



Rhode Island Executive Office of Health and Human Services
 3 West Road, Virks Building, Cranston, RI 02920
 phone: 401.462.5274 fax: 401.462.3677

Name of Regulation: **Home Care and Home Health Providers, 210-RICR-20-05-1**
 Posted for Public Comment on **11/26/24**
 Public hearing held on **N/A**
 Comment Period Ended on **12/26/24**
 Summary Response to Comments **5/2/25**

	Respondent	Nature of the Comments	EOHHS' Response
1.	Nicholas Oliver Executive Director RIPHC 12/19/24	1) Can the definitions for "home care services" within the proposed Section 1.6.A be changed to conform with 216-RICR-40-10-17.3(A)(17)? 2) Can proposed Section 1.6.A.5 be eliminated to conform with proposed Section 1.6.A.3 as well as, R.I.G.L. § 23-17-9.2(a)(3) and 216-RICR-40-10-17.3(A)(26)? 3) Can the definitions for "home health services" within the proposed Section 1.6.B be changed to conform with 216-RICR-40-10-17.3(A)(18)? It is unclear as to whether this term applies to Rhode Island Department of Health (DoH) licensed home nursing care providers and/or home care providers. 4) Can proposed Section 1.6.A.4 be revised or eliminated as personal care services cannot be delivered via telehealth?5) Related to Section 1.8, how will contracted providers be held accountable or liable to proposed Section 2 if or when a direct care individual or a patient or client is determined not truthful?	1. RIDOH licensing does not align perfectly with federal Medicaid service definitions. Home care has a specific meaning within Medicaid as it has a separate federal authority pathway, therefore we are not able to map our service definitions to the licensure regulations. These services are the S5125 and S5130 codes. The definition has been revised to denote that these are Medicaid home care services. 2. This clause has been deleted. 3. RIDOH licensing does not align perfectly with federal Medicaid service definitions. The definition specifies that the Medicaid definition of home health services includes home health aide and skilled home health. These are G0156 and X0043, respectively. The language has been revised to denote that these are Medicaid home care services. 4. 1.6.A.4 has been deleted. 5. This will be tracked using EVV.



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		<p>6) Will EOHHS provide guidance to contracted providers as to how it will collect the information related to proposed Section 2 and subsequently how the state agency will conduct investigations?</p> <p>7) Can EOHHS provide clarification related to proposed Section 1.9.C? It refers to federal regulation, 42 C.F.R. § 441.301(c)(2), related to a person-centered service plan. However, this regulation is utilized by case managers to develop a plan related to the level of care necessary for a Medicaid beneficiary to remain successfully stabilized and safe at home and in their community. This is not applicable to contracted providers. Contracted providers provide an individualized plan of ADL supports offered to the client for each scheduled visit based on the level of care determined by the case worker and authorized by the case management agency on behalf of the Medicaid Program. EOHHS seems to be conflating two separate documents utilized for the provision of care.</p> <p>8) Related to proposed Section 1.6.A.1, if a contracted provider possesses a home nursing care provider (HNCP) license through the Rhode Island Department of Health (DoH), but only provides personal care services or non-skilled care, is said provider required to seek and obtain a physician's authorization or order for a client's care plan?</p>	<p>6. EOHHS welcomes any requests for particular guidance. As a general matter, investigations would be conducted through PI/review of EVV data.</p> <p>7. This clause is stating that the provider cannot bill for LTSS home care if the person does not have an authorized person-centered plan, consistent with HCBS conflict-free case management requirements. This is different from the plan that the home care provider is responsible for creating pursuant to licensure rules at 216-RCR-40-10-17. Language has been revised to clarify this distinction.</p> <p>8. EOHHS has revised the language at Section 1.6.A.1 to clarify that a physician's order and prior authorization approval are both required for non-LTSS home care services. The language also notes that home care providers must develop a plan of care in accordance with 216-RICR-40-10-17. For clarification, note that these provisions refer to non-LTSS home care services that are currently billed under CPT codes S5125 and S5130. As explained above, LTSS home care services (which may also be billed under S5125 and S5130) are authorized via the person-centered plan and prior authorization and do not need a separate physician's order to be on file. EOHHS anticipates that the physician order for non-LTSS home care will be a component of the documentation needed to obtain prior authorization for those services. EOHHS does not anticipate that home care providers will be responsible for seeking out the physician order; rather, providers will only be responsible for maintaining the physician order</p>



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		<p>9) If contracted providers are billing their private pay clients less than the “Medicaid rate”, how will EOHHS intend to legally conduct any investigations on said billing rates for clients outside of the scope of the Medicaid Program?</p> <p>10) In defining the “Medicaid rate”, is EOHHS presuming that the “Medicaid rate” is equivalent to the “fee-for-service” (FFS) rate as set by the General Assembly in accordance with R.I.G.L. § 40-8.9-9(f)(3) and R.I.G.L. § 40-8.9-9(g) or by the Medicaid Program’s managed care organization (MCO) health insurance company participants’ respective contracted rates, which differ from each other as well as differs from the FFS rates?</p> <p>11) How will EOHHS determine whether private pay clients are billed less than the “Medicaid rate”, which may differ within the program by fifteen-minute units or single visits compared to in the private pay market by hourly or block rates?</p>	<p>in their records, and for not submitting any claims unless such an order is properly on file. Physician-prepared written plans of care are not required for either LTSS or non-LTSS home care services, only for home health services. As described in the regulation, home health services must be provided pursuant to a physician order and written care plan, which the physician reviews at least every 60 days. The home health provider must retain that physician care plan in the provider’s records. Prior authorization is not required. Home health services include home health aide services and the general home health requirements apply to home health aide services. Home health aide services are similar in nature to home care services – both include personal care and/or homemaker services – but home health aide services are generally incidental to skilled nursing services or therapies provided in the beneficiary’s home. Home health aide services are currently billed under CPT code G0156.</p> <p>9. Nothing in the regulation purports to govern non-Medicaid payment or operations in any way, and EOHHS does not intend to conduct any investigations into private billing rates.</p> <p>10. This is a re-statement of existing billing policy that providers are not permitted to be paid a higher amount by Medicaid than the providers charge in general. EOHHS believes this is accomplished through the Medicaid rate-setting process and no additional action is needed.</p> <p>11. This is a re-statement of existing billing policy that providers are not permitted to be paid a higher amount by Medicaid than the providers charge in</p>



