rihca
Rhode Island Health Care Association
57 KILVERT STREET, SUITE 200, WARWICK, RI 02886-1009 (401) 732-9333
FAX (401) 739-3103 www.rihca.com

July 15, 2026

The Honorable Richard Charest - Secretary
Rhode Island Executive Office of Health and Human Services
3 West Road
Cranston, RI 02920

Re: Proposed Amendments to 210-RICR-20-00-1 – Medicaid Payments and Providers

Dear Secretary Charest:

On behalf of the Rhode Island Health Care Association (RIHCA), I am pleased to submit the enclosed publication entitled 'Administrative and Policy Analysis of Proposed Amendments to 210-RICR-20-00-1.'

RIHCA supports the overall modernization of Rhode Island's Medicaid provider enrollment regulations and appreciates EOHHS's efforts to align state requirements with current federal standards. Our recommendations are intended primarily to strengthen implementation through clear guidance, consistent administrative practices, provider education, and ongoing stakeholder engagement.

The enclosed review reflects the operational perspective of Rhode Island nursing facilities and is offered in the spirit of collaboration. We hope it serves as a practical resource as EOHHS finalizes and implements the regulation.

Thank you for the opportunity to provide comments. RIHCA looks forward to continuing to work with EOHHS to support successful implementation and high-quality care for Rhode Island Medicaid beneficiaries.

Sincerely,

John E. Gage, MBA, NHA
President & CEO
Rhode Island Health Care Association

rihca

Rhode Island Health Care Association

Enhancing Quality through Advocacy & Education

RIHCA Policy & Regulatory Review

RR-2026-01

Administrative and Policy Analysis
of Proposed Amendments to 210-RICR-20-00-1

Medicaid Payments and Providers

Final Publication
Version 3.1

PREPARED BY

John E. Gage, MBA, NHA
President & Chief Executive Officer
Rhode Island Health Care Association

SUBMITTED TO

The Honorable Richard Charest
Secretary
Rhode Island Executive Office of Health and Human Services

July 2026

Table of Contents

Contents

Foreword

Medicaid is the foundation upon which long-term care is delivered to thousands of Rhode Islanders. Because nursing facilities participate in virtually every aspect of the Medicaid program, regulatory modernization affects not only providers but also the residents and families who depend upon them.

The Rhode Island Health Care Association supports thoughtful modernization of Medicaid regulations that promotes accountability, strengthens program integrity, and aligns Rhode Island's requirements with evolving federal standards. At the same time, effective regulation must recognize the operational realities of delivering complex health care services while preserving providers' ability to devote their primary resources to resident care.

This publication reflects RIHCA's comprehensive review of the proposed amendments to 210-RICR-20-00-1. Our objective is to provide constructive policy analysis and practical implementation recommendations that support both effective administration and continued access to high-quality long-term care services throughout Rhode Island.

We appreciate the Executive Office of Health and Human Services' commitment to stakeholder engagement throughout this rulemaking process and look forward to continued collaboration during implementation of the final regulation.

John E. Gage, MBA, NHA
President & Chief Executive Officer
Rhode Island Health Care Association

Statement of Regulatory Philosophy

Regulation and Quality Care

RIHCA believes that effective regulation is essential to maintaining public confidence in the Medicaid program and protecting the health, safety, and welfare of the individuals served by Rhode Island's health care providers. Regulation establishes minimum standards for participation, promotes accountability, safeguards public resources, and helps ensure that providers possess the qualifications necessary to deliver high-quality services.

Implementation Matters

The effectiveness of regulation depends not only upon the standards adopted but also upon the manner in which those standards are implemented. Well-written regulations can become unnecessarily burdensome if administrative expectations are unclear, implementation varies among reviewers, or providers lack practical guidance regarding compliance.

Partnership Rather Than Adversarial Advocacy

RIHCA views the rulemaking process as an opportunity for collaboration between regulators and the provider community. Providers possess practical operational experience implementing Medicaid requirements daily, while regulators are responsible for ensuring program integrity and protecting public resources. These perspectives are complementary.

Program Integrity

RIHCA strongly supports initiatives designed to prevent fraud, waste, and abuse; promote ownership transparency; ensure accurate provider enrollment; strengthen provider accountability; and maintain public confidence in Medicaid.

Administrative Fairness

Administrative expectations should be clearly communicated, administrative decisions should be consistent, and technical administrative deficiencies should be distinguished from intentional misconduct where permitted by law. Educational assistance and corrective action frequently produce more durable compliance than punitive enforcement alone.

Resident-Centered Regulation

Every recommendation contained in this publication ultimately reflects one guiding objective: protecting Rhode Island residents by supporting high-quality care. Administrative processes should be designed to support-not unnecessarily divert from-the delivery of resident-centered care.

Executive Summary

This publication presents RIHCA's administrative and policy analysis of the proposed amendments to 210-RICR-20-00-1 governing Medicaid provider enrollment and participation. It is intended to support constructive rulemaking dialogue, inform implementation planning, and provide operational guidance for Rhode Island nursing facilities.

The proposed amendments modernize Rhode Island's Medicaid provider enrollment framework by consolidating provider eligibility, enrollment, ownership disclosure, screening, participation requirements, sanctions, and appeals into a single regulatory structure. Many provisions implement existing federal Medicaid requirements while improving organization and administrative consistency.

RIHCA supports the overall modernization of the regulation and recognizes the importance of maintaining program integrity, ownership transparency, and provider accountability. Rather than recommending broad revisions to the proposed rule, the Association focuses primarily on implementation strategies that promote consistency, provider understanding, and efficient administration.

For Rhode Island nursing facilities, the principal operational impacts involve provider enrollment, ownership disclosures, managing employee reporting, site visits, operational readiness verification, revalidation, reporting obligations, denial and termination standards, and administrative sanctions. Because nursing facilities already operate under extensive federal and state oversight, implementation should complement existing regulatory systems wherever permissible.

Principal Recommendations

1. Adopt the proposed regulation substantially as published.
2. Develop comprehensive implementation guidance before the effective date.
3. Publish a Provider Enrollment Manual and Frequently Asked Questions.
4. Standardize site visit procedures and ownership reporting guidance.
5. Conduct statewide provider education.

6. Establish ongoing stakeholder engagement during implementation.
7. Evaluate implementation using objective performance measures.

