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State/Territory Name: RI

State Plan Amendment (SPA) #: 25-0014

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

November 25, 2025

Richard Charest, Secretary
Executive Office of Health and Human Services
State of Rhode Island
Cranston, RI 02920

RE: Rhode Island State Plan Amendment Transition Number (TN) 25-0014

Dear Secretary Charest:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Rhode Island state plan amendment (SPA) to Attachment 4.19-D TN 25-0014, which was submitted to CMS on August 29, 2025. This plan amendment revises the nursing facility reimbursement methodology by updating the Direct Care rate component to utilize the Patient-Driven Payment Model (PDPM) nursing case-mix component in place of the Resource Utilization Group (RUG-IV) methodology. The SPA also provides for a 5.3 percent rate increase.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of October 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Novena James-Hailey at 617-565-1291 or via email at Novena.JamesHaiely@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0014

2. STATE: RI

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 2,865,781
b. FFY 2027 $ 4,494,889

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D pages 1-25
Attachment 4.19-D page 25b

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D pages 1-8, 12, 14-26 (TN 13-006)
Attachment 4.19-D page 9 (TN 21-0015), 10 (TN 22-0008)
Attachment 4.19-D pages 11 (TN 23-0003)
Attachment 4.19-D page 11a (TN 22-0019)
Attachment 4.19-D pages 25, 25b (TN 21-0020)

9. SUBJECT OF AMENDMENT
RUG to PDPM

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Richard Carest

13. TITLE
Secretary, EOHHS

14. DATE SUBMITTED
8/29/25

15. RETURN TO
EOHHS
3 West Road
Cranston, RI 02920

FOR CMS USE ONLY

16. DATE RECEIVED
08/29/2025

17. DATE APPROVED
November 25, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
10/01/2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

Rhode Island

Executive Office of Health and Human Services

PRINCIPLES OF REIMBURSEMENT FOR NURSING FACILITIES

October 1, 2025

Medicaid
Principles of Reimbursement
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APPLICABLE FEDERAL AND STATE LAWS

Legal Basis for Program

The Rhode Island Medical Assistance Program was established on July 1, 1966. It was formed under the provision of Title XIX of the Social Security Act, as amended by Public Law 89-97, which was enacted by the Congress on July 30, 1965. The enabling state legislation is Rhode Island General Law (RIGL) 40-8, as amended.

The Powers of the Director

Rhode Island General Laws 42-7.2-2(b) provides that the Secretary of the Executive Office of Health and Human Services shall make and promulgate rules, regulations, and fee schedules for the proper administration of the Medical Assistance Program, and to make the Office's State Plan for Medical Assistance conform to the provisions of the Social Security Act.

Penalties for Misrepresentation or Fraudulent Acts

Penalties for misrepresentation or fraudulent acts involving this program are covered by both Section 1909 (a) of the Social Security Act; RIGL Sections 11-41-3, 11-41-4, 40-8.2-3, 40-8.2-4, and 40-8.2-7; and any other applicable statutes. These criminal penalties are in addition to civil actions for damages, recoveries of overpayments, injunctions to prevent continuation of conduct in violation of RIGL 40-8.2, as well as suspension or debarment from participation in the program by state or federal authorities.

Payment to Providers

The state will pay services by participating providers of long-term care facility services in accordance with these Principles of Reimbursement (Principles).

Rhode Island reimburses a provider monthly for Medicaid patient days times the assigned prospective per diem rate. This also applies to state-only days. In determining the number of days for which payment may be made the date of admission is counted, however the date of death or discharge is not counted.

The per diem rate for eligible Title XIX recipients is a full payment rate and, therefore, under federal regulations, subsidy for patient care by the patient, relatives, or friends to the facility in any manner is prohibited.

If an overpayment to a participating provider of long-term care services is identified, repayment will either be made by direct reimbursement or by offsetting future payments to the provider. Such repayment may include interest charges on the overpayment amount.

The state reserves the right to investigate and adjust reimbursement rates for facilities which do not substantially comply with all standards of licensure.

RECORDS RETENTION

AS PROVIDED FOR BY THE RI STATUTE OF LIMITATIONS
(RIGL 12-12-17)

Each provider of long-term care services participating in the Title XIX Medical Assistance Program, in accordance with the provisions of these Principles, will maintain within the State of Rhode Island all original records or hard copies of records and data necessary to support the accuracy of the entries on the annual BM-64 Cost Report. Records include all ledgers, books, source documents (invoices, canceled checks, contracts, purchase orders, minutes of board of directors meetings, time cards, other employee attendance data and any other material used in the preparation of the annual cost report. Statistical records supporting both Medicaid and total patient days must be maintained in a clear and consistent manner for all reporting periods. The detailed record of all patient days must agree with monthly attendance reports. In calculating patient days, the date of admission is counted as one day, however, the date of death or discharge is not counted as a day. Records must be auditable and substantiate the reasonableness of specific reported costs. All records used to prepare the BM-64 Cost Report must be retained in Rhode Island for at least ten (10) years following the month in which the cost report to which the materials apply is filed with EOHHS as required by the RI Statute of Limitations. Each provider will make available upon request such records and all other pertinent records to representatives of EOHHS, representatives of the Federal Department of Health and Human Services, and the state's Medicaid Fraud Unit.

