STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT 74-13 Attachment 4.11A

OFFICIAL

State Rhode Island

STANDARDS FOR INSTITUTIONS

The Rules and Regulations for licensing of hospitals and group care homes set forth in the publication of the Dempartment of Health, as published, August, 1973, is on file in Medical Standards and Review of the Rhode Island Department of SRS.

St. R.I. Tr. 1/15/73 Incorp 12/6/74 Effective ~~12/31/73~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Rhode Island

Utilization Control of Care and Services

The Surveillance and Utilization Control Program conducts the following activities in accordance with federal requirements and regulations, including, but not limited to, 42 CFR 456.22, 456.23, and 456.3:

- Quarterly retrospective paid claim reviews of beneficiary and provider claims data
- Provider or service specific audits of claims data when recommended by the Program Integrity Unit
- Monthly generation and mailing of Recipient Explanations of Member Benefits (REOMB) statements
- Monitors national trends and conducts research to evaluate the impact, or potential impact, on the Medicaid program
- Initiates and thoroughly investigates tips and targeted queries; reviews a minimum of 15 months of claims for each standard recipient or provider case under investigation.
- Recoups and adjusts claims payments either by an individual evaluation or sampling methodology that is conducted following an analysis of paid claims data
- Analyses and prepares reports detailing any of the above issues
- Recommends corrective actions and the recoupment or adjustment of claims as applicable

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

4.16-A

DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES

OFFICE OF THE DIRECTOR

600 New London Avenue
Cranston, Rhode Island 02920

OFFICIAL 80-21

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MEMORANDUM OF UNDERSTANDING
BETWEEN
MEDICAL ASSISTANCE PROGRAM
AND
VOCATIONAL REHABILITATION

In order to continue the present cooperative working relationship between the Rhode Island Medical Assistance Program and Vocational Rehabilitation and to provide high quality medical services for clients eligible for Medical Assistance (Title XIX) and Vocational Rehabilitation, the following is presented to delineate the responsibilities of the agencies concerned.

It is understood that Vocational Rehabilitation should do everything possible to rehabilitate individuals as Vocational Rehabilitation has the responsibility for the administration of all services needed to preserve or develop to the maximum the self-sufficiency of the individual.

In order to fully utilize the services of both agencies, Vocational Rehabilitation will assume responsibility for the following services:

(1) A complete general medical examination providing an appraisal of the current medical status of the individual.

(2) Examination by specialists in all fields as needed, including psychiatric and/or psychological examinations in all cases of suspected mental or emotional illness.

(3) Such laboratory tests, x-ray services and other indicated studies as are necessary to establish the diagnosis(es) to determine the extent to which disability limits the individual's daily living and work activities and to estimate the potential results of physical restoration services.

(4) The initial purchase of durable medical equipment and surgical and prosthetic appliances required as part of a Vocational Rehabilitation plan.

(5) In-patient and out-patient services provided by rehabilitation facilities not covered within the scope of services of the Rhode Island Medical Assistance Program.

(6) Private psychiatric services within the normal limitations of the Vocational Rehabilitation program.

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(7) All other medical services and supplies which are required as part of an overall Vocational Rehabilitation plan that are not covered by the Rhode Island Medical Assistance Program.

The Medical Assistance Program will assume responsibility for payment of the following services:

(1) Hospital services in licensed general hospitals certified for participation in the Title XVIII and Title XIX Programs when provided in accordance with applicable federal and state rules and regulations.

(2) Durable medical equipment and surgical and prosthetic appliances utilized on an on-going basis.

(3) Hemodialysis treatments provided in hospital and hemodialysis facility settings.

(4) All other medical services and supplies which are medically justifiable and are included within the scope of services of the Rhode Island Medical Assistance Program but not covered by Vocational Rehabilitation.

All medical services and supplies paid for by the Medical Assistance Program will be provided in accordance with established methods of reimbursement, fee schedules and other applicable rules and regulations. Since certain hospital out-patient department services and services provided in out-of-state hospitals require prior authorization, consultation between the two agencies will be required before authorization is granted for such services. All rehabilitative services will be provided within the scope of services of Vocational Rehabilitation. Referrals between the two agencies will be administered as agreed upon by both agencies.

Vocational Rehabilitation will take the initiative to evaluate and determine those services needed to return an individual to a remunerative occupation. Those medical services not directly connected with the clients major disabling condition and the Vocational Rehabilitation process will be excluded. The Medical Assistance Program will be responsible for the on-going medical needs not directly related to the Vocational Rehabilitation process.

Vocational Rehabilitation will provide on-going counseling and guidance and other needed non-medical services required to achieve the client's vocational objective.

Vocational Rehabilitation and Medical Assistance will exchange information on case situations as well as statistical data concerning relevant material required for both programs.

This memorandum of understanding is presented as a guide to provide the highest quality medical services for mutually served

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effective 10/1/82

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clients in an effort to preserve the self-dependency and integrity of the individual.

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This cooperative working arrangement between these agencies within the Department of Social and Rehabilitative Services which will be implemented effective May 1, 1979, shall remain in effect until a change is requested in writing by either agency sixty (60) days prior to the annual anniversary date.