RIHCA believes the proposed amendments establish a sound framework for modernizing Rhode Island's Medicaid provider enrollment program. The Association respectfully offers the recommendations contained in this publication to assist EOHHS in implementing the regulation in a manner that promotes program integrity, administrative efficiency, and continued access to high-quality care for Rhode Island Medicaid beneficiaries.

Methodology and Sources

This publication was prepared following review of the proposed amendments to 210-RICR-20-00-1 as provided in the June 30, 2026 Rhode Island Department of State Rules and Regulations Notification, comparison to cited federal Medicaid authorities where reflected in the proposed text, and operational analysis from the perspective of Rhode Island nursing facilities. Recommendations are categorized as regulatory, administrative implementation, educational initiatives, or operational guidance.

Source note. The proposed rule text reviewed includes Title 210, Chapter 20, Part 1, Medicaid Payments and Providers, including sections 1.1 through 1.12 and related federal citations embedded in the proposal. All citations and section references should be verified against the version formally published by the Rhode Island Secretary of State before filing.

Master Recommendation Library

A. Regulatory Text Recommendations

ID	Recommendation	Priority
A-1	Clarify operational readiness language if final text could be read to duplicate nursing facility survey functions.	Medium
A-2	Clarify staffing verification language for nursing facilities if necessary to avoid creation of new enrollment-based staffing standards.	Medium

B. Administrative Implementation Recommendations

ID	Recommendation	Priority
B-1	Publish a comprehensive Provider Enrollment Manual.	High
B-2	Publish standardized statewide Site Visit Protocols.	High
B-3	Develop an Ownership Disclosure Guide with examples and sample organizational charts.	High
B-4	Clarify managing employee reporting expectations through examples.	High
B-5	Develop reporting checklists and standardized forms.	High
B-6	Standardize administrative communications for enrollment, deficiencies, site visits, and revalidation.	Medium
B-7	Establish an implementation Technical Assistance Program.	High
B-8	Develop an implementation Performance Dashboard.	Medium
B-9	Conduct quarterly stakeholder meetings during the first implementation year.	High

C. Educational Initiatives

ID	Recommendation	Priority
C-1	Conduct statewide provider webinars and recorded training.	High
C-2	Develop an administrator toolkit and facility readiness materials.	High
C-3	Maintain dynamic implementation FAQs.	High

D. Operational Guidance

ID	Recommendation	Priority
D-1	Issue revalidation reminders and standardized timelines.	High
D-2	Coordinate continuity-of-care procedures when enrollment changes affect residents.	High
D-3	Encourage centralized Medicaid enrollment files and internal compliance audits.	Medium

Part I - Medicaid Provider Enrollment Modernization

Chapter 1 - Provider Eligibility, Enrollment, and Screening Requirements (§ 1.6)

Executive Overview

Section 1.6 is the operational foundation of the proposed regulation. It establishes standards that determine whether a provider may initially enroll in, continue participating in, and remain eligible for the Rhode Island Medicaid program.

For Rhode Island nursing facilities, this section is particularly significant because Medicaid participation is fundamental to the delivery of long-term services and supports. Enrollment requirements should therefore be viewed as core participation standards affecting virtually every Medicaid-certified nursing facility.

The proposed rule modernizes Rhode Island's enrollment framework by consolidating provider eligibility requirements, ownership disclosures, screening standards, site visit procedures, reciprocity provisions, provider agreements, and ongoing enrollment obligations into a single integrated regulatory structure.

Issue	RIHCA Position	Primary Recommendation
Enrollment requirements	Support	Retain framework and publish Provider Enrollment Manual.
Basic eligibility standards	Support with clarification	Standardize communications and documentation expectations.
Ownership disclosures	Support with clarification	Publish Ownership Disclosure Guide and examples.
Provider screening	Support	Provide education and risk-category guidance.
Site visits	Support with clarification	Publish Site Visit Protocols and clarify relationship to existing survey/licensure oversight.
Revalidation and reporting	Support with clarification	Issue revalidation timelines, reminders, and reporting checklists.

Enrollment Requirements and Basic Eligibility Standards

Subsections 1.6(A) and 1.6(B) establish the threshold requirements for participation in the Rhode Island Medicaid program. They clarify that providers furnishing Medicaid-covered services must enroll with EOHHS and maintain enrollment as a condition of participation.

RIHCA supports the Department's clarification that enrollment constitutes an ongoing condition of participation rather than a discrete administrative event. For nursing facilities, these provisions largely reinforce existing expectations. Facilities already maintain state licensure, federal certification, Medicare participation where applicable, compliance programs, regulatory reporting systems, and survey readiness processes.

Bottom line. RIHCA supports the proposed enrollment framework. The Association's implementation recommendations are summarized in Recommendations B-1, B-5, B-6, and D-3.

Ownership Disclosure, Controlling Interests, and Managing Employees

Ownership transparency is a cornerstone of Medicaid program integrity. Section 1.6(C) organizes disclosure requirements concerning ownership, controlling interests, managing employees, business relationships, and related program integrity information.

RIHCA supports robust ownership disclosure requirements and recognizes that many disclosure requirements implement existing federal law. Because nursing facilities may operate through layered organizational structures involving separate entities for real estate ownership, licensed operations, management services, financing, and affiliated companies, implementation guidance will be essential to accurate reporting.

Complex ownership structures should not be viewed as indicators of inappropriate conduct. Many facilities operate through multiple legal entities for legitimate financing, tax, property, liability, and succession-planning reasons. Implementation should focus on accurate disclosure rather than organizational simplicity.

Bottom line. RIHCA supports ownership transparency and recommends practical reporting examples and standardized guidance. See Recommendations B-3 and B-4.

Provider Screening, Site Visits, Fingerprinting, and Verification

Section 1.6(D) establishes the Department's provider screening framework. It authorizes risk-based screening, verification of enrollment information, database checks, site visits, fingerprint-based screening for high-risk providers, and verification of operational readiness.

RIHCA supports provider screening as an important program integrity tool. The Association's recommendations focus on how screening should be implemented to ensure consistency, transparency, and administrative fairness.

Site visits should complement-not duplicate-existing licensure and certification reviews. Nursing facilities already operate under extensive Rhode Island Department of Health licensure and CMS certification oversight. Enrollment site visits should verify provider eligibility and operational readiness rather than perform clinical survey functions already addressed through other regulatory processes.

