

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State South Carolina

STANDARDS AND METHODS OF ASSURING HIGH QUALITY

- I. Standards and methods of assuring high quality of medical remedial care and services used by the South Carolina Health and Human Services Finance Commission (HHSFC) are: State Licensure Laws, Accreditation Surveys, Certification Surveys, Peer Review, the Professional Review Organization, the Medical Care Advisory Committee, Provider Contracts, Reimbursement Policies, and Surveillance and Utilization Review. The use of these standards and methods as they apply to each covered services is listed below.
- II. COVERED SERVICES:
- A. Hospital services, other than services in an institution for tuberculosis or mental diseases.
1. Licensing and certification by the Department of Health and Environmental Control (DHEC) is required for in-state hospitals.
  2. Licensing and certification by the officially designated authority for state standard setting is required for out of state hospitals.
  3. Inpatient hospital utilization review services are performed under contract with a Peer Review Organization (PRO).
  4. HHSFC monitors PRO activities.
  5. Provider contracts are executed for services and prospective payment rates based on DRGs for inpatient hospital services and a fee schedule for outpatient hospitals services.
  6. Advice about health and medical services is provided to HHSFC by the Medical Care Advisory Committee (MCAC).
  7. Policy and billing procedures are sent to providers in Provider Manuals and Bulletins by HHSFC.
  8. ICD-9 diagnosis and surgical procedure codes are required by HHSFC.

B. Rural Health Clinic Services

1. Certification for Medicare by DHEC is required.
2. Provider contracts are negotiated with appropriate standards for allowable costs by HHSFC.
3. Advice about health and medical services is provided to HHSFC by the Medical Care Advisory Committee.
4. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by HHSFC.
5. ICD-9 Diagnostic Codes are required by HHSFC.
6. Surveillance and Utilization Review will be conducted by HHSFC using class group exception profiles, patterns of service provision, recipient profiles, and if necessary, treatment analyses, on-site visits and Peer Review.

C. Other Laboratory and X-RAY Services:

1. Certification for Medicare by DHEC is required.
2. Provider contracts are negotiated with appropriate standards for allowable costs by HHSFC.
- 3.

D. Nursing Facility Services for Individuals Age 21 and Older (Other Than Services in An Institution for Tuberculosis or Mental Diseases). EPSDT, and Family planning services and supplies.

1. Nursing Facility Services:

- a. Licensure by DHEC is required.
- b. Certification by DHEC is required.
- c. Concurrent quality assurance, concurrent review and medical care evaluation studies are based upon Survey and Certification reports, auditing of PASARR compliance and case mix validation sampling, all conducted under contract with DHEC.
- d. Provider contracts are negotiated with appropriate standards for allowable costs by SHHSFC.
- e. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
- f. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
- g. Surveillance and Utilization Review will be conducted by SHHSFC using Survey and Certification reports, PASARR compliance audit reports and validation of resident case mix classifications, all accomplished through sampling conducted under contract with DHEC. If necessary, treatment analyses, on-site visits, and Peer Review are utilized.

2. EPSDT Services:

- a. Provider contracts are negotiated with appropriate standards for allowable costs and screening protocols by SHHSFC.
- b. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
- c. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
- d. ICD-9 and CPT-4 diagnostic and procedure codes are required by SHHSFC.
- e. Surveillance and Utilization will be conducted by SHHSFC using class group exception profiles, patterns of service provision, and recipient analyses, on-site visits, and Peer Review.

3. Family Planning Services and Supplies:
  - a. Provider contracts are negotiated with appropriate standards for allowable costs by SHHSFC.
  - b. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
  - c. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
  - d. ICD-9 and CPT-4 Diagnostic and Procedure Codes are required by SHHSFC.
  - e. Surveillance and Utilization Review will be conducted by SHHSFC using class group exception profiles, patterns of service provision, and recipient profiles and if necessary, treatment analyses, on-site and Peer Review.