Approved by:

John J. Affleck, Director
Dept. of Social and Rehabilitative Services

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Effective 10/1/80

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AGREEMENT
BETWEEN CRIPPLED CHILDREN'S SERVICES IN THE
R. I. STATE DEPARTMENT OF HEALTH
AND THE
R. I. STATE DEPARTMENT OF SOCIAL WELFARE

PURPOSE

The Rhode Island State Department of Social Welfare and the Crippled Children's Division within the State Health Department recognize and accept their mutual responsibilities of providing high quality medical services to all physically handicapped children in the community. They agree to effect a close inter-agency working relationship in order to more effectively achieve this goal.

It is mutually understood by both agencies that the Rhode Island Department of Social Welfare through the provisions of Title XIX will supplement those services presently being provided by the Crippled Children's Division. (See attached report by Crippled Children)

It is mutually agreed that the Department of Social Welfare and the Rhode Island State Department of Health should do all that is humanly possible to prevent chronic dependency upon the Department of Social Welfare when other community resources can be utilized to provide adequate medical services for these children. Basically, the goal is to have all physically handicapped children retain their independence to the greatest extent possible.

The Rhode Island State Department of Social Welfare will act as a supplementary agency and provide those medical services and supplies and financial assistance for which the Crippled Children's Division is unable to assume responsibility because of limitations in their resources and scope of medical services. These medical services and supplementary financial payments

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will be provided by the State Department of Social Welfare within the scope of its Title XIX Program. This type of arrangement should better serve the needs of the patient and the ultimate goals of both agencies. 80-21

CONDITIONS FOR ACCEPTANCE OF CASES BY CRIPPLED CHILDREN'S SERVICES.

In order to qualify for Crippled Children's services, the applicant must be a Rhode Island resident under 21 years of age and handicapped by reason of a physical defect(s), disability, disease, or a condition which is likely to result in a physical handicap. Any individual falling within this broad definition is eligible for those services generally available through the Division of Child Health, Crippled Children's Section within the State Department of Health.

Diagnostic services are available without charge to any child who resides in Rhode Island; without restriction or requirements as to the economic status or legal residence of the child's family or relatives, and without any requirement of the referral of such child by an individual agency.

Financial eligibility for therapeutic services is determined by the medical social worker from the Crippled Children's Section. These children whose parents have adequate financial resources are referred to private sources for their treatment. There are no restrictions imposed by reason of race.

RECIPROCAL REFERRAL SERVICES.

The Department of Social Welfare will refer to the Crippled Children's Program such persons who may appropriately be served by that agency. The Crippled Children's agency will accept such referrals and will make prompt arrangements to provide a comprehensive review and evaluation of the needs of such persons and will, thereafter, provide whatever services the agency

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is able to provide in accordance with its established scope of service and its usual agency criteria. The Crippled Children's agency will refer to the Department of Social Welfare those persons who are felt to be in need of 80-21 medical care or services whose needs can be more appropriately met under the provisions of the Medical Assistance Program. The Department of Social Welfare through its Division of Public Assistance will make prompt arrangements to interview and/or evaluate such persons and will provide whatever direction and assistance available to eligible recipients within the established scope of services within the Title XIX Program.

In those cases eligible for services of both agencies simultaneously, appropriate courses of action will be effected through joint planning by the two agencies for the attainment of their mutual goals intended to provide for the optimal medical care of the patient.

The Crippled Children's Division will assume responsibility for all professional services usually provided eligible recipients except in the areas of mental health and dental care. Because the Crippled Children's Program does not have provision for services in these areas of medical care, the Department of Social Welfare will assume responsibility for the payment of these medical services when the individual needs or other requirements set forth by the Department of Social Welfare are met as they relate to eligibility for such services.

It should be noted, however, that the Crippled Children's Agency will assume responsibility for payment for dental services when such services are related to a more basic physical defect; e.g., cleft palate, etc.

With regard to hospitalization, the Rhode Island State Department of

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Social Welfare will assume responsibility for the payment of hospital services for those children who qualify. All cases will be subject to the rules and regulations of the Rhode Island State Department of Social Welfare. It is in this category of hospital services that the Rhode Island State Department of Social Welfare can be expected to provide one of the more important elements of its supplementary assistance for the effective memdical care of the crippled child.

Responsibility for in-patient and out-patient physicians' services will be assumed by the Director of Child Health Services. Planning in this area will, therefore, require close cooperation among the Crippled Children's social worker, the Office of Medical Service in the Rhode Island State Department of Social Welfare and the Social Service Department of the hospital providing the services.

EXCHANGE OF REPORTS

In all cases involving mutual responsibility there will be an exchange of information and reports of progress. This cooperative interchange will serve to avoid duplication of services and the possibility of duplication of payment for the same by both agencies involved.

When one agency makes a referral to the other agency, the referring agency will forward all pertinent facts relating to the individual being referred to the accepting agency. The agency accepting the referral will, in turn, provide a report of all services which have been provided to the person referred for medical care or services.

PRIMARY AREAS TO BE SERVED BY THE CRIPPLED CHILDREN'S PROGRAM

The Crippled Children's Program has recently been expanded and extensively revised in response to the need for high quality medical services to

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the handicapped and in keeping with the latest developments in the various areas of medical research. The Crippled Children's Program makes provision for services in the following areas: 80-21

1. An Orthopedic Program.
2. A Cardiac Program including the care of congenital cardiacs as well as rheumatic fever patients.
3. A Metabolic Disease Program which includes treatment of patients with Cystic Fibrosis and Nephrosis.
4. A Cleft Lip or Cleft Palate Program as part of a newly instituted program of reconstructive and plastic surgery.
5. A speech and hearing program including the purchase of hearing aids.