EOHHS will maintain all cost reports submitted for at least ten (10) years after the month in which the cost report was filed by the provider.

GENERAL PROVISIONS

REPORTING

Annual BM-64 Cost Report (Cost Report)

All facilities must file an annual BM-64 Cost Report (Cost Report) on a calendar year basis. The Executive Office of Health and Human Services (EOHHS) determines the report format. The report must be filed on or before May 31 following the close of the year.

The Cost Report must be completed in accordance with generally accepted accounting principles and prepared on the accrual basis of accounting wherein both revenues and expenditures are recognized in the period when earned or incurred regardless of when actual cash payments are made and received.

Providers who do not submit the Cost Report on time without an authorized extension from EOHHS will have their rates frozen until an acceptable cost report has been filed. Request(s) for extensions must be submitted to the Medicaid Finance Division via email and must include the facility's name, justification for extension, and proposed date of submission.

A final Cost Report must be filed within ninety (90) days after an ownership change, facility closing, or provider's departure from the Medicaid program.

STATE OF RHODE ISLAND

Admission Policy

Participating Nursing Facilities must admit Title XIX patients to all parts of the facility without discrimination, in accordance with the provisions of RIGL 23-17.5-19 and 23-27.5-21, based solely upon specialized medical and related needs of the patient. In addition, as provided in RIGL 23-17.5-24, patients have the right to remain in a facility after the depletion of private funds.

Participation

Facilities and at least twenty-five (25) percent of all their nursing facility beds must be dually certified for participation in both Medicare (Title XVIII) and the Rhode Island Medical Assistance (Title XIX) Program on and after October 1, 1990. Ideally all nursing facility beds should be dually certified.

The Secretary of the Executive Office of Health and Human Services may waive the requirement for Medicare certification upon his or her determination, upon consultation with the director of the state surveying agency, in the event that: (1) there is an imminent peril to public health, safety, or welfare; and/or (2) it is in the best interest of the state and the residents of the facility.

The Medicaid Director must approve an increase in the licensed bed capacity, new beds, or beds out of service brought back into service, for participation and payment in Title XIX Medicaid.

Method for Determining Nursing Facility Payment Rates

The State has broad flexibility to establish Medicaid payment rates and methodologies. Rates must be consistent with efficiency, economy, and quality of care in accordance with section 1902(a)(30)(A) of the Social Security Act. For more specific information regarding the nursing facility payment process, please refer to the EOHHS website: https://eohhs.ri.gov/providers-partners/provider-directories/nursing-homes.

A. Per Diem Base Rate: Each nursing home will have a base per diem rate that applies to all residents. The base per diem rate is comprised of the following components:

- Direct Nursing Care
  Direct Nursing is comprised of nursing salaries, (RNs, LPNs, and CNAs) and fringe benefits. The base per diem rate for Direct Nursing Care is $133.46 .

- Other Direct Care
  This component includes other direct care expenses such as recreational activity expenses, medical supplies, and food. The base per diem rate for Other Direct Care services is $23.74.

- Indirect Care
  This component includes all other nursing facility operating expenses, e.g. administration, housekeeping, maintenance, utilities, etc. A base rate for this component is $53.53.

- Fair Rental Value (FRV)
  The FRV component is facility specific. The base FRV for each nursing home is the 7/1/2012 rate calculated under the previous principles of reimbursement. A full description of the

- methodology used to calculate the Fair Rental Value for each nursing facility as of 7/1/2012 is described below.

- Property Taxes
  The property tax component is facility specific, i.e., based on actual property taxes assessed and paid.

- Provider Assessment
  The provider assessment is an amount equal to 5.82% of the sum of the above components to recognize the state's Provider Assessment Tax. Should the state's 5.5% Provider Assessment Tax rate change, this add-on will be adjusted accordingly. Below is an example of the adjustment to the add-on in the provider tax were to be changed to 4.0%.

1.	Per diem base rate (excl. provider tax):	$200.00
2.	Calculate per diem rate with 4.0% tax:	$200.00 divided by .96 = $208.33
3.	Calculate provider tax amount:	$208.33 minus $200.00 = $8.33
4.	Calculate add-on percent:	$8.33 divided by $200.00 = 4.165%
5.	Calculate provider tax add-on:	$200.00 times 4.165% = $8.33
6.	Calculate per diem rate incl. tax:	$200.00 plus $8.33 = $208.33

B. Adjustments to Base Rate

Patient Acuity
Patient acuity refers to the severity of an illness or medical condition. The patient acuity factor is a measure of the patient specific acuity and is applied as an adjustment factor to the direct care rate portion of the nursing facility per diem. The patient acuity factor is determined via a case-mix classification methodology or system, which groups patients together with similar characteristics, such as medical conditions, treatments and severity levels.

Effective 10/1/2025, EOHHS will use the Patient Driven Payment Model (PDPM), a patient-centered approach that focuses on specific treatments and services designed for the individual with CMS system and data support. PDPM consists of five case-mix adjusted components: Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), Non-Therapy Ancillary (NTA), and Nursing, along with a non-case-mix multiplier (for room and board, capital cost, and overhead). For each of the case-mix adjusted components, there are a number of groups to which a patient may be assigned, based on the relevant MDS data assessment for that component. Each of these five category components corresponds to a digit in the Health Insurance Prospective Payment System (HIPPS) coding process. These billing codes establish the process by which payment determinations are made.