E. Physician's Services:

1. Physician's Services:
  - a. Licensure by the State Board of Medical Examiners of South Carolina is required.
  - b. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
  - c. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
  - d. ICD-9 Diagnostic and CPT-4 and HCFA Supplemental Procedure Codes are required by SHHSFC.
  - e. Surveillance and Utilization Review will be conducted by SHHSFC using class group exception profiles, patterns of service provision and recipient profiles, and if necessary, treatment analyses, on-site visits, and Peer Review.
2. Community Mental Health Services:
  - a. Provider contract is negotiated with appropriate standards for allowable costs and services by SHHSFC.
  - b. Advice about health and medical services is provided to SHHSFC by Medical Care Advisory Committee and S. C. Department of Mental Health.
  - c. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.

- d. ICD-9 Diagnostic and CPT-4 and HCFA Supplemental Procedure Codes are required by SHHSFC.
  - e. Surveillance and Utilization Review will be conducted by SHHSFC using class group exception profiles, patterns of provision, and recipient profiles, and if necessary, treatment analyses, on-site visits, and Peer Review.
- F. Medical or Other Remedial Care Providers by Licensed Practitioners:
- 1. Podiatrist's Services:
    - a. Licensure by the State Board of Podiatry Examiners is required.
    - b. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
    - c. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
    - d. ICD-9 Diagnostic and CPT-4 and HCFA Supplemental Procedure Codes are required by SHHSFC.
    - e. Surveillance and Utilization Review will be conducted by SHHSFC using class group exception profiles, patterns of service provision, and recipient profiles, and if necessary, treatment analyses, on-site visits, and Peer Review.
  - 2. Optometrist's Services:
    - a. Licensure by the South Carolina Board of Examiners in Optometry is required.
    - b. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
    - c. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
    - d. ICD-9 and Vision Care Diagnostic and Procedure Codes are required by SHHSFC.
    - e. Surveillance and Utilization Review will be conducted by SHHSFC using class group exception profiles, patterns of service provision, and recipient profiles, and if necessary, treatment analyses, on-site visits, and Peer Review.

## F. Medical or Other Remedial Care Provided by Licensed Practitioners:

## 3. Licensed Midwives' Services:

- a. Licensure by the Department of Health and Environmental Control is required.
- b. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
- c. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
- d. ICD-9 Diagnostic and CPT-4 and HCFA Supplemental Procedure Codes are required by SHHSFC.
- e. Surveillance and Utilization Review will be conducted by SHHSFC using class group exception profiles, patterns of service provision, and recipient profiles, and if necessary, treatment analyses, on-site visits, and Peer Review.

## G. Home Health Services:

1. Certification for Medicare by DHEC is required.
2. Provider contracts are negotiated with appropriate standards for allowable costs by SHHSFC.
3. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
4. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
5. ICD-9 and Home Health Diagnostic and Procedure Codes are required by SHHSFC.
6. Surveillance and Utilization Review will be conducted by SHHSFC using class group exception profiles, patterns of service provision and recipient profiles, and if necessary, treatment analyses, on-site visits and Peer Review.

## H. Dental Services:

1. Licensure by the South Carolina State Board of Dentistry is required.
2. Advice about dental services is provided to SHHSFC by the Dental Advisory Committee.
3. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.

