210-RICR-20-05-1

TITLE 210 – EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 20 – Medicaid Payments and Providers

SUBCHAPTER 05 - Requirements and Limits Applicable to Specific Providers

Part 1 – Home Care and Home Health Providers

1.1 Scope and Purpose

A. The purpose of this Rule is to outline the requirements and limitations pertaining to home care and home health provider agency participation in and payment by the Rhode Island Medicaid program. This Rule also includes parameters and limitations for incentive payments available to certified nursing assistants and homemakers providing services on behalf of home care and home health providers participating in the Rhode Island Medicaid program. This rule does not apply to services delivered through the Personal Choice program pursuant to 210-RICR-50-10-2.

1.2 Authority

A. Federal Authority

1. Federal Law: The Rhode Island Medicaid Program provides health care coverage authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396w-8, and Title XXI of the Social Security Act, 42 U.S.C. §§ 1397aa-1397mm.

2. The Rhode Island Medicaid State Plan and Section 1115 demonstration waiver granted under the authority of § 1115 of the Social Security Act, 42 U.S.C. § 1315.

B. State Authority

1. R.I. Gen. Laws § 40-8.9-9 and § 42-7.2.

1.3 Incorporated Materials

A. These regulations hereby adopt and incorporate 42 C.F.R. § 440.70 (2023) 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. § 441.301(c)(2) (2023) 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.

1.4 Definitions

A. As used in this Part, these definitions have the following meaning:

1. "Audit" means an examination or investigation by EOHHS of provider practices by means of an on-site visit; a review of claim and payment records; and/or a review of financial, medical, and other records including but not limited to: prior authorizations, Electronic Visit Verification (EVV) data, employee records and time sheets, invoices, audited financial statements, and other financial statements. EOHHS conducts audits to ensure provider and member compliance with laws and regulations governing the Medicaid program.

2. "Clawback" means the return, recoupment, or recovery of funds that were previously disbursed by EOHHS.

3. "Compensation" means base salary or hourly wages or other remuneration as defined by the Fair Labor Standards Act, 29 U.S.C. § 201 et seq., benefits, other compensation, and associated employer share of payroll taxes for direct care staff. Compensation does not include: gift cards, physical gifts, vouchers, coupons, costs for required training, travel costs, or services and goods provided at no cost.

4. "Direct care staff" means CNAs, nursing assistants and homemakers providing personal care and homemaker services on behalf of home care and home health providers.

5. "Executive Office of Health and Human Services" or "EOHHS" means the State agency established under the provisions of R.I. Gen. Laws § 42-7.2 designated as the Single State Agency responsible for the administration of the Rhode Island Medicaid program.

6. "Family relationship" means the following relationships:

    a. Parent-child (including stepparent/stepchild) regardless of whether the beneficiary is the parent or child of the direct care staff and regardless of the age of the child;

    b. Grandparent-grandchild (including step-grandparent/step-grandchild) regardless of whether the beneficiary is the grandparent or grandchild of the direct care staff and regardless of the age of the grandchild;

    c. Sibling (including step-sibling); and

d. Spouse.

7. "Home care and/or home health provider" means an agency licensed by the Rhode Island Department of Health as a home care provider and/or home nursing care provider under the provisions of R.I. Gen. Laws § 23-17 and 216-RICR-40-10-17 and authorized by EOHHS to provide Medicaid home care and/or home health services.

8. "Homemaker" means a homemaker as defined in 216-RICR-40-10-17.

9. "Homemaker services" means services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for themself or others in the home.

10. "Nursing Assistant" means an individual who is registered and licensed by the Rhode Island Department of Health as a nursing assistant pursuant to the provisions of R.I. Gen. Laws § 23-17.9 and 216-RICR-40-05-22 and delivering services on behalf of a Medicaid home care and/or home health provider. Under this Title, the terms "nursing assistant," "Certified Nursing Assistant" or "CNA," and "home health aide" have the same meaning.

11. "Pass-through" means the funds paid to a Medicaid provider based on Medicaid-covered service(s) rendered, that must then be paid as compensation to the direct care staff who delivered the service(s).

12. "Personal care services" means a range of assistance to enable a beneficiary to accomplish tasks that they would normally do for themselves if they did not have a health condition preventing them from doing so. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task.

13. "Shift differential" means additional compensation to incentivize time worked outside of day shifts. These shifts include evenings from 3p.m. to 11p.m., nights from 11p.m. to 7a.m., weekends, and State holidays.

