

**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:

**Out-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 outpatient hospital rates effective July 1, 2016. This change is projected to yield an estimated increase of approximately \$81,000 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](http://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](mailto: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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE  
PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

1. Fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent they are available.
2. Participation in the program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure.
3. Payment for physician, dentist and other individual practitioner services will be equal to the lesser of the billed charge or the State's fee for that service. Fee schedules are posted on the Executive Office of Health and Human Services web site under the Providers and Partners tab: <http://www.eohhs.ri.gov/ProvidersPartners/BillingampClaims/FeeSchedule.aspx>. All governmental and private service providers are reimbursed according to the same published fee schedule. The Medical Assistance Program rates were set as of July 21, 2008 and are effective for services on or after that date.
4. The following is a description of the payment structure by items of service.
  - a. Inpatient hospital services: as described in attachment 4.19A.
  - b. Outpatient hospital services: The Medical Assistance Program will pay for outpatient hospital services using a fee schedule approach based on, but not necessarily identical to, the Medicare outpatient prospective payment system. Specific provisions are as follows:
    1. In general, payment will be by fee schedule, with the fee multiplied by the number of allowable units on the claim line. Fees will be derived as follows:
      - a. For visits, surgeries, imaging procedures, drugs, and other services where Medicare pays hospitals using Ambulatory Payment Classification (APC) groups, the fees are effective for claims with a date of service on or after July 1, 2016. The APC fee schedule can be found on the EOHHS website at the address listed above.
      - b. For physical, occupational, and speech therapy services, Medical Assistance will pay APC fees for these services. The fees are effective for claims with a date of service on or after July 1, 2016. The APC fee schedule can be found on the EOHHS website at the address listed above.
      - c. For laboratory services with dates of service on or after January 1, 2016, payment will be at the non-hospital community laboratory rate. The fees are effective for claims with a date of service on or after January 1, 2016. The fee schedule can be found on the EOHHS website at the address listed above.
      - d. For observation services, Medical Assistance will pay an hourly fee from the 8<sup>th</sup> to the 24<sup>th</sup> hour of observation.
      - e. For any remaining outpatient hospital services covered by Medical Assistance, fees will be based on fees for similar services as identified elsewhere in the State plan. For unlisted services and other rare situations where no fee can be calculated, payment will be at a percentage of charges.
    2. Payment by fee will be modified in the following situations:
      - a. For bilateral services as appropriately designated by the modifier 50, payment will be at 150% of the otherwise applicable amount.
      - b. For drugs covered under Section 340B of the Public Health Service Act as appropriately designated by the modifier UD, payment will be at 100% of billed charges.
    3. Certain types of services are subject to discount payment when a claim contains more than one line showing procedure codes within each type of service. The line with the highest fee will be paid at 100%, the line with the second-highest fee will be paid at 50% of the otherwise-applicable fee, the line with the third highest fee will be paid

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at 25% of the otherwise-applicable fee, and the fourth and all subsequent lines will be paid zero. Discounting will only apply within each type of service. For example, if a claim contains three lines for an x-ray, a CT scan, and an ultrasound, each line will be paid 100%. The seven types of service are as follows:

- a. Significant procedures subject to discounting as designated by Medicare with APC Status "T." (In general, Medical Assistance will use the same list of procedures as Medicare, but specific exceptions may be made.)
  - b. Computed topography scans
  - c. Ultrasound
  - d. X-rays
  - e. Therapeutic radiology
  - f. Nuclear medicine scans
  - g. Magnetic Resonance Imaging
4. Some claim lines will be packaged, that is, the line will be considered paid but with a payment of zero. Packaging will apply to lines with anesthesia and recovery room codes (regardless of procedure code), lines without procedure codes, and lines with procedure codes designated as packaged under Medicare. (In general, Medical Assistance will use the same list of packaged procedures as Medicare, but specific exceptions may be made.)
  5. Out-of-State hospitals will be reimbursed for outpatient surgery services provided to Rhode Island Medical Assistance Recipients at a rate equal to fifty-three (53%) of the out-of-state hospital's customary charge(s) for such services to Title XIX recipients in that state. The outpatient reimbursement for all other services, exclusive of laboratory, imaging, and physicians, will be sixty-four percent (64%) of the outpatient surgery rate.
  6. Payment for all outpatient services will be final, with no year-end settlement process.
  7. Hospital outpatient claims and payments are processed through MMIS.
  8. Only hospitals and provider based entities, in accordance with 42 CFR 413.65, are reimbursed according to the outpatient hospital reimbursement methodology.
  9. Outpatient Supplemental Payment and UPL Calculation
    - a. For the outpatient services provided for the period after July 1, 2009 each hospital as defined in Section 23-17-38.I(c)(1) is paid an amount determined as follows:
      - 1) Determine the sum of all Medicaid payments from Rhode Island MMIS to hospitals made for outpatient and emergency department services provided during each hospital's fiscal year ending during 2008, including settlements.
      - 2) Multiplying the result of (1) above by a percentage consistent with Medicare cost finding principles; and
      - 3) The Outpatient UPL calculation is an estimate of Medicare outpatient cost for private hospitals. Specifically, a ratio of Medicare outpatient costs to Medicare outpatient charges is applied to Medicaid outpatient and emergency room charges to determine total Medicaid cost (the limit). Total Medicaid outpatient and emergency room payments are then subtracted to determine the UPL gap, which is the basis for the size of the outpatient supplemental payment. The UPL gap is calculated using an aggregate of the individual hospital gaps for state owned and operated, non-state owned and operated, and private hospitals. The outpatients UPL calculation is a reasonable estimate of the amount Medicare would pay for equivalent Medicaid services.

Cost information is from each providers Medicare cost report (CMS 2552), Worksheet D, Part V, Column 5, Line 202.

Charge information is from each providers Medicare cost report (CMS 2552), Worksheet D, Part V Columns 2, Line 202.

The UPL is trended for inflation and utilization using CPI-U: Hospital and Related Service – CMS Health Care Indicators, Table 7: Percent Change in Medical Prices, and OP PPS Payment Increase and Market Basket Update

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- 4) Pay each hospital on July 20, October 20, January 20, and April 20 one-quarter of the product created by multiplying the result of (1) above and (2) above.
- c. Payment will be made for rural health clinic services at the reasonable cost rate per visit established by the Medicare carrier. Payment for each ambulatory service, other than rural health clinic services, will be made in accordance with the rates or charges established for those services when provided in other settings.