210-RICR-20-00-1

TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 20 – MEDICAID PAYMENTS AND PROVIDERS

SUBCHAPTER 00 – N/A

PART 1 – MEDICAID PAYMENTS AND PROVIDERS

1.1 Legal Authority

A. The Rhode Island Medicaid Program provides health care coverage authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396w-7 (Federal Medicaid Law) and Title XXI of the Social Security Act, 42 U.S.C. §§ 1397aa-1397mm (Federal Children's Health Insurance Program ("CHIP") law) as well as the State's Medicaid State Plan and Section 1115 demonstration waiver granted under the authority of § 1115 of the Social Security Act, 42 U.S.C. § 1315. To participate in the Medicaid program, health care providers must be certified and agree to abide by the requirements established in federal law, Rhode Island General Laws, and State and Federal Rules and Regulations.

B. To qualify for Federal matching funds, payments to certified providers for authorized services must be made in accordance with methodologies established by the State and approved for such purposes by the Secretary of the U.S. Department of Health and Human Services (DHHS) and/or the Federal Centers for Medicare and Medicaid Services (CMS). The Secretary of the EOHHS is authorized to set forth in Rule, contractual agreements, provider certification standards, and/or payment methodologies the requirements for obtaining Federal financial participation established in Federal laws, Regulations, or other such authorities. This Rule governs participation of and payments to health care providers participating in the Medicaid program.

1.2 Incorporated Materials

A. These Regulations hereby adopt and incorporate ~~42 C.F.R. § 424.518 (2021)~~42 C.F.R. § 424.518 (2024) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these Regulations.

B. These Regulations hereby adopt and incorporate 42 C.F.R. § 455.470 (2021) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these Regulations.

C. These Regulations hereby adopt and incorporate 42 C.F.R. § 1002.214 (2021) by reference, not including any further editions or amendments thereof, and only

to the extent that the provisions therein are not inconsistent with these Regulations.

D. These Regulations hereby adopt and incorporate 42 C.F.R. § 1002.215 (2021) by reference, not including any further editions or amendments thereof, and only to the extent that the provisions therein are not inconsistent with these Regulations.

1.3 Definitions

A. As used in this Rule, the following terms and phrases have the following meanings:

1. "Conviction" means as assigned in R.I. Gen. Laws §§ 42-7.2-18.2 and 42-7.2-18.4.

2. "Disqualifying conviction" means a conviction, federal or state, for any of the crimes listed in R.I. Gen. Laws §§ 42-7.2-18.2 and 42-7.2-18.4.

3. "High-risk provider" means a provider that poses a high risk of fraud, waste or abuse. These providers are:

   a. Designated by the Centers for Medicare and Medicaid Services as high categorical risk according to ~~42 C.F.R. § 424.518 (2021)~~42 C.F.R. § 424.518 (2024);

   b. Individual personal care attendants and homemakers providing direct care to individuals under Chapter 50-10-2 of this Title; ~~and~~

   c. Shared living caregivers providing direct care to individuals under Chapter 50-10-1 of this Title~~.~~; and

   d. Community Health Workers (CHWs).

4. "Limited-risk provider" means a provider that is neither a moderate-risk provider nor a high-risk provider.

5. "Moderate-risk provider" means a provider that poses a moderate risk of fraud, waste or abuse. These providers are:

   a. Providers designated by the Centers for Medicare and Medicaid Services as moderate categorical risk according to ~~42 C.F.R. § 424.518 (2021)~~42 C.F.R. § 424.518 (2024);

   b. Severely disabled nursing home care providers;

   c. Providers employing personal care attendants and homemakers; and

d. RIte Share co-pay providers.

6. "Provider" means an individual or entity including physicians, nurse practitioners, physician assistants, and others who are engaged in the delivery of medical/behavioral health care services, or ordering or referring for those services, and is legally authorized to do so by the State in which the provider delivers the services. This includes fee-for-service and managed care providers.