As a result of the type of working agreement outlined in the preceding paragraphs - whereby the Rhode Island Department of Social Welfare has agreed to provide payment for supplementary medical services required by those eligible Medical Assistance recipients, the Crippled Children's Program will be in a more advantageous position to utilize more effectively its limited Federal and State appropriations in serving a larger number of children suffering from crippling or potentially crippling physical defects.

This agreement is to become effective January 1, 1968. It will be evaluated jointly by the two State agencies on a periodic basis - not less frequently than annually.

Date 12/6/67 Signed Augustine W. Riccio
Augustine W. Riccio
R. I. Department of Social Welfare

Date January 2 1968 Signed [illegible] M.D.
Joseph E. Cannon, M.D.
R. I. Department of Health

T. R I SA Approved 11/1/80 RO Approved 12/15/80
Effective 10/1/80

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AGREEMENT
BETWEEN MATERNAL AND CHILD HEALTH SERVICES IN THE
RHODE ISLAND STATE DEPARTMENT OF HEALTH
AND THE
RHODE ISLAND STATE DEPARTMENT OF SOCIAL WELFARE

PURPOSE:

The Rhode Island State Department of Social Welfare and the Division of Child Health within the Rhode Island State Health Department have the mutual objective of providing optimal maternal and infant care for the eligible recipients. In striving to attain these goals of both agencies, the Rhode Island State Department of Social Welfare will supplement the maternal and child health services presently being provided by the Division of Child Health within the scope and provisions of the Title XIX Program.

It is mutually agreed that the Rhode Island Department of Health and the Rhode Island Department of Social Welfare should do all that is possible to prevent chronic dependency upon the Department of Social Welfare when other community resources can be utilized to provide adequate medical services.

The Rhode Island Department of Social Welfare will act as a supplementary agency and provide whatever services and financial assistance the Division of Child Health is unable to assume because of limitations in resources and scope of medical service. These medical services and supplementary financial payments will be provided by the State Department of Social Welfare within the scope of its Title XIX Program. This type of arrangement should better serve the needs of the patient and the ultimate goals of both agencies.

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CONDITIONS FOR ACCEPTANCE OF CASES BY THE DIVISION OF CHILD HEALTH: 4.16-A

The conditions for acceptance in some of the major programs sponsored by the Division of Child Health are as follows: 80-21

1. Maternity and Infant Care Project at St. Joseph's Hospital.
   Through this project, prenatal, intrapartum, postpartum and newborn pediatric care are provided to unwed mothers throughout the State and to mothers of high risk residing in South Providence, Rhode Island.

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2. Immunization Program.
   All children in the first and fifth grades receive immunizations against diphtheria, tetanus, and measles.
3. Phenylketonuria (PKU) Control Program.
   Screening tests are performed for all newborn infants throughout the State.
4. Mental Retardation Evaluations.
   Diagnostic services are provided for those suspected of mental retardation and for all those persons up to age 21 who present a problem in delayed development or some type of inherited disease.
5. Instruction and Guidance of Expectant Mothers Program.
   This program takes the form of lectures given by specially trained public health nurses in several rural communities, as well as the metropolitan area.
6. Dental Care for Preschool and Mentally Retarded Children Program.
   Provision is made for dental care of preschool and mentally retarded children at the Joseph Samuels Dental Clinic.

Any individual falling within the above categories is eligible for maternal and child health services of the Division of Child Health.

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There are no restrictions pertaining to race of the potentially eligible recipient of services.

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RECIPROCAL REFERRAL SERVICES:

The Rhode Island Department of Social Welfare will refer to the Division of Child Health such persons who may appropriately be served by that agency. The Division of Child Health will accept such referrals and will make prompt arrangements to provide a comprehensive review and evaluation of the needs of such persons and will thereafter provide whatever services the agency is able to provide in accordance with its established scope of services and its usual agency criteria. The Division of Child Health will refer to the Rhode Island Department of Social Welfare those persons who are in need of medical care or services whose needs can be more appropriately met under the provisions of the Medical Assistance Program. The Department of Social Welfare through its Division of Public Assistance will make prompt arrangements to interview and/or evaluate such persons and will provide whatever direction, assistance, and services that are usually available to eligible recipients within the established scope of services of the Title XIX Program.

HOSPITAL SERVICE:

In regard to the Maternity and Infant Care Project at St. Joseph's Hospital, the Division of Public Assistance is meeting the hospital care costs for mothers and their newborn who are eligible for medical benefits under Title XIX and are included within the scope of the Maternity and Infant Care Project. (1)

DENTAL SERVICE:

All patients who are eligible for Title XIX dental care will be given a free choice of dentist when they are referred for dental treatment by the MIC Project.

(1) This arrangement will continue on a temporary basis - until such time as the financial posture of the Project improves.

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EXCHANGE OF INFORMATION:

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In all cases involving mutual responsibility there will be an exchange of information and reports of progress. This cooperative interchange will serve to avoid duplication of services and the possibility of duplication of payment for the same by both agencies involved. 80-21

When one agency makes a referral to the other agency, the referring agency will forward all pertinent facts relating to the individual being referred to the accepting agency. The agency accepting the referral will in turn provide a report of all services which have been provided to the person for medical care or services.

PROGRAM CONTENT OF THE DIVISION OF MATERNAL AND CHILD HEALTH:

(A comprehensive report is attached for review)

As a result of the type of working agreement outlined in the preceding paragraphs - whereby the Rhode Island Department of Social Welfare has agreed to provide payment for supplementary medical services required by those eligible Medical Assistance recipients - the Division of Maternal and Child Health will be in a more advantageous position to utilize more effectively its limited Federal and State appropriations in serving a larger number of eligible individuals.