4. ICD-9 and Dental Diagnostic and Procedure Codes are required by SHHSFC.
  5. Surveillance and Utilization Review will be conducted by SHHSFC using class group exception profiles, patterns of service provision, and recipient profiles, and if necessary, treatment analyses, on-site visits, and Peer Review.
- I. Prescribed Drugs, Dentures, Prosthetic Devices, and Eyeglasses:
1. Drug Services:
    - a. Licensure by the State Board of Pharmaceutical Examiners is required for dispensing.
    - b. Licensure by appropriate State Boards is required for prescribing.
    - c. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee, the Drug Formulary Advisory Committee, and the Pharmacist Advisory Committee.
    - d. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
    - e. Drug Procedure Codes are required by SHHSFC.
    - f. Surveillance and Utilization Review will be conducted by SHHSFC using class group exception profiles, patterns of service provision, and recipient profiles, and if necessary, treatment analyses, on-site visits, and Peer Review.
  2. Durable Medical Equipment:
    - a. Licensure by appropriate State Boards is required for prescribing.
    - b. Provider contracts are negotiated with appropriate standards for allowable costs by SHHSFC.
    - c. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
    - d. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
    - e. DME Procedure Codes are required by SHHSFC.
    - f. Surveillance and Utilization Review will be conducted by SHHSFC using class group exception profiles, patterns of service provision, and recipient profiles, and if necessary, treatment analyses, on-site visits and Peer Review.

- J. Inpatient Hospital Services, Nursing Facility Services and Nursing Facility Services in Institutions for Mental Diseases (IMDs) for Individuals Age 65 or Older.
1. Certification for Medicare by DHEC is required.
  2. Concurrent quality assurance, concurrent review and medical care evaluation studies are based upon inspection of care by DHEC for hospitals and hospital IMDs. Concurrent quality assurance, concurrent review and medical care evaluation studies for nursing facilities are based upon Survey and Certification reports, auditing of PASARR compliance, and case mix validation sampling, all conducted under contract by DHEC.
  3. Provider contracts are negotiated with appropriate standards for allowable costs by SHHSFC.
  4. Advice about health and medical services is provided by SHHSFC by the Medical Care Advisory Committee.
  5. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
  6. Surveillance and Utilization Review will be conducted by SHHSFC using Survey and Certification Reports, PASARR compliance audit reports, and validation of resident case mix classifications, all accomplished through sampling conducted under contract with DHEC. If necessary, treatment analysis, on-site visits, and Peer Review are utilized.
- K. Intermediate Care Facility Services/Department of Mental Retardation:
- a. Licensure by DHEC is required.
  - b. Certification by DHEC is required.
  - c. Concurrent quality assurance, concurrent review, and medical care evaluation studies are conducted by the Department of Mental Retardation or are based upon Inspection of Care by DHEC.
  - d. Provider contracts are negotiated with appropriate standards for allowable costs by SHHSFC.
  - e. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
  - f. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
  - g. Surveillance and Utilization Review will be conducted by SHHSFC using recipient profiles and if necessary, treatment analyses, on-site visits, and Peer Review.

- L. Inpatient Psychiatric Services for Individuals Under Age 21:
1. Accreditation by the Joint Commission for Accreditation of Health Care Organizations is required for Psychiatric Hospitals. For Psychiatric Residential Facilities, accreditation by the Joint Commission for Accreditation of Health Care Organizations; or the Commission on Accreditation of Rehabilitation Facilities; or the Council on Accreditation is required.
  2. Licensing and certification by DHEC is required for instate psychiatric hospitals. Instate Psychiatric Residential Treatment Facilities must hold valid and current DHEC licensure. For Psychiatric Residential Treatment Facilities, licensing is applicable April 1, 1994.
  3. Licensing, when required by state regulations, and certification by the officially designated authority for state standard setting is required for out of state psychiatric hospitals and psychiatric Residential Treatment Facilities.
  4. Provider contracts are negotiated with appropriate standards for allowable costs by SCDHHS.
  5. Advice about health and medical services is provided to SCDHHS by the Medical Care Advisory Committee.
  6. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
  7. ICD-9 Diagnostic and Procedure Codes are required by SCDHHS.
  8. Utilization Review of inpatient psychiatric services for individuals under age 21 is performed under contract with a Peer Review Organization (PRO).
  9. SCDHHS monitors PRO activities.
  10. Prior approval of all inpatient psychiatric facility services and psychiatric residential treatment facility placements will be required in order to verify medical necessity. All requirements described at 42 CFR 441.152 will be met.
- M. Any Other Medical Care or Remedial Care Recognized Under State Law and Specified by the Secretary:
1. Transportation Services:
    - a. Provider contracts are negotiated with appropriate standards for allowable costs by SCDHHS.
    - b. Advice about health and medical services is provided by SCDHHS by the Medical Care Advisory Committee.
    - c. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SCDHHS.