The proposed rule's reference to staffing verification should be clarified for nursing facilities. RIHCA recommends that EOHHS clarify that this provision is intended to verify operational capability for enrollment purposes and is not intended to establish new staffing requirements or duplicate existing federal and state staffing oversight.

Bottom line. RIHCA supports the proposed screening framework and recommends standardized site visit and operational readiness guidance. See Recommendations A-1, A-2, B-2, B-6, and C-1.

Managed Care, Reciprocity, Provider Agreements, Effective Dates, Reporting, Revalidation, and Continuity of Care

The remaining provisions of § 1.6 address managed care provider requirements, reciprocity with Medicare and other state Medicaid agencies, provider agreements, trading partner requirements, electronic funds transfer, effective and end dates of enrollment, ongoing checks, reporting changes, revalidation, and continuity of care.

RIHCA supports reciprocity with Medicare screening results where the provider is the same in Medicare and Medicaid and is in approved status. Reciprocity reduces duplication while preserving program integrity.

Reporting-change provisions should be implemented with clear guidance identifying reportable events, deadlines, required documentation, and submission processes.

Bottom line. RIHCA supports these provisions and recommends clear reporting, revalidation, and continuity-of-care guidance. See Recommendations B-5, D-1, and D-2.

Part II - Enforcement Framework

Chapter 2 - Denial, Termination, Administrative Sanctions, and Appeals (§§ 1.7-1.12)

Executive Overview

Sections 1.7 through 1.12 establish the enforcement framework governing provider participation in the Rhode Island Medicaid program. Collectively, these provisions identify the circumstances under which EOHHS may deny enrollment, terminate participation, impose administrative sanctions, recover payments, suspend participation, and provide administrative review and appeal.

RIHCA recognizes that EOHHS must possess effective enforcement authority to protect Medicaid beneficiaries, ensure responsible stewardship of public funds, and address fraud, abuse, and material noncompliance. The Association supports the Department's enforcement authority while recommending consistent, transparent, proportional, and procedurally fair implementation.

Denial of Eligibility (§ 1.7)

Section 1.7 identifies the circumstances under which EOHHS may deny an application for Medicaid enrollment or continued participation. The proposed section includes circumstances involving incomplete applications, failure to cooperate, exclusion from federal health care programs, false or misleading information, criminal convictions where applicable, ownership concerns, and other factors affecting provider eligibility.

RIHCA supports EOHHS's authority to deny enrollment where required by federal law or where the Department determines that an applicant is not qualified to participate in Medicaid. Implementation guidance should distinguish material eligibility deficiencies from technical or administrative deficiencies that may be corrected without compromising program integrity.

Bottom line. RIHCA supports the denial framework and recommends transparent notices, reasonable opportunities to supplement incomplete applications where permitted, and clear guidance distinguishing curable deficiencies from mandatory denial circumstances.

Provider Participation and Termination (§§ 1.8-1.9)

Sections 1.8 and 1.9 address continuing participation requirements and termination of participation. For nursing facilities, termination can affect residents, families, employees, hospitals, managed care organizations, and discharge planning.

RIHCA supports the Department's authority to terminate participation when required by law or necessary to protect Medicaid beneficiaries and program integrity. When termination affects an operating nursing facility, implementation should coordinate with relevant agencies and managed care organizations to preserve continuity of resident care.

Bottom line. RIHCA supports the participation and termination provisions and recommends guidance distinguishing mandatory termination from discretionary action, with interagency coordination where resident care may be affected.

Administrative Sanctions and Appeals (§§ 1.10-1.12)

Administrative sanctions serve an important program integrity function by allowing EOHHS to address noncompliance without necessarily terminating a provider's participation in Medicaid. RIHCA supports graduated enforcement tools that allow the Department to tailor responses to the seriousness of the conduct at issue.

RIHCA recommends that sanctions be applied according to proportionality, consistency, and corrective compliance where appropriate. Appeals should be timely, clear, and supported by a complete administrative record that allows providers to understand the basis of Department decisions.

Enforcement Principle	Application
Protect beneficiaries first	Prioritize health, safety, continuity of care, and protection of public funds.
Distinguish risk levels	Separate fraud or intentional misconduct from administrative deficiencies.
Promote voluntary compliance	Use education, technical assistance, and corrective action where legally permissible.
Ensure consistency	Use standardized review procedures and supervisory oversight.
Preserve transparency	Provide clear notices, factual bases, and appeal rights.

Bottom line. RIHCA supports a strong enforcement framework and recommends administrative practices that promote due process, consistency, proportionality, and resident access to care.

Part III - Implementation Framework

Chapter 3 - Implementation Strategy

The following implementation recommendations are offered to assist EOHHS in implementing the proposed amendments in a manner that promotes consistent statewide administration, supports provider compliance, and advances the Department's program integrity objectives. These recommendations can be implemented administratively and do not require changes to the proposed regulatory text.

Implementation Area	Actions
Provider Education	Provider Enrollment Manual, webinars, regional training, recorded education, implementation FAQs.
Administrative Guidance	Ownership examples, managing employee examples, reporting checklists, site visit guidance.
Communications	Standard notices, revalidation reminders, technical assistance contacts, provider bulletins.
Continuous Improvement	Quarterly stakeholder meetings, performance dashboard, annual implementation review, guidance updates.

Implementation Roadmap

Phase	Timeframe	Recommended EOHHS Actions
Phase I	Before Effective Date	Publish Provider Enrollment Manual, FAQs, standardized forms, site visit protocols, and technical guidance.
Phase II	First 6 Months	Conduct statewide education, open technical assistance channels, and hold stakeholder meetings.
Phase III	First Year	Evaluate enrollment processing, deficiency resolution, site visit consistency, revalidation completion, appeals, and provider inquiries.
Continuous Improvement	Ongoing	Update guidance, maintain FAQs, review performance metrics, and continue stakeholder engagement.