EOHHS will use the Nursing component to adjust the Direct Care rate.

Price Increases
The components of the base per diem rate will be increased annually, effective October 1 of each year, as follows:

1. Direct Nursing, Other Direct Care, and Indirect Care:
On an annual basis, unless otherwise specified, this component of the base per diem rate will be adjusted by the CMS Skilled Nursing Facility Prospective Payment System Market Basket Update without productivity adjustment.

The adjustment will be applied annually on October 1 (the start of a new federal fiscal year), using the CMS' actual regulatory market basket update without productivity adjustment for the previous federal fiscal year.

Effective October 1, 2021, eighty percent (80%) of any rate increase that results from application of the inflation index to a) the direct-care rate adjusted for resident acuity and b) the indirect-care rate, which is comprised of a base per diem for all facilities, shall be dedicated to increase compensation for all eligible direct-care workers in the following manner on October 1, of each year:

(i) Compensation increases shall include base salary or hourly wage increases, benefits, other compensation, and associated payroll tax increases for eligible direct-care workers. This application of the inflation index shall apply for Medicaid reimbursement in nursing facilities. For purposes of this subsection, direct-care staff shall include registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), certified medication technicians, licensed physical therapists, licensed occupational therapists, licensed speech-language pathologists, mental health workers who are also certified nurse assistants, physical therapist assistants, housekeeping staff, laundry staff, dietary staff or other similar employees providing direct-care services; provided, however that this definition of direct-care staff shall not include: RNs and LPNs who are classified as "exempt employees" under the federal Fair Labor Standards Act (29 U.S.C. § 201 et seq.); or CNAs, certified medication technicians, RNs or LPNs who are contracted or subcontracted through a third-party vendor or staffing agency.

(ii) By July 31, 2022 and by July 31st of each year thereafter, nursing facilities shall submit to the secretary or designee, a certification of compliance with increased compensation for all eligible direct care workers, that results from the inflation index applied on October 1. A collective bargaining agreement can be used in lieu of the certification form for represented employees. All data reported on the compliance form is subject to review and audit by EOHHS. The audits may include field or desk audits, and facilities may be required to provide additional supporting documents including, but not limited to, payroll records.

(iii) Any facility that does not comply with the terms of certification shall be subjected to a clawback of the unspent or impermissibly spent funds, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification and a twenty-five percent (25%) penalty based upon the amount of unspent or impermissibly spent funds, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification

Each facility shall have the necessary nursing personnel (licensed and non-licensed) in sufficient numbers on a twenty-four (24) hour basis, to assess the needs of residents, to develop and implement resident care plans, to provide direct resident care services, and to perform other related activities to maintain the health, safety, and welfare of residents. The facility shall have a registered nurse on the premises twenty-four (24) hours a day.

Effective, January 1, 2026, nursing facilities shall provide a quarterly minimum average of three and fifty-eight hundredths (3.58) hours of direct nursing care per resident, per day..

Director of nursing hours and nursing staff hours spent on administrative duties or non-direct caregiving tasks are excluded and may not be counted toward compliance with the minimum staffing hours requirement in this section. The minimum hours of direct nursing care requirements shall be minimum standards only. Nursing facilities shall employ, and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents and to ensure compliance with all relevant state and federal staffing requirements.

Compliance shall be determined quarterly by comparing staffing data from the CMS payroll-based journal and the facility's self-reported daily census. Facilities that fail to meet the minimum staffing requirements shall face a fine in the following quarter valued at three percent (3%) of the total Medicaid reimbursements, as calculated based on the most recent financial period. Facilities found to be out of compliance will receive a 30-day corrective notice. If compliance is not achieved within 30 days, payment reductions shall be enforced.

EOHHS will waive fines for facilities that demonstrate high quality-care. To qualify for a waiver, a facility must meet at least one of the following:

(i) Substantial Compliance: During the last 3 consecutive survey cycles, the facility received no substandard quality of care/immediate jeopardy deficiencies and was not placed under compliance orders, temporary management or quality monitoring;

(ii) Acuity criterion: A facility is considered to serve a lower-acuity resident population if its Nursing-Case Mix Index ranks in the lowest 25% of all Medicaid-participating nursing homes.

(iii) If the facility achieved compliance for at least 75% of operating days in the quarter.

Nursing home facilities must provide a list of all licensed staff, including name, license, and home address, to EOHHS upon renewal of the nursing home operator license or when there is a change in effective control of the nursing facility. Failure to provide the required list within 30 days of renewal or change in effective control shall result in direct monetary fines.

2. Fair Rental Value:
   IHS Markit Healthcare Cost Review second-quarter report, Skilled Nursing Facility Total Market Basket FY Table, Capital Costs %MOVAVG, third quarter.

3. Property Taxes~~:~~
   Facility specific property tax payments
   The Property Tax rates are based on allowable tax payments and total patient days reported in each facility's most recently filed cost report.