14. "State Fiscal Year" means each twelve (12) month period from July 1 to June 30 used for State financial reporting and budgeting under R.I. Gen. Laws § 35-2-1.

1.5 Home Care and Home Health Provider Eligibility

A. In addition to the general provider eligibility requirements in Part 20-00-1 of this Title, Medicaid Payments and Providers, a home care and/or home health provider must meet the following requirements to participate in the Rhode Island Medicaid program:

1. Be licensed by the Rhode Island Department of Health or, for providers located in border communities as defined in Part 20-00-3 of this Title, Medicaid Payments for Out-of-State Care, be in good standing with the licensure body in the provider's home state.

2. Be located and performing services in Rhode Island or in a border community as defined in Part 20-00-3 of this Title, Medicaid Payments for Out-of-State Care.

3. Be certified by the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicare program as a provider of home health services.

4. Obtain a Rhode Island Medicaid provider number before providing home care or home health services.

5. Agree to periodic inspections and audits, by EOHHS or its designee, that assess the quality of member care and ensure compliance with this Title.

6. Agree to comply with all other provisions of this Title.

1.6 Scope of Home Care and Home Health Services

A. Home Care Services – Medicaid home care services include personal care services, homemaker services, and combined personal care and homemaker services.

1. Home care services provided to Medicaid beneficiaries who are not enrolled in long-term services and supports (LTSS) must be ordered/prescribed by a physician and receive prior authorization approval. The home care provider must develop a written plan of care in accordance with 216-RICR-40-10-17. Non-LTSS home care services are limited to six (6) hours for an individual and ten (10) hours for a couple.

2. Home care services provided to Medicaid beneficiaries who are enrolled in LTSS must be included in the participant's person-centered plan for home and community-based services (HCBS), which must meet the requirements of 42 C.F.R. § 441.301(c)(2) (2023), and must receive prior authorization approval. The home care provider must develop a written plan of care in accordance with 216-RICR-40-10-17. LTSS home care services may exceed six (6) hours for an individual and ten (10) hours for a couple, but must be based on individual need as determined by the functional assessment described in Part 50-10-1 of this Title, LTSS Home and Community Based Services (HCBS).

3. Personal care, including when combined with homemaker services, may only be billed when delivered by a nursing assistant and cannot be billed when delivered by a homemaker.

4. Personal care services provided to Medicaid beneficiaries who are enrolled in LTSS may be delivered in an acute care hospital setting if these services are: described in the participant's person-centered service plan; provided to meet needs of the participant that are not met through the provision of hospital services; not a substitution for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the participant's functional abilities.

B. Home Health Services – Medicaid home health services, as defined in 42 C.F.R. § 440.70 (2023), include the following services provided by a home health provider in the patient's place of residence. Pursuant to § 1905(a)(7) of the Social Security Act, 42 U.S.C. § 1396d(a)(7), home health services are a mandatory Medicaid benefit and are provided to any Medicaid eligible individual based upon a determination of medical necessity as ordered by a physician and documented in a written plan of care that is reviewed at least every sixty (60) days.

1. Home Health Aide Services – Personal care and homemaker services that are generally incidental to skilled nursing services or therapies provided in the beneficiary's home. Home health aide services must be provided under supervision by a registered nurse or appropriate therapist.

2. Skilled Nursing Services

a. Skilled Nursing Services include the services of a registered nurse (RN) employed by or under contract with a home health provider. RN services include assessment of the individual's health status, identification of health care needs, determination of health care goals, and the development of the plan of care. Skilled nursing care includes teaching and counseling and is directed toward the promotion, maintenance, and restoration of health. The nurse evaluates responses of the family and individual to nursing interventions to determine the progress towards goal achievement and provider supervision to ancillary personnel.

b. Skilled Nursing Services are available for Medicaid beneficiaries experiencing acute or chronic periods of illness; must be required on a part-time or intermittent basis; and must be reasonable and necessary for the treatment of an illness or injury.

c. Skilled Nursing Services are also available for Medicaid beneficiaries who are experiencing or who are in the post-partum period following a high-risk pregnancy.

(1) Pregnancy-related Skilled Nursing Services must be provided by a Registered Nurse and be delivered to individuals at high risk of negative pregnancy outcomes.

(2) Services include evaluation of medical health status, obstetrical history, present and past pregnancy-related problems, and psychosocial factors such as emotional status, inadequate resources, supportive helping networks, and parenting skills. The provision for general health education also includes counseling, referral, instruction, suggestions, support and/or observation to monitor for any unforeseen changes in the condition of a prenatal or postpartum individual at high risk. This allows other medical or social services, when necessary, to be instituted during the prenatal or postpartum stage of childbearing.

