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State/Territory Name: Rhode Island

State Plan Amendment (SPA) 21-0016

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

May 24, 2022

Womazetta Jones, Secretary
Executive Office of Health and Human Services
State of Rhode Island
3 West Road, Virks Building
Cranston, RI 02920

RE: Rhode Island 21-0016

Dear Secretary Jones:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 21-0016. This amendment clarifies annual application of the CMS Inpatient Hospital Prospective Payment System market basket as it applies to updating the Diagnosis Related Group (DRG) base rate.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1923 and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This is to inform you that Medicaid State plan amendment TN 21-0016 is approved effective October 1, 2021. The CMS-179 and the amended plan page(s) are attached.

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

Sincerely,

Rory Howe
Director

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 AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21-0016

2. STATE: RI

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN XX☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY ~~2021~~ 2022 $ 0
b. FFY ~~2022~~ 2023 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, page 1
Attachment 4.19-A, page 2
Attachment 4.19-A, page 3
Attachment 4.19-A, page 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D page 1
Attachment 4.19-A, page 2
Attachment 4.19-A, page 3
Attachment 4.19-D page 4

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Annual Review and Inflationary Increases

11. 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
XX ☐ OTHER, AS SPECIFIED:
See Attached Letter

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Womazetta Jones

14. TITLE: Secretary

15. DATE SUBMITTED: December 3, 2021

16. RETURN TO:

EOHHS
3 West Rd, Virks Building
Cranston, RI 02920

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 3, 2021

18. DATE APPROVED:
May 24, 2022

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Rory Howe

22. TITLE: Director, Financial Management Group

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

FORM APPROVED
OMB No. 0938-0193

23. REMARKS:

State requested pen and ink change in box #7

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: Rhode Island

Payment for inpatient hospital care provided by Rhode Island and out-of-state hospitals under fee-for-service arrangements is as follows:

DRG Base Payment. In general, payment will be by diagnosis related group, using the All Patient Refined Diagnosis Related Group (APR-DRG) algorithm. The DRG Base Payment will equal the DRG Relative Weight specific to APR-DRG times the DRG Base Price times an age adjustor (if applicable as defined in section c below). For inpatient admissions on and after December 1, 2015, the DRG base rate paid to each hospital for inpatient services, as calculated pursuant to this payment methodology, will be reduced by 2.5%.

Effective July 1, 2016 the DRG base price will be increased by 3%, resulting in a base price of $11,093.

Effective July 1, 2017, and for each state fiscal year thereafter, the DRG base price will be increased by the CMS Hospital Prospective Reimbursement Market Basket for the applicable period, as reported in the quarterly Healthcare Cost Review published by the IHS Markit.

For the period of July 1, 2019 through June 30, 2020 the DRG base rate will be increased by 7.2%. Effective July 1, 2020 the DRG base rate will be increased by the CMS national Prospective Payment System (IPPS) Hospital Input Price Index. Effective July 1, 2022, the DRG base rate will be increased by the change in the "actual regulation market basket" as reflected in the CMS Inpatient Hospital Prospective Payment System Market Basket Update without productivity adjustment for the current federal fiscal year.

a. APR-DRG algorithm. Effective July 1, 2016, the Executive Office of Health and Human Services (EOHHS) is using the most current version of the APR-DRG algorithm. It is EOHHS's intention to update the version each year so that it uses the current version available as of the effective date of the rates.

b. DRG Relative Weights. Effective July 1, 2016, EOHHS is using the most current version of the national APR-Relative Weights as published by 3M Health Information Systems. For certain services where Medicaid represents an important share of the Rhode Island market, policy adjustors will be used to increase the Relative Weights in order to encourage access to care. These services (defined by APR-DRG) and policy adjustors are: neonatal intensive care, 1.25; normal newborns, 1.15; obstetrics, 1.15; mental health, 1.45; and rehabilitation, 1.45. Policy adjustors are intended to be budget-neutral; because payment for services with policy adjustors is higher than it otherwise would have been, payment for other services is lower than it otherwise would have been. Budget neutrality is achieved through the level of the DRG Base Price.

c. Age adjustor. To facilitate access to mental health care for children, calculation of the DRG Base Payment will include an "age adjustor" to increase payment for these stays. Effective May 5, 2015, the value of the pediatric mental health age

adjustor will be 2.50. This value was calculated so that, overall, payment for pediatric mental health stays would exceed the hospitals' estimated costs of providing this care.

d. DRG Payment. The DRG Payment equals the DRG Base Payment plus the DRG Cost Outlier Payment plus the DRG Day Outlier Payment.

e. Outlier payments. "Outlier" payments will be payable for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay. All mental health stays will be eligible for day outlier payments and all physical health (i.e., non-mental health) stays will be eligible for cost outlier payments. This paragraph is intended to meet the requirements of the Social Security Act §1902(s) (1) and to extend outlier protections to all other stays.

f. Day Outlier Payment. Day outlier payments will be made at a per diem rate for all days in a mental health stay after a day outlier threshold. Effective May 5, 2015, the Day Outlier Payment Rate is $850 for every day that exceeds the day outlier threshold of 20 days. Day Outlier Payments are made only for days for which the hospital has received prior authorization.

