STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

3/4/2021 PUBLIC NOTICE OF PROPOSED AMENDMENT TO RHODE ISLAND MEDICAID STATE PLAN

In accordance Rhode Island General Laws 42-35, notice is hereby given that the Executive Office of Health and Human Services (EOHHS) proposes to make the following amendment to the Rhode Island State Plan under Title XIX of the Social Security Act:

Psychiatric Residential Treatment Facilities (PRTF)

EOHHS is proposing to submit an amendment to the Medicaid State Plan. This amendment will codify the cost-based payment method for Psychiatric Residential Treatment Facilities (PRTF).

The proposed effective date of this change is April 1, 2021. This is not expected to have any financial impact to annual expenditures.

This proposed amendment is accessible on the EOHHS website (www.eohhs.ri.gov) or available in hard copy upon request (401-462-6348 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by April 3, 2021 to Melody Lawrence, Executive Office of Health and Human Services, 3 West Rd, Cranston, RI, 02920, or Melody.Lawrence@ohhs.ri.gov.

In accordance with the Rhode Island General Laws 42-35-3, an oral hearing will be granted on the proposed State Plan Amendment if requested by twenty-five (25) persons, an agency, or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within thirty (30) days of this notice.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, or handicap in acceptance for or provision of services or employment in its programs or activities.

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z. Physical Therapy, Occupational Therapy, and Speech Therapy

- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physical Therapy. The agency's fee schedule rate was set as of October 1, 2018 and is effective for services provided on or after that date. All rates are published at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf
- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Occupational Therapy. The agency's fee schedule rate was set as of October 1, 2018 and is effective for services provided on or after that date. All rates are published at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf
- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Speech Therapy. The agency's fee schedule rate was set as of October 1, 2018 and is effective for services provided on or after that date. All rates are published at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Fee%20Schedules/Medicaid%20Fee%20Schedule.pdf

aa. Psychiatric Residential Treatment Facilities

Except as otherwise noted in the plan, state-developed rates are the same for both governmental and private providers of Psychiatric Residential Treatment Facilities (PRTF).

Payment for Psychiatric Residential Treatment Facilities (PRTF) provided by state certified Providers will be paid on a cost basis as follows:

1. Overview of Cost-Based Payment

Upon meeting the requirements of the *Psychiatric Residential Treatment Facilities (PRTF) Rhode Island Certification Standards*, and in subsequent years of operation by every January 15, the Provider shall prepare and submit to the state the completed budget template described herein for the prior twelve (12) month period commencing June 30 (or the state's fiscal year). Upon approval by the Department of Children, Youth & Families (DCYF), the cost-based per diem rate will become initially effective upon the date DCYF certifies a facility as meeting certification standards and then, subsequently, on July 1 following resubmission of an updated budget template. The per diem payment rate for a facility will be determined using the attached budget request template, desk audits, and field office audits.

2. Documents to be Submitted by Provider

a. The DCYF Budget Template documents the PRTF's anticipated prospective operating budget, including labor expenses, facility and other direct costs, and general and administrative costs; the budget template shall be submitted during initial certification and annually thereafter.

b. The DCYF Annual Cost Report documents the same cost elements as the budget template to report allowable expenses incurred and service utilization during the prior fiscal year; this report shall be submitted within forty-five (45) days of the end of the state fiscal year.

3. Establishment of Initial Rates for First Year of Operation

For the first year of fiscal operation, rates will be established after a comprehensive desk audit of the applicable budget request is submitted. The desk audit is a comprehensive audit performed by the Rhode Island Department of Children, Youth and Families (DCYF) in which the auditor evaluates the accuracy of the information in the cost reports and supporting documentation in accordance with an audit program. The state may also, whenever possible, conduct onsite field audits to ensure the accuracy of the claims for reimbursement and consistency in reporting. Provider costs will be not considered in the calculation of the rate if the provider does not produce adequate documentation requested during a desk or field audit.

Following the desk audit and field audit, if deemed necessary, the per diem rate will be determined by dividing the allowable annualized costs in the detailed budget request by the number of approved beds at the Provider site; and then dividing that value by the number of days in the fiscal year. For the purpose of determining the first year of fiscal operations per diem rates, a provider may not use a utilization rate for available beds of less than eighty-five percent (85%) unless a complete and proper justification, such as that evidenced by sustained historical data, is approved by DCYF. A utilization rate below seventy-five percent (75%) may not be used at any time for the purpose of calculating a per diem rate, except during the first six (6) months of a PRTF's operation.