This agreement is to become effective January 1, 1968. It will be evaluated jointly by the two State agencies on a periodic basis and not less frequently than annually.

DATE _____ SIGNED _____
Augustine W. Riccio
Director of Social Welfare

DATE _____ SIGNED _____
Joseph Cannon, M.D.
Director of Health

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effective 01/1/80

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RHODE ISLAND DEPARTMENT OF HEALTH

DIVISION OF CHILD HEALTH

ATTACHMENT I

OBJECTIVE:

To promote personalized, quality family planning services to the economically disadvantaged of low income and low levels of general health care.

SUBSTANTIATION:

The Rhode Island Department of Health, (Division of Child Health) has been mandated to deliver medical services for family planning as a segment of comprehensive medical care to the women and children of our state. At present, the Division of Child Health supports and funds eight clinics throughout the state and services in excess of 17,000 patients.

DEFINITION OF SERVICE:

The medical services provided at our family planning clinics specifically include:

1. A manual examination of the breasts with referral to radiographic examination, if indicated.
2. Visualization of the lower genital tract, with Papanicolaou smear.
3. Referral for biopsy of cervix, if indicated.

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4. Bi-manual pelvic examination.
5. Recording of weight and blood pressure.
6. Urinalyses
7. Referral for indicated laboratory tests, such as urine, hemoglobin or hemocrit, and other special examinations, if indicated by physical examination on directive of the physician.
8. Venereal Disease Testing:

   Bloods are drawn for syphilis testing and a vaginal smear with culture medium is used for all patients 35 years or younger. If disease is diagnosed, treatment or referral for treatment is made.

MODES OF CONTRACEPTIVE SERVICES:

Oral Contraceptives

Intra-Uterine Devices

Diaphram and Contraceptive Jelly

Condoms

Spermicidal Foams

Rhythm

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METHODS OF PROVIDING SERVICES:

PROCEDURES:

An appointment is generally required. Clinic hours are scheduled during days and evenings (including Saturdays) as dictated by the needs of the community served.

Patients are interviewed by staff members of the clinics with social service training and a social and medical history is recorded. Patients are orientated to medical services offered through the family planning clinics.

Clinical personnel procure and record height, weight, blood pressure, urinalyses, a nurse draws blood for VD testing. The patient is then examined by a physician which includes a breast and pelvic examination, Papanicolaou smear, GC culture, and prescription of desired method. Additional oral and written instructions may be given by the nurse if necessary.

After this initial visit, patients who elect oral contraceptives are given an appointment to return in 6-months for a pelvic and breast exam and a Pap smear and thereafter are scheduled for annual visits.

Patients who elect intra-uterine devices are given an appointment for a one month check-up. Thereafter they are scheduled for annual visits.

Patients who elect other methods are given appointments for annual examinations.

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All patients are instructed to telephone their clinic in the event they have any questions or problems and are assured that they will be seen as often as necessary if they have any problems which require medical attention.

Minor medical problems are treated at the clinic, referrals are made for conditions requiring other treatment.

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STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HEALTH

DIRECTOR OF HEALTH
JOSEPH E. CANNON, M.D., M.P.H.

Division of Dental Public Health

December 8, 1967

Dr. P. Joseph Pesare
Medical Director
Rhode Island Department of Social Welfare
1 Washington Avenue
Providence, Rhode Island

Dear Dr. Pesare:

This letter is in confirmation of the discussion which Dr. Brown and I had with you and your representatives at your office on Monday, November 27, 1967, regarding dental work on Title XIX - eligible patients who are participating in the Maternity and Infant Care Program (MIC Program) at St. Joseph's Hospital.

(1) All patients who are eligible for Title XIX dental care will be given a free choice of dentist when they are referred for dental treatment by the MIC Program.

(2) In keeping with the established policy of the Department of Social Welfare, requests for authorization for dental work will be submitted to the Office of Medical Service by the private dental practitioner.

(3) The private dental practitioner will be asked to note on the face page of the application for authorization the words Maternity and Infant Care Program Patient (or MICP Patient) - St. Joseph's Hospital.

(4) In view of the fact that patients on the MIC Program are eligible for treatment only during their pregnancy and for a six months period postpartum, special attention will be given to work authorization requests for these patients by the Office of Medical Service. Work authorizations will be acted upon and the decision reached from such action transmitted to the practicing dentists by the Office of Medical Service within a two week period after receipt of the application for authorization.

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(5) Each case will be screened by Dr. Edward Brown, Dental Consultant to the Maternity and Infant Care Program, or his representative, and recommendations transmitted to your office.

(6) The MIC Program will notify the Office of Medical Service when any MIC Program patient is discharged from the program. It is understood that when the patient is no longer eligible for care under the MIC Program, preferential processing of authorizations for that patient will automatically cease.