7. "Rhode Island Medicaid program" means a combined State and Federally funded program established on July 1,1966, under the provisions of 42 U.S.C. §§ 1396-1396w-7. The enabling State legislation is to be found at R.I. Gen. Laws Chapter 40-8, as amended.

8. "Secretary" means the Rhode Island Secretary of the Executive Office of Health and Human Services (EOHHS) who is responsible for the oversight, coordination, and cohesive direction of State-administered health and human services, including the Medicaid agency, and for ensuring all applicable laws are executed.

9. "State agency" means the Rhode Island Executive Office of Health and Human Services (EOHHS) which is designated under the Medicaid State Plan as the Single State Agency responsible for the administration of the Medicaid Program.

1.4 Medicaid Payment Policy

A. Medicaid is the payor of last resort. Community, public, and private resources such as Federal Medicare, Veteran's Administration benefits, accident settlements, or other health insurance plans must be utilized fully before payment from the Medicaid program can be authorized, including for prenatal services, labor, delivery, and postpartum care services. However, the State makes payments without regard to third (3rd) party liability for pediatric preventive services, unless the State has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for ninety (90) days. The State may also make payments without regard to potential third (3rd) party liability for up to one hundred (100) days for claims related to child support enforcement beneficiaries.

B. Payments to physicians and other providers of medical services and supplies are made in accordance with contractual arrangements with health plans or on a fee-for-service basis in accordance with applicable Federal and State Rules and Regulations, the Medicaid State Plan, and the State's Section 1115 demonstration waiver.

C. Payments to Medicaid providers represent full and total payment. No supplementary payments are allowed, except as specifically provided in the

contract. Direct reimbursement to recipients is prohibited except in specific circumstances to correct a denial that is reversed on appeal.

1.5 Long-term Care Facilities – Surveys

A. The Rhode Island Department of Health surveys all Nursing Facilities (NF) and Intermediate Care Facilities for persons with Intellectual Disabilities (ICF/ID) for compliance with the Federal participation requirements of the Medicare and Medicaid programs. As a result of these surveys, reports are issued for certification purposes which cite provider deficiencies, if any exist, together with appropriate plans of correction. Subsequent corrections of deficiencies are also reported.

B. Statements of provider deficiencies must be made available to the public as follows:

1. Nursing Facilities (NF) – To the extent permitted by law, reports are sent to the Social Security Administration (SSA) district office that covers the area in which the facility is located and the Medicaid agency.

2. Intermediate Care Facilities/Intellectual Disabilities (ICF/ID) – Reports are sent to the Medicaid agency. The agency is required to send the reports for both Nursing and Intermediate Care Facilities to the appropriate Long-term Services and Supports (LTSS) Unit covering the district in which the facility is located. The agency must also send the ICF/ID reports to the SSA office covering the catchment area in which the facility is located.

C. These files are available to the public upon request. Material from each survey must be held at both the EOHHS and the LTSS Unit for three (3) years.

1.6 Provider Eligibility – Screening Requirements

A. EOHHS performs a screening of all providers to ensure that providers meet all State and federal requirements for enrollment and/or continued participation as a provider in the Medicaid program. The screening process corresponds to the provider's classification as a limited-risk provider, moderate-risk provider, or high-risk provider, as determined by EOHHS. If a provider could fit within more than one (1) risk level, the highest level of screening shall be applicable. The information gathered during this screening shall impact eligibility for participation as a Medicaid provider, as described herein.

B. EOHHS performs the minimum screenings required by State and federal law and regulations for each risk level. For moderate-risk and high-risk providers, federal law requires an unannounced site visit.

