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State/Territory Name: RI

State Plan Amendment (SPA) #: 25-0015

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

November 17, 2026

Kristin Sousa, Secretary
Executive Office of Health and Human Services
State of Rhode Island
Cranston, RI 02920

RE: Rhode Island State Plan Amendment Transition Number (TN) 25-0015

Dear Secretary Sousa:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Rhode Island state plan amendment (SPA) to Attachment 4.19-A, RI-25-0015, which was submitted to CMS on November 14, 2025. This plan amendment establishes an inpatient hospital payment methodology, outside of the DRG system, for Medicaid-eligible adults receiving qualifying services in designated Long-Term Behavioral Health Units (LTBHUs).

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30)(A), 1903 of the Social Security Act (the Act) as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), and 1923 of the Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of October 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

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

Sincerely,

[redacted]

Director
Financial Management Group

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0015

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
October 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
[redacted] Section 1905(a)(1) of the SSA; 42 CFR 440.10; 42 CFR 447.250

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ [redacted] 5,604,456
b. FFY 2027 $ [redacted] 6,527,716

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Section 4.19-A page 3
Section 4.19-A page 4
Section 4.19-A page 5

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Section 4.19-A page 3 (TN 21-0016)
Section 4.19-A page 4 [redacted] (TN 25-0013)
Section 4.19-A page 5 (TN 20-0008)
Section 4.19-A page 4a (TN 25-0013) - deleted

9. SUBJECT OF AMENDMENT
Inpatient Hospital Long-Term BH Payment

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
Richard Charest

13. TITLE
Secretary, EOHHS

14. DATE SUBMITTED
11/14/25

15. RETURN TO
EOHHS
3 West Road
Cranston, RI 02920

FOR CMS USE ONLY

16. DATE RECEIVED
November 14, 2025

17. DATE APPROVED
November 17, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

Pen and ink changes in Boxes 5, 6 & 8 per state request.

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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. Individuals aged eighteen (18) and older with a diagnosis of severe and persistent mental illness requiring acute hospital level of care for more than sixty (60) days in a Long-Term Behavioral Health Unit (LTBHU)

1. LTBHU services are available to Medicaid-eligible beneficiaries who meet the following criteria:
   a. Based on medical necessity, meet inpatient psychiatric hospital level of care criteria; and
   b. Require extended inpatient psychiatric treatment due to treatment resistance, persistent functional impairment, or clinical instability; and
   c. Have documentation by a licensed practitioner acting within their scope of practice that less restrictive settings have been considered and determined clinically inappropriate; and
   d. Have a person-centered treatment plan that documents eligibility criteria and medical necessity for LTBHU services.

2. LTBHU services include:
   a. 24-hour nursing services;
   b. Psychiatric evaluation;
   c. Medication management;
   d. Development and implementation of the person-centered treatment plan;
   e. Individual, group, and family therapy;
   f. Psychiatric rehabilitation;
   g. Community integration services;

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g. Peer support services; and
h. Care coordination and discharge planning.

3. To qualify for the rate described below, the hospital unit must:
   a. Be within a hospital licensed by the Rhode Island Department of Health (RIDOH) in good standing; and
   b. Have Department of Behavioral Health and Developmental Disabilities (BHDDH) facility status designation in good standing; and
   c. Be designated by the State Mental Health Authority as a Long-Term Behavioral Health Unit, pursuant to the State Mental Health Law; and
   d. Obtain Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation.

4. 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 upon admission to the designated Long-Term Behavioral Health Unit. Effective October 1, 2025, the per diem rate is $1,716. This rate will be increased annually on July 1 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.

p. 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.

q. 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.

r. Select carve-out drugs are excluded from the DRG payment and will be paid at 100% of the Actual Acquisition Cost (AAC). A separate claim will be submitted by the hospital for the reimbursement of these drugs in the manner specified on the listing of selected carve-out drugs that can be found at https://eohhs.ri.gov/providers-partners/provider-directories/pharmacy effective July 1, 2025.

s. 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/ProviderDirectori es/Hospitals.aspx

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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.

The 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 SFY 2019 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 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.