2. Nursing Facility Services for Individuals Under Age 21:
  - a. Licensure by DHEC is required.
  - b. Certification by DHEC is required.
  - c. Concurrent quality assurance, concurrent review and medical care evaluation studies are based upon Survey and Certification Reports, auditing of PASARR compliance and case mix validation sampling, all conducted under contract with DHEC.
  - d. Provider contracts are negotiated with appropriate standards for allowable costs by SHHSFC.
  - e. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
  - f. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
  - g. Surveillance and Utilization Review will be conducted by SHHSFC using Survey and Certification Reports, PASARR compliance audit reports, and validation of resident case mix classifications, all accomplished through sampling conducted under contract with DHEC. If necessary, treatment analyses, on-site visits, and Peer Review are utilized.
3. Emergency Hospital Services:
  - a. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
  - b. ICD-9 Diagnostic and Procedure Codes are required by SHHSFC.
  - c. Surveillance and Utilization Review will be conducted by SHHSFC using recipient profiles, and if necessary, on-site visits, and Peer Review.
4. Personal Care Aide Services:
  - a. Provider contracts are negotiated with appropriate standards for allowable cost by SHHSFC.
  - b. Advice about health and medical services is provided to SHHSFC by the Medical Care Advisory Committee.
  - c. Reimbursement policy and criteria are disseminated to providers in Provider Manuals and Bulletins by SHHSFC.
  - d. Surveillance, Utilization and Compliance Reviews will be conducted by SHHSFC and DHEC, through contractual agreement, using class group exception profiles, patterns of service provision, recipient and analyses, on-site visits, and Peer Review.

**ALTERNATIVE BENEFITS**

**STATE PLAN AMENDMENT  
BENCHMARK BENEFIT PACKAGE  
BENCHMARK EQUIVALENT BENEFIT PACKAGE**

1937(a), Section 1937(b)      X / The State elects to provide alternative benefits under 1937 of the Social Security Act.

A. Populations

The State will provide the benefit package to the following populations:

- a.    / Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006, will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals exempted from such a requirement.

List the population(s) subject to mandatory alternative coverage:

X / Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

List the populations/individuals who will be offered opt-in alternative coverage:

<b>Eligibility Group</b>	<b>Statutory Citation</b>
Transitional Medical Assistance	Section 1902(a)(10)(A)(i)(I)/Section 1925
General Hospital	Section 1902 (a)(10)(A)(ii)(I)
TEFRA - Katie Beckett Children	Section 1902(e)(3)
Breast and Cervical Cancer Program	Section 1902(a)(10)(A)(ii)(XVIII)
Partners for Healthy Children	Section 1902(a)(10)(A)(i)(VI) and (VII)
Working Disabled	Section 1902(a)(10)(A)(ii)(XIII)
Pregnant Women and Infants	Section 1902(a)(10)(A)(i)(IV)
Aged, Blind and Disabled	Section 1902 r(2)(A)
Section 1931 Low Income Families	Section 1902(a)(10)(A)(i)(I) and Section 1931
SSI	Section 1902(a)(10)(A)(i)(II)
Pass-along Categories	Section 1634(b), (c) and (d), Section 503 of Public Law 94-566
Ribicoff	Section 1902(a)(10)(A)(i)(I)

For the opt-in populations/individuals, describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

**Beneficiary Counselors:** Independent of this option, a beneficiary counselor program is being implemented in the State to assist client selection of appropriate delivery models. The counselor will discuss this option with the beneficiary at time of application, provide a comparison of the alternative plan to the regular Medicaid program, make sure the beneficiary knows that participation in the alternate plan is optional. The beneficiary will also be informed that after selection of the alternate plan, the beneficiary has the right to return to the regular Medicaid plan at any time. The member contacts the broker to request the change and it is effective the first day of the following month.