(3) To document medical necessity for pregnancy-related Skilled Nursing Services, the home health provider must maintain the following documentation: An order signed and dated by a licensed physician; individual recipient case records documenting one or a combination of the high risk indicator(s); an individual recipient plan of care which describes the pregnancy-related preventive prenatal and postpartum skilled nursing service(s) being provided and concurrently identifies the particular skilled nursing service(s) rendered. All documentation shall be subject to review by authorized EOHHS personnel upon request.3. Medical supplies, equipment, and appliances – As defined in 42 C.F.R. § 440.70(b)(3) (2023). Also known as Durable Medical Equipment.

4. Physical, Occupational, and Speech Therapy Services delivered by a home health provider.

a. All therapy services must be prescribed by a physician and be directly related to an active plan of care designed by the prescribing physician and of such a level of complexity and sophistication that the judgment, knowledge, and skills of a qualified therapist are required. All therapies must be medically necessary under accepted standards of medical practice to the treatment of the patient's condition.

b. Therapy must be provided by a licensed Physical Therapist, Occupational Therapist, or Speech Therapist, as appropriate for the specific therapy.

1.7 Prior Authorization

A. Prior Authorization is required for all home care services.

1.8 Staff Assignment Requirements

A. For all Medicaid home care and home health services, staff must be assigned by the home care and/or home health provider based on staff availability and ability to serve each individual Medicaid beneficiary receiving services from the provider.

1. The provider may not assign direct care staff to provide services to a beneficiary with whom the direct care staff resides.

2. The provider may not assign direct care staff to provide services to a beneficiary to whom the direct care staff has a family relationship.

3. The provider may not assign direct care staff to provide services to a beneficiary for whom the direct care staff:

   a. Has any type of guardianship;

   b. Has any type of power of attorney;

   c. Is the authorized representative designated on the individual beneficiary's application for Medicaid benefits.

1.9 Plans of Care

A. All Medicaid home health services must be ordered by a physician and documented in a written plan of care. The plan must be signed by the attending physician and incorporated into the home health provider's permanent record for the patient, which relates services to the patient's condition. Pursuant to 42 C.F.R. § 440.70 (2023), for the initiation of each episode of home health services, the ordering physician must document that there was a face-to-face encounter with the beneficiary related to the primary reason the beneficiary requires home health services within the ninety (90) days before or within the thirty (30) days after the start of services. The physician's written plan of care must:

1. Include the diagnosis and description of the patient's functional limitation resulting from illness or injury.

2. Specify the type and frequency of needed service, e.g., skilled nursing services, drugs and medications, special diet, permitted activities, rehabilitation and therapy services, home health aide services, medical supplies equipment and appliances.

3. Provide a long-range forecast of likely changes in the patient's condition.

4. Be reviewed by the attending physician in consultation with professional agency personnel every sixty (60) days, or more frequently as the severity of the patient's condition requires. Reviews must be dated and signed by the physician.

5. Include a certification by the attending physician that the services and items specified in the treatment plan can be provided through a home health provider in the patient's place of residence.

6. Any changes to the plan must be documented in writing and signed by the attending physician or by a registered professional nurse on the agency staff pursuant to the physician's oral orders.

B. All non-LTSS Medicaid home care services must be furnished under a written plan of care according to 216-RICR-40-10-17.

C. All LTSS Medicaid home care services must be furnished under a written person-centered plan that meets the requirements of 42 C.F.R. § 441.301(c)(2) (2023) and a written plan of care according to 216-RICR-40-10-17.

1.10 Electronic Visit Verification (EVV)

A. Home care and home health providers must comply with requirements for Electronic Visit Verification (EVV) under § 12006(a) of the 21st Century Cures Act, Pub. L. No. 114-255, codified at 42 U.S.C. 1396b(l).

B. Home care and/or home health providers must meet Rhode Island EVV requirements by using the EOHHS EVV system or an alternate, third-party EVV system that meets EOHHS system requirements.

1.11 General Reimbursement Guidelines

A. Home care and/or home health providers must bill the Medicaid Program at the Medicaid rate, or at the same usual and customary rate as charged to the general public, whichever is lower.

B. Regardless of the amount billed, payments to providers will not exceed the maximum reimbursement rate of the Medicaid Program.