Performance Dashboard

Performance Area	Suggested Measure	Desired Direction
Enrollment Administration	Average application processing time	Decrease
Ownership Reporting	Percentage of complete ownership disclosures	Increase
Provider Education	Webinar participation and FAQ use	Increase
Site Visits	Timely completion and	Improve

	documentation turnaround	
Administrative Enforcement	Appeal frequency and resolution time	Monitor / decrease where appropriate
Stakeholder Engagement	Implementation issues resolved through meetings	Increase

Appendix A – Federal Requirements vs. State Administrative Discretion

Topic	Federal Requirement Present?	State Administrative Discretion	RIHCA Recommendation
Enrollment screening	Yes	Limited in core requirements; meaningful in procedures	Provide education and clear procedures.
Ownership disclosures	Yes	Moderate in forms, examples, and guidance	Publish Ownership Disclosure Guide.
Site visits	Yes for specified risk levels	Significant in protocols and communication	Publish standardized Site Visit Protocols.
Fingerprinting	Yes for high-risk categories	Limited	Publish affected-provider guidance.
Corrective action	Partially	Significant where not federally precluded	Use corrective action for administrative deficiencies.
Provider education	No	Complete	Partner with RIHCA on statewide education.

Appendix B - Technical Drafting Corrections

The proposed rule text reviewed contains apparent formatting artifacts and drafting inconsistencies that should be reviewed before final publication. RIHCA recommends that EOHHS conduct a technical proofreading pass to correct non-substantive errors and ensure clarity.

Issue Type	Example / Description	Recommended Action
Formatting artifact	Merged words or remnants such as "requiresEOHHS" or "poisedprepared" appear in the working draft.	Correct typographical artifacts.
Numbering inconsistency	Some sections appear to contain duplicate numbering or formatting remnants.	Renumber sections and subparagraphs consistently.
Citation year typo	Some references appear as 20251 or otherwise inconsistent.	Verify all federal citation years.
Duplicated heading text	Some headings appear to combine old and new language.	Finalize clean heading text.
Table formatting	Some conviction and eligibility tables display formatting artifacts.	Reformat tables for clarity.

Appendix C - Nursing Facility Operational Considerations

- Nursing facilities operate continuously and maintain extensive resident-care obligations.
- Facilities are already subject to RIDOH licensure, CMS certification, Life Safety Code surveys, emergency preparedness requirements, and Medicaid cost reporting.
- Implementation should complement existing oversight wherever permissible.
- Enrollment actions affecting operating facilities should be coordinated to preserve continuity of resident care.
- Provider education should be tailored to administrators, business office personnel, compliance officers, and corporate leadership.

Appendix E - Companion Publications

Publication	Purpose
RR-2026-02 Official Comments to EOHHS	Formal public comment submission derived from this master analysis.
RR-2026-03 Comprehensive Regulatory Analysis	Technical reference and regulatory crosswalk.
RR-2026-04 Member Implementation Guide	Operational guide for nursing facility leaders.
RR-2026-05 Compliance Toolkit	Templates, checklists, and audit tools.
RR-2026-06 Board Presentation	Governance-level presentation.
RR-2026-07 Administrator Quick Reference Guide	Two-page implementation checklist.

Appendix F - Glossary

Term	Working Definition
Administrative implementation	Actions EOHHS can take through guidance, forms, procedures, education, and communication without amending regulatory text.
Managing employee	A person whose role requires disclosure under applicable Medicaid enrollment standards; examples should be clarified by EOHHS guidance.
Operational readiness	A provider's ability to begin or continue operations consistent with provider type requirements, licensure, staffing, records, and billing capacity.
Program integrity	Policies and activities intended to prevent fraud, waste, abuse, improper enrollment, and improper payment.
Revalidation	Periodic review of provider enrollment information to confirm continued eligibility and accuracy of records.
Site visit	EOHHS enrollment verification activity used to confirm provider location, operations, records, and eligibility criteria.

Final Conclusions

Following comprehensive review of the proposed amendments to 210-RICR-20-00-1, RIHCA concludes that the proposed regulation represents a thoughtful and appropriate modernization of Rhode Island's Medicaid provider enrollment framework.

RIHCA supports adoption of the proposed regulation, together with the implementation recommendations contained in this publication. The Association remains committed to working collaboratively with EOHHS to support successful implementation and to ensure that Rhode Island's Medicaid program continues to provide high-quality, accountable, and accessible care for the residents who depend upon it.

July 27, 2026

Madeline Becker
Executive Office of Health and Human Services
Virks Building
3 West Road
Cranston, RI 02920

Sent by email: madeline.becker@ohhs.ri.gov

Re: Careforth Comments on Proposed Amendment of EOHHS Rule, Medicaid Payments and Providers, 210-RICR-20-00-1

Dear Maddy,

Careforth appreciates the opportunity to comment on the proposed amendments to *Medicaid Payments and Providers, 210-RICR-20-00-1*. Careforth is a long-standing provider of RIte@Home Shared Living services to older adults and adults with disabilities who qualify for Medicaid Long-Term Services and Supports and are unable to live independently without assistance.

Careforth supports EOHHS's efforts to strengthen program integrity and is generally supportive of the proposed amendments to provider enrollment and screening requirements. We are submitting this comment letter to request clarification specifically as it relates to the RIte@Home Shared Living service.

Careforth seeks clarification regarding the application of Section 1.6(D)(1) of the Amended Rule to Shared Living Agencies. The Amended Rule identifies "Shared living caregivers providing direct care to individuals under the EOHHS Shared Living Program" as high-risk providers, but does not identify "Shared Living Agency" as a high-risk provider type. Shared Living Agency is identified only as a provider type under the definition of "provider type" in the Amended Rule.

Based on our reading of the proposed regulation, the risk-screening designation appears to apply by provider type or provider category and does not elevate a Shared Living Agency to high-risk status solely because Shared Living caregivers are categorized as high-risk "providers".

Careforth respectfully requests confirmation that Shared Living Agencies are not considered high-risk providers under Section 1.6(D)(1) solely by virtue of the high-risk designation applicable to caregivers participating in Shared Living.

Thank you for your consideration of this request for clarification.

Respectfully submitted,

Lori Sims

Lori Sims
Director of Government Relations
Lori.sims@careforth.com

Cc: Karen Statser

LeadingAge Connecticut & Rhode Island

July 28, 2026

Maddy Becker
Executive Office of Health and Human Services
Virks Building
3 West Road
Cranston, RI 02920

Re: Comments of LeadingAge Connecticut & Rhode Island on Proposed Regulation 210-RICR-20-00-1 Related to

Medicaid Payments and Providers

LeadingAge Connecticut & Rhode Island is a membership association representing nonprofit organizations that provide housing, care, and services to older adults throughout Rhode Island. Many of our members participate in the Medicaid program and deliver essential services to older adults who rely on Medicaid coverage.

