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 - 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 (Medicaid law) and Title XXI (federal Children's Health Insurance Program (CHIP) law) as well as the State's Section 1115 demonstration waiver. To participate in the Medicaid program, health care providers must be certified and agree to abide by the requirements established in Title XIX, Title XXI, 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 Definitions

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

1. "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.

2. "Rhode Island Medicaid program" means a combined state and federally funded program established on July 1,1966, under the provisions of Title XIX of the Social Security Act, as amended (P.L. 89-97). The enabling State legislation is to be found at R.I. Gen. Laws Chapter 40-8, as amended.

3. "Secretary" means the Rhode Island Secretary of the Executive Office of Health and Human Services 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.

4. "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 Title XIX Medicaid Program.

1.3 Medicaid Payment Policy

A. Medicaid is the payor of last resort. Community, public, and private resources such as federal Medicare, Blue Cross/Blue Shield, Veteran's Administration benefits, accident settlements, or other health insurance plans must be utilized fully before payment from the Medicaid program can be authorized.

B. Payments to physicians and other providers of medical services and supplies are made in accordance 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.

1.4 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.

1.5 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 Sections 1128 and 1128A of the Social Security Act, 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. Conviction of a criminal offense for any intentional, reckless, or negligent practice resulting in death or injury to beneficiaries.

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 comply with all applicable standards set forth in the Medicaid Provider Manuals available online: http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual.aspx and as agreed to in the EOHHS Provider Agreement Contract.

24. 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 claims prior to payment.

E. 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.

1.6 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 the Medicaid Code of Administrative Rules, Section 0110, “Complaints and Appeals.”

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 Title XVIII program if appropriate, state health care programs as defined in Section

1128(h) of the Social Security Act (as amended), 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 R.I. Gen. Laws § 40-8.2-17.

G. Reinstatement. Pursuant to 42 C.F.R. § 1002.214 Subpart C, 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)(l)(2)(3) Subpart C.

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). 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.

1.7 Severability

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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