For the opt-in populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.

**SEE ATTACHMENT 1 to ATTACHMENT 3.1-C**

c. X/ Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

List any geographic variations:

Initial implementation in Richland County.

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography limitations, or any other requirements or limitations.

Initial enrollment limited to 1000 beneficiaries in Richland County.

The State understands that the implementation of the 1000 volunteers cannot discriminate on the basis of sex, race, color, national origin, handicap, disability and age. The State will operationalize the 1000 volunteer limit by:

- Enrolling volunteers on a first come, first serve basis
- Establishing a waiting list should volunteers exceed 1000
- As volunteers withdraw or are otherwise removed from the program, the next beneficiary on the waiting list will be contacted to determine continued interest in the plan
- If the volunteer indicates continued interest, the plan is again reviewed to ensure understanding of the differences from regular Medicaid and the member is enrolled for the next month.

B. Description of the Benefits

  X   / The State will provide the following alternative benefit packages (check all that apply).

1937(b)

1.   X   / Benchmark Benefits

a.      / **FEHBP-equivalent Health Insurance Coverage** - The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(1) of Title 5, United States Code.

b.   X   / **State Employee Coverage** - A health benefits coverage plan that is offered and generally available to State employees within the State involved. The State has sought to make this plan as close as possible to the Standard State Health Plan. Certain policy exceptions apply:

- There is no pre-existing condition;
- Maternity coverage for dependent is provided;
- Pharmacy payments are made without payment from the beneficiary (pass through).

Additionally, the following chart describes differences/limitations in coverage between Medicaid State Plan and the Benchmark Plan.

Purpose: This chart identifies the differences in coverage between the Medicaid State Plan and the Benchmark Plan.

Service	State Health Plan	Medicaid
Ambulance	No benefits are payable for service used for routine, non-emergent transportation including but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment.	Emergency transport or non-emergency transport to a non-scheduled medical service (i.e. transport from nursing home to hospital, home to hospital or scene to hospital) or when the beneficiary is non-ambulatory and a health care professional certifies that the health condition requires an ambulance.
Chiropractor	Neuromuscular condition only; spinal axis aches, sprains, nerve pains and functional disabilities of the spine; limited to \$500/year after annual deductible met.	Manual manipulation of the spine, to correct a subluxation identified by x-ray; 1 treatment/visit, 1 visit/day, 12 visits/year, 2 x-ray/year.
Complications of non covered service, including complications from a covered person's use of discount services	No benefit	Covered if medically necessary
Over the counter (OTC) medicines	No benefit	Member must obtain a written prescription from their provider for the OTC. The OTC counts in the limit of 4.
Routine physical exams	One per year (including OB-GYN annual)	Once every 5 years.
Smoking cessation or deterrence products	No benefit.	Coverage of certain pharmaceuticals used to facilitate the discontinuance of tobacco products. A written prescription is required.
Out of network service	No benefit	Covers Medicaid covered service provided by a Medicaid enrolled provider

Attach a copy of the State's employee benefits plan package.

SEE ATTACHMENT 2 to ATTACHMENT 3.1-C  
With link to [www.eip.sc.gov](http://www.eip.sc.gov)

c. \_\_\_/ **coverage Offered Through a Health Maintenance Organization (HMO)** - The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved. Attach a copy of the HMO's benefit package.

d. \_\_\_/ **Secretary-approved Coverage** - Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State's plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

2. \_\_\_/ **Benchmark-Equivalent Benefits.**

Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan: .

a. \_\_\_/ The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) using generally accepted actuarial principles and methodologies; 3) using a standardized set of utilization and price factors; 4) using a standardized population that is representative of the population being served; 5) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and 6) takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage. Attach a copy of the report.

b. \_\_\_/ The State assures that if the State provides additional

services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c. \_\_\_/ The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1) \_\_\_/ **Inclusion of Basic Services** - This coverage includes benefits for items and services within the following categories of basic services: (Check all that apply).