C. For the following providers, and if a provider entity all persons with a five percent (5%) or greater direct or indirect ownership interest in such providers, state and

federal law require a national criminal records check supported by fingerprints, conducted through the Office of Attorney General:

1. Providers designated by the Centers for Medicare and Medicaid Services (CMS) as high categorical risk;

2. Individual personal care attendants and homemakers providing direct care to individuals under Chapter 50-10-2 of this Title; ~~and~~

3. Shared living caregivers providing direct care to individuals under Chapter 50-10-1 of this Title; and~~.~~

4. Community Health Workers (CHWs).

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D. Upon determining that a provider or applicant to become a provider requires a national background check supported by fingerprints, EOHHS shall make a written request to submit fingerprints. The individual shall submit a set of fingerprints within thirty (30) days upon written request from EOHHS. The individual is responsible for the cost of the fingerprint.

E. Fingerprints shall be valid for a five (5) year period.

1.7 Provider Eligibility – Eligibility Criteria

A. To be eligible to participate in the Rhode Island Medicaid program as any provider type, a provider must:

1. Be fully licensed, certified, registered, and/or credentialed, where required by the State, as an active practitioner by the agency or board overseeing the specific provider type;

2. Be registered with appropriate state and federal agencies to prescribe controlled substances, for any provider type that is legally authorized to write prescriptions for medications;

3. Never have been the subject of and/or never have had common parties in interest with any provider subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without the consent of the provider, by any state or federal agency, or board, including the Rhode Island Medicaid program or another state's Medicaid program;

4. Never have purchased or otherwise obtained its practice or business entity from any provider suspended or terminated from participation in the Rhode Island Medicaid program due to violations of applicable laws, rules, or regulations; or from a provider that is currently subject to a withholding of Medicaid payments for a credible allegation of fraud or who terminates

or has its Medicaid participation terminated while subject to such a withholding of Medicaid payments;

5. Cooperate with the Rhode Island Medicaid program during any application, revalidation of enrollment, or other review process, such as permitting, facilitating site visits, and submitting fingerprints, as determined by EOHHS;

6. Not be subject to a moratorium on enrollment imposed in accordance with 42 C.F.R. § 455.470 (2021); and

7. Not have any evidence of a disqualifying conviction that is revealed during a national criminal records check or otherwise revealed during EOHHS' provider risk screening process.

B. A provider who does not meet the requirements of this section may, at EOHHS' sole discretion, participate in the Rhode Island Medicaid program only if, in the judgment of EOHHS, such participation:

1. Would not threaten the health, welfare, or safety of members; and

2. Would not compromise the integrity of the Rhode Island Medicaid program.

C. A provider who does not meet the requirements of this section is entitled to a hearing on the issue of eligibility pursuant to the State's Administrative Procedures Act, as found at R.I. Gen. Laws Chapter 42-35, as amended, and in conformance with Part 10-05-2 of this Title, Appeals Process and Procedures for EOHHS Agencies and Programs.

1.8 Provider Eligibility – Termination of Participation for Ineligibility

A. When a provider fails or ceases to meet any one (1) or more of the State or federal eligibility criteria applicable to such provider, the provider's participation in the Rhode Island Medicaid program may be terminated. If such termination is based upon a finding, ruling, conviction, decision, order, notification, or statement of any nature (including an agreement with the provider) by any federal, state, or quasi-public board, department (other than EOHHS), or other agency or another state's Medicaid program that revokes, voids, suspends, or denies the issuance, renewal, or extension of a license, certificate, or other statement of qualification that constitutes a statutory prerequisite or other eligibility criterion, the correctness or validity of the action taken by the issuing agency will be presumed, the termination will be effective as of the earliest date on which the provider failed or ceased to meet any of such criteria, and EOHHS shall not afford a hearing as to the correctness or validity of such action. If such termination is based solely upon a determination of ineligibility by EOHHS, the provider shall be afforded notice and an opportunity for hearing in substantially

the manner set forth in § 1.10 of this Part, and any termination will be effective as of the date of receipt of notice thereof.