On behalf of our members, we respectfully submit the following comments regarding the Executive Office of Health and Human Services' proposed regulation, **210-RICR-20-00-1: Medicaid Payments and Providers**.

1.6 Provider Eligibility – Enrollment and Screening Requirements

We are concerned that the proposed eligibility requirements include a new provision that is overly broad and could potentially disqualify a significant number of qualified aging services providers from participation in the Medicaid program.

The proposed disqualifying criterion states that a provider must:
"Never have been the subject of any disciplinary action, sanction, limitation, or restriction imposed by any state agency, federal agency, or board."

This provision fails to account for the realities of the current state and federal inspection and oversight processes. Aging services providers are routinely subject to extensive regulatory review, and surveys often result in findings of varying severity that could be characterized as disciplinary actions, sanctions, limitations, or restrictions. These findings may range from minor deficiencies that are promptly corrected to more significant enforcement actions.

The use of the word "never" is particularly problematic. It creates what appears to be a lifetime prohibition and does not distinguish between:

- A current license limitation;

- A serious exclusion or program termination;
- A fraud-related conviction or enforcement action; or
- A minor, historical, corrected, or otherwise unrelated regulatory finding.

While we understand that the state's intent may be to establish a high standard that captures only the most serious disciplinary actions, the current language is far broader than that objective and could produce unintended consequences. As drafted, it risks excluding providers that have maintained good standing and provided high-quality services for many years despite having experienced routine regulatory findings at some point in their history.

We respectfully urge the Executive Office of Health and Human Services to reconsider and revise this provision so that it is appropriately tailored to address serious and material compliance concerns rather than any disciplinary action, regardless of severity, age, or relevance.

Provider Appeals and Regulatory Discretion
More broadly, we are concerned that several provisions throughout the proposed regulations are unduly restrictive and do not provide adequate opportunities for provider appeal or the exercise of reasonable regulatory discretion.

In particular, the proposed **site visit** provisions would disqualify a provider if a second attempt to conduct an unannounced site visit is unsuccessful. While the regulations provide an opportunity for a provider to cure deficiencies identified during a site visit, they offer no comparable opportunity to appeal or otherwise address circumstances in which the site cannot be accessed within the first two attempted visits.

Although the state has a legitimate interest in ensuring access for enrollment and screening purposes, there may be valid and unavoidable circumstances that prevent access at a given time. For example, infection control protocols, public health quarantines, or other emergency conditions may temporarily restrict entry to a facility. While such situations may be uncommon, the regulations should include a mechanism for providers to explain these circumstances and request reasonable accommodations or review before facing disqualification.

Accordingly, we recommend that the regulations incorporate an appeal process and provide the agency with discretion to consider documented extenuating circumstances when evaluating unsuccessful site visits.

Notice of Suspension or Termination
Finally, we object to the proposed removal of the requirement that providers receive notice by registered mail of an intent to formally suspend or terminate participation.

Registered mail provides clear documentation of when legal notice has been sent and received. Eliminating this requirement could create uncertainty regarding the timing and receipt of important notices and may undermine due process protections for providers facing significant enforcement actions.

We respectfully recommend retaining the registered mail notification requirement, or at a minimum adopting an alternative method that provides comparable proof of delivery and receipt.

Conclusion

LeadingAge Connecticut & Rhode Island appreciates the opportunity to comment on proposed regulation 210-RICR-20-00-1. We support the state's efforts to maintain program integrity and accountability within the Medicaid program. However, we urge the Executive Office of Health and Human Services to revise the provisions discussed above to ensure that qualified providers are not unnecessarily excluded from participation and that appropriate procedural safeguards, appeal rights, and regulatory discretion are preserved.

Thank you for your consideration of these comments.

Respectfully submitted,

Mag Morelli, President
LeadingAge Connecticut & Rhode Island

APhA
American Pharmacists Association

July 29, 2026

Maddy Becker
Executive Office of Health and Human Services
Virks Building
3 West Road
Cranston, RI 02920

RE: Public Comment on Proposed Amendment to 210-RICR-20-00-1 (Medicaid Payments and Providers) — Pharmacist Provider Enrollment and Controlled-Substance Registration

Dear Ms. Becker:
The American Pharmacists Association (APhA) appreciates the opportunity to comment on the proposed amendment to 210-RICR-20-00-1.[1,2] APhA supports the Executive Office of Health and Human Services' (EOHHS) efforts to strengthen Medicaid provider enrollment and program integrity. Because the proposed amendment is intended to codify and fully document Rhode Island Medicaid's provider enrollment processes, APhA respectfully urges EOHHS to address two narrow issues before adopting the final rule.

APhA recommends that EOHHS:

- Add "Pharmacist" to the recognized provider types in § 1.3(A)(14) and configure the enrollment portal to accept individual pharmacists, using a Type 1 NPI, for the enrollment role applicable under EOHHS policy, including ordering, prescribing, or referring (OPR)-only enrollment.
- Revise § 1.6(B)(2)(d) so that state and federal controlled-substance registrations are required only when applicable to the controlled substances an individual provider prescribes or intends to prescribe.

These corrections would permit Rhode Island Medicaid to recognize pharmacists as individual providers while preserving EOHHS's authority over covered services, reimbursement, credentialing, and program integrity.

1. The proposed rule creates an enrollment mismatch for pharmacists.
The proposed rule defines a "Provider" to include an individual or entity that furnishes Medicaid-funded items or services or orders, prescribes, or refers for those items or services, when legally authorized to do so under state law. Section 1.6(A)(1) then requires each furnishing or OPR provider to enroll with EOHHS under the appropriate provider type as a condition of Medicaid payment.

