STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

6/29/2016 PUBLIC NOTICE OF PROPOSED AMENDMENT TO RHODE ISLAND MEDICAID STATE PLAN

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

In-patient Hospital Rates

In accordance with Article 7 of the State Fiscal Year 2017 budget enacted by the General Assembly, EOHHS is seeking federal authority to change the inpatient hospital DRG base rate effective July 1, 2016. This change is projected to yield an estimated increase of approximately $782,000 to the aggregate expenditures by the Rhode Island Medical Assistance Program in SFY 2017.

This proposed amendment is accessible on the EOHHS website (www.eohhs.ri.gov) or available in hard copy upon request (401-462-6348 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by July 29, 2016 to Melody Lawrence, Executive Office of Health and Human Services, 74 West Rd, Cranston, RI, 02920, or melody.lawrence@ohhs.ri.gov.

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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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:

a. 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).

b. APR-DRG algorithm. Effective May 5, 2015, the Executive Office of Health and Human Services (EOHHS) will use the most current version of the APR-DRG algorithm.

c. DRG Relative Weights. Effective May 5, 2015, EOHHS will use 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.

d. 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.

e. DRG Payment. The DRG Payment equals the DRG Base Payment plus the DRG Cost Outlier Payment plus the DRG Day Outlier Payment.

f. 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.

g. 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.

h. 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%.

i. 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.

j. 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.

k. Allowed amount. The allowed amount will equal the DRG Payment, with adjustments for transfers or incomplete eligibility as appropriate, plus the Add-on Amount.

l. 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.

m. 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.

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n. 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.

o. 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.

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 National CMS Prospective Payment System (IPPS) Hospital Input Price Index; 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. 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: http://www.eohhs.ri.gov/AboutthisSite/SearchResults.aspx?q=APR+DRG&cx=008299334994399521686%3aey0jk2e4nto&cof=FORID%3a9&safe=inactive.