STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

06/27/2024 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:

Ambulatory Service Centers

EOHHS is seeking approval from the Centers for Medicare and Medicaid Services (CMS) to update the Medicaid State Plan to include the payment methodology for Ambulatory Service Centers and reflect a new payment methodology for dental surgery in ASCs, in accordance with the FY2025 Enacted Budget.

The changes have an effective date of July 1, 2024 and have an estimated fiscal impact of $252,259 in SFY2025 and $299,713 in SFY 2026.

This proposed amendment is accessible on the EOHHS website (www.eohhs.ri.gov) or available in hard copy upon request (401-462-2407 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by July 27, 2024 to Brittany Church, Executive Office of Health and Human Services, 3 West Rd, Cranston, RI, 02920, or Brittany.Church@ohhs.ri.gov or via phone at (401) 462-2407.

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 ten (10) 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.

Original signed by Kristin Pono Sousa, Medicaid Director, Rhode Island Executive Office of Health and Human Services
Signed this 27th day of June, 2024

- "3" on Section B, Items 1, 2, and 3
- "8" on Section E, Item 1
- "4" on Section E, Item 2 and 3
- "18" on Section H, Items 1, 2, and 3

- How to Receive Reimbursement: Submit the adapted MDS on all Medical Assistance clients directly to DXC. All MDS forms must be signed by an R.N., dated, and totaled for each section. Claims submitted for clients meeting the acuity standard should be billed at the correct amount with a modifier.

Note: Some claims may have two modifiers if the client meets the high acuity determination and the service is provided evenings, nights, weekends or holidays.

h. Clinic Services

1. Ambulatory Surgical Centers (ASCs)
   With the exception of code G0330, which is reimbursed at a rate equivalent of 95 percent of Medicare OPPS rate, ASCs are reimbursed according to the agency's fee schedule. The agency's fee schedule rates can be found on the EOHHS website https://eohhs.ri.gov/providers-partners/fee-schedules and were set as of July 1, 2024.

~~h~~i. Dental services: on the basis of a negotiated fee schedule.

~~i~~j. Prescribed drugs, dentures, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by the optometrist, whichever the individual may select.

(1) Outpatient and Specialty Drugs Dispensing Fee and Ingredient Cost

a. Payment for covered outpatient and specialty drugs dispensed to beneficiaries residing in the community includes the drug's ingredient cost plus an $8.96 professional dispensing fee. For drugs reimbursed at the providers' usual and customary charge to the public, there will be no professional dispensing fee added.

b. Payment for outpatient and specialty drugs dispensed to beneficiaries residing in an institutional long-term care facility will include the drug ingredient cost plus a $7.90 professional dispensing fee. For drugs reimbursed as the providers' usual and customary charge to the public, there will be no professional dispensing fee added.

c. The drug ingredient cost reimbursement shall be the lowest of:

i. The National Average Drug Acquisition Cost (NADAC); or
ii. Wholesale Acquisition Cost (WAC) + 0%; or
iii. The Federal Upper Limit (FUL); or
iv. The State Maximum Allowed Cost (SMAC); or
v. First Data Bank Consolidated Price 2 (SWD) – 19%; or
vi. Submitted price; or
vii. The providers' usual and customary (U & C) charge to the public, as identified by the claim charge.

(2) Clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence.

a. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence will include the drug ingredient cost plus $8.96 professional dispensing fee. For drugs reimbursed at the providers' usual and customary charge to the public, there will be no professional dispensing fee included.

b. The drug ingredient cost reimbursement shall be the lowest of:

i. The National Average Drug Acquisition Cost (NADAC); or
ii. Wholesale Acquisition Cost (WAC) + 0%; or
iii. The State Maximum Allowed Cost (SMAC); or
iv. First Data Bank Consolidated Price 2 (SWD) – 19%; or
v. Submitted price; or
vi. The providers' usual and customary (U & C) charge to the public as identified by the claim charge.

(3) 340 B Covered Entities

340B covered entities that fill Medicaid beneficiaries' prescriptions with drugs purchased at the prices authorized under Section 340B of the Public Health Services Act will be reimbursed at the actual acquisition cost for the drug plus a $8.96 professional dispensing fee. Drugs acquired by a covered entity under the 340B program and dispensed by the covered entity's contract pharmacy are not reimbursed.

Facilities purchasing drugs through the Federal Supply Schedule (FSS) or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program will be reimbursed no more than the actual acquisition cost for the drug plus $8.96 professional dispensing fee.

(4) Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) will be reimbursed no more than the actual acquisition cost (as defined in §447.502) for the drug plus a $8.96 professional dispensing fee. Nominal Price as defined in §447.502 of the Code of Federal Regulations, Part 42 means a price that is less than 10 percent of the average manufacturer price (AMP) in the same quarter for which the AMP is computed

(5) Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at 106% of the Average Sales Price (ASP). PADs without an ASP on the CMS reference file will be reimbursed at the provider's acquisition cost. Covered entities using drugs purchased at the prices authorized under Section 340B of the Public Health Services Act for Medicaid members must bill Medicaid their actual acquisition cost (as defined in §447.502).

(6) All Indian Health Service, tribal, and urban Indian pharmacies are paid at the encounter rate (also known as the "OMB Rate" or "IHS All-Inclusive Rate").

(7) Investigational drugs are not a covered service.

(8) Dentures: on the basis of a negotiated fee schedule.

(9) Surgical and prosthetic devices: all payments are made for covered

*The output for First Data Bank's Consolidated Price 2(SWD) is based on the application of the following criteria:

1. If suggested Wholesale Price (SWP) is available, SWP will be output
2. If SWP is not available, WAC will be output.
3. If neither SWP nor WAC are available, Direct Price will be output