It is with great pleasure that we have been able to work out this very liberal policy with the Department of Social Welfare. I'm certain I reflect the sentiments of the dental practitioners when I express to you my personal gratitude for your understanding of our problem with the MIC Program patients and your willingness to assist us. With kindest personal regards, I am

Sincerely,

Joseph A. Yacovone, D.M.D., M.P.H.
Chief, Dental Public Health

JAY:emp

C/C: Dr. John Hogan
Dr. Robert Barone
Dr. Edward Brown
Mrs. Bonnie Houle

JL R.J Effective 10/1/80 11/17/80 Approved 12/15/80

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

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Department of Social and Rehabilitative Services
OFFICE OF THE DIRECTOR
600 New London Avenue
Cranston, R. I. 02920

December 3, 1976

Joseph E. Cannon, M.D., M.P.H.
Director
Department of Health
Davis Street
Providence, Rhode Island

Dear Dr. Cannon:

This is in response to your request for verification that both the Washington County Health Center and Northwest Community Health Centers participate in the Rhode Island Title XIX Medical Assistance Program.

Both of these facilities receive reimbursement for physicians services provided eligible Title XIX recipients in accordance with the established fee schedule allowances of $10.00 for an initial visit and $8.50 for follow-up visits. Both facilities also receive a $20.00 allowance for Early and Periodic Screening, Diagnosis and Treatment examinations provided eligible recipients of the Rhode Island Medical Assistance Program under 21 years of age. It should be noted that this special allowance of $20.00 is based upon the completion of a comprehensive examination and the submission of a fully completed extensive report form which has been developed by the Department of Social and Rehabilitative Services.

We are most pleased that these facilities are able to serve eligible recipients of the Rhode Island Medical Assistance Program in general and the EPSDT Program in particular.

With best wishes, I am

Sincerely yours,

John J. Affleck
Director

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

Not Applicable.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

Not Applicable.

3. The State defines the terms below as follows:

- o estate
- o individual's home
- o equity interest in the home
- o residing in the home for at least one or two years on a continuous basis, and
- o lawfully residing.

Not Applicable.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

LIENS AND ADJUSTMENTS OR RECOVERIES

4. **The State defines undue hardship as follows:**

An undue hardship may be found to exist and execution of the lien may be postponed if a sale of real property, in the case of an individual's home, would be required to satisfy a claim, if all of the following conditions are met.

1) an individual was using the property as a principal place of residence on the date of the recipient's death; and,

2) that individual resided in the decedent's home on a continual basis for at least twenty-four (24) months immediately prior to the date of the deceased recipient's death; and,

3) that individual has, from the time the Department first presented its claim for recovery against the deceased recipient's estate and after, annual gross income in an amount not to exceed 250 percent of the then applicable federal poverty level (FPL) income standard based on the same family size, and assets not to exceed the then applicable Medically Needy resource standards (see section 0338.05).

In addition to the foregoing criteria, undue hardship will be determined by the Department on a case-by-case basis and will include, but will not be limited to, the following examples, e.g., the individual or self, on whose behalf the heir(s) or beneficiary(ies) is requesting a consideration of undue hardship, would:

A. be rendered homeless without the resources to find suitable housing; or,

B. lose his/her means of livelihood; or,

C. be deprived of food, clothing, shelter, or medical care such that life would be endangered should a finding of undue hardship be denied.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

LIENS AND ADJUSTMENTS OR RECOVERIES

5. **The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:**

If an individual meets the above criteria, the heir(s) or beneficiary(ies) may submit a request to the Department of Human Services, TPL Unit for consideration of undue hardship and the delay of the execution of the Department's lien against the property if it appears that the individual is able to continue to reside in the property.

Requests for consideration of undue hardship will be reviewed by a team of three members therein designated by the Director of the Department of Human Services, of which one member will be from the DHS Office of Legal Services. The review team will render decisions by giving due consideration to the equities involved as well as the obligations of the parties involved.

If the Department finds that an undue hardship exists, the execution of the lien is delayed for as long as:

- the undue hardship grantee is alive and residing in the property; and has income and assets not to exceed the amounts specified in Section 0312.40.
- the undue hardship circumstances upon which the decision is based continue to exist; and,
- as long as the property is adequately maintained and continues to exist in its then current state, (e.g., if the structure is destroyed by fire, the lien will be executed against the real estate if it appears that the home will not be rebuilt).

The circumstances of the hardship will be subject to review by the Department at least every two years provided, however, that the grantee must notify the Department of any material change in circumstances, income and/or assets.

If the owner of the property sells or transfers ownership of the home, the Department of Human Services will execute the lien.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: RHODE ISLAND

LIENS AND ADJUSTMENTS OR RECOVERIES

6. **The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):** If probate assets recorded in the case record exceed $3,000 at time of last recertification or if they include real estate, then recovery efforts are initiated upon notification of death.

7. **The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):**

   A. The TPL Unit initiates estate recoveries upon receipt of information (from internal or external sources) relative to the death of a Medical Assistance recipient who was at least 55 years of age, and responds to requests from estate representatives to release and/or discharge liens upon payment of reimbursable amounts or upon determination by the TPL Unit that a lien is inapplicable.

   B. The TPL Unit does not automatically file an encumbrance in the land evidence records. It is DHS' policy not to encumber the chain of title to real estate until the DHS claim is contested by the legal representatives of the estate, or until it appears that the legal representatives of the estate are unresponsive to the TPL Unit's inquiries or claims.