C. Home care and/or home health providers must submit claims to the Medicaid Program in accordance with the types of services provided.

1. If only personal care services are rendered, the time shall be billed as personal care.

2. If only homemaker services are rendered, the time shall be billed as homemaker.

3. When both homemaker and personal care services are delivered by a nursing assistant, the time shall be billed as combined personal care and homemaker services, regardless of the proportion of time spent on each individual service.

4. If personal care and/or homemaker services are rendered incident to skilled nursing services or therapies provided in the beneficiary's home such that they meet the home health aide service criteria, the time shall be billed as home health aide services rather than personal care or homemaker services.

1.12 Pass-Through Requirements

A. In order to ensure access to care in home and community-based settings, EOHHS pays an enhanced Medicaid rate, or shift differential modifier, to encourage the delivery of home care services outside of regular business hours (evenings, nights, weekends, and holidays). EOHHS also pays an enhanced Medicaid rate for home care services (personal care, homemaker, and combined personal care and homemaker) to providers who have at least thirty percent (30%) of their direct care staff certified in behavioral healthcare training through an approved behavioral health training program. In accordance with R.I. Gen. Laws § 40-8.9-9, home care providers are required to pass-through one hundred percent (100%) of the shift differential modifier increase directly to the direct care staff who render such services and one hundred percent (100%) of the behavioral healthcare training modifier increase directly to the direct care staff who have completed the behavioral healthcare training.

1.13 EOHHS Calculation of Pass-Through Amounts

A. EOHHS posts online, by November 30 following the close of the prior State Fiscal Year, a listing of the required pass-through amounts for each home care provider for the prior State Fiscal Year.

B. The shift differential pass-through amount is calculated utilizing all claims billed to Medicaid by each home care provider with shift differentials for service dates during the prior State Fiscal Year and paid through September 30. The shifts included are for Personal Care and Combined Personal Care and Homemaker services occurring during evening, night, weekend, and holiday hours. For each billed shift differential, EOHHS applies the amount specified in R.I. Gen. Laws § 40-8.9 to each paid claim.

C. The behavioral healthcare training pass-through amount is calculated utilizing all claims billed to Medicaid by each home care provider that qualifies for the behavioral healthcare training enhancement for service dates during the prior

State Fiscal Year and paid through September 30. For each billed behavioral healthcare training enhancement, EOHHS applies the amount specified in R.I. Gen. Laws § 40-8.9 to each paid claim.

1.14 Provider Compliance with Pass-Through Requirements

A. Following the November 30 posting of the required pass-through amounts by EOHHS, home care providers must submit to EOHHS an annual compliance statement by July 31 of the following calendar year. This compliance statement shall demonstrate that one hundred percent (100%) of the shift differential and behavioral healthcare training pass-through amounts calculated by EOHHS in the November 30 posting were passed through as compensation to direct care staff. EOHHS reserves the right to audit home care providers for compliance with these Regulations at any time.

1. Any home care provider that does not satisfy the compliance statement reporting requirement shall be subjected to a clawback of any unspent or impermissibly spent funds, paid by the home care provider to EOHHS. A list of non-compliant home care providers will be posted online by EOHHS.

    a. Any home care provider that fails to submit the compliance statement will be subject to clawback of the total pass-through amount calculated by EOHHS.

    b. Home care providers that submit the compliance statement but do not distribute one hundred percent (100%) of the required pass-through amount to direct care staff will be subject to clawback of any portion of the pass-through amount that is not distributed to direct care staff. However, if the home care provider is unable to pass-through the entire amount of money to direct care staff due to staff turnover, the home care provider, at EOHHS' discretion, may be granted thirty (30) additional days to pass through the remaining money and provide verification in the form of payroll documentation. If granted, the thirty (30) day period will begin the day after the compliance statement due date. If the home care provider is unable to pass through the money to direct care staff because they are no longer providing working with the home care provider and cannot be reached, the home care provider shall pass through the remaining funds to current direct care staff. Failure to distribute the remaining pass-through amount after the thirty (30) day period will result in a clawback of the remaining money.

1.15 Administrative Sanctions

A. Medicaid home care and/or home health providers that do not observe the requirements of this Part are subject to sanctions and notice requirements under the provisions of Part 20-00-1 of this Title, Medicaid Payments and Providers.

1.16 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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CHAPTER 20 - MEDICAID PAYMENTS AND PROVIDERS

SUBCHAPTER 05 - REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC PROVIDERS

PART 1 - HOME CARE AND HOME HEALTH PROVIDERS

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