Exceptions to price increases
Annual adjustments to the base per diem rates for Direct Nursing, Other Direct Care, and Indirect Care stated above will not occur in the following years, and will instead be adjusted as noted below:

- 2015 no increase
- 2017 no increase
- 2018 base rates increased by 1.5% effective July 1 and 1% effective October 1
- 2019 base rates increased by 1% effective October 1
- 2022 base rates increased by 3% effective October 1
- The rates in effect on 9/30/2025 shall be increased by 5.3% on 10/1/2025.

C. Rate Add-ons

Add-on for Discharges to Nursing Facilities of Complex Behavioral Health Patients
Nursing facilities can receive a behavioral health per-diem add-on of $175 for particularly complex residents who have been hospitalized for six months or more; meet nursing facility level of care criteria; and, have been approved for specialized serviced through a Level II Preadmission Screening and Resident Review (PASRR).

The $175 add-on rate is in addition to the PDPM payment base rate, and is not influenced by the annual inflationary adjustments detailed in Section B "Adjustments to Base Rate"
To receive the $175 rate add-on, a Medicaid-certified and Rhode Island Department of Health licensed nursing facility may apply for the certification of an NFSPU that will remain a distinct and separate unit within its facility. The NFSPU must be dedicated exclusively to individuals who live with serious/serious and persistent mental illness (SMI and SPMI) and who (a) meet the NFSPU eligibility requirements; and (b) have been approved for admission to the NFSPU.

Facilities with an NFSPU must demonstrate that the overall treatment and mission of its psychiatric rehabilitation program addresses major domains of functioning and skill development including defined psychiatric rehabilitation principles detailing specific rehabilitation techniques and methods, and the type/level of staff utilized to provide each service to the residents and the evidence-based practices supporting such principles. Facilities must also provide a therapeutic environment for referred individuals that meets and addresses the clinical needs of NFSPU residents including an array of individual and group therapeutic activities, including:

- Daily therapeutic and skill-training groups
- Therapeutic recreation programming
- Community safety and life skills training
- Substance use and self-help groups
- Crisis intervention services

These items are included in the $175 per diem rate and should not be considered specialized services mandated by a PASRR Level II screening. If the PASRR II screening recommends specialized services in addition to the NFSPU placement, the nursing facility is required to work with a licensed behavioral health provider to ensure the recommended specialized services are provided to the individual. The NFSPU itself is not a specialized service.

Facilities with an NFSPU are required to submit frequent reports to EOHHS detailing the status of NFSPUs EOHHS reserves the right to conduct on-site reviews and the review of any clinical records and documentation without prior notice to the nursing facility. Participating facilities must annually recertify with EOHHS to continue to operate a NFSPU.

Detailed facility requirements can be found in the NFSPU Certification Standards.

D. Periodic Rate Review

Beginning in October 2024, the state shall revise rates as necessary based on increases in direct and indirect costs utilizing data from the most recent finalized year of facility cost report. The direct care and indirect care components will be adjusted accordingly to reflect changes in direct and indirect care costs since the previous rate revision. Nursing homes are required to submit cost reports annually.

Rates for Newly Constructed Facilities

Newly constructed for-profit facilities will be paid a rate determined in the manner described for all facilities under these Principles. The initial Fair Rental Value component shall be calculated using the methodology described herein. The Tax component will use an occupancy rate equal to 98% of the statewide average of the previous calendar year.

Requests For Rate Adjustments

EOHHS may consider the granting of a rate that reflects demonstrated cost increases in excess of the rate that has been established by the application of the percentage increase. Conditions under which an application may be considered as well as required application materials are available on the EOHHS website: https://eohhs.ri.gov/providers-partners/provider-directories/nursing-homes

Process for Rate Adjustments

All requests for rate increments shall be limited to one request per nursing facility per calendar year. Additional requests for a per diem cost increase which are more than one percent of the nursing facility's previously assigned aggregate per diem rate shall be reviewed at the discretion of EOHHS.

- Before a facility can request a rate increase, it must demonstrate to EOHHS that the additional operating costs were sustained for at least three (3) months.

- If the facility submits the rate increase request within one hundred twenty (120) days after the costs were first incurred, any increase granted will be retroactive to the date the costs were actually incurred.

- Requests received more than within one hundred twenty (120) days after the costs were first incurred will be effective on the first day of the month following the filing of the request.

Application and instructions for a rate adjustment are available on the EOHHS website: https://eohhs.ri.gov/providers-partners/provider-directories/nursing-homes

EOHHS will review the request and contact the provider for additional documentation to support the request. Supporting documentation containing PHI or personally identifying information must be sent securely. All requests and supporting documentation are subject to an audit by the state.

A request for rate increase does not guarantee that a rate increase will be granted.

Appeals Process

Any provider who is not in agreement with the reimbursement rate assigned for the applicable rate period, may within fifteen (15) days from the date of notification of rate assignment file a request for a review conference to be conducted by the Medicaid Director, or other designee assigned by the EOHHS Secretary. The request should be sent via email to OHHS.MedicaidFinance@ohhs.ri.gov

The Medicaid Director or designee shall schedule a review conference within fifteen (15) days of receipt of the request. As a result of the review conference, the Medicaid Director or designee may modify the rate of reimbursement. The Medicaid Director or designee shall provide the provider with a written decision within thirty (30) days from the date of the review conference.

