DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

July 29, 2013

Steven M. Costantino, Secretary
Executive Office of Health and Human Services
57 Howard Avenue
Louis Pasteur Building
Cranston, Rhode Island 02920

Dear Secretary Costantino:

This letter is being sent as a companion to our approval of your State Plan Amendment (SPA) No. 13-010, approved July 29, 2013. During our review of the SPA, we performed an analysis of the reimbursement methodology for hospice services on Attachment 4.19-B page 3 of the Medicaid state plan. Based on that review, we have determined that the methodology, as currently described in the state plan, is not comprehensive for hospice services and other services that appear on this page of the State Plan. We are commenting on the payment methodology for all of these services because we anticipate Rhode Island will take corrective action by submitting Attachment 4.19-B page 3 which CMS then will review, and approve, in its entirety. CMS notes that this page has not been modified since July 1, 1988. Your cooperation in updating your State Plan to comply with all Federal requirements is appreciated by CMS.

I. Reimbursement Comments

1. State Plan Comprehensiveness

Section 1902(a) of the Act requires that states have a State Plan for Medical Assistance that meets certain federal requirements that set out a framework for the state program. Implementing regulations at 42 CFR 430.10 require that the State Plan be a comprehensive written statement containing all information necessary for CMS to determine whether the plan can be approved as a basis for Federal Financial Participation (FFP) in the state program. In addition, section 1902(a)(30)(A) of the Act requires that states have methods and procedures in place to assure that payments to providers are consistent with efficiency, economy, and quality of care. To be comprehensive, payment methodologies should be understandable, clear, and unambiguous. In addition, because the plan is the basis for FFP, it is important that the plan language provide an auditable basis for determining whether payment is appropriate.

To meet the comprehensiveness requirement please add the following language to the reimbursement provisions for the services noted below:

"Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of (name services here). The agency's fee schedule rate was set as of (date here - see note below on the effective date) and is effective for services provided on or after that date. All rates are published at (website URL)."

Eyeglasses	(Attachment 4.19B Page 3 i. (4))
Home and Community-based Services	(Attachment 4.19B Page 3 p.)
Rehabilitation services	(Attachment 4.19B Page 3 q.)
Case Management services	(Attachment 4.19B Page 3 r.)
Ambulance services*	(Attachment 4.19B Page 3 o. 1.)
Nurse Midwife services*	(Attachment 4.19B Page 3 m.)

*Please also remove the reference to a "negotiated" fee schedule because this is not a comprehensive methodology.

Note: The effective date for each of these services is the most recent date the fee schedule was updated for that individual service; however, the state must make public notice in accordance with 42 CFR 447.205 should it wish to update the fee schedule.

2. Cross-references to Institutional Services

The 4.19B Section of the State Plan is used solely for the authorization of Non-Institutional reimbursement methodologies. We strongly suggest that you remove the inclusion of and references to Institutional services that are aptly found in Sections 4.19A & D. These occurrences are as follows:

Attachment 4.19B Page 3. j.
"Services for individuals age 65 or older in institutions for mental diseases:
(1) Inpatient hospital services: as described in Attachment 4.19A
(2) Skilled nursing and intermediate care facility services: as described in attachment 4.19D."

Attachment 4.19B Page 3. k.
"ICF/ICF-MR services: as described in attachment 4.19D."

Attachment 4.19B Page 3. l.
"Inpatient psychiatric services for individuals under 22: as described in attachment 4.19A"

Attachment 4.19B Page 3. o (2)
"(2) Skilled Nursing Facility services for individuals under age 21: as described in attachment 4.19D."

3. Clarification of Hospice Rate

Rhode Island must make clear in the State Plan that the state pays at least as much as the CMS set Medicaid rate. Please revise the description found in Attachment 4.19 n Page 3. n "Hospice services" to make clear that the CMS set Medicaid rate is based on Medicare. Here, is the suggested, comprehensive language that you may use:

"The Medicaid Hospice rates are set prospectively by CMS based on the methodology used in setting Medicare Hospice rates, which are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register and daily Medicaid hospice payment rates announced through CMS's memorandum titled "Annual Change in Medicaid Hospice Payment Rates---ACTION"."

"Rates and fees can be found by accessing the agency's website at www.RI website. The rates available at this website include all annual or periodic adjustments to the fee schedule made in accordance with changes made by CMS for hospice services. Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers."

II. Coverage Comments

Hospice Coverage Limit
Section 1902(a)(10) of the Social Security Act requires that, "medical assistance for hospice care...may not be made available in an amount, duration or scope less than that provided under title XVIII [Medicare]." When Medicare changed its regulation on benefit periods to two 90 day periods and an unlimited number of 60 day periods, Medicaid interpreted the statutory provision to require that it had to allow an "unlimited duration" approach as well. The Social Security Act at section 1905(o)(1)(B) (2) governs "an individual's voluntary election" of hospice under Medicaid: An individual's voluntary election shall be made in accordance with procedures for the election of hospice "that are consistent" with the Medicare procedures; shall be for a period or periods which need not be the same as Medicare..."

In order to comport with statutory requirements, please remove the limitation language in Attachment 3.1- A. Supplement to Page 7 #18, as hospice coverage must be available for an unlimited duration.

The State has 90 days from the date of this letter until October 25, 2013 to address the issues described above. Within this 90-day period, the State may submit a SPA to address these issues or may submit a corrective action plan describing in detail how the State will resolve the issues identified above in a timely manner. Failure to respond within the 90 days will result in the initiation of a formal compliance process. During the 90-day period, CMS will provide any required technical assistance to assist you in resolving these issues.

If you have any questions regarding this matter you may contact Lynn DelVecchio at (617) 565-1201 or by e-mail at Lynn.DelVecchio@cms.hhs.gov. We look forward to working with you on these issues.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

cc: Sandra Powell, Director, Department of Human Services
Elena Nicolella, Medicaid Director
Darren McDonald, State Plan Coordinator