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		<p>12) How did EOHHS determine that its' Medicaid Program has the legal authority to investigate patient or client cases outside of said program, such as, but not limited to private pay and non-Medicaid commercial plans?</p> <p>13) How did EOHHS determine that its' Medicaid Program has the legal authority to control rates charged within the private market outside of the Medicaid Program?</p> <p>14) Is it the intention of EOHHS to set pass-through amounts in addition to those set by the General Assembly within R.I.G.L. § 40-8.9-9(g)?</p> <p>15) Per the previous question, if so, how did EOHHS determine that its' Medicaid Program has the legal authority to set pass-through amounts outside of those prescribed by the General Assembly within R.I.G.L. § 40-8.9-9(g)?</p> <p>16) Per the previous two questions, are said pass-through amounts within proposed Section 1.5 applicable to FFS rates only?</p> <p>17) Related to Question 14, if any pass-through amounts include MCO rates, is it the intention of EOHHS to define such in this regulation or otherwise intend to regulate such a provision through each contracted provider's private contract with each MCO?</p>	<p>general.</p> <p>12. Nothing in the regulation purports to govern non-Medicaid payment or operations in any way.</p> <p>13. Nothing in the regulation purports to govern non-Medicaid payment or operations in any way.</p> <p>14. These regulations are not in addition to RIGL 40-8.9-9, these regulations are in fact based on and in response to RIGL 40-8.9-9. EOHHS is not setting pass-through amounts in addition to those put into place by the legislature. This regulation is intended to support implementation and enforcement of the pass-through requirements set by RIGL 40-8.9-9.</p> <p>15. These regulations are not in addition to RIGL 40-8.9-9, these regulations are in fact based on and in response to RIGL 40-8.9-9. EOHHS is not setting pass-through amounts in addition to those put into place by the legislature.</p> <p>RIGL 40-8.9-9(g)(2)(b) states "EOHHS may adopt any additional necessary regulations and processes to oversee this subsection."</p> <p>16. This applies to both fee for service and MCO claims, and has already been calculated thus far using both.</p>



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		<p>18) Is EOHHS capturing pass-through data through electronic visit verification (EVV)?</p> <p>19) If EOHHS is publicly reporting the total pass-through amounts on November 30 of each year, why is the Medicaid Program requiring an attestation of compliance by the contracted provider by July 31 of the subsequent year?</p> <p>20) Will EOHHS disclose the document requiring an attestation of compliance ahead of promulgating these proposed regulations?</p> <p>21) Will EOHHS offer guidance as to the successful completion of said annual attestation of compliance, including all additional information required by the contracted provider to disclose publicly?</p>	<p>17. As the regulation states, EOHHS uses all claims in its calculation of the pass-through amount (including Managed care).</p> <p>18. EOHHS does not foresee EVV data utilization within the scope of reviewing compliance for the pass-through program.</p> <p>19. EOHHS must use July 31st to be aligned with the language in RIGL 40-8.9-9. However, it would not be feasible to complete this in July of the same year, since the total claims for that year would not have been submitted or analyzed at that point. Therefore, the due date has been pushed back to allow agencies more time to adjust their compensation if necessary. EOHHS can provide any guidance that may help the agencies become compliant with the shift differential pass through.</p> <p>20. EOHHS has issued the shift differential provider guidance for this year's reporting period in the Gainwell provider updates. The link to the new webform, as well as the required pass-through amounts is here: SFY 24 Home Health Agency Shift Differentials Increase Executive Office of Health and Human Services.</p> <p>21. Gainwell manages the BH Enhancement compliance (collection of attestations) and contacts providers/informs them when they are late. Additionally, if any provider is having difficulty submitting the attestation or needs education/guidance on what is required during an audit of the shift differential, EOHHS is more than</p>



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		<p>22) Related to proposed Section 1.8.A.1, does this proposed section contradict patient-centered rights within R.I.G.L. § 23-17-19.1? Does this create unnecessary conflict between case management agencies and home care providers? Will the case managers receive guidance as how to support home care providers when conflicts arise?</p> <p>23) Related to proposed Section 1.9.C, can EOHHS provide guidance to contracted providers as how this proposed section does not conflict with 216-RICR-40-10-17.6.5.B?</p>	<p>happy to provide guidance and clarify what is needed from them to be compliant.</p> <p>22. The language at 1.8.A.1 has been deleted.</p> <p>23. This clause is stating that the provider cannot bill for LTSS home care if the person does not have an authorized person-centered plan. This is different from the plan that the home care provider is responsible for.</p>
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