1.9 Provider Eligibility – Suspension of Participation Pursuant to United States Department of Health and Human Services Order

A. When a provider is the subject of a notice by the United States Department of Health and Human Services (HHS) requiring the provider's suspension or the denial, termination, or refusal to renew a provider contract pursuant to § 1902(a)(39) of the Social Security Act, 42 U.S.C. § 1396a(a)(39), or any other section of the Social Security Act, 42 U.S.C. §§ 301-1397mm, the provider's participation in the Rhode Island Medicaid program shall be suspended or its provider contract shall be denied, terminated, or not renewed in accordance with the HHS notice. The Rhode Island Medicaid program agency shall not afford a hearing to the provider as to the correctness or validity of the action taken by HHS.

1.10 Medicaid Provider Administrative Sanctions

A. In accordance with R.I. Gen. Laws Chapters 42-35 (The Administrative Procedures Act), and 40-8.2, the EOHHS is authorized to establish administrative procedures to impose sanctions on providers of health services and supplies for any violation of the Rules, Regulations, standards, or laws governing the Rhode Island Medicaid Program. The Federal Government mandates the development of these administrative procedures for the Title XIX Medicaid Program in order to ensure compliance with §§ 1128 and 1128A of the Social Security Act, 42 U.S.C. §§ 1320a-7 and 1320a-7a, which imposes Federal penalties for certain violations.

B. Sanctionable Violations. All providers of Medicaid and CHIP-funded health care services and supplies are subject to the R.I. Gen. Laws and the Rules and Regulations governing the Medicaid program. Sanctions may be imposed by the EOHHS against a Medicaid provider for any one (1) or more of the following violations of applicable law, Rule, or Regulation:

1. Presenting or causing to be presented for payment any false or fraudulent claim for medical services or supplies.

2. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than to which the provider is legally entitled.

3. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

4. Failure to disclose or make available to the Single State Agency or its authorized agent records of services provided to Medicaid recipients and records of payments made for such services.

5. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as determined by an official body of peers.

6. Engaging in a course of conduct or performing an act deemed improper or abusive of the Medicaid Program or continuing such conduct following notification that said conduct should cease.

7. Breach of the terms of a Medicaid provider agreement or failure to comply with the terms of the provider certification of the Medicaid claim form.

8. Overutilizing the Medicaid Program by inducing, furnishing, or otherwise causing a beneficiary to receive services or supplies not otherwise required or requested by the beneficiary.

9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid beneficiary referral.

10. Violating any provisions of applicable Federal and State laws, Regulations, plans, or any Rule or Regulation promulgated pursuant thereto.

11. Submission of false or fraudulent information in order to obtain provider status.

12. Violations of any laws, Regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

13. Any disqualifying conviction.

14. Failure to meet standards required by State or Federal laws for participation such as licensure and certification.

15. Exclusion from the Federal Medicare program or any State health care program administered by the EOHHS because of fraudulent or abusive practices.

16. A practice of charging beneficiaries or anyone acting on their behalf for services over and above the payment made by the Medicaid Program, which represents full and total payment.

17. Refusal to execute a provider agreement when requested to do so.

18. Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from the Single State Agency.

19. Formal reprimands or censure by an association of the provider's peers for unethical practices.

20. Suspension or termination from participation in another governmental health care program under the auspices of Workers' Compensation, Office of Rehabilitation Services, Medicare, or any State program administered by the EOHHS or one of the agencies under the EOHHS umbrella.

21. Indictment for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

22. Failure to produce records as requested by the State Agency.

23. Failure to repay or make arrangement for the repayment of identified overpayments or otherwise erroneous payments.

C. Provider Sanctions. Any one (1) or more of the following sanctions may be imposed against providers who have committed any one (1) or more of the sanctionable violations above:

1. Termination from participation in the Medicaid program or any State health care program administered by the EOHHS.

2. Suspension of participation in the Medicaid Program or any State health care program administered by the EOHHS or an agency under the EOHHS umbrella.

3. Suspension or withholding of payments.

4. Transfer to a provider agreement not to exceed twelve (12) months or the shortening of an already existing provider agreement.