   C. Usually, the recovery process begins with a letter to the next of kin or legal representatives requesting estate asset information. In most cases, there are no assets left after payment of funeral expenses and other preferred debts (R.I.G.L. 33-12-11), and no recovery is pursued by DHS. If requested, the TPL Unit will issue a discharge of lien. If there are any assets remaining to pay the DHS claim, in whole or in part, the TPL Unit will request reimbursement by letter which provides an accounting of the Medical Assistance expenditures. Upon receipt of payment, the TPL Unit will issue a discharge of lien.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **RHODE ISLAND**

LIENS AND ADJUSTMENTS OR RECOVERIES

D. If DHS is notified of the pendency of a probate estate either in response to a written notice from the executor/administrator, (see In Re: Estate of Santoro, 572 A. 2d 298, R.I. (1990) and R.I.G.L. 33-11-5.1 for notice to creditor requirements), the TPL Unit will file a formal claim in the estate. Land evidence lien notices are not normally filed at this time (see B. above). Lien notices are filed in the land evidence records if the claim is contested.

E. In accordance with R.I.G.L. 40-8-15(b), and R.I.G.L. 33-11-5.1, legal representatives and/or the heirs-at-law of the decedent are required to provide to the DHS, TPL Unit, within sixty (60) days of the date of death, written notice identifying the decedent, the assets included in the individual's probate estate, the social security number and date of birth of the decedent, and the names and addresses of all persons interested in, or entitled to take any share of the individual's probate estate.

A requestor shall mail his or her application for an undue hardship consideration in writing to the Department within 45 days after the date the Department has filed its claim with probate court. The application shall include the following information:

1. the relationship of the undue hardship applicant to the decedent and copies of documents establishing that relationship; and,
2. the basis for the application and documentation supporting the undue hardship applicant's position; and,
3. supporting documentation that the requestor has the legal standing and will be allowed to continue to reside in the property indefinitely should the undue hardship request be approved.

The Department may require additional documentation, such as a current title examination, a list of existing creditors, etc. as adequate proof that its decision to defer its lien will not otherwise adversely affect its claim.

The Department shall review each application and issue a written decision within 90 days after the application was received by the Department. The Department shall consider and base its decision on all information received with the application and any independent investigation it may undertake. The decision shall be the final decision of the Department.

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Medicaid Premiums and Cost Sharing

State Name: Rhode Island

OMB Control Number: 0938-1148

Transmittal Number: RI - 19 - 0005

Cost Sharing Requirements	G1
1916 1916A 42 CFR 447.50 through 447.57 (excluding 447.55)	
The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid.	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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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 5.0%. Effective 7/1/2023, 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

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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
Hospitals, beneficiaries and other interested parties can find current interim rates on the Executive Office of Health and Human Services website, which will be updated annually in January: http://www.eohhs.ri.gov/ProvidersPartners/GeneralInformation/ProviderDirectories/Hospitals.aspx.

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Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A) of this State plan.

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A) of this State plan.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Non-Payment for Hospital Acquired Conditions:
In accordance with Title XIX of the Social Security Act — Sections 1902, 1903 and 42 CFRs 434, 438, and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPC) which includes Health Care-Acquired Condition (HCAC).

For all Medicaid patients, requests for Diagnosis Related Groups (DRGs) attributable to Present on Admission (POA) conditions will be reimbursed for allowable charges.

Provider Preventable conditions (PPC), which includes Health Care-Acquired Condition (HCAC), with diagnosis codes with Y or W, or as defined by CMS, will be considered in the DRG calculation. Conversely, any diagnoses codes with N or U, or as defined by CMS, will not be considered in the DRG calculation. Providers must identify and report PPC occurrences.

For hospitals reimbursed under a per diem methodology, to the extent that the cost of the hospital acquired condition can be isolated, payment for the cost of the hospital acquired condition will be denied.

Non-Payment for Other Provider Preventable Conditions

- E876.5 — Performance of wrong operation (procedure) on correct patient
- E876.6 — Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 — Performance of correct operation (procedure) on wrong side/body part

The provider may file a separate claim for the same Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report other provider preventable conditions.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply: (i) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

Prohibition on payments for PPC, and HCAC, shall not result in a loss of access to care or services for Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions, contained in 4.19A, including Medicaid proportionate share hospital payments. In the event that individual cases are identified throughout the PPC implementation period, July 1, 2012 through January 10, 2013, the State will adjust reimbursements according to the methodology above.

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Disproportionate Share Hospital Policy

Disproportionate Share Hospitals

I. Criteria

For purposes of complying with Section 1923 of the Social Security Act, the Executive Office of Health and Human Services, the designated Single State Agency for the Title XIX Medical Assistance Program, will determine which hospitals can be deemed eligible for a disproportionate share payment adjustment.

1. Rhode Island defines disproportionate share hospitals as those licensed hospitals within the State providing inpatient and outpatient services meeting the following criteria:

A. A Medical Assistance inpatient utilization rate at least one (1) standard deviation above the mean medical assistance Inpatient utilization rate for hospitals receiving medical assistance payments in the State; or

B. A low-income inpatient utilization rate exceeding twenty five (25) percent; or

C. A Medical Assistance inpatient utilization rate of not less than one (1) percent, and

D. The hospital has at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the Rhode Island Medical Assistance Program. This requirement does not apply to a hospital where: a) the inpatients are predominantly individuals under eighteen (18) years of age; or b) did not offer non-emergency obstetric services as of 12/22/87.

II. Definitions

1. Medical Assistance inpatient utilization rate means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for Rhode Island Medical Assistance Program in a period (regardless of whether the services were furnished on a fee-for-service basis or through a managed-care entity), and the denominator of which is the total number of the hospital's inpatient days in that period.