[1] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2026-06/Public%20Notice_210-RICR-20-00-1.pdf
[2] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2026-06/Proposed%20Rule%20210-RICR-20-00-1.pdf

2215 Constitution Ave. NW
Washington, DC 20037
800 237 2742
pharmacist.com

Rhode Island law authorizes pharmacists to provide numerous patient care services and The FY 2027 budget further added independent pharmacist prescribing authority for specified drug categories and devices, subject to regulations adopted by the Department of Health. The expanded categories include medications for opioid use disorder treatment, tobacco cessation, hyperlipidemia, asthma or COPD, diabetes, hypertension, and treatment following specified positive point-of-care tests.[3,4]

Nevertheless, the proposed list of recognized provider types in § 1.3(A)(14) includes "Pharmacy" and "OPR Only," but not "Pharmacist." "Pharmacy" is an organizational provider type, not the individual practitioner who issues a prescription. The proposed rule itself requires a Type 2 NPI for organizational providers and a Type 1 NPI for individual providers, and separately identifies pharmacies among organizational providers subject to an application fee.

The generic "OPR Only" category does not resolve this problem unless the enrollment portal and its licensure and taxonomy validation are configured to recognize an individual pharmacist. Rhode Island stakeholders report that the current portal does not provide a pharmacist pathway. Because the rule is intended to fully document the provider enrollment architecture, expressly listing "Pharmacist" is the clearest and most durable way to eliminate ambiguity. At minimum, the final rule and accompanying enrollment guidance should expressly confirm that pharmacists may enroll as OPR-only providers and should ensure that the portal can accept and validate those applications.

2. Enrollment is necessary for pharmacist-issued prescriptions to be payable for Medicaid beneficiaries.
Rhode Island Medicaid has advised providers that pharmacy claims deny when the prescriber is not enrolled and that prescribers may enroll either as billing providers or as OPR-only, non-billing providers.[5]

This policy reflects federal Medicaid requirements. CMS guidance explains that claims for ordered, referred, or prescribed items must contain the NPI of the professional who issued the order or prescription and that the state must validate whether the NPI belongs to an enrolled provider. When an eligible provider actually writes the prescription, another practitioner's NPI may not be substituted for that individual's NPI.[6]

Accordingly, the absence of a workable pharmacist enrollment pathway is not merely an administrative inconvenience. It can prevent a dispensing pharmacy's claim from being paid when a Medicaid beneficiary presents a prescription lawfully issued by a pharmacist.

3. Adding the provider type would implement existing legislative direction without deciding payment policy.
In 2023, the General Assembly authorized pharmacist prescribing of hormonal contraceptives and directed the Secretary of EOHHS to pursue and implement any necessary Medicaid waiver amendments, State Plan Amendments, or changes to rules, regulations, and procedures "as soon as practicable." That direction took effect July 1, 2023.[3]

The 2026 scope expansion increases the importance of completing the enrollment infrastructure. It also requires EOHHS, by January 1, 2027, to report on payment parity, network adequacy, technology

[3] https://webserver.rilegislature.gov/PublicLaws/law23/law23234.htm
[4] https://webserver.rilegislature.gov/PublicLaws/law26/law26084-12.htm
[5] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/pu312.pdf
[6] https://www.medicaid.gov/medicaid/program-integrity/downloads/mpec.pdf

upgrades, Medicaid impacts—including potential State Plan Amendments and managed care organization contracts—and alignment across insurance markets.[4]

Adding "Pharmacist" as a provider type now would not, by itself, establish a covered service, create a reimbursement rate, compel any pharmacist to enroll or prescribe, or confer broad provider status. Those policy questions can remain within the State Plan, EOHHS guidance, managed care contracts, and the forthcoming report. The requested correction would simply ensure that the enrollment architecture can recognize an individual practitioner whom Rhode Island law authorizes to prescribe.

4. The controlled-substance registration requirement should be tied to actual applicability.
As drafted, § 1.6(B)(2)(d) requires a provider to:

> "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."

The trigger is authority to prescribe any "medications," even when the individual prescribes no controlled substances. This could require a pharmacist who enrolls solely to prescribe hormonal contraceptives, antihypertensives, insulin, inhalers, or other noncontrolled medications to obtain and maintain controlled-substance registrations that are unrelated to the pharmacist's practice.

At the same time, the 2026 law includes medication-assisted treatment for opioid use disorder among the categories that may be addressed through implementing regulations. The final rule should therefore not assume that controlled-substance registration is categorically irrelevant to pharmacists. Instead, the requirement should apply when an individual provider will prescribe controlled substances and is required by state or federal law to hold the applicable registration.

APhA recommends replacing § 1.6(B)(2)(d) with:

> "Maintain all state and federal controlled-substance registrations required by law for any controlled substances the provider prescribes or intends to prescribe."

This language is consistent with § 1.6(C)(1)(d), which requires proof of a DEA registration "where applicable," and maintains appropriate program-integrity protections without imposing an unnecessary credential on providers who prescribe only noncontrolled medications.

5. CMS has approved pharmacist provider recognition in other state Medicaid programs.
CMS approved Delaware State Plan Amendment 24-0008 in September 2024, expressly adding pharmacists as a provider type and recognizing pharmacist services furnished within the scope of state law. Delaware addressed payment through its existing professional fee-schedule methodology.[7]

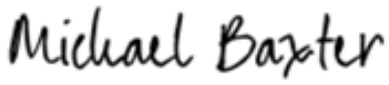
The Delaware approval demonstrates that pharmacist recognition is compatible with federal Medicaid requirements and that enrollment architecture, covered services, and payment methodology can be addressed in a deliberate sequence. The precedent simply confirms that recognizing pharmacists as individual Medicaid providers is administratively and legally feasible.

APhA appreciates EOHHS's consideration of these comments and would welcome the opportunity to provide technical assistance regarding pharmacist taxonomy, licensure verification, OPR enrollment, or the pharmacist scope-of-practice report required by R.I. Gen. Laws § 42-7.2-21. If you have any questions or

[7] https://www.medicaid.gov/medicaid/spa/downloads/DE-24-0008.pdf

require additional information, please don't hesitate to contact E. Michael Murphy, PharmD, MBA, APhA Senior Advisor for State Government Affairs, by email at mmurphy@aphanet.org.

Sincerely,



Michael Baxter
Vice President, Government Affairs

About APhA: APhA is the largest association of pharmacists in the United States, advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health. **In Rhode Island, with 1,170 licensed pharmacists and 1,590 pharmacy technicians, APhA represents the pharmacists and student pharmacists who practice in numerous settings and provide care to many of your constituents.** As the voice of pharmacy, APhA leads the profession and equips members for their role as the medication expert in team-based, patient-centered care. APhA inspires, innovates, and creates opportunities for members and pharmacists worldwide to optimize medication use and health for all.