g. Cost Outlier Payment. Cost outlier payments will be made to stays that qualify as a cost outlier stay, which will be determined by comparing the hospital's estimated loss on a particular stay with the cost outlier threshold amount. If a stay qualifies as a cost outlier then the cost outlier payment will equal the statewide marginal cost percentage times the estimated loss. The estimated loss will be calculated as the hospital's covered charges for a particular stay times the most recent applicable hospital-specific ratio of cost to charges as calculated by EOHHS from Medicare cost reports. (For hospitals outside Rhode Island, proxy ratios of cost to charges will be used.) Effective May 5, 2015, the cost outlier threshold amount is $27,000 and the statewide marginal cost percentage is 60%.

h. Transfer adjustments. When a patient is discharged to another acute care hospital or leaves the hospital against medical advice, a transfer adjustment payment will be calculated. This adjustment applies to discharge statuses 02, 05 and 07. The transfer adjustment will involve calculation of a per diem amount equal to the DRG Base Payment divided by the nationwide average length of stay for the particular APR-DRG. The per diem amount will be multiplied by the actual length of stay plus one day, to reflect the additional costs associated with hospital admission. If the transfer adjustment payment is lower than the payment otherwise calculated, then the hospital will be paid the transfer adjustment payment.

i. Incomplete eligibility. When a patient has Medicaid eligibility for only part of an inpatient stay, payment will be prorated to reflect the incomplete eligibility. A per diem amount will be calculated as described in paragraph k above and will be multiplied by the actual length of stay. If the prorated payment is lower than the

payment otherwise calculated, then the hospital will be paid the prorated payment.

j. Allowed amount. The allowed amount will equal the DRG Payment, with adjustments for transfers or incomplete eligibility as appropriate, plus the Add-on Amount.

k. Add-on Amount. The Add-on Amount is a mechanism to make payments for services that are unrelated to the DRG calculation. Effective May 5, 2015, the Add-on Amount is zero.

l. Interim payments. If the length of stay exceeds 29 days then the hospital can choose to submit an interim claim and receive an interim payment. Effective May 5, 2015, the interim payment amount is $850 per day. This provision is intended to provide cash flow and ensure access for patients needing exceptionally long lengths of acute care. Once a patient has been discharged, interim payments will be recouped and final payment calculated as described above.

m. Prior authorization. In general, all admissions require prior authorization. The only exceptions are deliveries and normal newborns (i.e., newborns not admitted to neonatal intensive care). In general, prior authorization of the length of stay is not required. The only exception is when payment for a mental health stay is by DRG and the length of stay exceeds the day outlier threshold. Authorization for days over the threshold is required if the stay is to be eligible for Day Outlier Payment.

n. Children with dual diagnoses of mental health and intellectual disability requiring acute care for periods of weeks or months. Subject to prior authorization, these stays will be outside the scope of the DRG payment method and will be paid on a per diem basis. The per diem rate will be based on the cost of care as estimated from Medicare cost reports.

o. Medicare crossover claims. These stays, where Medicaid acts as a secondary payer behind Medicare, are outside the scope of the DRG payment method. Medicaid payment is calculated as the Medicare coinsurance and deductible times the hospital-specific ratio of cost to charges as calculated by EOHHS from the Medicare cost report.

p. Annual review. EOHHS will review the DRG payment method at least annually, making updates as appropriate through the rule-making process. The scope of the annual review will include at least the DRG algorithm version, the DRG Relative Weights, the DRG Base Price(s), the outlier thresholds, outlier payment parameters, policy adjustors and the age adjustors. With respect to the DRG Base Price, EOHHS will take into consideration at least the following factors in deciding what change, if any, to implement: changes or levels of beneficiary access to quality care; the Center for Medicare and Medicaid Services (CMS) Inpatient Hospital Prospective Payment System Market Basket Update without

productivity adjustment for the current federal fiscal year; technical corrections to offset changes in DRG Relative Weights or policy adjustors; changes in how hospitals provide diagnosis and procedure codes on claims; and budget allocations.

q. Posted information. Hospitals, beneficiaries and other interested parties can find current versions of a DRG Calculator (including the DRG Base Payment rate for each APR-DRG) on the Executive Office of Health and Human Services website, updated as of July 1, 2019: http://www.eohhs.ri.gov/ProvidersPartners/GeneralInformation/ProviderDirectories/Hospitals.aspx

Payment for inpatient hospital care provided by government-owned and -operated hospitals will be paid on a cost basis as follows:

a. Cost-Based Payment

From January 1 through December 30, providers will be reimbursed using interim rates that are calculated using data that is from the cost report of the prior state fiscal year (July 1 – June 30). Cost reports for the prior state fiscal year (July 1 – June 30) are due to the state November 30. Rates from those cost reports are also used for the final settlements of the prior state fiscal year (July 1 – June 30). The Medicaid rate is equal to the per diem found on the Cost Report at Worksheet D-1 Line 38 plus an amount equal to adding the costs on Worksheet A-8-2, Column 4, Line 200 and dividing by inpatient days found on Worksheet D-1, Column 1, Line 2.

These final rates will be used in a reconciliation for the previous state fiscal year (July 1 – June 30) and become the interim rates for the following calendar year (January 1 – December 30).

For each state fiscal year (July 1 – June 30), the final per diem rates (that are calculated using the cost reports that are due the following November 30) will be multiplied by the number of paid Medicaid inpatient days for dates of service in the relevant state fiscal year, to generate the total amount owed by Medicaid for that state fiscal year.

The total amount owed by Medicaid will be compared to the total sum of interim payments made in aggregate to the hospital in the corresponding state fiscal 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 hospital 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 reconciliation of interim to final rates will occur within one year post the end of the applicable state fiscal year (i.e. reconciliation for SFY2019 rates will be reconciled by June 30, 2020).

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, 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