2. Low Income utilization rate means, for a hospital, the sum of

A. A fraction (expressed as a percentage), the numerator of which is the sum (for the hospital's fiscal year designated in Section 111,1,F) of the total medical

assistance revenues paid to the hospital for patient services (regardless of whether the services were furnished on a fee-for-service basis or through a managed-care entity), and the amount of the cash subsidies for patient services received directly from State and local governments, the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in that period; and

B. A fraction (expressed as a percentage), the numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in the hospital's fiscal year designated in Section 111,1,F less the portion of any cash subsidies described in subparagraph (A) in that period reasonably attributable to inpatient hospital services, and the denominator of which is the total amount of revenues of the hospital's charges for inpatient hospital services in the hospital in that period.
The numerator under subparagraph (6) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance).

III. Payment Adjustment

1. For Federal fiscal year 2017 and for Federal fiscal years thereafter, the State shall make payment to each qualifying facility in accordance with the following formula:

A. Pool D: For non-government and non-psychiatric hospitals licensed within the State of Rhode Island, whose Medical Assistance inpatient utilization rate exceed 1.0%, there shall be a payment not to exceed the total computable DSH allotment as reported on Form CMS-64.9D Column G, Line 1 to compensate hospitals for uncompensated care (as defined below) distributed among the qualifying hospitals in direct proportion to the individual qualifying hospital's uncompensated care to the total uncompensated care costs for all qualifying hospitals. To the extent that audit findings demonstrate that DSH payments exceeded the documented hospital-specific limit, the excess DSH payments are distributed by the State to other qualifying hospitals in direct proportion to the individual qualifying hospital's uncompensated care to the total uncompensated care costs for all qualifying hospitals as an integral part of the audit process.

B. Uncompensated care is defined as stated in Section 1923 of the Social Security Act and issued by CMS in the Medicaid DSH reporting and auditing final regulation on December 19, 2008 (Federal Register/Vol. 73, No. 245).

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The utilization rates, costs, and uncompensated care for the most recently completed hospital fiscal year for which data is available (hospital fiscal year 2014 will be utilized to determine each hospital's payment). 2014 uncompensated care costs shall be indexed by the uncompensated care index as defined in Rhode Island General Law 40-8.3-2(5) for each subsequent year to calculate the costs for the year in which payments are made. The total payment to a qualifying facility will not exceed the facility-specific caps described in Section 1923(g).

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The state has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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GRADUATE MEDICAL EDUCATION SUPPLEMENTAL PAYMENTS

Effective July 1, 2021, Graduate Medical Education Supplemental Payments are eliminated.

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INPATIENT HOSPITAL SUPPLEMENTARY PAYMENT

For inpatient services provided on and after July 1, 2022, each acute care hospital may be paid up to an amount determined as follows:

1. Determine the sum of gross Medicaid payments (including TPL, but excluding the cross-over claims for which Medicare is the primary payer) from Rhode Island MMIS and all other Medicaid FFS inpatient payments to hospitals made for inpatient services provided during each hospital's preceding fiscal year, including settlements

2. The Inpatient UPL calculation is an estimate of Medicare inpatient cost for private hospitals. Specifically, a ratio of Medicare inpatient costs to Medicare inpatient charges is applied to Medicaid inpatient charges to determine total Medicaid UPL amount. This is then inflated to adjust from the cost report year to the UPL year, and the Medicaid Provider Tax cost is added to determine the Adjusted Medicare UPL amount. Total Medicaid inpatient payments Inflated to Demonstration Year are then subtracted from the Adjusted Medicare UPL amount to determine the UPL gap, which is the basis for the size of the inpatient supplemental payment. The UPL gap is calculated using an aggregate of the individual hospital gaps for private hospitals. The inpatient UPL calculation is a reasonable estimate of the amount Medicare would pay for equivalent Medicaid services.

Except for Bradley Hospital, Medicare routine and ancillary cost information is from each provider's as-filed Medicare cost report (CMS 2552), Worksheet D-1, Part 2, Line 49 (PPS services and sub-providers).

Medicare routine and ancillary charge information is from each provider's as-filed Medicare cost report (CMS 2552), Worksheet D-3, Column 2, Lines 30-41 and 202 (PPS services and sub-providers)

For Bradley Hospital, Medicare routine and ancillary charge information is from the provider's as filed Medicare cost report (2552-10), Worksheet G-2, Part I, Column I, Line 28. To determine the Bradley Hospital's inpatient cost information:

A. Identify total inpatient charges (detailed above)
B. Identify outpatient charges (from filed Medicare cost report (2552-10), Worksheet G-2, Part I, Column 2, Line 28)
C. Calculate total inpatient and outpatient charges (A + B)
D. Calculate the percentage of inpatient charges to total charges (A / C)
E. Identify total inpatient and outpatient costs from filed Medicare cost report (2552-10), Worksheet G-2, Part II, Column 2, Line 43)

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F. Calculate total amount of inpatient costs (D * E)

The State shall use a Medicare cost report for the hospital's fiscal year beginning in the federal fiscal year two years prior to the state demonstration year. For example, a SFY 23 demonstration submitted in June 2023 (end of SFY23, within FFY 23) would use a Medicare cost report for the hospital fiscal year beginning in FFY 21 (10/1/2020 and 1/1/2021 reporting start dates, both in FFY 21)

RI's UPL calculations rely on Medicare and Medicaid data from prior periods. Rhode Island trends data for a Medicaid Inflation Factor and a UPL inflation Factor. The Medicaid Inflation Factor shall be 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 federal fiscal year 2021 (SFY 22) multiplied by a 5.0% hospital rate increase enacted by the Rhode Island General Assembly for SFY 23. Effective July 1, 2023, the Medicaid Inflation factor will be 5% multiplied by the "actual regulation market basket" as reflected in the CMS Inpatient Hospital Prospective Payment System Market Basket Update without productivity adjustment for federal fiscal year 2023.

