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State/Territory Name: RI

State Plan Amendment (SPA) #: 21-0007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group

July 10, 2023
Richard Charest, Secretary
Executive Office of Health and Human Services
State of Rhode Island
3 West Road, Virks Building
Cranston, RI 02920

RE: Rhode Island State Plan Amendment (SPA) 21-0007

Dear Secretary Charest:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 21-0007. This amendment proposes to codify the cost-based payment methodology for Psychiatric Residential Treatment Facilities (PRTF).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of April 1, 2021. We are enclosing the CMS-179 and the amended approved plan pages.

As described in the state's letter to CMS dated April 29, 2022 regarding its Hospital Licensing Fee (HLF) and in CMS's response letter dated May 19, 2022, please note that CMS's approval of this State Plan Amendment (SPA) whose non-federal share source may include the HLF relates only to the requested change in payment methodology, not the source of non-federal share. Approval of this SPA does not relieve the state of its responsibility to comply with federal laws and regulations, and to ensure that claims for federal financial participation are consistent with all applicable requirements

If you have any questions, please contact Diana Dinh at Diana.Dinh@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21-0007

2. STATE: RI

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2021

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.203, 42 CFR 440.160, 42 CFR 441 Subpart D

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2021 $ 0
b. FFY 2022 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

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

7.	8.
Supplement 4 to Attachment 4.19-A, Page 1	NEW
Supplement 4 to Attachment 4.19-A, Page 2	NEW
Supplement 4 to Attachment 4.19-A, Page 3	NEW
Supplement 4 to Attachment 4.19-A, Page 4	NEW
Supplement 4 to Attachment 4.19-A, Page 5	NEW
Supplement 4 to Attachment 4.19-A, Page 6	NEW
Supplement 4 to Attachment 4.19-A, Page 7	NEW

9. SUBJECT OF AMENDMENT

Psychiatric Residential Treatment Facilities (PRTF) Payment Methodology

10. 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
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Kristin Pono Sousa

13. TITLE
Medicaid Program Director

14. DATE SUBMITTED
May 11, 2023

15. RETURN TO
EOHHS
3 West Rd, Virks Building
Cranston, RI 02920

FOR CMS USE ONLY

16. DATE RECEIVED
May 11, 2023

17. DATE APPROVED
July 10, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
April 1, 2021

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: RHODE ISLAND

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.