Monday, July 27, 2026

Madeline Becker
Executive Office of Health and Human Services
Virks Building, 3 West Road
Cranston, RI 02920
madeline.becker@ohhs.ri.gov

RE: Public Comment on Proposed Amendment to 210-RICR-20-00-1 (Medicaid Payments and Providers) — Omission of a Pharmacist Provider Type

Dear Ms. Becker,

I'm Jeffrey Bratberg, a pharmacist licensed in the State of Rhode Island. I am submitting this comment in my individual capacity as a licensed pharmacist, not on behalf of any employer, institution, or organization. I write because the proposed amendment, as drafted, would prevent Rhode Island pharmacists from being recognized for services the General Assembly has authorized them to provide.

The proposed rule authorizes no way for a pharmacist to enroll as a prescriber.

Rhode Island law now authorizes pharmacists to prescribe. Under R.I. Gen. Laws § 5-19.1-36 (2023), a pharmacist may prescribe and dispense short-term hormonal contraceptives. Under R.I. Gen. Laws § 5-19.1-36.1, enacted in this year's budget, a pharmacist may independently prescribe medications including inhalers for asthma and COPD, insulin and diabetes medications, medications for blood pressure and cholesterol, tobacco-cessation products, and treatment following a positive point-of-care test for influenza, COVID-19, or group A strep.

The proposed rule defines a "Provider" at § 1.3(A)(13) by function — any individual legally authorized by the State to order, prescribe, or refer — and § 1.6(A)(1) requires every such Provider to enroll with EOHHS as a condition of Medicaid payment. But the list of recognized provider types at § 1.3(A)(14) does not include "Pharmacist." "Pharmacy" is listed, but a pharmacy is the dispensing business, enrolled on an organizational NPI; it is not the individual clinician, and it cannot be the prescriber on a claim.

The result falls on Medicaid patients.

The effect is that a Rhode Island pharmacist can be authorized by the State to write a prescription that cannot be attributed to any enrolled prescriber — which means the claim can be denied and the patient's medication left unfilled. This is not because the medication is uncovered, and not because the dispensing pharmacy is unenrolled. It is because the prescriber has no provider type under which to enroll. A newly enacted state law is, in practical terms, inoperable for the Medicaid population until this is fixed.

Why this matters to me as a licensed pharmacist.

Rhode Island made a deliberate decision to expand what pharmacists are permitted to do, in order to improve access to care. That decision is undermined if the Medicaid program provides no way for pharmacists to be recognized for the services the State has authorized. As a licensed pharmacist, I have a direct professional interest in pharmacists being able to practice to the full extent of their license, and in Medicaid beneficiaries — often the patients with the fewest alternatives — being able to receive the care the General Assembly intended for them. A prescription a pharmacist is legally authorized to write should not be one a Medicaid patient is unable to fill.

This change is overdue, and it is well precedented.

When Rhode Island authorized pharmacist prescribing of contraceptives in 2023, the same law directed the Secretary of the Executive Office of Health and Human Services to pursue and implement any state plan amendment, waiver amendment, or changes to rules and procedures needed to carry it out, *"as soon as practicable"* (P.L. 2023, ch. 234). Three years later, there is still no provider type under which a pharmacist can enroll. Other states have already closed this gap: Delaware added pharmacist as a Medicaid provider type with CMS approval in 2024, and North Carolina recognizes and reimburses qualifying clinical pharmacist practitioners. Adding a pharmacist provider type would bring Rhode Island in line with steps CMS has already approved elsewhere.

What I am asking.

I respectfully ask EOHHS to make two changes before this rule is finalized:

1. **Add "Pharmacist" to the list of recognized provider types in § 1.3(A)(14),** so that a licensed pharmacist authorized by Rhode Island law to prescribe can enroll and be recognized as the prescriber on a claim.
2. **Correct § 1.6(B)(2)(d),** which as written would require a controlled-substance registration of any prescriber authorized to prescribe "medications." Most of what pharmacists are authorized to prescribe are not controlled substances, so a pharmacist prescribing only those medications would be required to hold a registration unrelated to anything they prescribe. The fix is a single word — replacing "medications" with "controlled substances" — which ties the requirement to controlled-substance authority, consistent with the conditional approach § 1.6(C)(1)(d) already takes:

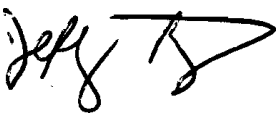
   Current: *"Be registered with appropriate state and federal agencies to prescribe controlled substances, for any provider type that is legally authorized to write prescriptions for* ***medications****;"*

   Proposed: *"Be registered with appropriate state and federal agencies to prescribe controlled substances, for any provider type that is legally authorized to write prescriptions for* ***controlled substances****;"*

I understand that neither change would require any pharmacist to enroll or to prescribe, and that neither creates an obligation for Medicaid to cover or pay for pharmacist services. Enrollment would remain voluntary. I am asking only that the enrollment system be capable of recognizing a practitioner the State has already authorized to prescribe.

Thank you for considering this comment and for the opportunity to participate in this rulemaking.

Respectfully,



Jeffrey Bratberg, PharmD, FAPhA
Rhode Island Pharmacist License RPH04344
Jefbratberg@gmail.com 401-419-6303

Wednesday, September 9, 2026
Madeline Becker
Executive Office of Health and Human Services
Virks Building, 3 West Road
Cranston, RI 02920
madeline.becker@ohhs.ri.gov

RE: Public Comment on Proposed Amendment to 210-RICR-20-00-1 (Medicaid Payments and Providers) — Omission of a Pharmacist Provider Type

Dear Ms. Becker,

I am a pharmacist living in the State of Rhode Island. I am submitting this comment in my individual capacity as a pharmacist, not on behalf of any employer, institution, or organization. I write because the proposed amendment, as drafted, would prevent Rhode Island pharmacists from being recognized for services the General Assembly has authorized them to provide.

The proposed rule authorizes no way for a pharmacist to enroll as a prescriber.