Appeals beyond the Medicaid Director or the designee appointed by the EOHHS Secretary of the Executive Office of Health and Human Services will be in accordance with the Administrative Procedures Act. The provider must file a written request for an Administrative Procedures Act hearing no later than fifteen (15) days of the decision noted in the paragraph above.

Special Prospective Rate Appeal

Any facility that has been directed by the Department of Health to appoint an independent quality monitor, engage an independent quality consultant or temporary manager, and/or develop and implement a plan of correction to address concerns regarding resident care and coincident financial solvency may file for a Special Rate Appeal. The Special Rate Appeal components are as follows:

1. The provider must submit a written request (including a copy of the plan of correction) via email to OHHS.MedicaidFinance@ohhs.ri.gov.

2. The request must be based on the approved spending plan set forth in the plan of correction and remediation.

3. The provider must submit evidence that the approved spending plan cannot be accommodated by the existing per diem rate.

4. The rate appeal will not be for a period of less than six (6) months.

5. EOHHS, at its discretion, may provide for subsequent extensions for six (6) month periods for a maximum total period of twenty-four (24) months.

6. The provider must submit a BM-64 Cost Report for each six (6) month appeal period.

7. EOHHS will recoup any funds not expended during the six (6) month appeal period.

8. In calculating the Special Prospective Rate Appeal, the Office may establish a per diem amount to be added to the facility's existing per diem rate.

9. Upon conclusion of the six (6) month period (or subsequent extension periods), the per diem rate will revert to the provider's normal per diem rate.

RECORD KEEPING

Financial Reviews of Provider Costs

The state can conduct reviews of the financial and statistical records of each participating provider in operation. Examples in which financial reviews could be necessary are:

- Oversight by state agencies;
- Evaluation due to emergency or extraordinary situations;
- Examination or review for purposes of program integrity;
- Assessment of evolving adverse financial condition;
- Fair rental value adjustment requests;
- Establishing rates for newly constructed facilities;
- Appeal requests for prospective rate increments;
- Evaluating hardship requests
- Compliance with reimbursement for staffing;
- Assessment of potential changes to the rate setting methodology.

Financial reviews include any tests of the provider's records deemed necessary to ascertain that costs are proper and in accordance with Medicaid principles of reimbursement and that personal needs accountability are in compliance with existing regulations. The knowing and willful inclusion on non-business related expenses, non-patient related expenses, or costs incurred in violation of the prudent buyer concept may be subject to criminal and/or civil sanctions. Failure of auditors of EOHHS to identify the above items or their adjustment of same shall not constitute a waiver of any civil or criminal penalty.

ALLOWABLE COSTS

Reasonable Costs

The provision of Nursing Facility Care Services to Medicaid recipients is provided only to those individuals who meet resource and income eligibility criteria. Consequently, the cost of services for those individuals with limited income and resources must be reasonable. EOHHS shall have the discretion to determine through its review of submitted costs, and in accordance with these principles, what constitutes reasonable and allowable cost.

Not all reasonable and allowable costs must be reimbursed. These Principles of Reimbursement—through the establishment and application of base rates for Direct Nursing Care, Other Direct Care, and Indirect Care—provide for payment to nursing facilities under the Medicaid Program on a prospective basis. Rates are reasonable and adequate to meet costs of efficiently and economically operated nursing facilities that provide services in conformance with state and federal laws, regulations, and quality and safety standards.

Reasonable costs are costs of an individual facility for goods, and services which, when compared, will not exceed the costs of like goods and services of comparable facilities in license and size. Reasonable costs include the ordinary, necessary, and proper costs of providing acceptable health care subject to the regulations and limits contained herein. Participants in the Medicaid program are expected to establish operating practices which assure that costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service.

In the absence of specific definitions and/or elements of allowable and disallowable costs that may not be contained herein, the Rules and Regulations of Federal Medicare - Title XVIII will prevail.

The state reserves the right to determine allowable costs in areas not specifically covered in these Principles or in the Rules and Regulations of Federal Medicare - Title XVIII.

Allowable Cost Guidance

The federal Office of Management and Budget (OMB) "Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, Final Rule (Uniform Guidance) from December 26, 2013"; 2 CFR Part 200 (Omni Circular) provides guidance with regard to certain items of costs, including information as to whether certain types of indirect costs are allowable or unallowable.

Additional details are available through the following link:
https://www.federalregister.gov/documents/2013/12/26/2013-30465/uniform-administrativerequirements-cost-principles-and-audit-requirements-for-federal-awards

Common unallowable costs categories described in the Omni Circular include, but are not limited to, fundraising costs; investment management costs; donation/contributions made by the vendor; fines and/or penalties; costs of goods and/or services purchased for the personal use of provider employees or officers; amortization or expensing of current or prior capital losses other than depreciation; cost of goods and services that would be procured by self-dealing or related party transactions unless it is affirmatively shown that the costs of such is no greater than what the same would have cost when procured independently; lobbying and advocacy costs; and noncapital debt interest cost (capital debt interest and principal cost for an asset may be included if the provider does not include a use or depreciation allowance for such asset in its fee basis). General selling, marketing, promotion, and public relation costs

are typically unallowable except to the extent that they are expected to be incurred solely because they are required for the provider to perform the scope of work proposed.

