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State/Territory Name: Rhode Island

State Plan Amendment (SPA) #:18-007

This file contains the following documents in the order listed:

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

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

October 11, 2018

Eric Beane, Secretary
Executive Office of Health and Human Services
State of Rhode Island and Providence Plantations
3 West Road
Cranston, RI 02920

Dear Secretary Beane:

On August 1, 2018, the Centers for Medicare and Medicaid Services (CMS) received Rhode Island State Plan Amendment (SPA) transmittal number 18-007 proposing to revise the reimbursement methodology for the Program of All Inclusive Care for the Elderly (PACE).

Based on information that was provided, we are pleased to inform you that RI SPA 18-007 was approved on October 9, 2018 with an effective date of July 1, 2018. The approved state plan pages are enclosed.

If you have any questions regarding this matter you may contact Lynn DelVecchio (401) 380-5604 or by e-mail at Lynn.DelVecchio@cms.hhs.gov

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Cc: Patrick Tigue, Medicaid Director
Melody Lawrence, Interdepartmental Project Manager

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18-007

2. STATE: RI

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2018

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 460.182

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 $ 111,880
b. FFY 2019 $ 808,124

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 3 to Attachment 3.1-A, Page 6

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Supplement 3 to Attachment 3.1-A, Page 6

10. SUBJECT OF AMENDMENT:
Update PACE program rates

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
XX ☐ OTHER, AS SPECIFIED:
See Attached Letter

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Eric J Beane

13. TYPED NAME: Eric Beane

14. TITLE: Secretary

15. DATE SUBMITTED: August 1, 2018

16. RETURN TO:

EOHHS
3 West Rd, Virks Building
Cranston, RI 02920

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: August 1, 2018

18. DATE APPROVED: October 9, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Richard R. McGreal

22. TITLE: Associate Regional Administrator, Centers for Medicare and Medicaid Services, Boston Regional Office

23. REMARKS:

I. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1.___ Rates are set at a percent of fee-for-service costs
2.___ Experience-based (contractor's/State's cost experience or encounter data) (please describe)
3.___ Adjusted Community Rate (please describe)
4._X_ Other (please describe)

Effective July 1, 2018 the Executive Office of Health and Human Services (EOHHS) will calculate Program for All-Inclusive Care for the Elderly (PACE) capitation rates on a three-year cycle. During the first year, as per the methods elaborated below, EOHHS will calculate a PACE Amount which is Otherwise Payable (AWOP) using the experience of a similar Medicaid population receiving care through Managed Care Organizations (MCOs) and/or Fee-for-Service (FFS). For the second and third years of each cycle, the first-year rate will be adjusted according to the CMS Market Basket inflation factor for Home Health Agencies. The re-calculation of the AWOP for the first year of the following cycle will ensure that the PACE rates remain below the AWOP.

The State's AWOP methodology reflects the comparative costs paid by EOHHS for Medicaid recipients enrolled in the State's Medicaid Managed Long Term Services and Supports (MLTSS) Program. The data and experience used for establishing the AWOP adheres to the general standards of reasonableness and accuracy required for rate development for Medicaid managed care. The AWOP include adjustments for residential setting, Medicare status, the relative age and acuity of PACE members, and additional Medicaid services provided outside of the MLTSS Program.

The State will establish an AWOP for the following three different PACE rating groups:

- Duals aged 55-64 (PC55) and receiving services in the Community or Nursing Home (NH); [CP1]
- Duals aged 65 and older (PC65) and receiving services in the Community or NH; and
- Medicaid Only (PCMA) recipients receiving services in the Community or NH.

As the MLTSS Program includes rating groups that are different from PACE, EOHHS creates and then blends six comparable rating subgroups; a separate HCBS and NH rating group for each of the three PACE rating groups. Based upon the age distributions in PACE and the MLTSS Program, Age Group Adjustment factors are calculated and applied against the medical component of the comparable capitation rates developed for the MLTSS Program

To account for frailty differences of members enrolled in the MLTSS Program and PACE, EOHHS calculates a frailty adjustment factor based on differences in the average Reutilization Utilization Group (RUG) score of the two populations.

EOHHS identified two groups enrolled in the MLTSS Program that are comparable to the PACE population:

- those individuals, receiving HCBS, who have either a High or Highest Level of Care determination; and,
- those individuals residing in a Nursing Home who had also previously received HCBS and had Medicaid eligibility for at least 90 days prior to residing in a Nursing Home.

EOHHS excludes the following groups for purposes of establishing a PACE-comparable population:

- those who are already residing in the Nursing Home prior to obtaining Medicaid eligibility;
- those who enter the Nursing Home within 90 days of receiving Medicaid eligibility (as per RHO rules); and,
- those who enter the Nursing Home without ever having received HCBS.

Based on the above selection criteria, EOHHS estimates the proportion of members enrolled in the MLTSS Program who would otherwise be residing in a Nursing Home. The percentages calculated are then increased to account for additional enrollees who might have transitioned into a Nursing Home had they not been enrolled in PACE.

EOHHS then applies to the weighted Medical Component PMPM of each capitation group the following: a Medical Gain/Loss percentage; an Administrative PMPM; a Margin PMPM; a Dental PMPM; and a Non-Emergency Transportation Broker PMPM.

To determine PACE AWOP for the current year[CP2], EOHHS applies the current CMS Home Health Agency Market Basket rate percent to each capitation group.

The PACE rates are set at 98% of the calculated AWOP.

The AWOP and PACE reflect EOHHS' Medicaid base expenditures prior to the collection of any Patient Share paid by the Medicaid beneficiary.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

II. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.