The UPL Inflation Factor is the product of 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 federal fiscal years corresponding to each hospital's Medicare Cost Report (Report) end date. For example, a SFY 23 demonstration due 6/30/2023 uses hospital data from Report end dates of 9/30/2021 (FFY 2021) and 12/31/2021 (FFY 2022). Therefore, the inflationary adjustments are the FFY 21 and FFY 22 CMS Inpatient Hospital PPS Market Basket Updates without productivity adjustment. The amounts of these two inflationary adjustments are multiplied together to determine the total UPL inflation factor to use in RI's UPL demonstration.

An amount not to exceed the aggregate UPL gap is distributed quarterly (by the 20th of July, October, January and April) among all eligible hospitals based on the percentage relationship of each hospital's Medicaid payments to total Medicaid payments for all the private hospitals. No hospital will be paid more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. Eligible hospitals are actual facilities and buildings in existence in Rhode Island that are licensed by the Rhode Island Department of Health to provide short-term acute inpatient care to persons who require definitive diagnosis and treatment for injury, illness, disabilities, or pregnancy

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Psychiatric Residential Treatment Facilities

Except as otherwise noted in the State 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 cost report described herein that includes the anticipated costs for the forthcoming twelve (12) month period commencing the following 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 cost report. The per diem payment rate for a facility will be determined using cost reports, desk audits, and field office audits (when needed).

2. Cost Reports to be Submitted by Provider
    a. By January 15 annually: Provider submits to DCYF a cost report that documents the PRTF's anticipated prospective operating budget, including labor expenses, facility and other direct costs, and general and administrative costs; the cost report shall be submitted during initial certification of provider and annually thereafter.

    b. Annually within sixty (60) days of the end of the state fiscal year : Provider submits to DCYF a cost report that documents the same cost elements as the January cost report, and reports allowable expenses incurred and service utilization during the prior fiscal year; this report shall be submitted within sixty (60) days of the end of the state fiscal year.

    c. All cost reports will reflect Medicaid-attributable costs and service utilization throughout the year, less adjustments for unallowable costs. The cost report must be completed in accordance with generally accepted accounting principles (GAAP) and the Medicare Principals of Reimbursement 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 report submission shall be certified by an authorized corporate officer or licensed professional. Cost reports shall be subject to desk and field audits.

i. The desk audit is a review performed by a DCYF staff member in which staff member evaluates the accuracy of the information in the cost reports and supporting documentation in accordance with an audit program.

ii. If DCYF or the Executive Office of Health and Human Services (EOHHS) suspects misappropriation of funds, fraud, or failure to adhere to the Medicare Principals of Reimbursement, DCYF or EOHHS can conduct an onsite field audit to ensure the accuracy of the claims for reimbursement and consistency in reporting. DCYF and EOHHS can conduct an on-site audit at any time if it needs to investigate concerns related to resident care.

iii. Provider costs will not be considered in the calculation of the rate if the provider does not produce adequate documentation requested during a desk or field audit.

3. 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 shall follow general accounting principles and shall be in accordance with the OMB Omni Circular described above.

4. Establishment of Initial Rates for First Year of Operation

For the first year of fiscal operation, rates will be established after a desk audit of the applicable cost report submitted by the provider

Following the desk audit and optional field audit, 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 will 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%) will 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.

5. Annual Rate Redetermination

Annually on January 15, the provider shall submit an updated cost report 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 cost report 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 cost report 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%) will 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%) will not be used for the purpose of re-calculating a per diem rate.

The desk audit of the January cost report can be subject to an on-site audit. Anticipated costs will be disallowed for rate determination purposes if the provider does 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.

6. Annual Cost Report and Reconciliation

Sixty (60) 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 that reflects Medicaid-attributable costs and service utilization throughout the year, less adjustments for unallowable costs previously detailed.

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DCYF shall review the actual costs incurred by the provider during the previous year. The total amount owed by the State will be compared to the total sum of interim payments made in aggregate to the facility in the corresponding fiscal year. If the revenue owed by the State to the facility is less than the sum of the interim payments, the provider shall return to the State (via a reconciliation payment) the amount that is equal to that difference. This return payment to the State must be made within 90 days of notification from DCYF, unless contested by the provider as described below.

7. 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. If a cost appears higher, DCYF can survey businesses offering similar products or cross reference with available cost information from nearby states for residential treatment-specific costs. If the 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.

8. 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.

9. Prospective Rate Adjustments

DCYF will 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 is justified.
e. Significant, unanticipated increases in prevailing market wages for necessary staff positions.
f. 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 the 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.

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

A provider that 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.

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 policy for admitting any youth for whom the service is deemed medically necessary through certification by an appropriately qualified psychiatric team, subject to bed availability and as is consistent with the population that a facility is licensed to serve. 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:
    i. Assessing the recipient's immediate and long-term therapeutic needs, developmental priorities, and personal strengths and liabilities;
    ii. Assessing the potential resources of the recipient's family;
    iii. Setting treatment objectives; and
    iv. Prescribing therapeutic modalities to achieve the plan's objectives, as needed

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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* to:

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 *Residential Child Care Regulations for Licensure*. In addition, all PRTF's are subject to the Provider certification requirements.