are based on the following Key Employees, the FTE devoted to HH service and corresponding salary:

Medical Director	.25 FTE	\$94,640
HH Coordinator	1 FTE	\$81,120
Registered Nurse	1 FTE	\$81,120
Case Manager	2 FTE	\$108,160
Pharmacist	.1 FTE	\$18,928
Administrative Level Coordinator (shared position across HH sites)	.1 FTE	\$10,816
Staff Training (shared half time position across HH sites)	.05 FTE	\$5,408
Technology/IT (shared half time position across HH sites)	.05 FTE	\$8,112

As described in previous sections, this staffing composition is crucial to the implementation of HH services.

Rates and staffing will be reviewed at six month and one year intervals to assess continued need for shared training and IT positions. It is expected there will be greater need for these positions in the first six months and may decrease thereafter.

BHDDH will continue to require programs to submit Human Resource data including salary of medical directors on an annual basis. For Health Homes, we will also require programs to report annually on their contractual arrangements for pharmacists. Should either of these figures

change, the Health Home rate would be changed accordingly. In addition, BHDDH will monitor the amount of time that these positions dedicate to Health Homes and annually assess the needed allocation of this resource.

Agency Rates

Collapse

Describe the rates used *

- ☐ FFS Rates included in plan
- ☐ Comprehensive methodology included in plan
- ☒ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date *

10/01/2026



Website where rates are displayed *

https://providersearch.riproviderportal.org/ProviderSearchEOHHS/FFSFeeSc

Rate Development

Collapse

Provide a comprehensive description in the SPA of the manner in which rates were set

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5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
 - a. the frequency with which the state will review the rates, and
 - b. the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Assurances

Collapse

- ☒ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Home services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved *

There are no 1915(c) waivers in RI - everything is under 1115 demonstration waiver authority. The only payments for targeted case management is to Persons Living With HIV/AIDS. EOHHS and BHDDH will identify clients who receive targeted care mangement through Ryan White funding and also receiving OTP Health Home services and coordinate on a case-by-case basis to eliminate duplication of services.

- ☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- ☒ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- ☒ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Collapse

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- Valid file extensions: pdf; ppt; doc; docx; xlsx; xls; pptx

☐	Name	Date Created	↑
No items available			

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DELETE DOCUMENT(S)

SAVE DOCUMENT(S)

Validation & Navigation

Would you like to validate the reviewable unit data?

☐ Yes ☒ No

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