Rhode Island law now authorizes pharmacists to prescribe. Under R.I. Gen. Laws § 5-19.1-36 (2023), a pharmacist may prescribe and dispense short-term hormonal contraceptives. Under R.I. Gen. Laws § 5-19.1-36.1, enacted in this year's budget, a pharmacist may independently prescribe medications including inhalers for asthma and COPD, insulin and diabetes medications, medications for blood pressure and cholesterol, tobacco-cessation products, and treatment following a positive point-of-care test for influenza, COVID-19, or group A strep.

The proposed rule defines a "Provider" at § 1.3(A)(13) by function — any individual legally authorized by the State to order, prescribe, or refer — and § 1.6(A)(1) requires every such Provider to enroll with EOHHS as a condition of Medicaid payment. But the list of recognized provider types at § 1.3(A)(14) does not include "Pharmacist." "Pharmacy" is listed, but a pharmacy is the dispensing business, enrolled on an organizational NPI; it is not the individual clinician, and it cannot be the prescriber on a claim.

The result falls on Medicaid patients.

The effect is that a Rhode Island pharmacist can be authorized by the State to write a prescription that cannot be attributed to any enrolled prescriber — which means the claim can be denied and the patient's medication left unfilled. This is not because the medication is uncovered, and not because the dispensing pharmacy is unenrolled. It is because the prescriber has no provider type under which to enroll. A newly enacted state law is, in practical terms, inoperable for the Medicaid population until this is fixed.

Why this matters to me as a licensed pharmacist.

Rhode Island made a deliberate decision to expand what pharmacists are permitted to do, in order to improve access to care. That decision is undermined if the Medicaid program provides no way for pharmacists to be recognized for the services the State has authorized. As a pharmacist, I have a direct professional interest in pharmacists being able to practice to the full extent of their license, and in Medicaid beneficiaries — often the patients with the fewest alternatives — being able to receive the care the General Assembly intended for them. A prescription a pharmacist is legally authorized to write should not be one a Medicaid patient is unable to fill.

The pharmacist is the most easily accessible health care professional in our communities. Many Medicaid recipients have transportation barriers that make this geographical and timely accessibility even more critical. Pharmacists have the skills, knowledge, and abilities to be able to provide a higher-level of care to patients in their communities. Including individual pharmacists as a provider type to facilitate Medicaid enrollment is necessary if we want Medicaid beneficiaries to reap the benefits of the expanded scope of practice that the State has passed into law.

This change is overdue, and it is well precedented.

When Rhode Island authorized pharmacist prescribing of contraceptives in 2023, the same law directed the Secretary of the Executive Office of Health and Human Services to pursue and implement any state plan amendment, waiver amendment, or changes to rules and procedures needed to carry it out, *"as soon as practicable"* (P.L. 2023, ch. 234). Three years later, there is still no provider type under which a pharmacist can enroll. Other states have already closed this gap: Delaware added pharmacist as a Medicaid provider type with CMS approval in 2024, and North Carolina recognizes and reimburses qualifying clinical pharmacist practitioners. Adding a pharmacist provider type would bring Rhode Island in line with steps CMS has already approved elsewhere.

What I am asking.

I respectfully ask EOHHS to make two changes before this rule is finalized:

1. **Add "Pharmacist" to the list of recognized provider types in § 1.3(A)(14),** so that a licensed pharmacist authorized by Rhode Island law to prescribe can enroll and be recognized as the prescriber on a claim.
2. **Correct § 1.6(B)(2)(d),** which as written would require a controlled-substance registration of any prescriber authorized to prescribe "medications." Most of what pharmacists are authorized to prescribe are not controlled substances, so a pharmacist prescribing only those medications would be required to hold a registration unrelated to anything they prescribe. The fix is a single word — replacing "medications" with "controlled substances" — which ties the requirement to controlled-substance authority, consistent with the conditional approach § 1.6(C)(1)(d) already takes:

   > **Current:** *"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****;"*
   >
   > **Proposed:** *"Be registered with appropriate state and federal agencies to prescribe controlled substances, for any provider type that is legally authorized to write prescriptions for* ***controlled substances****;"*

I understand that neither change would require any pharmacist to enroll or to prescribe, and that neither creates an obligation for Medicaid to cover or pay for pharmacist services. Enrollment would remain voluntary. I am asking only that the enrollment system be capable of recognizing a practitioner the State has already authorized to prescribe.

Thank you for considering this comment and for the opportunity to participate in this rulemaking.

Respectfully,
Michelle L. Caetano, PharmD
Cumberland, RI 02864

Dear Ms. Becker,

I am a pharmacist licensed in the State of Rhode Island and am submitting this comment in my individual capacity, not on behalf of any employer or organization.

I strongly support updating the proposed Medicaid rule to recognize pharmacists as an enrolled provider type. Rhode Island law now authorizes pharmacists to prescribe a growing number of medications, including hormonal contraceptives, medications for asthma, COPD, diabetes, hypertension, hyperlipidemia, tobacco cessation, and treatment following certain point-of-care tests. However, without a mechanism for pharmacists to enroll as Medicaid prescribers, Medicaid patients may be unable to receive medications that pharmacists are legally authorized to prescribe.

Throughout my career, including my direct patient care work at Coastal Medical, Inc., Central Drug in Central Falls, and currently at the Rhode Island Free Clinic, I have seen many patients referred by physicians specifically for pharmacist expertise in medication management. In these situations, the inability to make necessary medication changes during the visit creates unnecessary delays in care, additional appointments, and barriers for patients who often have limited access to healthcare. Allowing pharmacists to serve as recognized Medicaid prescribers would improve timely access to care and better utilize the expertise the General Assembly has already authorized.

I respectfully ask EOHHS to:

1. Add **"Pharmacist"** to the list of recognized provider types in § 1.3(A)(14) so licensed pharmacists may enroll as Medicaid prescribers.
2. Revise § 1.6(B)(2)(d) by replacing the word **"medications"** with **"controlled substances,"** so the controlled substance registration requirement applies only to provider types authorized to prescribe controlled substances.

These changes would not require pharmacists to enroll or prescribe, nor would they mandate Medicaid coverage of pharmacist services. They would simply allow Rhode Island's Medicaid program to recognize pharmacists for the prescribing authority already granted under state law and improve access to care for Medicaid beneficiaries.

Thank you for your consideration.

Respectfully,

Anita N. Jacobson, Pharm.D., R.Ph.

2752 Kingstown Road, Kingston RI 02881