4. Annual Rate Redetermination

Annually on January 15, the provider shall submit an updated budget template to DCYF that contains the anticipated reasonable, allowable costs for operating the relevant PRTF site in the following state fiscal year (beginning on July 1). DCYF will review the reasonable, allowable costs contained in the budget template and redetermine a new rate for PRTF services to be delivered by each certified site in the coming state fiscal year. In a manner similar to the determination of the initial payment rate, the per diem rate shall be redetermined by dividing the allowable annualized costs in the budget template by the number of approved beds at the site; and then dividing that value by the number of days in the fiscal year. For the purpose of these calculations, a utilization rate for available beds of less than eighty-five percent (85%) utilization may only be used if a complete and proper justification, such as sustained historical data that shows utilization below eighty-five percent (85%), has been provided to and approved by DCYF. A utilization rate below seventy-five percent (75%) may not be used for the purpose of re-calculating a per diem rate.

Annual budget template submissions may be subject to desk audits and field audits, as deemed necessary by DCYF, to verify anticipated costs included in the budget template. Anticipated costs may be

disallowed for rate determination purposes if they do not meet allowability or reasonableness guidelines provided below. Within forty-five (45) days of acceptance of a cost report as complete by DCYF, DCYF shall issue an updated rate for PRTF services that shall become effective at the commencement of the subsequent state fiscal year beginning July 1.

5. Annual Cost Report and Reconciliation

Forty-five (45) days after the end of the initial PRTF performance period (which is the State Fiscal Year July 1 - June 30), and each subsequent year thereafter, providers will submit a cost report in a format and template provided by DCYF with the same cost elements as the budget template and that reflects Medicaid-attributable costs and service utilization throughout the year, less adjustments for unallowable costs detailed in the section below. The cost report must be completed in accordance with generally accepted accounting principles (GAAP) 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. The cost submission shall be certified by an authorized corporate officer or licensed professional. As with budget template submissions, cost reports shall be subject to desk and field audits.

DCYF shall review the actual costs incurred by the provider during the previous year. Based on the payments made and costs reported, RI EOHHS shall recover any unexpended funds paid through the per diem in excess of five percent (5%) of the total payments made in the fiscal year. To determine the reconciliation amount, the total allowable costs reported will be compared to the total sum of payments made in aggregate to the provider in the corresponding fiscal year. If the total payments exceed total allowable costs and the difference between the total paid amount and total actual allowed costs is more than five percent (5%) of the total payments issued, then the provider shall return the difference between ninety-five percent (95%) of the total paid amount and the actual allowable costs to EOHHS via a reconciliation payment. This return payment to EOHHS must be made within 90 days of notification from DCYF, unless contested by the Provider as described below.

6. Reasonable Costs and Adequacy of Rates

Providers will be paid rates that are reasonable and adequate to meet costs that must be incurred by efficiently and economically operating the PRTF in order to provide services in conformance with state and federal laws, regulations, and quality and safety standards. Reasonable costs shall mean those costs of an individual Provider for items, goods and services which, when compared, will not exceed the costs of like items, 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.

In addition, providers are expected to establish operating practices that assure that costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. Where it is determined that reported costs exceed those levels and in the absence of proof that the situation was unavoidable, the excessive costs will not be included in a rate calculation.

7. Record Retention and Penalties

Providers must maintain accurate, detailed, and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or until the final resolution of

any appeal involving a rate for the period covered by the annual cost report, whichever occurs later, and in accordance with state and federal record retention regulations. Providers must maintain complete documentation of all of the financial transactions and census activity of the Provider and affiliated entities including, but not limited to, the books, invoices, bank statements, canceled checks, payroll records, governmental filings, and any other records necessary to document the provider's claim for reimbursement. Providers must be able to document expenses relating to affiliated entities for which reimbursement is claimed whether or not they are related parties.

Providers will be subject to a penalty in the amount of up to fifteen percent (15%) of its payments if that provider fails to submit required information. DCYF will notify the provider in advance of its intention to impose a penalty.

If the program is no longer in operation, the facility shall retain the records and have available at DCYF's request, in accordance with timeframes established through state and federal regulation.

8. Prospective Rate Adjustments

DCYF may consider the granting of a prospective rate change during a performance year that reflects demonstrated cost increases in excess of the rate established previously. In order to qualify for the rate increase, the provider must demonstrate increased cost attributable to one of the following:

a. Demonstrated errors made during the rate determination process.
b. Significant increases in operating costs resulting from the implementation of new or additional programs, services or staff if approved prior to implementation by DCYF. A significant increase is defined as an increase of ten percent (10%) or more in operating costs, expected to be incurred for three (3) months or more during the performance year.
c. Significant increases in operating costs resulting from capital renovations, expansion, or replacement required for compliance with fire safety codes and/or certification requirements as requested or required by DCYF. Increased energy costs that the Provider can demonstrate are a result of the Provider having expended funds for heating, lighting, hot water, and similar costs associated with the consumption of energy provided by public utilities.
d. Significant increases in workers' compensation and/or health insurance premiums which cannot be accommodated within the provider per diem rate, if the cost justified.
e. Other extraordinary circumstances, including but not limited to, acts of God, that might substantially and materially increase costs of providing services.