General and Administrative (G&A) costs are known as indirect costs. Indirect costs are those associated with operating and providing a service, but which are not easily or directly associated only with the particular service. Certain indirect costs may not be allowable for allocation to the Nursing Facility rate. The provider shall list any indirect costs related to nursing facility services, and the provider shall describe the methodology used to allocate those costs to the service being proposed. Indirect cost allocation methodologies shall follow general accounting principles and shall be in accordance with the OMB Omni Circular described above.

Additional Cost Guidance

Real Estate and Property Taxes

For Medicaid purposes, the allowable real estate and personal property taxes will be the four quarterly amounts due and payable during the reporting year or the tax based upon the assessed valuations of the prior December 31. For example, the amount allowable for calendar year 2024 will be the four (4) quarterly installments due and payable during calendar year 2024 or the total tax based on the December 31, 2023 valuations. The basis for reporting will be determined by the provider but must remain consistent from year to year.

Personnel Costs

Owner Compensation: Compensation to an owner or related individual must be reasonable and associated with patient care in order to be reimbursable.

Administrator Compensation: An administrator must be a duly licensed person in the State of Rhode Island and be responsible for the overall management and supervision of a facility. Administrators must work on a full-time basis and be substantiated by appropriate time records. Assistant Administrators working full-time or part-time must also be substantiated by time records. Compensation of an administrator is an allowable cost to the extent it does not exceed established maximums governed by bed capacity as shown on the attached schedule.

Administrator Compensation limits are available in the annual cost report instructions and available online at https://eohhs.ri.gov/providers-partners/provider-directories/nursing-homes

This is adjusted annually by the amount of percentage change reflected by the Wage and Salary Component of the National Nursing Home Input Price Index as projected by the Centers for Medicare and Medicaid Services. Assistant Administrators will be limited to the lower of actual salary paid or 75% of the Administrator's salary allowance.

Facilities Operated by Members of a Religious Order: The recognized salary allowance for members of a religious order providing patient care services will be limited to the lower of actual stipend paid on their behalf or the salary equivalent that would be recognized by these Principles of Reimbursement for similar services.

Professional Services

The fees must meet the test of reasonable costs, and must be fully documented by billing which clearly describes the nature of the services rendered.

An example of admissible cost is the fee for legal services in connection with a directive to comply with fire codes regulations. A legal or accounting charge resulting from a buy/sell agreement between related parties is inadmissible. Professional fees associated with future construction must be deferred and included with the project construction costs.

Fringe Benefits: Fringe benefits such as prepaid health insurance, group life insurance, employees' child daycare, dental plans, and retirement plans, are allowable costs, providing they are offered to all full-time employees. Similar benefits or partial benefits offered to all permanent part-time employees working at least twenty (20) hours per week will also be recognized. Fringe benefits which advantage officers, owners, or other related individuals in a disproportionate manner will be adjusted to reflect equity of application. Fringe benefits by employee classification must be addressed in the facility's personnel and policy manual in order to be recognized. Benefits other than those stated above must be reasonable and necessary for the efficient, effective, and economical operation of similar facilities participating in the Rhode Island Medicaid Program.

Vacation time and sick leave time are not recognized for reimbursement under the accrual method of accounting. Vacation time and sick leave time will be recognized as an expense when actually paid to the employee by the facility.

Other Operating Costs: All operating costs, including nursing, medicine chest, and over-the-counter drug supplies which have been determined as reasonable and acceptable will be allowed after reduction for items not related to patient care.

Accounting and Auditing Fees: Accounting and auditing services are generally a necessary and proper function in the fiscal operation of long-term care facilities. The employed firm must clearly identify recognized fees associated with these services for responsibility, function of activity, hourly billing rate, and time element for each function. The Rate Setting Unit shall determine an appropriate amount for such services to be recognized for reimbursement purposes taking into consideration such factors as facility employed accountant(s), controller(s), comptroller(s), bookkeeper(s), condition of books and records maintained by the facility, and the necessary direct involvement of the Accounting/Auditing firm.

Routine Services: Expenses pertaining to utilization review of all patients, physical therapy, and other remedial therapeutic services will be accepted and considered as routine services for rate calculation. Expenses pertaining to the services of a Behavior Health Specialist, licensed by the State of Rhode Island and not eligible for direct reimbursement under the Rhode Island Medical Assistance program, will be considered routine services and accepted for rate calculation.

Educational Activities: The reasonable cost of full-time employee educational activities will be included as an allowable cost provided that such activities are directly related to improving adequate patient care or the administration of the facility. In addition, the activity must be formally organized by a recognized school or organization approved by the state.

Physicians' Fees: Reasonable fees which pertain to utilization review, medical director, employees' physical examinations and services required by OBRA-87 are considered allowable costs.

Conference Expenses: Reasonable expenses related to attendance at meetings and conferences are considered allowable costs.

Medicine Chest Supplies, Transportation, and Laundry Expenses: The established per diem base rates include the expenses of nursing and medicine chest supplies; transportation of patients who can be transported by auto to and from physician's office, dental services, medical laboratories, and hospitals for outpatient treatment; as well as laundry expenses including personal laundry with the exception of dry-cleaning costs; therefore, facilities must not charge Title XIX patients or their relatives for these services.