5. Prior authorization required before providing any covered medical service and/or covered medical supplies.

6. Monetary penalties.

D. Prepayment audits will be established to review all future claims prior to payment.

E. EOHHS will initiate recovery procedures to recoup any identified overpayment.

F. Except where termination has been imposed, a provider who has been sanctioned may be required to attend a provider education program as a

condition of continued participation in any health care program administered by EOHHS.

1. A provider education program will include instruction in:

    a. Claim form completion;

    b. The use and format of provider manuals;

    c. The use of procedure codes;

    d. Key provisions of the Medicaid Program;

    e. Reimbursement rates; and

    f. How to inquire about procedure codes or billing problems.

1.11 Notice of Violations and Sanctions

A. When the Medicaid agency intends to formally suspend or terminate a provider as a consequence of a sanctionable violation, a notice of violation must be sent to the provider by registered mail. The notice must include the following:

1. A plain statement of the facts or conduct alleged to warrant the intended EOHHS action. If the Medicaid agency is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved and a detailed statement shall be furnished as soon as is feasible.

2. A statement of the provider's right to a hearing that indicates the provider must request the hearing within fifteen (15) days of the receipt of the notice.

B. Informal Hearing. Within fifteen (15) days after the receipt of a notice of an alleged violation and a sanction, the provider may request an informal hearing with the Medicaid agency.

1. This informal hearing provides an opportunity for the provider to discuss the issues and attempt to come to a mutually agreeable resolution, thereby obviating the need for a formal administrative hearing. Informal dispositions may also be made of any contested case by stipulation, consent order, or default.

C. Administrative Hearing. The right to an administrative appeal is conditioned upon the appellant's compliance with the procedures contained in this Rule and the hearing will be held in compliance with the provisions of the State's Administrative Procedures Act, as found at R.I. Gen. Laws Chapter 42-35, as

amended, and in conformance with Part 10-05-2 of this Title, Appeals Process and Procedures for EOHHS Agencies and Programs.

D. Appeal for Judicial Review. Any provider who disagrees with the decision entered by the Hearing Officer as a result of the Administrative Hearing has a right to appeal for judicial review of the hearing decision by filing a complaint with the Superior Court within thirty (30) days of the date of the decision in accordance with R.I. Gen. Laws § 42-35-15.

E. Administrative Actions. Once a sanction is duly imposed on a provider, EOHHS shall notify the applicable State licensing agent and the Federal Medicare program if appropriate, State health care programs as defined in 42 U.S.C. § 1320a-7(h), State-funded health care programs administered by the Medicaid agency, or any other public or private agencies involved in the issuance of a license, certificate, permit, or statutory prerequisite for the delivery of the medical services or supplies. Furthermore, EOHHS shall notify all affected Medicaid beneficiaries.

F. Stay of Order. Orders may be stayed in accordance with R.I. Gen. Laws §§ 42-35-15 and 40-8.2-17.

G. Reinstatement. Pursuant to 42 C.F.R. § 1002.214(c) (2021), a State may afford a reinstatement opportunity to any provider terminated or suspended at the State's initiative. The provider may only be reinstated to participate in the Medicaid program by the EOHHS, in its capacity as the Medicaid Single State Agency. The sanctioned provider may submit a request for reinstatement to EOHHS at any time after the date specified in the notice of termination or suspension.

H. EOHHS may grant reinstatement only if it is reasonably certain that the types of actions that formed the basis for the original exclusion have not recurred and will not recur. Factors EOHHS will consider in making such a determination are contained in 42 C.F.R. § 1002.215(a) (2021).

I. If EOHHS approves the request for reinstatement, it will provide the proper notification to the excluded party and all others who were informed of the exclusion, specifying the date when participation will resume in accordance with 42 C.F.R. § 1002.215(b) (2021). If EOHHS does not approve the request for reinstatement, it will notify the excluded party of its decision. Any appeal of a denial of reinstatement will be in accordance with State procedures and not subject to administrative or judicial review.

1.12 Severability

A. If any provisions of these Regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these Regulations which can be given effect, and to this end the provisions of these Regulations are declared to be severable.

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