Before a provider shall be permitted to file for a rate increase, increases in operating costs set forth in accordance with above provisions must have been incurred for a period of not less than three (3) months in order to establish proof of the increase. Rate adjustments granted as a result of a request filed within one hundred twenty (120) days after the costs were first incurred shall be made effective retroactively to the date the costs were actually incurred; provided, further, any adjustments granted as a result of requests filed more than one hundred twenty (120) days after the costs were first incurred will be effective on the first day of the month following the filling of the request.

9. Appeal of Rates Following Annual Redetermination or Prospective Rate Adjustment Request

A provider who is not in agreement with the final rate determination may, within fifteen (15) days from the date of notification of a rate adjustment request decision, file a written request for a review conference. The review conference will be conducted by the DCYF Chief Financial Officer (CFO) or

designee and will be approved by the Medicaid Director or designee. The written request must identify the remaining contested audit adjustment(s) or rate assignment issue(s). The DCYF CFO or designee shall schedule a review conference within fifteen (15) days of said request and subsequently issue a final decision. This decision made by the DCYF CFO and approved by the Medicaid Director or other designee is a decision appealable under the EOHHS appeals process in accordance with the State Administrative Procedures Act.

10. 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-administrative-requirements-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 PRTF rate. The PRTF provider shall list any indirect costs related to the PRTF service, and the provider shall describe the methodology used to allocate those costs to the service being proposed. Indirect cost allocation methodologies must follow general accounting principles and shall be in accordance with the OMB Omni Circular described above.

11. Prior Authorizations and Description of Service Provided

The Provider must agree to accept referrals made by DCYF and, specifically, DCYF's Division of Community Services and Behavioral Health (CSBH). The Provider agrees that referrals from other sources must be directed to the DCYF's Division of Community Services and Behavioral Health (CSBH) in order to be accepted. All non-emergency admissions must be certified through DCYF. The Provider will review the referral materials provided by CSBH as available for the purpose of meeting the needs of

the youth referred. The Provider agrees that there will be instances when immediate attention is needed, and the services for the youth and/or family shall be provided as an immediate response. DCYF will work with the Provider in the referral process to establish a protocol outlining the circumstances when a family or youth is to be seen right away. The Provider agrees to accept admissions of a youth when DCYF determines that it is an emergency situation. The Provider maintains continuous "24/7" and 365/6-day per year admission availability.

The Provider shall maintain a "no reject, no eject" policy; no youth shall be refused services or discharged from service due to their previous history or reluctance to engage in the program. The Provider shall submit this policy for review and approval to DCYF.

All referrals are subject to a review process if the Provider asserts it is unable to meet the needs of the referred youth. In such instances the Provider will explain in writing and in detail why they believe their services cannot meet the needs of the youth in those instances. If after reviewing this information and discussion with the Provider, DCYF concludes that the referral meets the needs of the youth, then the Provider shall accept the decision of DCYF as final and shall accept the referral and admit the referred youth. The Provider agrees to provide detailed written dispositions for referrals within the time requirements specified by the CSBH division.

Before authorization for payment, the attending physician or staff physician shall establish a written plan of care for each applicant or recipient. The plan of care shall be:

a. Based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.
b. Developed by a team of professionals and in consultation with the recipient and his/her parents, legal guardians, or others in whose care he or she will be released after discharge:
c. Based on education and experience, preferably including competence in youth psychiatry, the team is capable of:
d. Assessing the recipient's immediate and long-term therapeutic needs, developmental priorities, and personal strengths and liabilities;
e. Assessing the potential resources of the recipient's family;
f. Setting treatment objectives; and
g. Prescribing therapeutic modalities to achieve the plan's objectives, as needed.

The plan shall be reviewed every thirty (30) days by the care team specified in the *Psychiatric Residential Treatment Facilities (PRTF) Rhode Island Certification Standards*:

a. Determine that services being provided are or were required on an inpatient basis; and
b. Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

The plan of care must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

A PRTF's clinical programming and treatment shall be reflective of the Building Bridges Initiative (BBI) Core Principles, which include family-driven and youth-guided care, cultural and linguistic competence, clinical excellence and quality standards, accessibility, community involvement and transition planning (between settings and from youth to adulthood): *https://www.buildingbridges4youth.org/*

All PRTF programs shall comply with the State of Rhode Island *Regulations for Child Placing Regulations for Licensure*, including *Residential Child Care Regulations for Licensure*. In addition, all PRTF's are subject to the Provider certification requirements.