Insurance: Generally acceptable insurance coverage for business enterprises, including the types listed below, is reimbursable:

1. Liability Insurance
2. Malpractice Insurance
3. Worker's Compensation
4. Property Insurance

Payment of health and life insurance premiums which provide benefits to an employee or his/her beneficiary are considered fringe benefits and should be claimed as such by the provider. Premiums related to insurance on the lives of officers and key employees which name the provider as beneficiary are not allowable costs. If the individual or his estate are beneficiary, the premiums can be considered compensation to the individual and the cost would be allowable to the extent his/her total compensation is reasonable.

Insurance costs applicable to transportation vehicles will be allowable.

Mortgage insurance premiums are generally not an allowable cost. However, where the principal mortgagee specifically requires that the insurance be obtained as a prerequisite to completing financing arrangements and the insurance agreement stipulates that total proceeds must apply to the mortgage balance, then the premiums shall be reimbursable.

Non-Patient Care Costs

The following are examples of, but not limited to, items which are not recognized for cost reimbursement purposes:

1. Personal expenses,

2. Items and services for which there is no legal obligation to pay,

3. Business expenses not related to patient care,

4. Physician fees, prescription drugs and medications, as they are covered by means of a separate program,

5. Reimbursed expenses,

6. Costs of meals sold to visitors and employees,

7. Costs of drugs, items, and supplies sold to other patients,

8. Cost of operation of a gift shop intended to produce a profit. Where expenses cannot be specifically identified the revenue derived will be used to reduce the total operating expenses of the facilities

9. Expenses which exceed amounts under the prudent buyer concept,

10. Accrued expenses not paid within ninety (90) calendar days after close of the reporting period, except for bankruptcy proceedings, or at time of the audit, examples include, but are not limited to:
    a. Professional services including attorney and accounting fees,
    b. Unpaid compensation of employees, officers, and directors owning stock in a closely-held corporation,
    c. Fringe benefits,
    d. Consultant fees,
    e. Suppliers and vendors, and
    f. Trade association dues.

Any accrued expenses so disallowed will, however, be recognized when eventually paid by adjusting the costs of the year in which the expense was incurred.

11. State and federal income taxes,

12. Directory and display advertising or other means of advertising,

13. Bad debts,

14. Management fees,

15. Expenses attributed to anti-union activities as specified in H.I.M.-15,

16. Excessive purchases of supplies when compared to previous years and years subsequent to base years,

17. Employment agency fees/agency contract for purpose of recruitment,

18. Costs of beepers,

19. Costs of telephone in motor vehicles, and,

The inclusion of costs, such as those set forth in 1-19 above, which are not related to patient care may constitute a violation of RIGL 40-8.2-4, as well as other provisions of state and federal law and may result in criminal and civil sanctions and possible exclusion from participation in the Medicaid Program.

The state reserves the right to make determinations of admissible and/or inadmissible costs in areas not specifically covered in the principles.

Service and Affiliated Organization Costs

General

Any company or business entity which provides products and/or services to an affiliated nursing home or group of homes, where common ownership exists, must be reported to EOHHS in order to meet reimbursement requirements.

Reporting Requirements

The report form required to be filed will include but not be limited to:

1. Explanation of the need for such an organization,

2. Ownership interest and legal form of organization,

3. Type of product or services to be rendered, and

4. Names of all affiliated facilities to be serviced.

Submission of this information will allow for a determination of whether or not charges from the related service company to the nursing facility are reasonable.

The state requires in addition to the BM-64 Cost Report, the following:

1. Financial statements of the related service company,

2. Tax returns if above statements are not available.

If centralized services such as accounting, purchasing, administration, etc., are involved, complete details regarding the allocation of charges must be provided.

Cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. Costs include those actually incurred to which may be added reasonable handling and administrative charges. Profit add-on in the form of markups or by other means is neither permitted nor acceptable for reimbursement under the Rhode Island Medical Assistance Program.

Home Office Charges

Long-term care facilities sometimes operate through a central home office resulting in home office charges. Cost-related expenses may be reimbursable providing that the central home office is physically located within the state of Rhode Island and if they can satisfy the reasonable cost-related concept previously described and if they can demonstrate and document that central management, purchasing, and accounting services were uniformly performed for all facilities.

Home office cost-related expenses, if the above is satisfied, will be pro-rated to each facility and enterprise for which services are being provided. The central home office must prepare and file with the Rate Setting Unit a cost report annually, in an approved format showing line-cost and allocation to each facility or enterprise. Additionally, each enterprise for which services are provided must be fully disclosed.

In-State Central/Home Office

Cost will be allocated and reimbursed through the Indirect Care Base Rate. An in-state central office requires maintaining a minimum of three (3) Nursing Care Facilities.

Out-of-State Central/Home Office

Charges will be recognized to the extent of the lesser of reported reasonable costs of central home office plus costs in Account Numbers:

- No. 7421 - Other Administrative Salaries,
- No. 7435 - Computerized Payroll and Data Processing Charge,
- No. 7436 - Accounting and Auditing Fees, or the average allowable amount for facilities of like size and licensure for Account Numbers
- No. 7421 - Other Administrative Salaries,
- No. 7435 - Computerized Payroll and Data Processing Charge, and
- No. 7436 - Accounting and Auditing Fees.