- \_\_\_/ Inpatient and outpatient hospital services;
- \_\_\_/ Physicians' surgical and medical services;
- \_\_\_/ Laboratory and x-ray services;
- \_\_\_/ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices
- \_\_\_/ Other appropriate preventive services, as designated by the Secretary.
- \_\_\_/ Clinic services (including health center services) and other ambulatory health care services.
- \_\_\_/ Federally qualified health care services
- \_\_\_/ Rural health clinic services
- \_\_\_/ Prescription drugs
- \_\_\_/ Over-the-counter medications
- \_\_\_/ Prenatal care and pre-pregnancy family services and supplies
- \_\_\_/ Inpatient Mental Health Services not to exceed 30 days in a calendar year
- \_\_\_/ Outpatient mental health services furnished in a State-operated facility and including community-based services
- \_\_\_/ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)
- \_\_\_/ Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements.
- \_\_\_/ Nursing care services, including home visits for private duty

nursing, not to exceed 30 days per calendar year  
\_\_\_/ Dental services  
\_\_\_/ Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year  
\_\_\_/ Outpatient substance abuse treatment services  
\_\_\_/ Case management services  
\_\_\_/ Care coordination services  
\_\_\_/ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders \_\_\_/ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services.  
\_\_\_/ Premiums for private health care insurance coverage \_\_\_/ Medical transportation  
\_\_\_/ Enabling services (such as transportation, translation, and outreach services  
\_\_\_/ Any other health care services or items specified by the Secretary and not included under this section

(2) Additional benefits for voluntary opt-in populations: \_\_\_/ Home and community-based health care services  
\_\_\_/ Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

### 3. Wrap-around/Additional Services

a. X/ The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary. Wraparound benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure early and period screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).

**Any medically necessary services that are identified as a result of an EPSDT screening but not covered by the benchmark plan, will be forwarded to Medicaid for payment.**

b.  / The State has elected to also provide wrap-around or additional benefits.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

C. Service Delivery System

Check all that apply.

1.  / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.

2.  / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1915(b)(1).

3.  / The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirements.

4.  / Alternative benefits provided through premium assistance for benchmark-equivalent in employer-sponsored coverage.

5.  / Alternative benefits will be provided through a combination of the methods described in items 1-4. Please specify how this will be accomplished.

The alternative benefits will be provided through a fee for service basis administered through a Third Party Administrator (TPA) type arrangement. Since the plan is a high-deductible model, claims will be submitted to the TPA for consideration. If the service is a covered service under the State Health Plan, the allowable amount will be reported to the provider, the account manager and the recipient. The allowable amount is based on the State Health Plan fee schedule effective on the date of service. As the State Health Plan fee schedule is updated, it will be used for this option. There will be no agreement between the provider and the State to transfer back to the Medicaid Agency any amount of the payment the provider receives which is in excess of the standard Medicaid fee schedule rate for the service. A deduct for the allowable amount will be made from the recipient's account

by the account manager and remitted to the provider. If the member obtains services that are not covered, the amount will not count toward the deductible nor will a payment be made.

Once the annual deductible of \$3000 for an individual and \$6000 for a family has been met, regular state plan cost sharing rules apply. The TPA will make payments to the providers at its normal fee for service rates. The TPA is not under risk and bills the State a single invoice for the monthly provider payments with a backup file of services and its administrative fee.

The State Health Plan High Deductible plan includes instances of member penalties for inappropriate utilization. For the Medicaid option, these penalties are administrative. Specifically, the member receives a warning letter naming the inappropriate utilization and prescribing proper behavior. The second occurrence will cause the member to be removed from the plan and returned to regular Medicaid.

D. Additional Assurances

a. X/ The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

b. X/ The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).

E. Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

X/ The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

G. Implementation Date

X/ The State will implement this State Plan amendment on April 1, 2007.