

*Global Waiver Change: 12-03-CII*

**Rhode Island Global Consumer Choice Compact Waiver**

**Project Name: Durable Medical Equipment**

**Project Number: 12-03-CII**

**Category II Change**

<b>Date of Request:</b>	May 18, 2012
<b>Proposed Implementation Date:</b>	July 1, 2012

**Fiscal Impact**

	<b>FFY 2012</b>	<b>FFY 2013</b>
<b>State:</b>	(\$120,000)	(\$487,400)
<b>Federal: FMAP calculated @ 52.12% FFY 2012; @51.26 FFY 2013</b>	(\$130,300)	(\$512,600)
<b>Total</b>	(\$250,000)	(\$1,000,000)

**Description of Change:**

Attachment A

**Assurances:**

Attachment B

**Standard Funding Questions:**

Attachment C

## **Attachment A: Description of Change**

Rhode Island is submitting a change request to the Rhode Island Global Choice Compact Waiver, with an effective date of July 1, 2012 to modify the rate paid for Durable Medical Equipment (DME) services. This change is a part of the State Fiscal Year 2012 Budget as passed by the State Legislature.

This change is submitted as a Category II submission.

### **Background**

The Rhode Island Medicaid Program currently reimburses DME vendors at 95 % of the Medicare fee schedule. In 2009 RI Medicaid issued an RFP soliciting bids from DME providers in an effort to receive competitive pricing on five (5) categories of services: Medical Supplies, Medical Equipment, Respiratory Equipment, Orthotics and Prosthetics, and Hearing Aids. After dialogue with the provider community, it was decided to create a 6<sup>th</sup> category for Complex Rehab Equipment. The goal of the selective contracting was to establish 1 or 2 providers that would be able to furnish all the services for the Medicaid FFS population and for those clients who had a primary insurance or were enrolled in a MCO, where the required service was not a covered benefit under their primary medical insurance plan.

As mentioned, the prime goal of selective contracting was to have one provider (when possible) be able to provide all the service that a client might need. However, based on the submitted bids, no one or two vendors were able to supply the required services. In fact, the service would be fragmented among multiple vendors, which in Medicaid's opinion would restrict access for our recipients.

What Medicaid learned through the solicitation is that vendors are willing to accept 85% or less of the Medicare fee schedule as payment for services provided to Medicaid recipients. Based on this information RI Medicaid will begin paying for DME services at 85% of the Medicare fee schedule effective July 1, 2012.

## **Attachment B: Assurances**

### **The State assures the following:**

- This change is consistent with the protections to health and welfare as appropriate to title XIX of the Social Security Act (the Act)
- The change results in appropriate efficient and effective operation of the program, Including Justification and Response to Funding Questions
- This change would be permissible as a State Plan or Section 1915 Waiver Amendment and is otherwise consistent with sections 1902, 1903, 1905, and 1906, Current Federal Regulations, and CMS Policy.

## Attachment C: Standard Funding Questions

1. Section 1903(a)(I) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

**Providers receive and retain the total Medicaid expenditures claimed by the State. No portion of the payments is returned to the State, local governmental entity, or any other intermediary organization**

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation were not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the nonfederal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
  - (i) a complete list of the names of entities transferring or certifying funds;
  - (ii) the operational nature of the entity (state, county, city, other);
  - (iii) the total amounts transferred or certified by each entity;

- (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations)

**The State share is funded through general revenue funds appropriated by the legislature for this purpose.**

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

**No supplemental or enhanced payments are made.**

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

**N/A**

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

**No governmental providers receive payments that in the aggregate exceed their reasonable costs of providing services.**