Transactions which Reduce Reported Cost of Patient Care

Operations may result in the receipt of revenue from sources other than the direct care of patients. Where it is determined that these amounts are in fact, reductions of previously incurred costs or are added revenue associated with the business purposes of the facility, such amounts must be offset against operating costs. For example, sale of meals, interest income, sale of supplies, etc., should be used to reduce costs.

Refunds, Discounts, and Allowances

Refunds, discounts, and allowances received on purchased goods or services must be netted against the purchase price

Energy Conservation Retention Credit

Every licensed nursing facility participating in the Medicaid medical assistance program that:

1. Expends funds for energy conservation measures and the use of renewable fuels, energy sources, and so called "green" sources of energy that result in a reduction of energy consumption; and

2. Which methods the facility can demonstrate, to the satisfaction of EOHHS, result in the facility's "pass through" per diem cost in the next base year in comparison to the immediately preceding base year, shall be permitted to retain the difference in the previous per diem and the new per diem for a period of twenty-four (24) months.

Provided that such retained funds shall be utilized by the nursing facility solely for either (1) costs directly associated with employing labor at the facility or (2) to pay down any debt of said nursing facility incurred directly through the purchase of energy saving, conservation and renewable energy, or so-called "green" devices.

Energy conservation measures would include but not be limited to; insulation, lighting projects and retrofits, furnace replacements, HVAC upgrades, weatherproofing, window and door replacements, energy managements systems, etc. Renewable fuels energy sources and green sources of energy would include but not be limited to; wind power, solar power, geothermal, water related power, etc.

Providers must document savings from one calendar year to the next calendar year in similar energy cost categories such as, electricity, fuel, gas, etc. The first documented savings year would be calendar year 2008, as compared to calendar year 2007, which would assign a credit effective October 1, 2009.

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Payment for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) will be paid on a cost bases as follows:

a. Cost-Based Payment

From January 1 through December 31st, providers will be reimbursed using interim rates that are calculated using data that is from the cost report of the prior calendar year (January 1 through December 31). Cost reports for the prior calendar year (January 1 through December 31) are due to the state by March 31. Rates from those cost reports are also used for the final settlements of the prior calendar year (January 1 – December 31).

1. To determine total eligible Medicaid expenditures, EOHHS shall use the total expenses as reported in Schedule 2 of the cost report, reflecting applicable adjustments. Applicable adjustments include, but are not limited to:

    - Reductions for the patient's clothing allowance (Schedule 1)
    - Interest Income (Schedule 2)
    - Depreciation (Schedule 9)
    - One-time sources of revenue or expenditures (for example, grants given by the State to the facility during states of emergency)

2. To determine the Medicaid per diem rate, divide total Medicaid reimbursable expenditures by the total inpatient days. Inpatient days are based on MMIS data obtained from the State's intermediary fiscal agent.

3. To this amount, $1.00 is added for allowable clothing allowance, which becomes the actual rate for the previous calendar year. This rate will be used in the reconciliation for the previous calendar year (January 1 – December 31).

Settlement for Previous Calendar Year

The total amount owed by Medicaid will be compared to the total sum of interim payments made in aggregate to the facility in the corresponding calendar year. If the total amount owed by Medicaid is greater than the sum of the interim payments, EOHHS will reimburse the provider via a reconciliation payment in an amount that is equal to that difference. If the revenue owed by Medicaid to the facility is less than the sum of the interim payments, the provider shall return to EOHHS (via a reconciliation payment) the amount that is equal to that difference. This

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reconciliation of interim to final rates will occur within one year past the end of the applicable calendar year (i.e., reconciliation for CY 2020 rates will be reconciled by December 31, 2021).

Determination of Prospective Rate for Current Calendar Year

1. Determination of total Medicaid-eligible expenses is the same way as detailed above, except that EOHHS adjusts total expenditures by an inflationary factor. The inflationary factor used is the CMS Actual Inpatient Hospital PPS Market Basket without productivity adjustment for the federal fiscal year aligned with the current state fiscal year in which a prospective rate is calculated.

2. Total Medicaid-eligible expenses are then divided by projected inpatient days.

    a. To determine this amount, EOHHS examines the most recent monthly census reports to determine an average daily census then multiplies the average monthly census by 365 (or 366 for leap years).

3. To this amount is added $1.00 for allowable clothing allowance, which becomes the interim reimbursement rate for the current calendar year (January 1 through December 31).

Any such payment or recoupment resulting from the reconciliation will be added to Medicaid payments in the UPL demonstration that utilizes that year's base year data.

b. Prior Authorizations and Description of Service Provided

All admissions require prior authorization by the Department of Human Services, Long Term Care unit, however prior authorization of the length of stay is not required. The services provided in the setting are acknowledged to be inclusive of a variety of State Plan approved benefits, and levels of intensity of services. Services that are provided are based on the beneficiaries' plan of care/ treatment plan and differ in intensity based on the beneficiaries' acuity. Services that are provided encompass a complete continuum of care.

c. Annual review

EOHHS will review the cost-based payment method at least annually, making updates as appropriate through the state plan amendment process.

d. Posted Information

Beneficiaries, and other interested parties can find interim rates on the Executive Office of Health and Human Services website here: https://eohhs.ri.gov/providers-partners/provider-directories/icfiid which will be updated annually.